

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

WADE LYNN,

Claimant,

v.

PROCORE PROPERTY SOLUTIONS, LLC,

Employer,

and

STATE INSURANCE FUND,

Surety,

Defendants.

IC 2009-027777

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

July 13, 2012

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee LaDawn Marsters, who conducted a hearing in Boise on January 5, 2012. Claimant, Wade Lynn, was present in person and represented by Daniel J. Luker, of Boise. Employer, Procore Property Solutions, LLC (Procore) and Surety, the State Insurance Fund, were represented by James A. Ford, also of Boise. The parties presented oral and documentary evidence. Post-hearing depositions were taken and briefs were later submitted. The matter came under advisement on May 9, 2012.

ISSUES

By agreement of the parties, the issues to be decided as a result of the hearing are:

1. Whether Claimant is medically stable.
2. Whether and to what extent Claimant is entitled to the following benefits:

- a. Medical care;
- b. Permanent partial impairment (PPI); and
- c. Disability in excess of impairment.

3. Whether apportionment for a pre-existing or subsequent condition is appropriate pursuant to Idaho Code § 72-406.

Claimant did not address the issue of his entitlement to temporary partial and/or temporary total disability benefits (TPD/TTD) in either of his briefs. Therefore, that issue is deemed waived.

CONTENTIONS OF THE PARTIES

On October 16, 2009, Claimant fell off the chair on which he was standing while he was tightening an overhead screw with a drill. He landed “flat” on his back. Claimant contends that he still suffers significant pain due to conditions he incurred as a result of his fall, including cervical strain, thoracic strain and a protruding disc at T6-7. He asserts that his injuries were not medically stable until May 2, 2011, and seeks continued medical care to control his pain, including physical therapy, medications for pain and depression, and steroidal pain injections. He also seeks permanent partial impairment benefits equivalent to 6% of the whole person and permanent partial disability of at least 23%, based upon the opinions of Drs. Brus and Frizzell, and the vocational recommendations of Douglas Crum.

Defendants deny that Claimant suffered any permanent impairment or disability attributable to his industrial accident. They assert that his cervical and thoracic strains have healed, that Claimant has failed to prove that his T6-7 disc protrusion is either the result of the industrial accident or the cause of his pain, and that, based upon the opinion of Dr. Kadyan, largely supported by the subsequent opinion of Dr. Sant, no medical restrictions were necessary

or appropriate after he reached medical stability on April 22, 2011. Further, Claimant has actually been working without medical restrictions or limitations, earning more money than at the time of his industrial injury. Defendants also argue that they are not liable for additional medical benefits, in any case, because they paid all of Claimant's accident-related medical costs through May 2, 2011 (the latest date on which Claimant could reasonably be found medically stable), and, further, because Claimant's condition does not warrant an award of medical benefits after medical stability.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The pre-hearing deposition testimony of Claimant, taken February 10, 2011;
2. The testimony of Claimant, Shelly Wade and Richard Barker taken at the hearing;
3. Joint Exhibits 1 through 46, admitted at the hearing; and
4. The post-hearing deposition testimony of:
 - a. William Brus, M.D. and R. Tyler Frizzell, M.D., taken January 12, 2012;
 - b. Vic Kadyan, M.D., taken January 25, 2012;
 - c. Douglas N. Crum, CDMS, taken January 26, 2012; and
 - d. Michael O. Sant, M.D., taken February 6, 2012.

OBJECTIONS

All pending objections are overruled.

After considering the above evidence and the arguments of the parties, the Referee submits the following findings of fact and conclusions of law for review by the Commission.

FINDINGS OF FACT

INTRODUCTION

1. Claimant was 39 years of age and residing in Eagle, Idaho at the time of the hearing. He has a relevant medical history characteristic of an active and athletic individual and has undergone treatment for various accidental injuries and acute pathologies, as well as for joint aches and pains without known etiology. He has also participated in an alcohol addiction program and takes medication for gout. Although Claimant reported work-related fatigue and stress prior to October 16, 2009, and received prescription medication for depression after that date, there is no evidence in the record that he has ever been evaluated by a psychological health professional. Claimant's prior medical records in evidence are summarized, below.

- a. Left knee. As a sixth grader, Claimant underwent left knee surgery after he complained of pain he thought was related to a five-year-old wrestling injury. X-rays, though nondistinct, were suspicious for an old healed osteochondritis dissecans of his medial femoral condyle. Following surgery, however, the treating physician opined "that no surgical pathology was found." JE-5.
- b. Right eye. At age 22, Claimant underwent right eye surgery to correct diplopia related to "lazy eye".
- c. Appendix. When he was 24 years old, Claimant underwent an emergency appendectomy after seeking treatment for severe abdominal pain. On removal, his appendix was greatly enlarged and gangrenous.
- d. Right flank, left ankle. At approximately age 25, in early 1998, Claimant suffered a right flank contusion in a dirt bike accident. He also injured his left ankle when he was walking on a board and slipped off. Ankle x-rays demonstrated no

fracture, but reflected joint widening suggestive of a ligamentous injury. For several years, Claimant periodically sought treatment for left ankle pain that he attributed to this injury. In 2003, when he was 31, Claimant sprained his left ankle while riding a motorcycle over a jump. X-rays revealed no fracture, and medications and icing were prescribed. In 2004, Claimant continued to report pain. Repeat x-rays of the left foot showed mild degenerative changes (but still no evidence of acute injury), and left ankle x-rays demonstrated a small bony excrescence projecting off the anterior aspect of the left distal tibia at the tibiotalar joint. William Brus, M.D., Claimant's family physician, posited that Claimant had probably suffered a fracture of the distal tibia in the past and that arthritis had set in. He prescribed stretching exercises.

- e. Low back. As a 27-year-old in 1999, Claimant sought treatment for severe, constant low back pain, worse on the left side, related to no known injury. "Any movement makes the pain much worse." JE-83. "Feels better when lying flat. Pain worse when bending over. Pain shoots to left hip." JE-87. On exam, Claimant had obvious muscle spasm along his left paraspinous musculature. During this period, Claimant also received the first of many treatments for thrombosed hemorrhoids which ultimately culminated in hemorrhoidectomy surgery in 2002.
- f. Right foot. A day before his 28th birthday, Claimant sought treatment for a puncture wound to the top of his right foot he sustained when he dropped a gate onto it the day before. X-rays showed no fractures. Claimant developed cellulitis, which was successfully treated over the next few days. At 29, Claimant

was treated for a right heel laceration a day or so after incurring the injury. The wound was not bleeding, but Claimant reported he felt like it was being ripped open each time he stepped on it. Debridement and suturing apparently fixed the problem.

- g. Neck, left and bilateral shoulders, fatigue. When he was 30 (in about 2002), Claimant was treated by Dr. Brus for left-sided neck pain radiating into his shoulder that started when he picked someone up and threw that person into a pool. Claimant had already seen a chiropractor repeatedly for these injuries, without relief. On exam, Claimant had tenderness along his left lateral neck muscles. Dr. Brus prescribed pain and anti-inflammatory medications, ice and heat, home exercises and a follow-up appointment in two weeks. Claimant did not, however, return for a recheck of his neck condition. Around this time, Claimant also began obtaining treatment for chronic bilateral shoulder pain. Over time, tendinitis, bursitis, rotator cuff impingement syndrome, and shoulder spurring¹ were all diagnosed. Claimant managed well with periodic steroid injections into his shoulders for several years. Also during his 30th year, Claimant underwent a comprehensive medical exam in which he reported fatigue over the past two years, job stress and occasional interrupted sleep due to a racing heartbeat.
- h. Right foot, left toe, gout. Claimant continued to report pain in various joints over the next several years, for which steroid injections or pills were sometimes prescribed. In 2006, medical records document that Claimant was drinking four

¹ No finding as to the relationship, if any, between Claimant's shoulder spurring and his shoulder pain or treatment therefor is made herein.

to five beers a day to *ease* his joint pain, that his liver function tests (LFTs) were elevated, and that Dr. Brus recommended that he cease drinking alcohol. Following workup for sudden onset of right foot pain and swelling without known injury in 2007, and right ankle pain with similar onset in 2008, Dr. Brus diagnosed gout and again advised Claimant to stop drinking, among other activities, because they aggravate gout pain. Also in 2007, Claimant reported (to a different physician) left great toe pain which he attributed to his 2005 left ankle injury. Blood testing revealed an abnormally heightened uric acid content; however, there was no follow-up regarding a gout diagnosis at the time because Claimant's symptoms were alleviated by a steroid injection before the blood test results became known. Although collateral ligament instability of the medial collateral ligament of the interphalangeal joint of the great toe was the working diagnosis at the time Claimant received that steroid injection, it would appear that gout played a part in his symptomatology, whereas his 2005 left ankle injury was likely not a causal factor.

