BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

PATRICIA SIMMONS, Claimant, v. WINCO FOODS, INC., Employer, and INDUSTRIAL INDEMNITY/ IDAHO INSURANCE GUARANTEE ASSOCIATION, Surety, and LIBERTY NORTHWEST INSURANCE CORPORATION, Surety, Defendants.	)	**IC 2001-008816** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** Filed: September 8, 2009

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 Idaho Falls, Idaho, on August 24, 2007. James C. Arnold of Idaho Falls represented Claimant. Justin P. Aylsworth of Boise represented Employer and Surety Industrial Indemnity/Idaho Insurance Guaranty Association

(II/IIGA).[1] E. Scott Harmon of Boise represented Employer and Surety Liberty Northwest Insurance Corporation (Liberty).[2] The parties submitted oral and documentary evidence at hearing. Two post-hearing depositions were taken and the parties submitted post-hearing briefs. The matter came under advisement on April 13, 2009 and is now ready for decision.[3]

ISSUES

The issues to be heard remained in flux through the lengthy pendency of this proceeding. At the outset of the hearing, the parties agreed that the following issues remained extant:

1. Whether Claimant has complied with the notice limitations set forth in Idaho Code § 72-701 through Idaho Code § 72-706 and whether these limitations are tolled pursuant to Idaho Code § 72-604;

2. Whether Claimant has complied with the notice limitations set forth in Idaho Code § 72-448;

3. Whether Claimant's cause of action is barred by Idaho Code § 72-439;

4. Whether Claimant's cause of action for indemnity benefits is barred by Idaho Code 72-437;

5. Whether the condition or conditions for which Claimant seeks benefits were caused by an accident or injury occurring March 21, 2001;

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[1] Fremont Indemnity Company was the surety on Employer's workers' compensation risk until May 1, 2001, when it was succeeded by Liberty. Fremont subsequently became insolvent and its obligations were assumed by II/IIGA on or about July 2, 2003.

[2] Because Employer is represented by two different sureties in this proceeding, each with different theories of liability, this Recommendation will refer to the parties as Claimant, II/IIGA, and Liberty, and all references to the two sureties will necessarily include the Employer as a co-defendant.

[3] There was a fifteen-month delay between the close of the hearing and the last post-hearing deposition taken in this proceeding. The delay was due to the difficulty of locating and/or scheduling the two physicians' depositions. One of Claimant's physicians had left the Idaho Falls area and was eventually located in Pennsylvania. Claimant's local treating surgeon was difficult to contact and schedule.

6. Whether Claimant suffers from a compensable occupational disease;

7. Whether Claimant's current condition is the result of an accident that occurred or an occupational disease that manifested before May 1, 2001;

8. Whether and to what extent Claimant is entitled to the following benefits:

a. medical care;

b. temporary partial and/or temporary total disability benefits (TTD/TPD);

c. permanent partial impairment (PPI); and

d. disability in excess of impairment;

9. Whether apportionment for pre-existing or subsequent conditions pursuant to Idaho Code § 72-406 is appropriate;

10. Whether Employer and II/IIGA are exempt from any claim related to Claimant's alleged injuries suffered after May 1, 2001; and

11. Whether all and/or part of Claimant's claims against Employer and II/IIGA are barred as a result of the June 5, 2003 lump sum settlement agreement with Liberty.

At hearing, Claimant asserted that the issues of PPI and PPD were not yet ripe for decision, noting, in particular, the opinion of II/IIGA's IME physician. II/IIGA voiced the only concern expressed at hearing about removing the issues from consideration. Given the twenty-month interval between the IME report and the date of hearing, it is surprising that there was no discussion of reserving these two issues during the three pre-hearing conferences that occurred during the period. Nevertheless, in view of the substantial medical information contained in the record, and particularly in light of the fact that II/IIGA ordered the IME, it is clear that Claimant's medical stability remains in question. Therefore, the Referee reserves issues 8c and 8d for determination at some future time when Claimant's medical stability has been determined

and she has received an impairment rating.

CONTENTIONS OF THE PARTIES

CLAIMANT

Claimant asserts that approximately a year after going to work for Employer making pizza, she began to notice occasional numbness, tingling, and mild pain in both her hands. In early 2001, Claimant's symptoms began to worsen, eventually resulting in a March 2001 referral by Employer to a physician who diagnosed bilateral arm and wrist pain, possibly carpal tunnel syndrome (CTS). Based on the diagnosis, Claimant, with the help of Employer, filed a First Report of Injury or Illness on March 23, 2001. Claimant's claim was accepted. Employer referred Claimant to a second physician, who initiated a chain of referral, diagnosis, and treatment that eventually included four treating physicians and a full return to work without restrictions in September 2001. II/IIGA paid for Claimant's treatment until she was released from care. At the time she was released from care, Claimant was still experiencing the identical wrist and hand symptoms with which she originally presented.

Claimant continued to work and continued to experience hand and wrist symptoms. In January 2002, she slipped and fell on a wet floor at work. The fall temporarily exacerbated the pain in her upper extremities, but had resolved by the following morning. Claimant did not report the fall and did not seek medical treatment. In February 2002, Claimant injured her right wrist while at work. She did not initially report the incident, but a supervisor noted her red and swollen right wrist. Employer sent her to a physician who diagnosed a wrist sprain as a result of the fall, but also noted Claimant's bilateral upper extremity complaints dating back to 2001.

During the course of treatment for her wrist sprain, Claimant saw a notice that a new medical clinic was offering free CTS screenings, and frustrated that she was still experiencing

upper extremity pain, she decided to visit. Ultimately, Iris Brossard, M.D., diagnosed bilateral epicondylitis, CTS and bilateral dysfunction of the basal joints of Claimant's thumbs. Claimant underwent bilateral CTS releases and then additional surgeries on both thumbs in an attempt to restore her ability to use her hands. None of Claimant's medical care was paid for by II/IIGA. Claimant or her private insurance paid for the costs of her medical care, or it remains unpaid. At the request of II/IIGA, Troy Watkins, M.D., conducted an IME in December 2005, and opined that Claimant needed an additional surgery to stabilize her right thumb. Dr. Watkins was the last physician Claimant saw for her thumb complaints as of the time of hearing.

Claimant's epicondylitis, CTS and subsequent bilateral thumb dysfunction are occupational diseases brought on by the nature of her work for Employer, incurred in the year following her employment by Employer, manifested in March 2001, and have never completely resolved. Claimant has not worked for Employer since May 12, 2002, because she has not been released to return without restriction—a requirement of Employer. Claimant asserts entitlement to reasonable and necessary medical care, which includes all of the treatment she has received for her bilateral upper extremity complaints since September 2001. Because she has not worked since May 2002, Claimant seeks TTD or TPD benefits, as appropriate, from May 12, 2002 until the time of hearing, and thereafter until she is medically stable.

Finally, Claimant notes that she never asserted that her injuries were the result of an industrial accident, but rather were a repetitive use injury first diagnosed on March 15, 2001 and reported to Employer on March 21, 2001. Therefore, Claimant believes that the issues pertaining to notice and to causation as it relates to accident and injury are not really at issue in this proceeding. Claimant has proven her entitlement to medical and time loss benefits, and it is not her concern which Surety is ultimately responsible for paying her benefits.

DEFENDANTS

Defendant II/IIGA contends that there is no evidence that Claimant's upper extremity complaints were related to her work; instead, they are the result of a non-industrial accident in November 2000, and the two industrial accidents in early 2002, by which time II/IIGA was no longer the Surety for Employer. In any event, II/IIGA cannot be liable on the claim under Idaho Code § 72-437 because Claimant was not disabled from performing her job when II/IIGA went off the risk on May 1, 2001, and cannot be liable under Idaho Code § 72-439 because Claimant's "last injurious exposure" occurred while Liberty was the Surety on the risk. Finally, II/IIGA cannot be liable for any part of the claim because Claimant entered into a lump sum settlement agreement (LSSA) with Liberty for the February 2002 industrial accident, including CTS claims.

Defendant Liberty concurs with Claimant that she has an occupational disease that was caused by her work for Employer and is compensable. Liberty asserts that all of Claimant's upper extremity symptoms relate back to her March 21, 2001 manifestation of bilateral CTS. Neither of her subsequent industrial accidents permanently aggravated or exacerbated her condition, leaving all the liability for Claimant's injuries with the March 2001 Surety, Fremont, now II/IIGA. Further, even if it were determined that Claimant's CTS was the result of the two industrial accidents that occurred in early 2002, Liberty entered into an LSSA with Claimant for the latter of those accidents (the February 2002 wrist sprain), and has no additional liability on the claim.

Finally, Liberty asserts that whereas Claimant has admitted from the outset of this proceeding that her condition arose prior to the issuance of Liberty's policy; and whereas her condition was not worsened or hastened by the industrial accidents that occurred while Liberty had the coverage; and whereas Claimant has failed to establish that Liberty was liable under the

Nelson doctrine; and whereas Claimant entered into an LSSA absolving Liberty of further liability, sanctions should be imposed against both Claimant and II/IIGA for costs and attorney fees for pursuing of a frivolous claim and against Claimant pursuant to the terms of the LSSA.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant, taken at hearing;

2. Joint exhibits 1 through 28; and

3. The post-hearing depositions of Iris Brossard, M.D., taken April 4, 2008, and Heidi Michelson-Jost, M.D. (Jost), taken December 8, 2008.

All objections raised during the post-hearing depositions are overruled. After having considered all the above evidence and the briefs of the parties, the Referee submits the following findings of fact and conclusions of law for review by the Commission.

FINDINGS OF FACT

1. At the time of hearing, Claimant was forty-eight years of age. She lived in Idaho Falls with her husband and two grandchildren, ages 8 and 9, for whom she was the legal guardian.

2. Claimant went to work for Employer in April 1999 as a pizza clerk. Her duties included mixing large batches of pizza dough, making pizzas, putting away freight, taking customer orders and operating the cash register. Claimant testified that she made, on average, between 50 and 100 pizzas on the days that she worked. Although the dough was made in a commercial mixer, Claimant was required to handle the forty pounds of dough, and repetitively used her hands to knead individual balls of dough and flatten them into discs that would then be run through a machine to make them fit the pizza pan. Spreading sauce and applying toppings

was also done manually. Working with the pizza dough and unloading freight were both activities that entailed repetitive use of her hands and wrists. At the time Claimant started working for Employer, she had no prior history of upper extremity complaints.

ONSET OF BILATERAL UPPER EXTREMITY SYMPTOMS

3. Sometime in the early spring of 2000, when Claimant had been working for Employer for about a year, she began to notice that her hands would sometimes "go to sleep" at night. She also experienced occasional numbness, tingling, and pain in both hands. These symptoms occurred frequently enough to be noticeable, but were relatively mild and did not affect her ability to work or perform activities of daily living.