- i. Multiple joints. In 2006, Dr. Brus prescribed prednisone and considered referring Claimant to a pain clinic to help him manage severe and constant multiple joint pain of unknown etiology, primarily in his shoulders, hips and left ankle, likely related to old sports injuries to his bilateral shoulders, neck, low back, hips and left ankle.
- j. Left thigh paresthesia. In December 2008, Claimant reported to Dr. Brus left thigh numbness lasting up to three hours. Dr. Brus assessed left thigh intermittent paresthesias of unclear etiology, possibly due to deconditioning.

- k. Right arm, shoulder, gout. During the month before his industrial accident, Claimant sought treatment for right forearm pain on extension, with onset two months previously. Dr. Brus prescribed stretching exercises and prednisone, but Claimant's pain remained. After a couple of weeks, his pain expanded into his posterior right shoulder. Dr. Brus's chart note of October 8, 2009 records an inquiry from Claimant as to whether his right arm and shoulder pain could be due to gout. Apparently, Dr. Brus did not think so; he prescribed Valium three times per day. On his own, Claimant took colchicine, a gout medication, and a week later he reported it had alleviated his symptoms. Dr. Brus then diagnosed a gout flare as the cause of Claimant's right arm and shoulder pain. Also in October 2009, Claimant had an elevated LFT.
- l. Hyperlipidemia, hypertension, obesity. Prior to his industrial accident, Claimant had a history of hyperlipidemia, high blood pressure readings, and obesity (approximate BMI = 33).

INDUSTRIAL ACCIDENT AND RELATED MEDICAL TREATMENT

2. At the time of his industrial injury, Claimant was a maintenance worker at Procore, a residential and commercial property management company. On October 16, 2009, Claimant was standing on a chair and drilling overhead with both hands, when the drill bit slipped off the head of the screw he was drilling, causing him to lose his balance and fall. He recalled that he landed "flat" on his back and that he hit his head but did not lose consciousness. Claimant felt extreme pain and was frightened that he had broken his back. He laid there until someone found him. Then his wife, who also worked at Procore, drove him to Mercy Medical Center in Nampa (Mercy Medical). Claimant reported neck and back pain. Following

examination and medical imaging² which revealed mid back degenerative changes at all levels from T7-T12, but no fractures or acute injuries, Claimant received pain medications and instructions to follow up with his primary care physician.

3. Claimant followed up with Dr. Brus, by telephone message, on October 20, 2009. He reported continuing pain in his “neck area” and a need for more pain medication. JE-260. Dr. Brus apparently reviewed Claimant’s records from Mercy Medical, then noted his understanding of Claimant’s condition:

He fell off the ladder at work and landed on his back. He lay on the ground for 45 minutes and his wife came to get him, took him to the ER in Nampa and there he had a head CT³ along with neck X-Rays [*sic*] and these are reportedly normal. He was told that he has degenerative changes in the mid back area, however. He was sent home on pain medication, but he continues to work. He has severe headaches at night.

JE-260. Claimant’s complaints centered on his neck pain and headaches, which Dr. Brus attributed to “muscle spasms in the neck, neck sprain, and upper back pain.” JE-261. Dr. Brus recommended follow-up with either a chiropractor or a physical therapist; Claimant initially chose a chiropractor.

4. On November 3, 2009, Claimant had his initial chiropractic consultation. On the intake sheet, he indicated spine pain, from his neck down to about his waistline, which he described as throbbing, aching, tingling and associated with stiffness. On exam, Claimant had tenderness over T2, T6 and T11, a positive Soto Hall test indicating his pain originated in his thoracic spine, and foraminal compression at T2. Claimant was diagnosed with subluxation at T2, T6 and T11 and his prognosis was “good”. JE-324. Two to three weeks of chiropractic treatment was recommended; however, Claimant only followed up once.

² Claimant underwent x-rays of his entire spine and CT scans of the cervical and thoracic levels.

³ Dr. Brus’s chart note from later that day, when he examined Claimant, also erroneously notes Claimant underwent a head scan. There is no other indication in the record that Claimant underwent a head CT.

5. Claimant kept Dr. Brus updated by leaving messages with his office. In November 2009, he left four. They indicate that he was having headaches, that pain medications helped alleviate his pain, and that some days he had no symptoms and others he had severe head and neck pain, among other things. There are no reports of mid back pain during this time frame.

6. On December 2, 2009, Claimant was evaluated by a physical therapist. Claimant's symptoms were recorded as follows:

Patient complains of mid back pain that is worse in the morning but is there throughout the day. States that by the end of the day it feels good to lay on a hard surface. States that by the end of the day his neck is stiff and sore. States that his neck pops a lot with a side bend to the left. States that the left side of his neck hurts the most. Having some days that I feel good. Sitting tall and standing tall are difficult. Have some degenerative arthritis in my back. Transient tingling in upper trap and low thoracic spine.

JE-387. Following examination, the physical therapist assessed significant thoracic spine deficits and moderate cervical spine deficits. "He has pain and rotational deficits in his thoracic spine. Also has cervical pain with signs of L side facet joint compression. I feel this is a result of guarding and postural changes related to his thoracic spine deficits." JE-388. The therapist requested approval for a maximum of 15 treatments, from December 2, 2009 through January 8, 2010, to treat Claimant's bilateral thoracic spine; however, both thoracic spine sprain and cervicgia were listed as diagnoses on each treatment chart note.

7. On December 4, 2009, Claimant reported to his physical therapist "that he felt good for a little bit after the first treatment but that night and the next day he had a lot of pain and now feels like he has a lower rib out. I have had one episode on the left of feeling the shock type feeling in my trap region. Mid back is the worst at this time." JE-389. Following

treatment, Claimant had improved spinal alignment and his rehabilitation prognosis was “good.”
Id.

8. Unfortunately, Claimant ultimately failed to improve with physical therapy. On December 21, 2009, the therapist noted that he “continues to have deficits at his upper thoracic spine and lower cervical spine that will require continued treatment,” and recommended that he also see a chiropractor in conjunction with his physical therapy. JE-396. The next day, Claimant reported that he had an appointment at a pain management clinic. On December 28, 2009, the therapist reported that Claimant still had “a lot of upper thoracic spine limitations.” JE-398.

9. On December 24, 2009, Claimant underwent another series of radiological imaging. X-rays of his cervical and thoracic spine showed no acute abnormalities, but confirmed mild midthoracic spondylosis and mild thoracic levoscoliosis. Interestingly, Claimant’s earlier x-ray reportedly demonstrated dextroscoliosis. One set of imaging was apparently inadvertently read from the back. In any case, the imaging reports are sufficient to establish that claimant suffered preexisting spine curvature.

10. On or about December 30, 2009, Claimant was examined at the Pain Care Clinic by Fred Friel, PA-C, physician assistant to William G. Binegar, M.D., a pain medicine specialist. Mr. Friel reviewed all of Claimant’s relevant imaging films and examined Claimant. Without addressing the etiology of Claimant’s condition, he diagnosed thoracic back pain, cervical neck pain and low back pain, and recommended medication, more physical therapy (with a different physical therapist) and a follow-up appointment in two weeks. In addition, “The patient has been encouraged to continue with his typical activities of daily living and to avoid bedrest as therapeutic treatment for his pain.” JE-440.