4. In November 2000, Claimant tripped and fell at her home, resulting in a sore and swollen left wrist. Claimant sought medical care from the emergency department at Eastern Idaho Regional Medical Center (EIRMC). X-rays were negative and she was diagnosed with a left wrist sprain. She was given a Velcro splint and anti-inflammatories, and advised to ice and elevate the left upper extremity. Claimant testified that she wore the splint for about a week, that her wrist was fine thereafter and that she had no further problems as a result of the incident. She did continue to experience the numbness, tingling, and mild pain she had first noticed in both hands several months earlier, and her hands continued to "fall asleep" at night.

5. In early 2001, a few months after her fall at home, Claimant's upper extremity symptoms became more frequent and more severe. Her pain became worse, both at night and when lifting. She began to experience more tingling and instances of her hands "going to sleep." Claimant advised her supervisor, Becky Peterson, about the upper extremity problems in late 2000 or early 2001. Ms. Peterson advised Claimant they should revisit the issue if or when Claimant's complaints warranted medical intervention.

6. By March 2001, Claimant was using ice and heat daily after work to try to ease the pain in her upper extremities, which now included her arms, elbows, wrists, and hands. The upper extremity pain was severe and caused her to wake in the night. Claimant told Becky that she wanted to see a doctor, and Becky gave her the name of Daniel McLaughlin, M.D.

MEDICAL CARE

Dr. McLaughlin

7. Claimant saw Dr. McLaughlin on March 15, 2001. Dr. McLaughlin noted tenderness over Claimant's carpal tunnel bilaterally, tenderness up her forearms, and decreased grip strength. His impression was that Claimant had wrist and arm pain and possibly CTS. His treatment plan included anti-inflammatories, heat applied to wrists, and an EMG to check for CTS. Dr. McLaughlin's treatment plan was not implemented because when Claimant reported Dr. McLaughlin's findings to Ms. Peterson on March 21, she suggested they should talk to Mark Wright, an upper-level supervisor. Mr. Wright had Claimant fill out an accident report form and sent her to see James C. Milam, M.D.

Dr. Harris

8. On March 22, 2001, Claimant went to see Dr. Milam, but he was not available. Instead, she saw Michael T. Harris, a partner in the practice. Claimant reported to Dr. Harris that "she has had some numbness in her arms for the last year with occasional pain at night. For the last 3 weeks symptoms have been dramatically increased with pains in her arm aching all night keeping her awake." Exhibit 6, p. 2. On exam, Dr. Harris found that Claimant's complaints were consistent with objective findings. Dr. Harris assessed her problems as a strain in the shoulders, arms and hands. He recommended conservative therapy, including physical therapy, improved body mechanics, a limitation on working above chest level with her arms, and a

twenty-five pound lifting restriction. Dr. Harris was aware of Claimant's fall in November 2000, but attributed no significance to the event because the November 2000 wrist sprain involved her left wrist, whereas he found her right wrist the more symptomatic.

9. Claimant attended three sessions of physical therapy and returned to Dr. Harris on April 5. Neither Claimant nor the therapist believed that physical therapy was having any positive effect. Claimant reported to Dr. Harris that her shoulders were better because of the lifting restrictions and not working with her arms above chest level. On exam, Claimant exhibited marked tenderness over the medial and lateral epicondyle and both elbows, with the left more symptomatic than the right. Claimant had marked tenderness in the carpalmetacarpal joints of her wrists, over the distal ulnar flexor carpiulnaris, and over the ulnar nerve at the wrist with a positive Tinel sign. Dr. Harris also noted "marked tenderness especially on the right wrist over the scaphoid navicular bone. She did fall some months ago and sprained her left wrist, but the right is more symptomatic." *Id.*, at p. 8. Claimant also exhibited decreased grip strength. Dr. Harris diagnosed epicondylitis, bilateral wrist sprain, and pain over the scaphoid bone—likely a result of ulnar nerve inflammation. He put Claimant in Spika wrist splints to immobilize the wrist, the thumb, and the thumb joints. He also prescribed tennis elbow bands and continued her physical therapy. He administered a steroid injection into the left brachial radialis tendon, which provided some relief, albeit more slowly than Dr. Harris expected.

10. Claimant returned to Dr. Harris on April 19. Claimant had been unable to obtain a Spika splint for her right hand, so had been wearing a regular wrist splint on the right. Claimant wore the Spika splint on her left wrist, but had to take it off at work because she needed to use her thumb. Claimant reported that the right upper extremity was getting worse, her left upper extremity was improving, and the steroid injection had not helped her left elbow.

Claimant and Dr. Harris discussed the issue of CTS and he noted that surgery could be an option. He also stated that her "diagnosis [of CTS] is really quite definitive regardless of what ENG [sic] testing may show." *Id.*, at p. 10. Claimant opted to proceed with EMG testing, so Dr. Harris referred her to David C. Simon, M.D., for further testing and treatment.

Dr. Simon

11. Claimant saw Dr. Simon on April 30. Claimant's reported history was consistent with her previous reports. Dr. Simon reviewed Dr. Harris's records and examined Claimant. He found tenderness in the lateral epicondyle and forearm extensor muscle mass and noted that Claimant had pain with resisted wrist extension and passive wrist flexion. Electrodiagnostic testing showed a mildly abnormal study, including borderline CTS bilaterally. Dr. Simon opined that Claimant's predominant problem was lateral epicondylitis/forearm tendonitis which, to date, had been properly treated with medication, physical therapy and steroid injection. Her right upper extremity complaints were consistent with CTS, but electrodiagnostic abnormalities were borderline. Dr. Simon prescribed a steroid taper, terminated her physical therapy in favor of home stretching exercises, restricted her to light-duty work, and told her to wear the wrist splints while at work.

12. Claimant returned to Dr. Simon on May 7. She had completed the steroid treatment and had been wearing her splints at work. She reported some improvement, but could not say whether it was the steroids or the wrist splints that had helped. Claimant stated she was working "light duty," which she explained as doing the same job, but doing it more slowly. On exam, she still had pain in the left lateral epicondyle region and pain in the wrists with resisted extension. In addition, the chart note states, "Carpal Tunnel Syndrome is positive bilaterally." Exhibit 7, p. 5. Dr. Simon advised her to continue with the home exercises, continue wearing the

splints and continue her light-duty work.

13. Claimant saw Dr. Simon again on May 21. She reported continued pain in both arms, worst at the left elbow. Dr. Simon did a steroid injection at the left lateral epicondyle with no immediate change in symptoms. He continued her work restrictions. Claimant returned on May 24 and reported that the steroid injection provided no benefit. Her condition remained essentially unchanged, both by her report and on examination. Dr. Simon opined that since Claimant was not improving, further work-up was needed. He ordered blood tests and a cervical MRI. The testing provided no insight into the cause of Claimant's complaints. When Claimant returned on June 15, her upper extremity pain had not improved with conservative treatment. Dr. Simon referred Claimant to David H. Hume, an orthopedic surgeon, for a consult.

Dr. Hume

14. Claimant saw Dr. Hume on August 2. Her presenting complaints included "[b]urning pain in elbows and forearms and wrists/arms and hands go numb—drop things, knots in arms." Exhibit 3, p. 3. Dr. Hume's examination resulted in findings consistent with those of her previous caregivers: tenderness over the left lateral and medial epicondyle and over the distal portion of the triceps tendon and discomfort in her left wrist. Dr. Hume's opinion was that Claimant had "some muscular soreness that has been magnified by worry and uncertainty as to whether it meant any more serious disease." *Id.*, at p. 5. He narrowed the focus to her left elbow and ordered an MRI, but told her that if the MRI were normal:

> my advice would be that these findings are normal parts of the muscular aches of every day life and that the numbness and tingling we cannot explain based so far on electromyographic testing and that at this stage, surgical treatment is inappropriate.

Id.

15. Claimant returned to Dr. Hume on September 17. The chart note states that the

MRI of the left elbow was "normal," although it did show "some minimal signal change in the extensor tendon." *Id.*, at p. 6. Claimant advised Dr. Hume that she continued to experience migratory pain in her arms and both wrists. Dr. Hume released Claimant from care with no restrictions and told her she should return to her normal activity and have lab and perhaps EMG testing repeated in three months. At hearing, Claimant described her visits to Dr. Hume:

> A. When he came in the room, he was ranting at me that I didn't have carpal tunnel even though he had the test in his hand. He said that he had carpal tunnel; that I didn't have carpal tunnel. He said since I was still complaining about pain in my left elbow, he would do an MRI to see if there was something there, any kind of disease or anything. And then when he got that result back, he told me, "It's abnormal," but I would get over it.
>
> And then he pretty much dismissed me.
>
> Q. How many times did you see Dr. Hume? Do you recall.
> A. I don't remember.
> Q. Did Dr. Hume tell you to continue working?
> A. He sent me back to work with no limitations even though I was still in the same pain I was in to begin with.

Tr., pp. 44-45. Claimant's deposition testimony was in a similar vein. Claimant's Depo., pp. 70-72. Claimant testified that at the time she was released by Dr. Hume, "I was still having the same pain in my elbows, the same pain and numbness and my hands going to sleep, the numbness in my wrist and hands. I was having the exact same symptoms I was having before." Although she returned to work, Claimant had difficulty completing her job duties. Her hands were weak, and she often dropped things. Ms. Peterson was aware of Claimant's problems and cut back her hours in an effort to accommodate her.

JANUARY 2002 INCIDENT

16. In January 2002, Claimant slipped and fell on a wet floor at work. At the time of the fall, Claimant had kitchen equipment in each hand. She did not drop the equipment in the fall, but did hit her right hand on a table and her left hand on the floor. She experienced immediate pain in her upper extremities, particularly her hands and wrists, that brought tears to

her eyes, but she got up and finished her duties. By the next morning, Claimant's acute symptoms had resolved and her symptoms "were the same as before the fall. They weren't intensified. I went on with my job just like I had before." Tr., p. 47. Claimant did not report the accident nor did she seek medical treatment.

FEBRUARY 19, 2002 INCIDENT

17. On February 19, 2002, Claimant was unloading thirty-pound boxes of pizza sauce from a pallet on the floor and placing them on a cart so they could be moved to the pizza preparation area. She had already put away a lot of freight, and her hands were weak. In the course of lifting one of the boxes of sauce, Claimant's left upper extremity gave out, knocking Claimant off balance and causing her to hit her right upper extremity, just above the wrist on the top of her arm, between the box of sauce and boxes already on the cart. As a result of the incident, Claimant's right arm appeared red and swollen. Claimant did not think much more about the incident until a supervisor noticed the redness and swelling later that same day and asked what had happened. When told about the incident, the supervisor insisted that Claimant file an accident report and seek medical care.

Dr. Perttula

18. Employer referred Claimant to Eric W. Perttula, M.D., for care of her February 19, 2002 right upper extremity injury. Claimant saw Dr. Perttula for the first time on February 25. Her presenting complaint was pain and swelling in her right wrist area as the result of being hit by a box of pizza sauce. Claimant also told Dr. Perttula that she had a two-year history of left wrist pain and a positive EMG test. On exam, Dr. Perttula found tenderness and swelling of the right wrist and positive Tinel and Phalen signs on the left wrist. He ordered x-rays of the right wrist and ultimately diagnosed a sprain. He prescribed anti-inflammatories and a splint for the

right wrist.