11. From January 12, 2010 until March 19, 2010, Claimant regularly attended physical therapy sessions at Mountain Land Physical Therapy. At his initial evaluation, he reported symptoms including “electricity flowing into left trapezius and...headaches about 1x/wk.” JE-465. A week later, the therapist confirmed that Claimant had radicular pain in his trapezius. On January 25, he reported that his back still felt broken. On February 9, Claimant’s pain was noted to be mainly in his low neck and low back. The plan was for Claimant to “[s]tart performing work-related tasks and improving body mechanics within tasks.” JE-481. On February 12, Claimant’s symptoms were isolated to his neck and low back, and he had “no electricity.” JE-484. On February 22, Claimant “had to push a car over weekend and neck is worse.” JE-487. On March 8, he reported tingling in his left hip for the past few weeks. At discharge, Claimant had shown no permanent improvement.

12. Also during this period, from January 19, 2009 through March 18, 2010, Claimant followed up at the Pain Clinic. On February 12, Dr. Binegar examined Claimant and noted that he had no radicular symptoms related to the cervical or thoracic spine, but that he did have tenderness over his C6-7, C7-T1, T1-2 and T7-8 interspinous ligaments, “but otherwise no further tenderness of the remaining interspinous ligaments of the cervical and thoracic spine.” JE-445. He also opined that Claimant’s pain could be related to inflammation of the above-identified interspinous ligaments as a result of his industrial accident and recommended pain injections:

I did review with Mr. Lynn the mechanics of his fall from a ladder approximately four months ago. I do feel that indeed this could be a result of inflammation of the above noted tender interspinous ligaments. I have recommended interspinous ligament injections with ultrasound guidance at the levels of C6-7, C7-T1 and T1-2...I discussed as far as further workup, my only other consideration would be possible bone scan with SPECT imaging, and however, my guess is that this would prove to be negative.

Id.

13. Claimant underwent pain injections, as recommended by Dr. Binigar, at C6-7, C7-T1 and T1-2, on February 25, 2010 and March 4, 2010. Each time, Claimant reported about 50% relief for a couple of days before his pain returned to baseline.

14. On March 31, 2010, Claimant returned to Dr. Brus, who summed up his treatment so far:

Patient is here for a F/U on neck and upper back pain related to an injury at work. He has had physical therapy, several chiropractic treatments, been on pain medication and muscle relaxers and I sent him to see Dr. Benigar [*sic*] for further evaluation and pain treatment. He received injections to the neck and upper back area with pain relief for several days, then symptoms would recur. CT scan of the neck showed no fractures or disk herniations and a bone scan done recently was noted to be normal. He has been working normally till about 1.5 weeks ago when his work decided to not have him come back because they felt he was at risk for more injury at work. I have not taken him off work as I felt that he was capable of continuing his normal activities since the pain medication and muscle relaxer allowed him to work better. He feels like there has been no progress in any of the therapies he has had and is wanting to know what else can be done...His wife gives him a massage from time to time and notes that the L trapezius muscle and R mid back muscles are persistently tight and tender. Physical therapy has not been able to relax these muscles and injection therapy has only worked temporarily.

JE-276. Following examination, Dr. Brus maintained that Claimant did not need to be limited from work, and wrote a note to that effect for Claimant's supervisor.

15. Also on March 31, 2010, Claimant returned to his chiropractor, who prescribed three to four weeks of treatment for his neck and upper back. Claimant's tenderness was now at

T2, T6 and T10, and he reported that his back felt like it was broken and that it felt better when he laid on the floor. The chiropractic diagnosis remained the same, but Claimant's prognosis was down-graded to "guarded" because it was now six months since his injury, and he had failed to improve following treatment at other facilities.

16. Over the next two months or so, Claimant underwent 16 chiropractic treatments to his neck, mid back and low back. He also tried acupuncture. He was still lying on the floor for pain relief, in addition to taking medications. Although Claimant was improving, he did not participate in further chiropractic treatment because Surety advised his chiropractor that, based upon Dr. Kadyan's April 22, 2010 independent medical evaluation (IME) recommendations (see below), it would no longer pay for Claimant's medical costs.

17. On April 22, 2010, Vic Kadyan, M.D., a physiatrist with subspecialties in spine injuries and IMEs, conducted an IME at Surety's request. He prepared a report and, on January 25, 2012, he also provided testimony at a deposition. By the time of his report, Dr. Kadyan had reviewed Claimant's medical records, taken an oral history from Claimant, examined Claimant, and reviewed Claimant's responses on various questionnaires. By the time of his deposition, he had reviewed Claimant's updated medical records, as well.

18. Dr. Kadyan opined that Claimant had suffered sprains/strains of his thoracic, cervical and lumbar spine, which had resolved. He explained that that 90% of these sprains/strains heal within 30 days, and the remaining 10% can be expected to heal within 60 days. So, since Claimant was still reporting pain more than 60 days out from these injuries, some other pathology was most likely causing his persisting symptoms. "I think in his case when I looked at it, you know, degenerative joint disease is a possibility. I think the arthritis, the gouty arthritis, is probably what bothered me the most." Kadyan Dep., p. 27.

19. Dr. Kadyan noted in his report that Claimant's pain was primarily in the T6 through T10 region. However, he did not believe Claimant's disc bulge at T6, which he characterized as fairly small, was causing Claimant's symptoms because, although the disc bulges into Claimant's spinal canal, it does not compress his spinal cord. This opinion is shared by the radiologist who initially read and reported Claimant's September 13, 2010 MRI findings at T6-7 as a small midline disc protrusion with mild canal stenosis, but without foraminal stenosis. (See JE-754). Likewise, Claimant's thoracic CT scan taken on the day of his fall demonstrated patent neural foramen throughout the thoracic spine, with no paravertebral swelling. (See JE-745).

20. At his deposition, Dr. Kadyan further explained why he does not believe Claimant's T6 disc is symptomatic:

Q. And this protrusion that's at T6 that you say in the studies, does it go into the spinal canal?

A. Yes, it bulges into the spinal canal.

Q. Does it impact or compress the spinal cord itself?

A. It does not compress the spinal cord.

Q. And you observe that on what?

A. So two ways of looking to see if it has any effect on the spinal cord. One is by imaging studies and one is by physical examination. And his history of both of those don't seem to show any significant spinal cord compression or effect on the cord.

Q. Kind of working backwards, if there had been compression on the spinal cord what would the physical examination have been like?

A. So compression on the spinal cord typically causes a numbness, tingling. It would be just at that

level, so radiating across the thorax or going down into the legs, distal foot. You would expect weakness, and depending on which, bowel or bladder issues.

Q. Did Mr. Lynn have any of those that would be consistent with the compression of the cord at that level?

A. He did not.

Q. And then otherwise, looking at imaging studies, what did you see?

A. With imaging studies what you want to make sure is that there is fluid all the way around the spinal cord. And so if the disc presses on the spinal cord the fluid, which shows up as white on the imaging studies, would be gone, and you would just see discs and then the spinal cord. And then you would also see the spinal cord being pushed towards the back, and those were not noted on the imaging studies.

Q. Okay. In stating the diagnosis you indicated that there was the thoracic spine strain and the cervical spine sprain/strain; did you feel those were related to the fall of October 16, 2009?

A. Yes.

Q. Why?

A. I think it would not be unreasonable, given his mechanism of injuries, pain complaints, that he would have injuries to the thoracic spine and that he would have sprains or tears in his muscles or ligaments in that area.

Kadyan Dep., pp. 29-31.

21. Dr. Kadyan also concluded that the medical record in Claimant's case was inadequate to support an opinion, to a reasonable medical probability, that Claimant's fall permanently aggravated any underlying conditions.

22. According to Dr. Kadyan, Claimant reached medical stability by April 22, 2010, and he did not require further medical treatment or any medical restrictions related to his industrial injury. He did, however, opine that Claimant should be evaluated by a rheumatologist because he suspected that an underlying arthritic disease unrelated to the industrial accident was causing Claimant's pain.

23. As a result of Dr. Kadyan's opinion, Surety denied any further medical claims. Then, at some point, it paid at least some of Claimant's medical costs through May 2, 2011, the date of Dr. Frizzell's opinion (see below).