19. Claimant returned to Dr. Perttula on March 22. The chart note records no change in Claimant's bilateral wrist pain since the first visit. Claimant exhibited tenderness bilaterally on exam and positive Tinel and Phalen signs on the left. Dr. Perttula's diagnosis was bilateral wrist strain and probable bilateral CTS. The chart note also mentions that in the interval since her first visit, Claimant had seen Dr. Brossard and had a repeat EMG. Dr. Perttula continued Claimant on anti-inflammatories, advised her to continue with the wrist splint, asked her to provide him a copy of the recent EMG results and included a note to consider a referral to an orthopedist.

20. Claimant saw Dr. Perttula again on April 8. He reviewed the most recent EMG results and noted mild to moderate medial neuropathy and mild ulnar neuropathy bilaterally. On exam, Claimant had positive Tinel and Phalen tests bilaterally. Dr. Perttula recommended that Claimant continue with physical therapy and follow up with the orthopedic referral as ordered by Dr. Brossard.

21. Claimant's last visit with Dr. Perttula was April 23, following which he transferred Claimant to the care of Dr. Brossard. At that time, Claimant advised that she was scheduled for right CT release surgery on May 13. Dr. Perttula's diagnosis remained the same—bilateral wrist sprain and probably CTS bilaterally.

22. Claimant did not believe that she sustained any new injury as a result of the pizza box hitting her wrist. Neither did she believe that the pizza box incident worsened her upper extremity symptoms, nor did it accelerate their progression. On June 9, 2003, Claimant entered into an LSSA with Liberty regarding the February 2002 incident. The LSSA included medical costs of $581.75 paid by Liberty and $2,000 as lump sum consideration, value of disputed

benefits and waiver of right to appeal. The LSSA was approved by the Commission on June 26, 2003.

Dr. Brossard

23. While under the care of Dr. Perttula, Claimant saw a notice that Dr. Brossard was opening a practice and was offering a free screening for CTS. She decided she should take advantage of the opportunity to see if Dr. Brossard agreed that she had CTS and whether Dr. Brossard could help her with her by now long-standing upper extremity symptoms.

24. Claimant first saw Dr. Brossard on March 15, 2002. The chart note includes a history that is consistent with the previous medical records and Claimant's prior reported history. On exam, Dr. Brossard noted positive Tinel's signs at the wrist bilaterally, mild atrophy of the right thenar eminence, decreased strength of the opponens pollicis (one of the muscles that allows the thumb to move in opposition) bilaterally, but greater on the right, and decreased response to pin prick in the first three to four fingers in each hand. Dr. Brossard diagnosed "probably bilateral carpal tunnel syndromes, lateral epicondylitis and myofascial pain syndrome." Ex. 9, p. 2. She referred Claimant to physical and occupational therapy with trigger point therapy and ordered new nerve conduction studies of both arms for comparison. The studies were conducted the same day and the findings were "consistent with mild to moderate median neuropathies and mild ulnar neuropathies bilaterally." *Id.*, at p. 4. Dr. Brossard also advised that Claimant should wear her splints if she was able to tolerate them.

25. Claimant returned to see Dr. Brossard on April 1. She had seen the physical therapist, but not the occupational therapist, which Dr. Brossard opined was a priority. Dr. Brossard's chart note sums up Claimant's situation:

> She has apparently really been around the block with this before being told by some doctors that she has carpal tunnel syndrome and by others that she did not. She has worn splints for a long time without much relief.

Id., at p. 5. Dr. Brossard wanted Claimant to continue therapy and get in to see the occupational therapist. Dr. Brossard also referred Claimant to Dr. Jost for a surgical consult regarding the bilateral CTS.

26. Sometime after her visit to Dr. Brossard, Claimant moved from her position as pizza clerk to a checker job in an attempt to accommodate her upper extremity complaints. Claimant reported that she was doing much better with the change of job.

27. Claimant returned to see Dr. Brossard on April 29. She had seen Dr. Jost and was scheduled for right CTS release on May 13. Claimant saw Dr. Brossard again on July 10, August 5, and September 17. Claimant received no further treatment from Dr. Brossard on these visits, as her care was being supervised primarily by Dr. Jost.

Dr. Jost

28. Claimant saw Dr. Jost for the first time on April 11, 2002. The history recorded in the chart note is consistent with prior records and Claimant's previous statements regarding the onset and treatment of her upper extremity symptoms. Claimant's presenting complaints included:

> Paresthesias in the (R) hand and the first through third digits 24/7 and in the (L) hand the first through third digits about 50% of the time. She also complains of pain at the (L) basal joint [thumb].
>
> * * *
>
> In addition to her hand and wrist complaints, [Claimant] has been treated for (L) lateral epicondylitis which has been injected about three times over the past year. She has been attending physical therapy for this and is improving.

Ex. 10, p. 2. On exam, Dr. Jost noted a positive grind test at the left basal joint as well as mild subluxation, tenderness in the tendon and muscles that permit opposition of the left thumb and

crepitus at the base of the middle digit on the left, positive Tinel's signs on the right into the palm, and localized at the elbow, and a positive Phalen's test bilaterally. Dr. Jost also reviewed the EMG results performed by Dr. Brossard and the bilateral wrist x-rays. Most notable on the wrist x-rays was a decrease in joint space at the left basal joint, along with some spurring at the joint. Dr. Jost's diagnosis was bilateral median neuropathy at the wrist, right greater than left, left basal joint synovitis, and mild subluxation. In light of Claimant's worsening symptoms and the failure of conservative care, Dr. Jost recommended a right median nerve decompression. She would continue to monitor the left wrist and Claimant should continue to wear the left wrist splint at night. Dr. Jost also performed a steroid injection into Claimant's left basal joint with immediate relief, and sent her to occupational therapy to have a thumb Spika splint made.

29. Claimant continued to work for Employer as a checker through May 12, 2002, the day before her first CTS surgery.

30. Although Dr. Jost continued to treat Claimant through May 2005, including several surgeries, the following information fairly summarizes Dr. Jost's course of treatment and its effects on Claimant's condition:

- May 13 – June 5, 2002—Right CT release leading to resolution of all CTS symptoms; increased complaints of left median nerve compression;
- June 18 – August 14 2002—Left median nerve decompression and left basal joint injection with immediate resolution of all CTS symptoms on the left; residual pain on the left thenar and hypothenar eminences and continued pain and discomfort in bilateral basal joints diagnosed as bilateral basal joint synovitis and subluxation and confirmed by imaging; basal joint complaints do not respond to conservative therapy; stabilization surgery planned;

- August 20, 2002—Left basal joint reconstruction/stabilization;
- August 28 – December 4, 2002—Claimant recovering from left basal joint stabilization; continues to have symptoms at right basal joint; splints, occupational and physical therapy and steroidal injections in right thumb have not helped;
- December 10, 2002—Right basal joint reconstruction/stabilization;
- December 11, 2002 – April 2003—Claimant recovering from right basal joint reconstruction; continues therapy for left basal joint reconstruction. Left thumb doing extremely well until sometime in April 2003 when tearing of the left thumb metacarpophalangeal joint (MCPJ) occurred; possible bilateral injections to basal joints, but no medical record of the visit;
- May 28, 2003—Follow-up bilateral basal joint reconstruction; "The patient last seen 1 month prior with an episode of tearing at the (L) thumb MCPJ. Since that time has had marked discomfort in the (L) thumb, unable to wean out of her splint." *Id.*, p. 49; right basal joint remains mildly symptomatic; x-rays show degenerative changes now present in the left basal joint; left basal joint steroid injection with immediate relief;
- June 25, 2003—Continued improvement of right basal joint; continued degeneration of left basal joint not responding to conservative therapy; discussed surgical procedure, ligament reconstruction and tendon interposition (LRTI).
- July 15, 2003—LRTI surgery, and MCPJ capsulodesis on left basal joint;
- July 16-November 12, 2003—Normal recovery from left basal joint LRTI and MCPJ capsulodesis; pain increasing in right basal joint likely due to overuse, not responding to conservative treatment; plan for right LRTI with flexor carpis radialis (FCR) tendon graft;

- November 18, 2003—Right LRTI with FCR tendon graft;
- November 19, 2003 – March 17, 2004—Recovery from right LRTI; rehabilitation on left LRTI completed; begins strengthening therapy on right LRTI;
- May 10, 2004- March 2005—Claimant continues with occupational therapy on her right hand; occasional pain in right wrist and thumb with overuse diagnosed as thumb MCPJ synovitis, and scaphoid tenderness; Claimant also has a flare-up of lateral epicondylitis on the right; continues therapy to address all three issues and right lateral epicondylitis resolves;
- March 7, 2005—MRI of right wrist shows erosive changes at base of first metacarpal, along the distal pole of the scaphoid and along the margins of the trapezoid, along with fluid in the mid-carpal row and an atrophic FCR tendon; diagnosis is scaphotrapezial cyst; consider injection under fluoroscopy at trapezoidal scaphoid articulation;
- March 15, 2005—Injection of right scaphotrapezial cyst under fluoroscopy;
- April 4, 2005—Injection into right scaphotrapezotrapezoidal joint (STTJ); occupational therapy discontinued; Claimant referred to Douglas T. Hutchinson at University of Utah for consultation;
- April 18, 2005—Claimant seen by Dr. Hutchinson, who tries a diagnostic injection into Claimant's carpometacarpal joint (CMCJ) with no relief. Dr. Hutchinson concluded that there were no further surgical options available to Claimant, although he could not identify the cause of her continuing symptoms on the right. Dr. Hutchinson recommended a permanent splint to be used prn., and opined that she was ready to be rated for permanent impairment.
- May 3, 2005—Claimant's last visit to Dr. Jost, who agreed with Dr. Hutchinson.

DR. WATKINS

31. At the request of Defendants, Claimant saw Troy B. Watkins, Jr., M.D., on December 7, 2005 for an independent medical exam (IME). Dr. Watkins reviewed Claimant's medical records, took additional x-rays, and examined Claimant. Based on her complaints and the new x-rays, Dr. Watkins determined that when Claimant used her thumb to pinch, there was a collapse of joint space so that her trapezioscaphoid joint was compromised. Dr. Watkins opined that Claimant's pain was the result of the compromised joint resulting from laxity of the ligamentous stabilization during her previous surgery. He proposed three potential treatment options: Do nothing and live with the pain; splint the right wrist and thumb; or perform a surgical stabilization of the right thumb. While he could not guarantee a good outcome with the surgical option, he did not think that the non-surgical options were satisfactory either. Claimant would like to have the stabilization surgery, but had not done so at the time of hearing.

CREDIBILITY

32. Claimant is a particularly credible individual. She was consistent in what she told the doctors, in reporting her symptoms, and in her testimony. Although she saw a number of care providers over a lengthy period of time, she maintained a good grasp of the chronology of her occupational disease. She was a partner with her physicians in her care and took time to understand the medical information and options discussed with her. She was diligent in following orders and doggedly persistent with her physical and occupational therapy. Even though most of her treating physicians could not pinpoint the underlying cause of her upper extremity complaints, not a single provider suggested that Claimant was magnifying her symptoms, and chart notes repeatedly observed that Claimant's subjective reports of pain were consistent with objective findings.