24. On May 12, 2010, Claimant underwent another set of x-rays of his entire spine. Irregularity at T10, T11 and T12, slight dextroscoliosis in the thoracic spine, narrowing of disc spaces at several levels in the lower thoracic spine, and some narrowing of the disc space at L4-5 were identified.

25. On May 13, 2010, Dr. Brus commented on Dr. Kadyan's opinions contained in his April 22, 2010 report and also examined Claimant. Claimant was still experiencing 5/10 pain with medication and 8/10 without, with no paresthesias or weakness in his extremities. "There is mid thoracic tenderness to palpation going from about T6-T10. Extending the back increases his pain. There was no tenderness in the paraspinous muscles today...No sensory deficits today, normal ROM on observation." JE-286. He disagreed that Claimant was medically stable because he seemed to be benefitting from chiropractic treatments. He recommended continuing chiropractic care for another month, home activities and pain medications. Dr. Brus also opined that Claimant would benefit from a physiatry evaluation to determine alternate therapeutic options in lieu of pain medications, as well as a rheumatology consultation to determine whether his mid back pain was related to an unidentified underlying

condition. Along those lines, Dr. Brus opined that Claimant's industrial accident permanently aggravated his underlying degenerative joint disease in his thoracic spine:

I would agree that the degenerative changes in the thoracic spine are pre-existing, however, the injury aggravated this and he now is having continuous pain. So, I don't believe the injury caused the degenerative changes, but it did make them worse, as he was asymptomatic prior to the injury.

JE-288. This was the last time Dr. Brus examined Claimant regarding his industrial injuries. Subsequent notes memorializing his involvement with evaluation or treatment of Claimant in this regard pertain to telephone consultations, either directly with Claimant or via telephone messages.

26. On June 2, 2010, Dr. Brus noted that Claimant quit going to the chiropractor two weeks previously because he was not getting any benefit from the treatments. So, he referred Claimant to Dr. Moore, a physiatrist, for chronic pain treatment. On June 21, Dr. Brus refilled Claimant's narcotic pain medication and muscle relaxers, but noted that Claimant was taking too much. Claimant still had not scheduled an appointment with Dr. Moore.

27. On July 7, 2010, Claimant was evaluated at Idaho Physical Medicine & Rehabilitation by Michael O. Sant, M.D., a physiatrist and practice partner of Monte H. Moore, M.D. (presumably the "Dr. Moore" to whom Dr. Brus referred Claimant). Claimant described his pain as a deep ache beginning in the middle of his neck and extending to his mid back, without radiculopathy, worse with physical activity and better with laying on a hard floor. He also had tingling in his left shoulder and left leg. On palpation, Claimant was significantly tender along his vertebral spine in the mid thoracic area and his cervical paraspinals, with no spasm, and he had a normal sensory exam. Dr. Sant's primary diagnosis was mid thoracic pain and his secondary diagnosis was neck pain (cervicalgia). He also noted Claimant was depressed

and tearful. Dr. Sant ordered MRIs of Claimant's cervical and thoracic spine and recommended facet injections for both therapeutic and diagnostic purposes, but he understood Claimant could not afford this procedure because Surety had ceased paying his medical costs. He also prescribed a Medrol Dosepak, Skelaxin and Cymbalta, and recommended that Claimant cease taking Valium due to its depressive effects. Claimant did not fill his prescriptions because of the cost.

28. On or after July 7, 2010, Dr. Sant replied to a letter from Surety seeking his position as to Dr. Kadyan's April 22, 2010 opinions. Dr. Sant responded, "I agree in essence, but feel we should try facet injections before closing the case." JE-548.

29. On July 20, 2010, Claimant obtained more narcotic pain and muscle relaxer medication from Dr. Brus. Dr. Brus encouraged Claimant to fill the Medrol Dosepak Dr. Sant prescribed and to ask for samples of Cymbalta. He also reminded Claimant that Flexeril had worked better in the past than Skelaxin. A week later, Dr. Brus discussed Claimant's alcohol use with him and recommended a follow-up chem panel to check Claimant's LFTs, which were elevated in October 2009. Claimant responded that he had been to Alcoholics Anonymous (AA) and had stopped drinking alcohol completely. The record belies no evidence that updated LFTs were ever performed.

30. On August 4, 2010, Claimant obtained more Percocet from David Deroin, M.D., a family practitioner, because, according to Claimant, Dr. Brus was out of town. There is no related chart note in Dr. Brus's records to confirm that he was out of town or that Claimant tried to contact him during this timeframe. Dr. Deroin's chart note indicates Claimant had been out of pain medication for two days and that Claimant was tearful and depressed. Although

Claimant only requested 15 Percocets, Dr. Derooin prescribed 60, and also gave him two-and-a-half months' worth of Lexapro, an antidepressant.

31. On September 23, 2010, Claimant returned to Dr. Sant, reporting significant neck pain with any bending of his neck forward or back. On exam, he had tenderness over his mid cervical spine. Dr. Sant reported Claimant's September 13, 2010 MRI results as showing "a thoracic disk bulge at T12 with possible encroachment on the left T12 nerve root" but that Claimant "does not have much pain referable to that area." JE-549. "He has degenerative changes in his C spine, most notable at C5-6 where there is potential encroachment on the R C5-6 foramen." *Id.* Dr. Sant was "still under the impression that [Claimant] has facet mediated pain that was aggravated [*sic*] by his fall." *Id.* He noted that Claimant's attorney was still working on getting Surety's approval for facet injections and that Claimant's depression had improved since Dr. Brus prescribed Lexapro. Dr. Sant again prescribed a Medrol Dosepak.

32. On September 28, 2010, Claimant obtained 45 more Percocet pills, as well as a 15-day supply of muscle relaxers from Dr. Brus. Two days later, he asked for more when he was being seen on an unrelated matter. Dr. Brus referred Claimant to Dr. Sant for a pain consultation and to the "healer" who had apparently had some success in using heat treatments on Claimant. JE- 295.

33. Dr. Sant again evaluated Claimant on October 14, 2010. Claimant reported his neck and back pain were unchanged and, on exam, he had tenderness in the lower cervical and upper thoracic paraspinals and into the rhomboids. Claimant took the Medrol Dosepak, without improvement. Dr. Sant continued to believe that facet injections may improve Claimant's condition:

I am not sure how to help this gentleman beyond the trial of injections. I am not at all comfortable giving him escalating doses of narcotics as his

anatomy does not justify it. I will continue with the Percocet for now and try changing his nsaid to meloxicam. I will wait to hear what happens with the injections. Beyond that, I don't have much to offer him. He needs continued help with his depression issues, which I think are playing a large role in his slow recovery.

JE-551. At his deposition, Dr. Sant recalled that, following this evaluation, he found it curious that no pain relief strategies were helping.

34. On November 3, 2010, Claimant followed up with Dr. Sant. When Dr. Sant arrived at the examining room, Claimant was lying down. Claimant completed another pain diagram, showing the same symptoms as before, and reported that he “looks forward every day to going home from work and laying down.” JE-554. He moved slowly on exam, but had no continued focal weakness and a normal gait. He was still waiting for approval for facet injections. Dr. Sant diagnosed cervicalgia as the primary problem, with thoracic spine pain as a secondary concern. He prescribed 1-2 Percocets per day, which he apparently maintained for several months, but noted concern about Claimant's narcotic usage:

He is taking more medication than is prescribed. We had a discussion about that. I explained that if he continues to do that, I cannot continue to give him that. I will refill his meds including his muscle relaxer to try and help him sleep.

JE-554. Dr. Sant also predicted that a CT myelogram may be in order in the event the proposed facet injections were performed without success.

35. On January 5, 2011, Claimant underwent facet injections into his C5-6 and C6-7 facets. On January 20, 2011, he reported only about a 10% overall improvement in his pain. Claimant reported upper back pain as his biggest problem, but Dr. Sant again listed cervicalgia as the primary diagnosis. On exam, Claimant reported tenderness in his cervical paraspinals, particularly around C7, and limited his neck range of motion due to pain. Dr. Sant prescribed more facet injections, into the C5-6, C6-7 and C7-T1 facets, which were performed on February

4, 2011. Claimant reported that after some temporary relief, his pain returned to baseline.