DISCUSSION AND FURTHER FINDINGS

33. In an effort to impose some organizational structure on what is otherwise a rather unwieldy set of issues put forward in this proceeding, the discussion will be divided into two main sections that correspond roughly with each party's burden of proof: Claimant's case-in-chief, and II/IIGA's and Liberty's defenses.

CLAIMANT'S CASE-IN-CHIEF

Burden of Proof

34. The burden of proof in a workers' compensation case is on the claimant. Whether asserting an injury as the result of an accident or an occupational disease, a claimant must prove, to a reasonable degree of medical probability, a causal connection between the condition for which compensation is claimed and the industrial accident or occupational exposure which caused the alleged condition. See, *Hart v. Kaman Bearing & Supply*, 130 Idaho 296, 299, 939 P.2d 1375, 1378 (1997) (proving causation in an injury/accident claim), and *Langley v. State Industrial Special Indemnity Fund*, 126 Idaho 781, 786, 890 P.2d 732, 737 (1995) (proving causation in an occupational disease claim). In either case, medical evidence is necessary to prove a probable causal connection. "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). Medical evidence required to prove causation may include expert testimony, medical records, or both. In the case of medical records, it is not a requirement that the medical records state the causation opinion in terms of medical probability. The medical records relied upon do not have to include the magic words "medical probability" or "more likely than not." What is required is that the medical evidence plainly and unequivocally conveys the opinion that events are causally related. See, *Jensen v. City of Pocatello*, 135 Idaho 406, 412, 18 P.3d 211, 217 (2000), citing

Paulson v. Idaho Forest Indus., Inc., 99 Idaho 896, 901, 591 P.2d 143, 148 (1979). As discussed extensively in *Jensen,* the causation opinion need not be an affirmative finding.

Injury/Accident

35. Claimant has never asserted in this proceeding that she sustained any injury as the result of an accident, and proof of an industrial accident resulting in injury is not a part of her case-in-chief. Liberty is in agreement with Claimant's position. This issue was included as a hearing issue at the insistence of II/IIGA, but was never argued in their post-hearing briefing. Because it has no legal significance in the Claimant's case-in-chief, it will not be addressed further in this section.

Occupational Disease

36. An occupational disease is defined as:

> . . . a disease due to the nature of an employment in which the hazards of such disease actually exist, are characteristic of, and peculiar to the trade, occupation, process, or employment, but shall not include psychological injuries, disorders or conditions unless the conditions set forth in section 72-451, Idaho Code, are met.

Idaho Code § 72-102(22)(a). As noted previously, Liberty concurred with Claimant that she suffered from a compensable occupational disease. This portion of the discussion is, therefore, limited to Claimant and II/IIGA.

37. Proving the compensability of an occupational disease claim is a two-step process: A claimant must prove, first, that he has a disease that meets the definitional elements of Idaho Code § 72-102(22)(a); and, second, that in his case, the disease was caused by his work, as opposed to some other condition or event. II/IIGA did not raise any defenses relating to the definitional elements of an occupational disease, instead limiting their argument to the issue of causation. II/IIGA asserted that Claimant failed to provide the medical evidence required relating her upper extremity complaints to her employment. Because they are not at issue, the

definitional elements of Idaho Code § 72-102(22)(a) will not be addressed further and this portion of the recommendation is limited to the issue of causation.

Causation

38. Claimant asserts that she has met her burden of proving the causal relationship between each of her upper extremity complaints—bilateral epicondylitis, CTS, and instability in the basal joints of her thumbs—and her work. As support, she cites to medical records and expert testimony that constitute a part of the record in this proceeding.

Pre-existing Conditions

39. There is no evidence in the record that Claimant had any prior history of epicondylitis, CTS, or basal joint instability in her upper extremities prior to the time she started to work for Employer. Although Claimant's November 2000 fall is referenced in Dr. Harris' chart notes, neither he, nor Drs. Simon or Hume, identified the incident as contributing in any way to her upper extremity complaints.

Epicondylitis and CTS

Medical Records

40. Dr. McLaughlin. The first doctor that Claimant saw for diagnosis and treatment of her upper extremity complaints was Dr. McLaughlin. His notes first raise the possibility of CTS, and he proposed to send Claimant for an EMG to confirm or rule out the diagnosis. Claimant only made one visit to Dr. McLaughlin because when she reported back to Employer, they sent her to see Dr. Harris.

41. Dr. Harris. The chart note for Claimant's first visit to Dr. Harris states that Claimant was reporting for treatment *at the request of Employer* where she worked preparing pizzas. From the outset, Dr. Harris tailored his treatment recommendations to Claimant's

working conditions. He reviewed her job description, and suggested ways that Claimant could modify her work or working conditions to try to ameliorate her upper extremity complaints. By mid-April 2001, Dr. Harris definitively diagnosed CTS:

> She does indeed have the symptoms consistent with carpal tunnel with tingling and numbness in her fingers that worsen at night awakening having to shake them out. She is advised that while surgery could be an option and the diagnosis is really quite definitive regardless of what ENG [sic] testing may show, she would like to go ahead with the testing.

Ex. 6, p. 10. In the same chart note, Dr. Harris observed that "[c]o-workers or supervisors have asked about testing for carpal tunnel." *Id.* It is clear from Dr. Harris' records that Claimant came to see him in the context of a work-related complaint, and his treatment recommendations focused primarily on how to modify her work to improve her condition or, at a minimum, to continue working without worsening her condition. Toward that end, he referred Claimant to Dr. Simon.

42. Dr. Simon. Dr. Simon's records indicate that he knew Claimant worked as a pizza clerk for Employer and, having reviewed Dr. Harris' records, that her upper extremity complaints allegedly arose out of her work. He diagnosed both lateral epicondylitis and borderline CTS. After several weeks of treatment, when Claimant was not improving, he noted: "Since she is not improving, it may be that there is something else going on besides *a repetitive strain tendonitis*. Further workup is needed." Ex. 7, p. 9, emphasis added. Additional testing provided no other explanation for her symptomology. Dr. Simon took Claimant off work for a short time to see if that helped her symptoms. Despite his inability to identify a specific pathology that explained Claimant's complaints, Dr. Simon never disputed the causal relationship between Claimant's work and her upper extremity symptoms. He posited no other possible cause for Claimant's complaints. Dr. Simon's medical records validate the beliefs of

Claimant, her co-workers, and Dr. Harris that her upper extremity problems were related to her work.

43. Dr. Hume. Claimant filled out an Industrial Accident Form in conjunction with her first visit to Dr. Hume. In the form, Claimant described her complaint as involving both arms from shoulders to fingertips and attributed her pain to "repetitive work and lifting freight." Ex. 3, p. 5. The medical records corroborate Claimant's testimony that Dr. Hume was dismissive of her complaints, despite the fact that she arrived at his office with a definitive diagnosis of CTS. Yet, even Dr. Hume's records do not dispute Claimant's initial description of her condition or its relationship to her work, nor do they offer any alternative cause.

44. It is also notable that each of these three physicians saw Claimant and made their diagnoses *before* the 2002 incidents that II/IIGA asserts were somehow causative of Claimant's eventual need for surgery.

45. Dr. Perttula. Claimant was sent to Dr. Perttula for care of the wrist injury she sustained while lifting the box of pizza sauce. Dr. Perttula quickly discerned that Claimant's arm, wrist, and hand complaints had been extant since March of 2000, had been diagnosed as epicondylitis and CTS in 2001, and had been treated conservatively, but without result. Dr. Perttula treated Claimant's on-going bilateral upper extremity complaints, as well as the wrist sprain that brought her to see him. In doing so, his treatment recommendations focused on Claimant's work situation. He suggested that Claimant would benefit by being moved from her job as pizza clerk to a job with less repetitive stress on the Claimant's arms and hands. At no time did Dr. Perttula question that Claimant's epicondylitis and CTS arose out of her work.

46. Dr. Brossard. By the time Claimant sought out Dr. Brossard, she had been suffering with her upper extremity pain for more than two years. It does not appear from

Dr. Brossard's initial chart notes that she was aware that Claimant's upper extremity complaints originated as an occupational disease claim. Dr. Brossard's focus was on Claimant's condition and treatment, not how it arose. However, during the course of Claimant's treatment, Dr. Brossard did become aware of the nature of Claimant's work for Employer and the connection between Claimant's work and her epicondylitis and CTS complaints. Dr. Brossard never disputed Claimant's assertion that her job and her upper extremity problems were medically related. Dr. Brossard was also aware that Claimant initially attempted to self-accommodate by working more slowly. Eventually, Employer tried to accommodate Claimant's limitations and reduce the repetitive stress to her upper extremities by first reducing her hours and eventually by removing her from the job making pizza and assigning her to a position checking groceries.

Expert Testimony—Dr. Brossard

47. On August 23, 2007, the day before the scheduled hearing in this matter, Dr. Brossard completed and signed a "check box" form sent to her by Claimant. In completing the form, Dr. Brossard answered three questions:

> 1) Are the physical complaints for which you evaluated and treated [Claimant] beginning on March 15, 2002, causally related on a more likely than not basis to her work activity at WinCo?
>
> 2) Are the physical complaints for which you evaluated and treated Ms. Simmons essentially the same physical complaints for which she sought treatment from Dr. Harris on April 5, 2001?
>
> 3) Is the event of in [sic] January 2002, wherein she states she slipped on some water and fell hitting a table with her right hand and the floor with her left hand; such that it would have been on a more likely than not basis the predominant cause of the symptoms for which you provided treatment to her as compared to her daily work activity prior to that time?

Ex. 9, p. 11. Dr. Brossard answered the first two questions in the affirmative and the third

question in the negative.

48. The Commission has expressed concern about the use of check box forms, especially when they are the only medical evidence used to establish or refute a claim. However, the Commission's concern goes more to the weight to be given to the opinions contained in the form than to the admissibility of the form. In the instant case, the check box form containing medical opinions to which Dr. Brossard ascribed is not the only medical evidence in the record on the issue of causation. Dr. Brossard was also deposed post-hearing and provided additional testimony on the issue of causation. During her deposition, Dr. Brossard testified that at the time she answered the questions discussed above, she had access to the medical records she had created, as well as the medical records from Drs. Hume and Harris. Based on those records, Dr. Brossard opined that the type of work that Claimant performed for Employer was causally related to her epicondylitis and CTS. By the time of her deposition, Dr. Brossard had received additional medical records[4] and the hearing transcript. After reviewing the portion of the hearing transcript where Claimant described her duties as pizza clerk, (Tr., pp. 36-37) the following exchange occurred:

> Q. [by Arnold] Doctor, are those—the physical activities described there, are those the types of physical activities that, in your experience, have causal relationship to the types of symptoms described by [Claimant]?
> A. Yes.