Dr. Sant prescribed more Percocet and recommended one more round of physical therapy:

He has not had much response to any treatment. I explained this does not appear to be a surgical problem. I really do not know what else to offer. He is already building a tolerance to his medications, which I warned would happen. I will try some PT one more time and explained that is really all I have left to offer. We need to get him off the pain meds once his PT is done. I will see him in a few weeks and see how he is doing.

JE-565-566.

36. On March 3, 2011, Claimant began treatment with Ed Race, D.C., a myofascial pain specialist. Dr. Race noted Claimant had severe neck and mid back pain, with abhorrent joint motion at C5, C6, T2, T3, T4, T5, T6 and his sacroiliac joint. Claimant attended approximately nine appointments through April 7, 2011, without improvement.

37. On March 10, 2011, Claimant reported increased neck and back pain to Dr. Sant. He also reported that he was taking more than the prescribed dosage of Percocet. Dr. Sant noted that Claimant continued to display pain behaviors and to report tenderness over the C7 spinous process and above the paraspinals, as well as headaches and sleeplessness. Claimant had not been to physical therapy yet, but reported he would start the next day. Dr. Sant noted Claimant had been seeing a myofascial pain specialist (Dr. Race), with no improvement. Dr. Sant reiterated that he had nothing else to offer in the event Claimant did not improve with physical therapy.

38. On March 11, 2011, Dr. Brus prescribed Viagra because Claimant was failing to achieve erections. Also on this date, Claimant began another course of physical therapy, at RehabAuthority. He reported he had fallen from a three-foot-height onto his back and neck. On a pain diagram, he indicated he had aching pain over his cervical and thoracic spine but, following examination, the therapist reported that Claimant's pain reports were centralized over

his neck and that he had “symptoms consistent with a cervical central and or symmetrical derangement.” JE-672. The therapist noted Claimant was depressed due to pain and decreased activity and that he was still lying on the floor for pain relief, among other things. Claimant had poor posture and point tenderness along the suboccipital region and the cervical paraspinals. Over several sessions, Claimant reported no change in his pain.

39. On March 17, 2011, Claimant reported to Dr. Brus that he had been to four sessions with Dr. Race and that the myofascial treatments were worsening his condition. Like Dr. Sant, Dr. Brus recommended physical therapy.

40. On March 24, 2011, Dr. Sant completed a check-box letter prepared by Defendants in which he opined (among other things) that at the completion of physical therapy, Claimant’s prescription pain medications should be discontinued, he would be at medical stability, and he would be able to return to his pre-injury employment activities without restrictions. He further opined that Claimant would not merit a permanent impairment rating because “there is no identifiable pathology or anatomical change referable to his pain complaints that is a direct result of his injury.” JE-572. As for the pathology demonstrated on Claimant’s MRIs, Dr. Sant agreed that they “are normal age related changes...[unrelated] to the any [*sic*] trauma, in particular, the October 16, 2009 injury.” *Id.*

41. On March 25, 2011, Claimant advised Dr. Brus that he missed work the previous day due to pain and that “he feels as if his neck is very “vulnerable and just feels broken.” JE-682.

42. On April 4, 2011, Claimant returned to Dr. Sant. He had taken a week off from work because physical therapy had exacerbated his neck pain. He reported his work hours had been cut back to 20 hours per week and that he was still going home and lying on a hard floor

which, he said, was the only way he could get relief. On exam, Claimant had a flat affect and held his neck stiff. He had no focal weakness or sensory loss. Dr. Sant advised that he could not identify a pain generator, so he had nothing to offer in the way of further treatment. Claimant elected to finish up his physical therapy over the next couple of weeks.

43. On April 15, 2011, Claimant reported to Dr. Brus that he was taking ten Percocet per day to control his pain. Dr. Brus declined to prescribe Percocet at this rate, but recommended physical therapy with Jill Thompson.

44. On April 18, 2011, Claimant reported he was out of Percocet. Apparently, Dr. Brus prescribed more, at the rate of four tabs per day. Claimant also reported that physical therapy had failed and that Dr. Sant had nothing more to offer, advising that Claimant needed to learn to live with his pain. Claimant requested a referral to an orthopedic surgeon, which Dr. Brus granted, with reservations:

He would like to visit with an orthopedic surgeon. I think this would be fine, but I would be skeptical about any benefit that could be gained from surgical intervention. If ortho has nothing to offer, I would consider one more physical therapist.

JE-305. Claimant had an appointment with Ms. Thompson in a few days.

45. On April 19, 2011, Dr. Sant last examined Claimant. His pain was the same and he reported his work hours remained reduced to 20 hours per week due to fatigue and pain. “On exam, he has mildly reduced cervical ROM, but it is functional. He has normal UE ROM and strength. He has normal sensation to light touch. Affect is flat.” JE-577. Dr. Sant offered no additional treatment and released Claimant from care without a permanent impairment rating or restrictions:

We have completed his treatment course. We have tried PT, injections of various kinds without relief. His MRI’s [*sic*] do not show pathology that would explain his symptoms. As before, I have been unable to find a

definitive generator for his pain complaints. At this point, I will release him from care. There is no anatomic for [sic] physiologic justification at this point for permanent restrictions or impairment.

Id.

46. On April 20, 2011, Claimant advised his physical therapist at RehabAuthority that he had been released from Dr. Sant's care and would not be returning. Throughout his therapy sessions, his pain had been centered in his cervical spine. Physical therapy failed to improve Claimant's pain.

47. Nevertheless, on April 22, 2011, Claimant was evaluated at Physical Therapy 180° by a practice partner of Ms. Thompson. Claimant reported the same symptoms. On exam he had pain/tenderness to palpitation at C7, T1 and T2, in addition to limited range of motion, tightness and other symptoms related to various areas. T6, however, was not specifically identified as correlating to any of Claimant's symptoms. A recommendation for further physical therapy was made, with a prognosis of "good", but Claimant did not return because Surety permanently ceased paying benefits in early May 2011.

48. On May 2, 2011, R. Tyler Frizzell, M.D., a neurosurgeon, performed an IME at Claimant's request. In preparing his opinions, Dr. Frizzell reviewed Claimant's medical records and imaging films associated with his industrial accident, interviewed Claimant, and ordered flexion and extension cervical spine x-rays, which had not previously been performed. The x-rays demonstrated a normal cervical spine. Dr. Frizzell also examined Claimant, but did not note this in his report. At his deposition, he testified that Claimant had a normal neurological exam, normal cervical range of motion, tenderness around C6-7, "fatigue" at T6, and normal grip strength. Frizzell Dep., p. 7. At his deposition, Dr. Frizzell commented that it was unusual for a patient to characterize thoracic spine pain as fatigue. "That word usually doesn't come up

that often. Trouble with sitting, standing or driving,⁴ that comes up fairly often with people with back problems.” Frizzell Dep., p. 16.

49. Dr. Frizzell diagnosed cervical and thoracic sprains, as well as a thoracic disc protrusion at T6-7, symptomatic but without radiculopathy,⁵ as a result of his October 16, 2009 industrial accident. In reaching his conclusion, Dr. Frizzell relied upon the medical records documenting thoracic pain since the industrial accident, as well as Claimant’s September 13, 2010 MRI, which he opined the attending radiologist “slightly under-read.” Frizzell Dep., p. 10. According to Dr. Frizzell, that film demonstrates core compression, which leads to pain. “It’s not significant enough to require surgery since he still has some spinal fluid around the core, but it certainly changes a normal oval-shaped spinal cord to a kidney-bean-type appearance.” Frizzell Dep., p. 9.

50. Dr. Frizzell also confirmed that Claimant had degenerative and preexisting pathology in his lower thoracic and cervical spine which were unrelated to his industrial accident. Along those lines, post-accident radiology reports demonstrate Claimant’s thoracic spine manifests conditions Dr. Frizzell opines are unrelated to the industrial accident, including: “some narrowing of the disc spaces at T7-8 through T11-12 with some irregularity of the endplates consistent with Schmorl’s nodes and degenerative marrow changes at several levels” (JE-745); “Slight dextroscoliosis...slight loss of the anterior height of the T10 and T12...narrowing of the disc spaces at several levels in the lower T-spine [and] irregularity of the endplate of T10” (JE-749); “Mild midthoracic spondylosis. Mild thoracic levoscoliosis.” (JE-751); and “Small left paracentral/foraminal T11/12 disk protrusion with mild left foraminal stenosis, and mild left lateral recess stenosis with possible mass effect on the descending left

⁴ Claimant also reported to Dr. Frizzell pain with sitting, standing or driving for extended periods.