Dr. Brossard Depo., p. 23. During her deposition, Dr. Brossard made it clear that her opinion on the occupational nature of Claimant's complaints was limited to Claimant's bilateral epicondylitis and her bilateral CTS.

Bilateral Basal Joint Dysfunction

49. Defendant II/IIGA asserts in its brief that even if one accepted the compensability

[4] All of the medical records which were admitted into evidence.

of Claimant's epicondylitis and CTS, she has failed to establish the necessary causal link to establish the compensability of her bilateral basal joint instability. II/IIGA's position is not supported by the record.

50. Dr. Brossard. When Dr. Brossard examined Claimant for the first time on March 15, 2002, the doctor noted atrophy of the right thenar eminence (the body of muscle on the palm of the human hand just beneath the thumb). In her April 1 referral letter to Dr. Jost, Dr. Brossard noted that Claimant had been wearing splints that immobilized her thumbs for several months before coming to see Dr. Brossard.

51. Physical Therapy Records. During the time that Dr. Brossard was treating Claimant, and thereafter while Claimant was under Dr. Jost's care, Claimant was participating in physical therapy at Dr. Brossard's facility. At Claimant's April 5, 2002 physical therapy session, her therapy team noted, "[Dr. Brossard] mentioned that the musculature in her [Claimant's] thumb has decreased to nothing and there is no way to rebuild those muscles." Ex 16, p. 10.

52. Dr. Jost. During Claimant's first visit to Dr. Jost, she complained of pain in the left basal joint in addition to her other upper extremity complaints. Dr. Jost testified that she recalled Claimant mentioning problems with her right basal joint during her initial visit, but Claimant was primarily concerned with her CTS and left basal joint complaints. On exam, Dr. Jost noted a positive grind test at the left basal joint, mild subluxation of the left basal joint, and some tenderness and crepitus involving the A1 pulley of the flexor tendon around the left thumb. X-rays of Claimant's wrists showed a mild decrease in joint space and some spurring at the left basal joint. Dr. Jost's diagnosis included left basal joint synovitis and mild subluxation. Dr. Jost injected Claimant's left basal joint with a steroid/anesthetic, which provided immediate relief. A second steroid injection of the left basal joint was administered in conjunction with

Claimant's left CTS release. As Claimant recovered from her bilateral CTS releases and regained the sensitivity and function in her hands that had been compromised, her bilateral basal joint instability became more symptomatic.

53. In her deposition, Dr. Jost initially opined as to the cause of Claimant's basal joint symptoms:

> Q. [By Aylsworth] The period leading up to July 17, 2002, Dr. Jost, do you have an opinion as to what was causing Ms. Simmons' basal joint symptoms?
> A. Again, you know, she gave me these two incidents, [the January and February 2002 incidents] and then there are the whole slew of other causes. I don't know that I really in my mind was worried about what caused it. I was worried about making her better.
> Q. Is [sic] the basal joint synovitis symptoms you were addressing here on July 17, 2002, were they in any way related to [Claimant's] carpal tunnel syndrome?
> A. Not related, but sometimes they are carried in the same gene pool on the same person. They're common to find together.
> Q. But one doesn't necessarily cause the other; am I hearing you correctly?
> A. No.
> Q. So if I understand your answer correctly then if one doesn't cause the other or vice versa, can one condition aggravate or mask the other condition, the symptoms?
> A. Well, if you really get scientific, carpal tunnel can decrease the strength of the muscles that support the basal joint. And if you have weakened thenar musculature the basal joint is not as supported by the musculature.

Dr. Jost Depo., pp 17-18.

54. When given the opportunity to review additional medical records and the Claimant's hearing testimony during the course of cross examination, Dr. Jost retreated from her initial opinion that Claimant's bilateral basal joint synovitis was the result of the two incidents (the January and February 2002 events) previously discussed. For the first time, Dr. Jost became aware of the actual timing of the incidents and the medical evidence and testimony regarding their relative insignificance in the Claimant's upper extremity disease process. In fact, once she had access to more facts, Dr. Jost was quick to admit that lack of use and weakness resulting

from CTS "absolutely" could cause basal joint instability: "A weakened thenar musculature can directly lead to basal joint instability." *Id.,* at p. 43. When asked if it was more likely than not that the CTS caused the loss of thenar musculature which in turn led to the basal joint instability, Dr. Jost replied, "I think it is possible." *Id.* When pressed as to whether it was *probable*, she responded: "It's very plausible. I can't say 100 percent. I know you want 51 percent." *Id.*, at p. 44. Though her opinion did not use the magic words, it is clear that Dr. Jost believed it was more probable than not that Claimant's basal joint dysfunction was caused by her occupational CTS and not the two incidents wherein she experienced minor and transient upper extremity discomfort.[5]

Manifestation

55. Because there are two sureties with potential liability should Claimant succeed in establishing the compensability of her claim, it is crucial to identify precisely the date on which the asserted occupational disease occurred. According to Idaho Code § 72-102(18), manifestation means:

> . . . the time when an employee knows that he has an occupational disease, or whenever a qualified physician shall inform the injured worker that he has an occupational disease.

The Idaho Supreme Court took up the issue of manifestation in *Sundquist v. Precision Steel & Gypsum, Inc.*, 141 Idaho 450, 111 P.3d 135 (2005). In *Sundquist*, the Court addressed the nature

[5] In their briefing, II/IIGA suggests that Dr. Jost's testimony on cross-examination, wherein she retreated from her initial opinions, was based on incomplete information—excerpts of the record—taken out of context. The Referee notes that Dr. Jost was deposed by Defendant II/IIGA. The Referee also notes that II/IIGA did not provide Dr. Jost with any of the medical records adduced at hearing or the transcript of the hearing. It is accurate to say that Dr. Jost's *direct examination* was based on incomplete information. But that lack of information rests squarely on the doorstep of II/IIGA. Once it became evident that Dr. Jost was completely unaware of much relevant evidence contained in the record, Claimant and Liberty had little choice on cross examination but to draw Dr. Jost's attention to excerpted portions of the record, which they did carefully, accurately, and in the context of the entire record.

of the knowledge requirement:

> This definition is subjective. The employee must know that he has an occupational disease or have been so informed by a qualified physician. In addition, the knowledge required is that he has an occupational disease, not that he has symptoms that are later diagnosed as being an occupational disease. Knowledge of symptoms is not synonymous with knowledge the symptoms are caused by an occupational disease.

Sundquist, 141 Idaho at 454, 111 P.3 at 139.

56. Applying the law set out in *Sundquist* to the facts of this case, Claimant's occupational disease became manifest on March 15, 2001 when she saw Dr. McLaughlin and understood that her upper extremity complaints related to her work, and might be tendinitis or CTS, or on March 21, the date she reported Dr. McLaughlin's opinion to Employer and filed her notice of injury. Employer's Surety on both March 15, 2001 and March 21, 2001 was Fremont, II/IIGA's predecessor in interest.

Doctrine of Compensable Consequences

57. The causal chain running from Claimant's work to her bilateral epicondylitis and CTS and subsequently to her bilateral basal joint instability is further buttressed by Idaho case law adopting the "compensable consequences" doctrine. This doctrine provides that when the primary injury (bilateral carpal tunnel syndrome) is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury (loss of musculature supporting the basal joint, resulting in instability) likewise arises out of and in the course of employment, unless it is the result of an independent intervening cause attributable to the claimant's own intentional conduct (not applicable here). While Larson's discussion of the doctrine pertains to "injury," the Commission's application of the doctrine clearly includes occupational diseases like overuse syndrome. See, *Quenton* 2003, IIC 0244 (2003) (left leg deep thrombosis from inactivity was compensable following compensable right leg injury). For a

sampling of previous Commission cases recognizing the compensable consequences doctrine, see, *Castaneda v. Idaho Home Health, Inc*., 1999 IIC 0538 (July 1999); *Martinez v. Minidoka Memorial Hospital*, 1999 IIC 0262 (February 1999); and *Offer v. Clearwater Forest Industries*, 2000 IIC 0956 (October 2000). *Schafer v. Smith Group International*, 2006 IIC 0120 (February 2006).

58. Despite seeing four different physicians for treatment of her initial upper extremity symptoms, Claimant never got better. In fact, her symptoms worsened in the seven months that she continued to work following her release by Dr. Hume. When Claimant saw Dr. Perttula in March 2002, she was experiencing the same symptoms that she reported in March of 2001. And although it was a separate injury that led her to Dr. Perttula's involvement, there is no evidence to suggest that injury or the unreported industrial fall in January 2002 aggravated or accelerated Claimant's underlying occupational disease in any way.

Medical Care

59. Idaho Code § 72-432 provides that once a Claimant has established the compensability of his or her workers' compensation claim, the employer shall provide such reasonable medical, surgical or other attendance or treatment, nurse and hospital service, medicines, crutches and apparatus, as may be required by the employee's physician or needed immediately after an injury or disability from an occupational disease, and for a reasonable time thereafter. If the employer fails to provide the same, the injured employee may do so at the expense of the employer. Idaho Code § 72-432 (1). It is for the physician, not the Commission, to decide whether the treatment was required. The only review the Commission is entitled to make of the physician's decision is whether the treatment was reasonable. *Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989).

60. The care Claimant initially received following her March 2001 notice to Employer was paid for by Fremont or its successor, II/IIGA. This included her visits to Drs. McLaughlin, Harris, Simon, and Hume, along with the medications and medical prostheses that they prescribed.

61. The care that Claimant received from Drs. Brossard and Jost, including physical therapy at Neuroscience Center Physical Therapy and Body Works Therapy Services, together with medical services provided relating to Claimant's six surgeries, rehabilitation, imaging, protheses, and medications, have not been paid. The record does not include an itemized listing of providers and amounts claimed, or whether and to what extent some of the medical costs identified herein may have been covered by private health insurance. No doubt the parties have this information, and it should not be difficult to determine amounts outstanding and to whom they are owed. To the extent that any private insurer paid for services related to Claimant's occupational disease, they are entitled to reimbursement pursuant to *Neel v. Western Construction, Inc.*, ____ Idaho _____, ____ P3d ____(2009), ACO IIC 1207, 1211.

> Any medical bills incurred during the time from when the accident occurred to the time when the claim was deemed compensable fall outside the workers' compensation regulatory scheme and may not be reviewed for reasonableness and must be paid in full by the surety.

Further, as II/IIGA's IME physician opined that Claimant might benefit from an additional surgery, II/IIGA is responsible for the costs of that surgery, along with all physical and occupational therapy, prescriptions and prostheses reasonably necessitated by the additional surgery, should Claimant opt to pursue that course.

Temporary Total and/or Temporary Partial Disability

62. Idaho Code § 72-408 provides for the payment of income benefits for injured workers during their period of recovery. Claimant was taken off work on May 13, 2002. At the

time of hearing, she had not been released to return to her time-of-injury position, nor had she been declared at maximum medical improvement. Attempts to return Claimant to work with restrictions were unsuccessful due to Employer's insistence that she could not return so long as she had restrictions.