⁵ Dr. Frizzell explained that no nerve roots attach to the midline of the spine, so he would not expect radiating symptoms because the “cord lesion” was not big enough to trigger them. Frizzell Dep., p. 10.

T12 root.” (JE-754). Dr. Frizzell further opined that thoracic spine disc protrusions are usually the result of the normal aging process.

51. Dr. Frizzell opined Claimant was not a surgical candidate and that he was medically stable. He also assessed a PPI rating of 6% of the whole person, with no apportionment, on account of Claimant’s thoracic disk protrusion at T6-7:

a. Utilizing the American Medical Association Guide to Evaluation of Permanent Impairment, fifth edition [*sic*], Mr. Lynn would be best evaluated using the DRE method of the thoracic spine which is table 15-4. He would be a DRE thoracic category II, with a protruded disk at the level which would be expected from objective clinical findings but without radicular findings. This would relate to his thoracic symptoms at T6-7. The other thoracic disk protrusions in my opinion are asymptomatic. This would result in a 6% impairment of the whole person. There would be no apportionment as he had no prior thoracic symptoms which I am aware of.

b. In terms of his cervical condition, he does have prior cervical spine symptoms and he has no cervical pathology, so there would be no impairment related to his cervical spine symptomatology.

JE-712.

52. As to medical restrictions, Dr. Frizzell referred Claimant for a functional capacity examination, which Claimant did not complete because he had a shoulder condition of which Dr. Frizzell was unaware. On June 21, 2011, after being advised of Claimant’s shoulder condition and without again examining Claimant, Dr. Frizzell opined that Claimant’s lifting should be restricted to 50 pounds occasionally and 25 pounds frequently, and that he should avoid continuous bending and twisting. At his deposition, he explained that these are “fairly customary restrictions for a disc protrusion” in order to protect patients from future injury and reduce pain. Frizzell Dep., pp. 14-15. Dr. Frizzell also testified that if the Commission determines that Claimant only suffered cervical and thoracic sprain/strains, he would still

recommend these restrictions. “And the rationale is that with some contouring of his spinal cord, I would be hesitant to allow this gentleman to work without restrictions.” *Id.*

53. On May 5, 2011, Dr. Brus authored a letter to Surety seeking approval for a course of physical therapy with Ms. Thompson. Dr. Sant conditionally concurred in this request. “I was not comfortable making the referral myself, as Mr. Lynn had already completed therapy with 2 other therapists...Dr. Brus felt this particular P.T. might help Mr. Lynn and I stated it was not unreasonable to try...I think it unlikely to improve his condition or pain complaints.” JE-581.⁶

54. Also in May 2011, medical records report that Claimant fell face-down onto his elbows, jamming his right shoulder. He underwent arthroscopic surgery on his right shoulder in July 2011. Claimant’s orthopedic surgeon noted on July 28, 2011 that Claimant “has had difficulty with pain all along and has required fairly large amounts of narcotics for relief. He is currently on OxyContin 20 mg b.i.d. and oxycodone 5 mg two to three tablets every three hours. He is also taking ibuprofen 400 mg b.i.d.”. JE-368. By six weeks post-operatively, however, medical records show Claimant was participating in physical therapy and “getting nearly close to discontinuing narcotics altogether.” JE-369. As of September 29, 2011, Claimant’s records reflect that he had some discomfort but was not taking any medications and that his range of motion was 80-90% of normal with physical therapy. His physician was pleased with his recovery.

55. On August 15, 2011, Dr. Sant responded to another check-box letter from Defendants generated after Dr. Sant reviewed Dr. Frizzell’s May 2, 2011 IME report. Dr. Sant continued to opine that Claimant is not entitled to a permanent impairment rating related to his

⁶ On June 22, 2011, Dr. Sant hand-wrote these responses on a check-box letter provided by Defendants.

industrial accident. At his deposition, Dr. Sant explained why he cannot opine, to a reasonable medical probability, that any of Claimant's pathology identified on his September 23, 2010 MRI resulted from his industrial accident:

Q. Okay. Now, you talked about your opinion that he had the cervical and thoracic strains as injuries from the accident.

He does have some pathology shown on the MRI both in the cervical region and then in the thoracic region.

In your opinion, are those findings related to the fall that he had that ultimately brought him into your practice. [*sic*]

A. Again, it's difficult to say with any degree of certainty. Those are fairly nonspecific findings and so it's difficult to say, you know, whether they are preexisting or due to the injury itself.

Sant Dep., p. 43.

56. On December 19, 2011, after spending about 45 minutes with Claimant's attorney and reviewing Dr. Frizzell's report and updated x-rays and MRIs of Claimant's neck and upper back, Dr. Brus opined:

The conclusion that I make is that Wade was injured in October of 2009 and since then has not been able to do what he used to do related to that injury. He has been through many and various treatments with limited success. He has probably reached maximal medical therapy. However, it was also suggested he try PT with Jill Thompson and also visit with the Mayo Clinic to see if there was anything more that could be done for Wade. At this time neither of those have happened. I have not see [*sic*] Wade since May of 2010.

JE-309. Contrary to Dr. Brus's unqualified assertion that he had not seen Claimant since May 2010, it would appear that he saw Claimant on three occasions after then for conditions

unrelated to his instant claims.⁷ Otherwise, as noted above, all of Dr. Brus's contact with Claimant following May 2010 was apparently conducted via telephone and/or telephone message.

VOCATIONAL EVIDENCE

57. On September 18, 2011 at Claimant's request, Douglas N. Crum, CDMS, authored a report in which he evaluated Claimant's vocational capacity. He relied upon Claimant's medical records provided by Claimant, his wage and income information, and additional information Claimant provided during an interview on August 11, 2011.

58. Based upon Dr. Frizzell's causation, PPI and medical restriction opinions, and assuming that Claimant is only able to work part-time, Mr. Crum concluded that Claimant has suffered a 39% reduction in wage earning capacity and a 23% loss of access to his local labor market, amounting to total PPD of 31% inclusive of PPI. In the event Claimant can work full-time, Mr. Crum opined he has sustained PPD of 21% inclusive of PPI. Based upon Dr. Sant's opinions, Mr. Crum opined that Claimant has suffered 0% PPD.

CLAIMANT'S CREDIBILITY

59. Given the central dispute over whether any objective evidence supports Claimant's pain complaints, it must be recognized that false reporting could potentially explain Claimant's record of persistent, debilitating pain ultimately unresponsive to various treatments over two years including physical therapy, chiropractic care, pain and muscle relaxer medications, steroid injections, and other interventions. Pain is a subjective experience, however, that cannot be accurately observed or measured by an outsider. A preponderance of evidence supports a finding that Claimant suffers from pain. Here, no physician has opined that

⁷ Medical records indicate Dr. Brus saw Claimant on September 28 and 30, 2010 to treat a skin lesion, and on December 21, 2010 to treat an upper respiratory infection.

Claimant has exaggerated his symptoms on exam. In fact, Dr. Kadyan noted in his report that Claimant evidenced no signs of symptom magnification. Further, the records pertaining to Dr. Brus's and Dr. Sant's long and committed treatment relationships with Claimant tend to demonstrate that they believe Claimant has experienced ongoing upper back and neck pain.

60. On the other hand, Dr. Kadyan also explained in his deposition that Claimant "denied ever having injuries or pain except for this injury, which was not consistent with what was in the chart." Kadyan Dep., p. 16. Also, Claimant inconsistently reported facts pertaining to the surface from which he fell and its height. He initially reported that he fell from a ladder, then that he fell from a chair (typically 20 inches or less), that he fell from a height of two-and-a-half feet, and that he fell from a three-foot height. Claimant explained that Employer requested him to report he fell from a ladder and that is why he initially lied. Although he corrected this inaccuracy, Claimant's initial decision to be untruthful with respect to facts relevant to this case casts some doubt on his overall credibility. In addition, Claimant's vacillation over the height from which he fell, between two heights that are significantly taller than chair height, tends to evidence a tendency toward self-advocacy.

61. The records further show that Claimant told Dr. Kadyan on April 22, 2010 that he had no alcohol issues and then, three months later, he told Dr. Brus he had been to Alcoholics Anonymous (AA) and had ceased drinking altogether. Dr. Brus advised Claimant in 2006, when he had an elevated LFT and was drinking to ease his joint pain, that he needed to stop drinking alcohol. In 2008, Dr. Brus diagnosed gout and again recommended that Claimant stop drinking, this time because drinking alcohol causes gout flares. It is possible that Claimant first went to AA and stopped drinking after he saw Dr. Kadyan and before he spoke to Dr. Brus. However, the evidence in the record is sufficient to support the conclusion that Claimant knew alcohol had

contributed to his medical issues in the past; nevertheless, he failed to report this information to Dr. Kadyan.

62. With respect to his reports of general upper back and neck pain, the Referee finds Claimant is a credible witness. However, he has not been a reliable reporter of some facts relevant to this case and, with respect to his alcohol use, he intentionally withheld relevant information from Dr. Kadyan. Claimant's testimony with respect to details concerning his alcohol use is given little weight herein. Further, where Claimant's testimony conflicts with information contained in an otherwise reliable contemporaneously made document, the Referee will adopt the documented facts as being more reliable.

DISCUSSION AND FURTHER FINDINGS

63. The provisions of the Idaho Workers' Compensation Law are to be liberally construed in favor of the employee. *Haldiman v. American Fine Foods*, 117 Idaho 955, 956, 793 P.2d 187, 188 (1990). The humane purposes which it serves leave no room for narrow, technical construction. *Ogden v. Thompson*, 128 Idaho 87, 88, 910 P.2d 759, 760 (1996). Facts, however, need not be construed liberally in favor of the worker when evidence is conflicting. *Aldrich v. Lamb-Weston, Inc.*, 122 Idaho 361, 363, 834 P.2d 878, 880 (1992).

CAUSATION

64. The Idaho Workers' Compensation Act places an emphasis on the element of causation in determining whether a worker is entitled to compensation. In order to obtain workers' compensation benefits, a claimant's disability must result from an injury, which was caused by an accident arising out of and in the course of employment. *Green v. Columbia Foods, Inc.*, 104 Idaho 204, 657 P.2d 1072 (1983); *Tipton v. Jannson*, 91 Idaho 904, 435 P.2d 244 (1967).

65. The claimant has the burden of proving the condition for which compensation is sought is causally related to an industrial accident. *Callantine v. Blue Ribbon Supply*, 103 Idaho 734, 653 P.2d 455 (1982). Further, there must be medical testimony supporting the claim for compensation to a reasonable degree of medical probability. A claimant is required to establish a probable, not merely a possible, connection between cause and effect to support his or her contention. *Dean v. Drapo Corporation*, 95 Idaho 958, 560-61, 511 P.2d 1334, 1336-37 (1973). See also *Callantine, Id.*.

66. The Idaho Supreme Court has held that no special formula is necessary when medical opinion evidence plainly and unequivocally conveys a doctor's conviction that the events of an industrial accident and injury are causally related. *Paulson v. Idaho Forest Industries, Inc.*, 99 Idaho 896, 591 P.2d 143 (1979); *Roberts v. Kit Manufacturing Company, Inc.*, 124 Idaho 946, 866 P.2d 969 (1993).

67. When the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury likewise arises out of employment, unless it is the result of an independent intervening cause attributable to claimant's own intentional conduct. *Larson's, The Law of Worker's Compensation*, § 13.

68. It is undisputed that Claimant suffered cervical and thoracic sprain/strains as a result of his October 16, 2009 industrial accident. However, the parties sharply disagree as to whether the industrial accident is the source of Claimant's continuing thoracic and cervical spine pain. Drs. Brus and Frizzell opined that Claimant has a permanent pain condition related to his industrial accident. Drs. Sant and Kadyan opined that he does not. Each opinion is evaluated, below.

69. **Dr. Brus.** Dr. Brus opined that Claimant's pain is the result of some unknown process related to underlying degenerative changes in his spine that was ignited by the trauma of his industrial accident. His medical opinion is based entirely on the timing of Claimant's pain complaints because "since then [he] has not been able to do what he used to do." JE-309. Temporal correlation between an industrial accident and onset of permanent pain, without more, is inadequate to establish a causal link to a reasonable medical probability. Further, Dr. Brus did not examine Claimant with respect to the subject injury after May 2010. Although Dr. Brus's long association with Claimant combined with his belief in the accuracy of Claimant's pain reports supports Claimant's credibility (as discussed, above), his opinion with respect to Claimant's ongoing pain lacks sufficient foundation and is unpersuasive.

70. **Dr. Sant.** After evaluating and treating Claimant over a nine-and-a-half month period, Dr. Sant could not identify an anatomical cause for Claimant's pain. For this reason, he could not opine, to a reasonable medical probability, that it was related to Claimant's industrial accident. Further, Dr. Sant recommended no additional treatment or evaluation, even after reviewing Dr. Frizzell's and Dr. Brus's medical records. Dr. Sant was in a better position to evaluate Claimant's condition than any other physician involved with this case. His chart notes indicate he earnestly investigated Claimant's symptoms. However, when Claimant failed to respond to diagnostic treatment for facet injuries, and the second course of physical therapy also failed to yield results, he conceded that Claimant's pain could not be sourced to the industrial injuries.

71. **Dr. Kadyan.** Dr. Kadyan opined that Claimant suffered cervical, thoracic and lumbar⁸ sprain/strains as a result of his industrial accident, but that his lumbar strain had fully

⁸ Based upon his evaluation and treatment of Claimant following the accident, Dr. Brus disagreed with Dr. Kadyan's

resolved, and his pain related to his cervical and thoracic sprain/strains had “essentially” resolved by April 22, 2010. “He did have some symptoms in the cervical spine along with thoracic spine, which seem to have improved and appear to have essentially resolved.” JE-532.

72. Dr. Kadyan also opined that Claimant’s T6-7 disc protrusion was not the source of his pain. Since objective testing related to Claimant’s accident revealed no reason for Claimant’s ongoing pain, he (like Dr. Brus) opined that some as-yet unidentified underlying pathology must be the cause, and recommended that Claimant follow up with a rheumatologist. Unlike Dr. Brus, however, Dr. Kadyan opined that the unknown cause was entirely unrelated to the industrial accident.

73. As of April 22, 2010, as discussed above, Dr. Kadyan’s opinion that Claimant’s condition was stable and unrelated to the industrial accident was premature and lacked sufficient foundation because the diagnostic and rehabilitative treatment credibly recommended by Dr. Sant, also a physiatrist, had not yet been administered. Following the failure of Dr. Sant’s treatment to alleviate Claimant’s pain, however, Dr. Kadyan maintained his ultimate opinion which, by that time (one year later), had ripened. Although Claimant was never evaluated by a rheumatologist, Dr. Sant’s workup and treatment superseded the recommendations for a rheumatology consultation, and neither Dr. Kadyan nor any other physician thereafter renewed this recommendation. Moreover, Claimant does not seek a rheumatological workup as a result of these proceedings.

74. Dr. Kadyan also opined that, regardless of whether Claimant’s T6-7 disc protrusion is symptomatic, there is insufficient medical evidence to establish that it was caused by the industrial accident:

opinion that his lumbar symptoms were related. Dr. Brus’s opinion is consistent with the medical records and is more persuasive on this point. Claimant does not seek benefits related to his lumbar spine condition.

Q. And, again, it's your opinion that the disc protrusion is not related?

A. Yes.

Q. What do you base that opinion on? I think we've talked about whether or not it's there and to what degree it's there.

A. A disc protrusion, there's multiple factors. So one in an individual who works for manual labor and has worked having -- there's studies that show as much as 70 or 80 percent will have disc protrusions. So to say that's related specifically to that one incident, it's very hard.