DEFENSES

63. II/IIGA raises a number of defenses which, if proven, could minimize or eliminate its liability on this claim. To a much lesser extent, Liberty also interposes defenses to the claim.

Notice

64. II/IIGA interposed affirmative defenses under Idaho Code §§ 72-701, *et. seq.*, and Idaho Code § 72-448 relatively late into the adjudication of the case, and as a result of II/IIGA's Answer to the Amended Complaint filed in late January 2006. Idaho Code §§ 72-701-706 are the notice statutes applicable to work injuries resulting from accidents. Idaho Code § 72-448 sets out the notice requirements for occupational disease claims.

Idaho Code § 72-448

65. From the outset of this proceeding, Claimant has asserted that her upper extremity complaints came on gradually as the result of repetitive injury incurred in the course of her work. Idaho Code § 72-448 sets out the notice requirements for a worker claiming a compensable occupational disease:

> (1) Unless written notice of the manifestation of an occupational disease is given to the employer within sixty (60) days after its first manifestation, or to the industrial commission if the employer cannot be reasonably located within ninety (90) days after the first manifestation, and unless claim for worker's [sic] compensation benefits for an occupational disease is filed with the industrial commission within one (1) year after the first manifestation, all rights of the employee to worker's [sic] compensation due to the occupational disease shall be forever barred.

Having once interposed this affirmative defense, and without ever conceding the point, II/IIGA

offered no evidence to support its position, nor did they argue the issue in their brief. Liberty raised no notice issues and, in fact, asserts in its brief that Claimant complied with Idaho Code § 72-448. While either surety could have chosen to argue the issue of when Claimant's occupational disease first *manifested*, neither did so.

Idaho Code §§ 72-701 through 706

66. A claim of injury resulting from an industrial accident has different notice requirements than an occupational disease claim. Those notice requirements are set out at Idaho Code §§ 72-701 through 706 and Idaho Code § 72-604. Claimant has never asserted that her upper extremity complaints arose as a result of an industrial accident, and Liberty agrees. As discussed previously, there were three incidents in which Claimant might conceivably have injured her wrists or hands—the non-industrial fall in November 2000, the unreported industrial fall in January 2002, and the reported industrial incident involving the box of pizza sauce in February 2002. II/IIGA was not the insurer of Employer's industrial risk after May 1, 2001. The two industrial accidents occurred *after* Liberty became Employer's workers' compensation surety and *long after* Claimant's occupational disease claim is alleged to have manifested. The only potentially causative incident that occurred while II/IIGA was the surety (November 2000) was non-industrial, and thus not subject to the notice requirements set out at Idaho Code §§ 72-701-706 and 72-604. The November 2000 fall may give II/IIGA defenses to Claimant's occupational disease claim, but has no bearing whatsoever on the notice issues.

67. The Referee finds that Claimant provided timely notice of her occupational disease claim to Employer pursuant to Idaho Code § 72-448.

Idaho Code § 72-439/Last Injurious Exposure

68. II/IIGA asserts that Idaho Code § 72-439 precludes a finding of liability against

II/IIGA as a successor in interest to Fremont Indemnity Company. The cited section provides in pertinent part:

> (3) Where compensation is payable for an occupational disease, the employer, or the surety on the risk for the employer, in whose employment the employee was last injuriously exposed to the hazard of such disease, shall be liable therefore.

II/IIGA's argument is that since Claimant continued to work for Employer at her same job for more than a year after Fremont went off the risk, the surety on the risk at the time of Claimant's *last injurious exposure* was Liberty. II/IIGA's argument misconstrues the purpose and application of the statute. As explained by the Idaho Court in *Sundquist*, 141 Idaho at 456, 111 P3d at 141 (2005):

> As an occupational disease develops over time, it is possible for the disease to be "incurred" by a claimant under a series of different employers before it becomes manifest. *In such a situation*, I.C. § 72-439(3) provides that it is the last such employer, or its surety, who is liable to the claimant. (Emphasis added.)

In the case at bar, Claimant's occupational disease *was incurred* and *became manifest* while she worked for Employer and while Fremont was the surety on the risk. There is only one employer with any connection to Claimant's occupational disease claim, and only one surety on the risk at the time that the occupational disease became manifest and a claim was filed. Quite simply, this case does not raise the issues that Idaho Code § 72-439(3) was enacted to address.

Idaho Code § 72-437

69. II/IIGA cites to Idaho Code § 72-437 in support of its position that it cannot be held liable for Claimant's occupational disease because she did not become disabled from her work until more than a year after Fremont went off the risk. Idaho Code § 72-437 provides:

> When an employee of an employer suffers an occupational disease and is thereby disabled from performing his work in the last occupation in which he was injuriously exposed to the hazards of such disease, or dies as a result of such disease, and the disease was due to the nature of an occupation or process in which he was employed within the period previous to his disablement as

> hereinafter limited, the employee, or, in case of his death, his dependents shall be entitled to compensation.

For many years, this provision was read as precluding *any* compensation, including reasonably necessary medical care, to an employee suffering from an occupational disease unless the employee was *disabled*—totally incapacitated from performing his work in the last occupation in which he was injuriously exposed because of an occupational disease. That reading of Idaho Code § 72-437 changed in 2000 with the Idaho Court's decision in *Mulder v. Liberty Northwest Insurance Company*, 135 Idaho 52, 14 P.3d 372 (2000). In *Mulder*, the Commission found that the claimant suffered from an occupational disease (CTS) and ordered the surety to pay for the cost of Mulder's CTS release surgery. The surety appealed, asserting that under Idaho Code § 72-437, Claimant was not entitled to compensation for medical care because he was not disabled prior to the surgery. The Court held:

> . . . that under Idaho worker's [sic] compensation law, where a claimant seeks compensation for an occupational disease, benefits for medical services, appliances and supplies are to be determined according to I.C. § 72-432. All other forms of compensation claimed for an occupational disease are to be determined pursuant to I.C. § 72-437.

Mulder, 135 Idaho at 58, 14 P.3d at 378. Thus, *Mulder* does not absolve II/IIGA of its liability for Claimant's reasonably necessary medical care related to her occupational disease. The question of whether II/IIGA is liable for income benefits is not yet ripe for decision, as Claimant is not medically stable and disability has not yet been addressed.

Lump Sum Settlement

70. Both Liberty and II/IIGA assert that all or a part of Claimant's claims against them are barred as a result of the June 5, 2003 LSSA.

Liberty

71. Liberty was not the surety on the risk at the time Claimant's occupational disease

was incurred and manifested. In order for Liberty to have any liability on the occupational disease claim, the record would have to include substantial evidence to support a finding that either or both of the work-related incidents in early 2002 advanced the course of Claimant's underlying occupational disease. The record does not support such a finding.

72. The LSSA between Claimant and Liberty does relieve Liberty of any liability flowing from the February 2002 incident which Liberty accepted and for which it paid benefits. The Agreement specifically provides that "[a]ll damages, disability, loss, expense and injury, past, present and future, *in any way resulting from or related to the alleged accident* are finally settled and discharged by this Agreement." Ex. 21, p. 2. Emphasis added.

II/IIGA

73. As noted, Claimant suffered an accident on February 19, 2002. She filed a timely claim for this accident in which she alleged that she suffered an injury to her right wrist while moving a box of pizza sauce. Surety accepted the claim and paid benefits thereon. Claimant filed a timely Complaint on or about September 17, 2002 for the accident of February 19, 2002. In her Complaint, she alleged that, as a consequence of the February 19, 2002 accident, she "strained wrist resulting in surgery." In this regard, it is notable that Claimant underwent right carpal tunnel surgery on May 13, 2002.

74. Claimant eventually settled her claim for the accident of February 19, 2002. By order dated June 26, 2003, the Industrial Commission approved the Lump Sum Settlement Agreement reached by the parties in connection with the February 19, 2002 accident. That Agreement specifies, *inter alia*:

> It is agreed that on or about 2/19/2002, the Claimant, Patricia Simmons, was employed by Winco Foods, Inc., in the County of Bonneville, Idaho, and on the same date the Claimant allegedly sustained an injury as a result of an industrial accident arising out of and during the course of employment which she then had

> with the Defendant, Winco Foods, Inc. These injuries include, but are not necessarily limited to, right wrist sprain/strain and carpal tunnel syndrome.
>
> All damages, disability, loss, expense and injury, past, present and future, in any way resulting from or related to the alleged accident are finally settled and discharged by this Agreement. This is the case whether or not these damages, disability, loss or expense are now known, recognized or foreseen.
>
> LSSA, 2.

75. The Lump Sum Settlement memorialized the payment of medical and other benefits that had been made as of the date of settlement. The Agreement further memorialized the parties' Agreement that Claimant would be paid $2,000.00 "new money" to resolve her claims for the February 19, 2002 accident.

76. Against this background, II/IIGA contends that Claimant is judicially estopped from asserting that her right carpal tunnel syndrome is causally related to the occupational disease claim of March 21, 2001. II/IIGA argues that since Claimant previously claimed that her right carpal tunnel syndrome was causally related to the February 19, 2002 accident, she is now estopped from asserting that her right carpal tunnel syndrome is, instead, causally related to the occupational disease claim of March 21, 2001. In response, Claimant responds that the medical evidence adduced in connection with the instant matter affirmatively demonstrates that Claimant's right carpal tunnel syndrome is causally related to the March 21, 2001 occupational disease claim, and that the evidence further tends to establish that Claimant's right carpal tunnel syndrome is, in no wise, connected to the minor wrist sprain/strain Claimant suffered on February 19, 2002.

77. At issue is the question of whether or not the doctrine of judicial estoppel is applicable to the facts of this matter. Specifically, it must be determined whether, on the facts set forth above, Claimant is now estopped from asserting that her right carpal tunnel syndrome is

causally related to the occupational disease claim of March 21, 2001, when she appears to have earlier contended that her right carpal tunnel syndrome and right carpal tunnel surgery of May 13, 2002 were casually related to the separate and discrete accident of February 19, 2002.

78. As II/IIGA has noted, Idaho recognizes the doctrine of judicial estoppel, as described in *McKay v. Owens*, 130 Idaho 148, 937 P.2d 1222 (1997) as follows:

> It is quite generally held that where a litigant by means of sworn statements, obtains a judgment, advantage, or a consideration from one party, he will not thereafter, by repeating such allegation and by means of inconsistent and contrary allegations through testimony, be permitted to obtain a recovery or a right against another party arising out of the same transaction or subject matter.
>
> . . . .
>
> Judicial estoppel, sometimes also known as the doctrine of preclusion of inconsistent positions, precludes a party from gaining an advantage by taking one position, and then seeking a second advantage by taking an incompatible position.

79. In *McKay,* Claimant contended that her son suffered injuries as a result of medical malpractice occurring during the delivery of the child. Represented by Owens, Plaintiff filed a malpractice suit against the medical providers. Plaintiff became dissatisfied with Owens' representation, and later retained Ellis to represent her interests in connection with the matter. Plaintiff wished to abandon the settlement negotiations and litigate the medical malpractice claim, but could not find an attorney to do so with Owens' attorney lien rights. As a result, Plaintiff felt she had to settle the claim. A settlement was eventually reached in the action, and a minor's compromise hearing was held before a magistrate to approve the settlement. Plaintiff harbored a number of objections to the settlement. However, at the actual hearing, both Plaintiff and Ellis stated on the record that they had no objections to the proposed settlement. Based on the representations made by Plaintiff and her attorney, the magistrate approved the minor's compromise. Thereafter, Plaintiff filed a legal malpractice action against Owens, alleging, *inter*

alia, that Owens was negligent in representing Plaintiff and that he settled the medical malpractice claim without Plaintiff's consent, and for a sum that did not fairly compensate Plaintiff and her son for the damages they had suffered. At issue was whether, having acceded to the minor's compromise in open court, Plaintiff was later estopped from asserting that she had not given her consent to the settlement.

80. Plaintiff argued that although she did agree to the terms of the minor's compromise when questioned by the magistrate, she never really meant to approve the settlement, stating that she always intended to file the legal malpractice action. She explained that she went through with the minor's compromise in order to demonstrate that she had made appropriate efforts to "mitigate" her damages.

81. After discussing the doctrine of judicial estoppel, the Court ruled that the doctrine applied under the facts of the case to stop Plaintiff from asserting, in her legal malpractice action, that she did not give her consent to the settlement. Plaintiff would not be heard to repudiate the statements made in open court, and by means of her inconsistent positions, obtain a recovery against another party, arising out of the same transaction. In this regard, the Court noted that while Owens was not a party to the medical malpractice action, as Plaintiff's attorney in the case, he was so intimately intertwined with the medical malpractice proceedings that the legal malpractice action can be termed to be "arising out of the same transaction."

82. In defense of her position, Plaintiff cited the Court to a number of cases from other jurisdictions, ostensibly demonstrating that a legal malpractice action could be brought following the settlement of the underlying case. However, in each of the cases cited by Plaintiff, the alleged malpractice was not discovered until after the settlement had been approved. This distinction has important relevance to the facts of the instant matter. Addressing Plaintiff's

argument, the *McKay* Court elaborated further on the circumstances under which the doctrine of judicial estoppel may be applied:

> For guidance purposes and to avoid misapplication of judicial estoppel, it should be made clear that the concept should only be applied when the party maintaining the inconsistent position either did have, or was chargeable with, full knowledge of the attendant facts prior to adopting the initial position. Stated another way, the concept of judicial estoppel takes into account not only what a party states under oath in open court, but also what that party knew, or should have known, at the time the original position was adopted. Thus, the knowledge the party possesses, or should have possessed, at the time the statement is made is determinative as to whether that person is "playing fast and loose" with the court.
>
> . . . .
>
> However, judicial estoppel is designed to preclude inconsistent *positions*. At the minor's compromise hearing, McKay took the position that she agreed to the settlement. Now, she is taking the position that she did *not* agree to the settlement. Judicial estoppel is meant to prevent taking inconsistent positions, whether legal or factual, at least absent newly discovered evidence or fraud.

83. From the foregoing, it is clear that in assessing whether the doctrine of judicial estoppel applies to a particular case, it is critical to ascertain what knowledge the parties had (or should have had) at the time the inconsistent positions were established. In *McKay*, it is clear that following her assent to the minor's compromise, Plaintiff's knowledge base did not expand to include new facts that might justifiably cause her to take a new position by the time she filed her malpractice action against Owens. Plaintiff knew that her stated position at the minor's compromise hearing was false at the time she took that position. Plaintiff was simply hiding in the weeds at the time of the minor's compromise, intending to reveal her true intent in connection with the subsequent legal malpractice proceeding. It is exactly this kind of "secret subjective intent" that the *McKay* Court found so offensive, and which it equated to an attempt to game the system.

84. Here, it is clear that at least one of the elements of judicial estoppel is met; Claimant did obtain an advantage as a result of making the statements that she did make in

connection with the February 19, 2002 accident. Claimant averred that, as a consequence of the accident, she developed right-sided carpal tunnel syndrome for which she required medical/surgical treatment. These claims were resolved by Surety's agreement to pay Claimant the sum of $2,000.00, new money, which Claimant accepted following approval of the Lump Sum Settlement Agreement by the Industrial Commission.

85. Where the doctrine of judicial estoppel becomes difficult to apply to these facts is in connection with the requirement that II/IIGA demonstrate that the position taken by Claimant in connection with the instant occupational disease claim is "inconsistent and contrary" with the position she staked out for herself in connection with the February 19, 2002 accident claim.

86. It is interesting to note that contemporaneous with the filing of the September 17, 2002 Complaint for the accident of February 19, 2002, Claimant also filed a Complaint for the occupational disease claim of March 21, 2001. The contemporaneous filing of the Complaints for the accidents of February 19, 2002 and the occupational disease of March 21, 2001 demonstrates that Claimant was of the view that she had suffered injuries as a consequence of both claims. However, the contemporaneous filing of the Complaints does not support the conclusion that Claimant's subsequent arguments in the occupational disease case are inconsistent and contrary to the allegations that she eventually made in connection with the resolution of the February 19, 2002 accident claim. It might well be that Claimant had no information leading her to believe that her upper extremity complaints were related to the accident versus the occupational disease. Claimant cannot be blamed for arguing in the alternative, and covering her bases during the time in which there was no clear medical opinion relating her right upper extremity complaints to the accident versus the occupational disease. Indeed, Claimant's counsel might have later been criticized for failing to protect against the

possibility that Claimant's right upper extremity complaints were, indeed, causally related to the discrete accident of February 19, 2002. However, with the passage of time, and the litigation of the subject occupational disease claim, the medical evidence has developed and matured such that it appears to be clear that the February 19, 2002 accident is not implicated in causing Claimant's right carpal tunnel syndrome, and that Claimant's complaints are wholly referable to the March 21, 2001 occupational disease claim. As explained in *McKay*, the doctrine of judicial estoppel will not apply where Claimant's apparent change in position is based on newly discovered and previously unavailable evidence.

87. Moreover, and unlike the much more egregious facts of *McKay*, the referee is not left with the impression that Claimant had a "secret subjective intent," or that she was attempting to "game" the system in the averments that she made in her Complaint and in the Lump Sum Settlement.

88. Finally, unlike the *McKay* case, it does not appear that the allegedly "inconsistent or contrary" statements were made in connection with the same transaction or subject matter. Claimant has not taken an inconsistent position with respect to a single claim. Rather, she has filed two Complaints, for two separate claims, and it is doubtful that assertions she made in connection with one of the claims can be said to arise out of the same transaction as assertions that she made in connection with the other claim. Again, until medical evidence was adduced which clearly relates Claimant's right carpal tunnel complaints to the March 21, 2001 occupational disease claim, Claimant cannot be criticized for asserting that her right-sided complaints might, in fact, be related to the February 19, 2002 accident. Simply, Claimant did not know what entity caused her right-sided complaints, and she was entitled to take the (apparently) inconsistent positions that she did in order to protect her interests against the day that the medical

evidence finally addressed the causation question to the satisfaction of the Industrial Commission.

89. Inasmuch as II/IIGA bears the burden of proving that the elements of judicial estoppel have been satisfied, the Referee rules that this burden has not been met, and that Claimant is not estopped from making her assertions concerning the relationship between her right-sided wrist complaints and the March 21, 2001 occupational disease claim. (*See, Heinze v. Bauer*, 145 Idaho 232, 178 P.3d 597 (2008). Although the Commission will not tolerate the "gaming" of the system, or the hiding of a "secret subjective intent," the facts of the instant matter simply do not parallel those of *McKay v. Owens*, 130 Idaho 148, 937 P.2d 1222 (1997) and *Loomis v. Church*, 76 Idaho 57, 277 P.2d 561 (1954).

Causation

Liberty

90. Liberty agrees that Claimant has established both that she suffers from an occupational disease and that she has presented substantial evidence that her disease arose from her work.

II/IIGA

91. II/IIGA asserts that Claimant has failed to meet her burden of proving the causal relationship between her work for Employer and her occupational disease eventuating in a series of surgical interventions. II/IIGA raises a number of arguments to support its position. Each will be discussed in turn.

Alternative Causes

92. II/IIGA asserts that Claimant's CTS and subsequent surgeries were not occupational at all, but the result of industrial and non-industrial accidents—in particular, the

non-industrial fall in November 2000, the unreported industrial fall in January 2002, and the reported industrial injury to her right wrist in February 2002.

93. November 2000 Fall at Home. This event occurred after Claimant had begun to experience the telltale symptoms of CTS in both of her hands, but before she first sought medical care for the numbness and tingling. Claimant was treated for the wrist sprain and wore a splint for about a week before returning to her pre-injury status. She testified that the symptoms from the fall were of short duration and that her CTS symptoms were not made worse by the fall. Once Claimant was being seen for her CTS, her physicians did not believe that the wrist sprain was in any way causative of her CTS and epicondylitis. Dr. Harris noted that Claimant had sprained her left wrist, but her CTS was more symptomatic in the right upper extremity. Dr. Brossard also opined that Claimant's November 2000 fall likely did not have any causal relationship to Claimant's upper extremity complaints, noting that Claimant's acute symptoms from the fall resolved completely within a short time.

94. January 2002 Slip and Fall at Work. This incident occurred *after* Claimant's initial treatment for symptoms of CTS and epicondylitis by Drs. McLaughlin, Harris, Simon, and Hume. The fall was so minor that Claimant did not report the incident or seek medical care. Claimant testified that by the next morning the symptoms from the fall had abated, and the incident had no effect on her pre-existing symptoms.

95. February 2002 Injury While Unloading Boxes of Pizza Sauce. Claimant did not initially report this incident and continued with her work. Claimant was sent to Dr. Perttula when a supervisor noticed the red mark and swelling later in the day. Dr. Perttula's chart notes confirm that Claimant's bilateral upper extremity pain pre-existed both the January 2002 incident and the February 2002 incident that led her to Dr. Perttula. Moreover, Dr. Perttula's notes

indicate that despite her acute right wrist injury, her left upper extremity was more symptomatic than her right. There is nothing in Dr. Perttula's records to suggest that either of Claimant's two industrial incidents in any way caused, exacerbated, or accelerated her pre-existing upper extremity problems.

96. The record does not support II/IIGA's assertions that Claimant's upper extremity problems were caused by the November 2000 fall, or were exacerbated or accelerated by the two incidents in early 2002.

Medical Evidence

97. II/IIGA argues that Claimant has failed to prove a causal connection between her work and her upper extremity complaints. The only medical evidence in the record offered to counter Claimant's contention as to the cause of her occupational disease was a portion of the testimony tendered by Dr. Jost during her deposition. As discussed elsewhere in this recommendation, this portion of Dr. Jost's opinion is seriously flawed and is ultimately insufficient to outweigh the Claimant's evidence on the issue. When first asked her opinion as to what caused Claimant's right CTS and eventually led to surgery, Dr. Jost stated:

> I don't have an opinion necessarily. I can go by the fact the patient explained she had these two incidents [January and February 2002 incidents]. There are multiple factors that can contribute to that besides these incidents.

Dr. Jost Depo., p. 11. When asked a similar question about the cause of Claimant's left side CTS and eventual surgery, Dr. Jost stated:

> Same thoughts as I had for the right. She notes these both [sic] incidents involving the arms and I take her word, and otherwise there are multiple other causes that can be.

Id., at p. 14. On cross examination, it became clear that Dr. Jost had not been provided a complete set of Claimant's medical records and was completely unaware of Claimant's medical

odyssey prior to the initial visit with Dr. Brossard. When advised of the visits to Drs. McLaughlin, Harris, Simon, and Hume and the multiple references to CTS in their medical records prior to either of her 2002 accidents, Dr. Jost had to reconsider her original opinion, stating, "And with all those physicians documenting the upper extremity overuse related to work I think that's very reasonable." *Id.,* at p. 40.

98. No defendant in this proceeding has presented any convincing evidence that controverts Claimant's proof on the causation issue. The medical records of Drs. McLaughlin, Harris, Simon, Hume, and Perttula and the testimony of Drs. Brossard and Jost plainly and unequivocally lead the Referee to the conclusion that Claimant's bilateral epicondylitis and bilateral CTS are causally related to her work as a pizza clerk and that her bilateral basal joint dysfunction was a direct result of her CTS.

Causation Summary

99. At the end of the day, Claimant established a causal relationship between her occupation and her epicondylitis and CTS and subsequently to her bilateral basal joint instability. Claimant wore wrist splints that immobilized her thumbs for the better part of a year. By the time she was seeing Dr. Brossard, the musculature supporting her basal joints was all but gone. Dr. Jost, the only doctor who treated Claimant's bilateral thumb complaints, clearly connected Claimant's basal joint instability with the loss of musculature caused by the CTS and the immobilization used to treat the CTS at the outset. Claimant's basal joint instability was natural sequelae of her original occupational complaints, bringing it squarely within the compensable consequences doctrine of Idaho workers' compensation law.

Medical Care

100. II/IIGA did not raise any objection to the necessity or reasonableness of any of the

treatment Claimant received for her occupational disease. Having found that Claimant established the causal relationship between her work and her occupational disease, and having determined that II/IIGA has no defenses that would preclude its liability, II/IIGA is obligated to pay for Claimant's medical care pursuant to Idaho Code § 72-432 and as set out in paragraph 63, *infra.*

TTDs

101. The Commission has found injured workers to be eligible for TTD/TPDs under an occupational disease theory when they can no longer perform the job tasks required of their time-of-injury employment. *See*, *Ewers v. Kit Manufacturing Co.*, 1994 IIC 0627. "Disability is defined as the state of becoming "actually and totally incapacitated" from further performing the particular tasks which induced such incapacity." *Id.*, *citing* Idaho Code § 72-102(18)(c); *Jones v. Morrison-Knudsen Co.*, 98 Idaho 458, 567 P.2d 3 (1977); *see also*, *Blang v. Basic American Foods*, 94.5 ISCR 241, 125 Idaho 275, 869, P.2d 1370.

Dr. Simon restricted Claimant to light-duty work on April 30, 2001. Claimant complied with Dr. Simon's light-duty recommendations, including wearing splints at work, but still had pain while performing her job tasks as a pizza clerk. Claimant's pain increased with the repetition of her required job tasks. Claimant, on her own volition, began to perform her job tasks "more slowly" to accommodate her burgeoning physical limitations and complaints beginning in May 2001. In this respect, Claimant considered herself on "light-duty" work, because she could no longer perform her job tasks at the same rate as before. Claimant continued at her job tasks, albeit at a slower rate

Noting that his restrictions and suggested treatment did not alleviate Claimant's pain, Dr. Simon referred Claimant to an orthopedic surgeon. In the meantime, Claimant's written

restrictions remained essentially unchanged, although her activities in reducing the rate of speed she performed her job suggested additional accommodations and/or restrictions may have been necessary. Employer even reduced Claimant's hours to allow her to remain as a pizza checker. Ultimately, Claimant's personal attempts to continue performing her job tasks as a pizza clerk were unsuccessful.

Around April 1, 2002, Claimant moved from her position as a pizza clerk to a light-duty checker job to accommodate her actual restrictions and ease her pain complaints. Finally, Claimant's physical complaints increased in magnitude, and she underwent a carpal tunnel decompression surgery with Dr. Jost on May 13, 2002. Claimant worked through May 12, 2002, the day before her carpal tunnel decompression surgery, and there is no clear evidence that she experienced any wage loss prior to her surgery. Subsequent to the May 13, 2002 surgery, Claimant has not obtained a full-duty release to return to work by a physician. Because Employer has required a full-duty release before allowing Claimant to return to her time-of-injury employment, Claimant has been unable to return to work since May 13, 2002. The Referee finds that Claimant is actually and totally incapacitated from performing her job tasks as of May 13, 2002. Claimant is entitled to TTD/TPD benefits from May 13, 2002 until she is stable.

Apportionment

102. II/IIGA asked to have an issue included in this proceeding regarding the potential apportionment for pre-existing conditions pursuant to Idaho Code § 72-406. This provision relates only to the apportionment of pre-existing impairment in assessing impairment and disability. Since the issues of PPI and PPD have been reserved for future resolution, the issue of apportionment under Idaho Code §72-406 is not yet ripe for determination.

REQUEST FOR SANCTIONS

103. In its post-hearing briefing, Liberty asked the Commission to impose sanctions, specifically attorney fees and costs, against Claimant and II/IIGA for pursuit of a frivolous claim, and against Claimant pursuant to the terms of the LSSA wherein Claimant agreed to indemnify Liberty for any subsequent claims made as a result of the February 2002 accident.

104. This issue was raised for the first time in Liberty's post-hearing brief, and did not include any legal citation or authority for the imposition of such sanctions. Because of the complex nature of this case, not the least of which was having one Employer and two Sureties as Defendants, the Referee believes that it was necessary to implead Liberty because of defenses asserted by II/IIGA. In particular, while the Referee agrees that the LSSA absolved Liberty from further liability for the wrist sprain, had the Referee determined that the last injurious exposure rule was applicable, Liberty could have had exposure on the occupational disease claim. Although at the end of the day it was determined that Liberty had no liability, that could only be sorted out at the end of the process, and Liberty was a necessary participant in that endeavor.

CONCLUSIONS OF LAW

1. The notice limitations set out in Idaho Code § 72-701 through 706 and the tolling of those limitations under Idaho Code § 72-604 are limited in their applicability to workers' compensation claims asserted to have been the result of an accident and injury and have no applicability to Claimant's occupational disease claim.

2. Claimant fully complied with the notice limitations set out in Idaho Code § 72-448.

3. Idaho Code § 72-439 relating to "last injurious exposure" is not applicable on the facts of this case.

4. Claimant is entitled to temporary total disability (TTD) or temporary partial disability (TPD) benefits from May 2002 until she is stable.

5. The conditions for which Claimant seeks benefits were not the result of an accident and injury occurring March 21, 2001.

6. Claimant suffers from a compensable occupational disease.

7. Claimant's occupational disease manifested before May 1, 2001, specifically, on March 15 or March 21, 2001.

8. Claimant is entitled to medical benefits as set out more particularly in paragraph 61 of this Recommendation.

9. Determination of issues of permanent partial impairment (PPI) and permanent partial disability (PPD) are not yet ripe for determination, as Claimant has not been found to be medically stable.

10. Apportionment pursuant to Idaho Code § 72-406 is not appropriate at this time, as there has been no determination of impairment or disability.

11. II/IIGA and Employer are exempt from claims related to Claimant's industrial accidents of January 2002 and February 2002.

12. The June 5, 2003 Lump Sum Settlement Agreement between Claimant and Liberty in no way relieves II/IIGA of any liability on Claimant's March 2001 occupational disease claim.

13. The Referee declines to award sanctions against Claimant or II/IIGA.

RECOMMENDATION

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

DATED this 4th day of August, 2009.

INDUSTRIAL COMMISSION

/s/_____
Rinda Just, Referee

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

PATRICIA SIMMONS, Claimant, v. WINCO FOODS, INC., Employer, and INDUSTRIAL INDEMNITY/ IDAHO INSURANCE GUARANTEE ASSOCIATION, Surety, and LIBERTY NORTHWEST INSURANCE CORPORATION, Surety, Defendants.	)	**IC 2001-008816** **ORDER** Filed: September 8, 2009

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. The notice limitations set out in Idaho Code § 72-701 through 706 and the tolling of those limitations under Idaho Code § 72-604 are not applicable to Claimant's occupational disease claim.

2. Claimant fully complied with the notice limitations set out in Idaho Code § 72-448.

3. Idaho Code § 72-439 relating to "last injurious exposure" is not applicable on the facts of this case.

4. Claimant is entitled to temporary total disability (TTD) or temporary partial disability (TPD) benefits from May 2002 until she is stable.

5. The conditions for which Claimant seeks benefits were not the result of an accident and injury occurring March 21, 2001.

6. Claimant suffers from a compensable occupational disease.

7. Claimant's occupational disease manifested on March 15 or March 21, 2001.

8. Claimant is entitled to medical benefits from II/IIGA, including the care provided by Drs. Brossard, Jost, and Hutchinson, and including physical therapy at Neuroscience Center Physical Therapy and Body Works Therapy Services, together with medical services provided relating to Claimant's six surgeries, rehabilitation, imaging, protheses, and medications. Should Claimant proceed with the surgery recommended by Dr. Watkins, all medical expenses relating to that treatment are also compensable. Reimbursement for medical benefits is subject to the Idaho Supreme Court's decision in *Neel v. Western Construction, Inc.*, 147 Idaho 146, 206 P3d 852 (2009), ACO IIC 1207, 1211.

9. Liberty has no liability on the occupational disease claim that is the basis for this proceeding.

10. Determination of issues of permanent partial impairment (PPI) and permanent partial disability (PPD) are not yet ripe for determination, as Claimant has not been found to be medically stable.

11. Apportionment pursuant to Idaho Code § 72-406 is not appropriate at this time, as there has been no determination of impairment or disability.

12. II/IIGA and Employer are exempt from claims related to Claimant's industrial accidents of January 2002 and February 2002.

13. The June 5, 2003 Lump Sum Settlement Agreement between Claimant and Liberty does not relieve II/IIGA of any liability on Claimant's March 21, 2001 occupational disease claim.

14. The Referee declines to award sanctions against Claimant or II/IIGA.

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

DATED this 8th day of September, 2009.

INDUSTRIAL COMMISSION

/s/_____
R.D. Maynard, Chairman

/s/_____
Thomas E. Limbaugh, Commissioner

/s/_____
Thomas P. Baskin, Commissioner

ATTEST:

/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 8th day of September, 2009, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** and **ORDER** were served by regular United States Mail upon each of the following persons:

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djb /s/_____