If you look at his imaging studies and you see disc protrusion of multiple levels, his tenderness is at multiple levels, it's not necessarily at T6, it starts at T6. And when you look at his low back, his imaging studies are much worse at T11 and T12 than they are at T6.

So to say that all of that is accounted for by T6, to me, doesn't add up. He had numbness and tingling in his legs well before his injury, which could have been when one of the discs first took place. So it's very hard to say that that particular disc is the source of his discomfort and that it happened at that time.

The last six discs also herniate fairly rarely, so I'm surprised that he has two to three discs that are herniated or bulging in there.

Q. Dr. Frizzell mentioned the concept of calcification when he -- that was his interpretation of the discs that weren't at T6.

Did you see evidence of this calcification concept?

A. Well, Dr. Frizzell is accurate that if the disc is calcified, it indicates it's an open injury. The calcification, because it's harder and it's more of a bony thing, will show up better on the CAT scans. I did review the original CAT scans with a

radiologist, and there were no calcifications in their impression, or mine, that T6, or the lower one, so it was very hard to say whether they were acute or chronic.

Kadyan Dep., pp. 40-41.

The Referee finds Dr. Kadyan's opinion as of the hearing date rests on sufficient foundation and is credible.

75. **Dr. Frizzell.** Dr. Frizzell's opined that Claimant sustained cervical and thoracic sprain/strains and a T6-7 disc protrusion as a result of his industrial accident. However, he further concluded that, to a reasonable medical probability, only the T6-7 protrusion is causing on-going pain. At his deposition, Dr. Frizzell explained that he based his causation opinion on Claimant's September 13, 2010 MRI films, taken approximately eleven months after the industrial accident, which show his spinal column to be kidney bean-shaped as a result of the protrusion. He does not, however, opine that the images demonstrate that Claimant's disc was protruding onto his spinal cord, the point at which Dr. Kadyan would agree that his disc protrusion was likely symptomatic.

76. Dr. Frizzell had no pre-accident thoracic spine MRI findings with which to compare Claimant's September 2010 results, and he notes no characteristics on these images that would distinguish the time of onset of his T6-7 disc protrusion from his disc protrusions at T3-4, T8-9 or T11-12. On exam, Claimant had tenderness at C6-7 and "fatigue" at T6. Otherwise, his exam was within normal limits for strength and range of motion. This evidence is insufficient to establish, to a reasonable medical probability, that Claimant's industrial accident caused his T6-7 disc protrusion, particularly in light of Dr. Kadyan's opinion in that regard.

77. Dr. Frizzell also acknowledged that Claimant had degenerative changes in his lower thoracic spine and that trauma can convert a previously asymptomatic degenerative

condition into a symptomatic one. However, Dr. Frizzell's opinion fails to support a causal link by the "permanent aggravation" route because he also opines that Claimant's T6-7 disc was fairly normal-looking. Moreover, he does not specifically advance this opinion.

78. The Referee does not doubt that Claimant's pain is real. However, the weight of the evidence fails to support a determination that his pain is related to his industrial accident, for the following key reasons:

- a. Claimant has a prior medical history punctuated with treatment for unexplained joint pain in several joints, including in his neck and low back areas, cervical injuries, and complaints of a type of pain for which laying on a flat surface provides the only relief. He also has a history of gout affecting not just his lower extremities, but his right upper extremity, as well.
- b. Radiologic imaging on the day of the industrial injury and afterward fails to identify, to a reasonable medical probability, a pain source.
- c. On exam, Claimant's pain was, early on, often but not always localized to a thoracic region including his T6 vertebral area. As time progressed, however, his medical records demonstrate that his pain was primarily in his cervical spine. For instance, Dr. Sant testified that Claimant most often complained of cervical spine pain, so he only injected Claimant's cervical spine facets and rendered no specific treatment to his thoracic spine. Dr. Frizzell's examination identified tenderness at the cervical level and fatigue but no tenderness, at the thoracic level. This pain migration pattern is inconsistent with Dr. Frizzell's opinion that his T6-7 disc protrusion was causing Claimant's pain.

- d. In addition to cervical and thoracic pain, Claimant has also reported post-accident low back pain, which Dr. Kadyan opined was related to the industrial accident, but which the Referee, above, determined is not. The fact that Claimant was occasionally treated for low back pain after his industrial accident, however, tends to show that Claimant has generalized spine pain, which in turn favors the conclusion that there is a non-industrial cause for Claimant's ongoing pain.
- e. Claimant's medical records reveal a potential subsequent alternative cause for his continuing pain symptoms since his industrial accident: on February 22, 2010, Claimant's cervical symptoms worsened after he helped move a car.
- f. Drs. Kadyan and Frizzell both opined that it would be unlikely that unresolved sprain/strain pain accounts for Claimant's symptoms.
- g. Dr. Frizzell opined that thoracic spine disc protrusions are usually the result of degeneration as a part of the normal aging process.

79. The Referee finds inadequate objective medical evidence to establish that Claimant sustained any permanent injury due to his October 16, 2009 industrial accident.

MEDICAL CARE BENEFITS / MAXIMUM MEDICAL IMPROVEMENT

Idaho Code § 72-432(1) obligates an employer to provide an injured employee reasonable medical care as may be required by his or her physician immediately following an injury and for a reasonable time thereafter. It is for the physician, not the Commission, to decide whether the treatment is required. The only review the Commission is entitled to make is whether the treatment was reasonable. *See, Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989). A claimant must provide medical testimony that supports a claim for compensation to a reasonable degree of medical probability. *Langley v. State, Industrial Special*

Indemnity Fund, 126 Idaho 781, 890 P.2d 732 (1995). “Probable” is defined as “having more evidence for than against.” *Fisher v. Bunker Hill Company*, 96 Idaho 341, 344, 528 P.2d 903, 906 (1974).

A claimant reaches medical stability at such time that no further change in his or her condition can be reasonably expected.

80. After accepting Claimant’s claim, Defendants ceased paying medical care benefits, in reliance on Dr. Kadyan’s report which asserted Claimant was medically stable as of April 22, 2010. Eventually, they resumed paying medical care benefits on Dr. Sant’s recommendation for facet injections, and they continued paying until after Dr. Sant released Claimant from care on April 19, 2011.

81. It is undisputed that Claimant’s condition was medically stable by May 2, 2011, the date of Dr. Frizzell’s examination and report. Defendants argue, however, that Claimant reached medical stability by April 22, 2010 because no treatment after that date improved Claimant’s symptoms. Citing *Sprague v. Caldwell Transp., Inc.*, 116 Idaho 720 (1989), Defendants claim they are not liable for the cost of medical treatment Claimant received after April 22, 2010 (the date of Dr. Kadyan’s IME report) because it was not reasonable.

82. *Sprague* governs certain disputes in which a claimant seeks reimbursement for past medical care. In that case, the Idaho Supreme Court overturned the Commission’s decision that chiropractic treatment, rendered after Defendants’ IME physician opined Claimant was medically stable, was unreasonable. In doing so, it relied upon the Commission’s findings that 1) the claimant had gradually improved from the treatment, 2) the treatment was required by the claimant’s physician, 3) the treatment was within that physician’s standard of practice, and 4) the treatment charges were reasonable. The precedential effect of *Sprague* is that when a claimant

satisfies the *Sprague* factors, he or she is entitled to reimbursement for costs of past relevant medical care. The case does not, however, deem the *Sprague* factors minimum requirements that must be met by every claimant in every case in which medical cost reimbursement is sought. It does not exclude other circumstances under which a claimant may also prove that the medical care was reasonable under Idaho Code § 72-432.

83. The treatment at issue in *Sprague* was for continuing symptoms related to a compression fracture of the 12th thoracic vertebrae and a subluxation complex of the lumbar spine. In contrast, while Claimant's ongoing pain condition generally related to the anatomical areas affected by his industrial accident, it remained undiagnosed throughout the entire period in which Defendants claim no liability for benefits. Further, Claimant's pain reports are credible. Under these circumstances, denying benefits just because⁹ he has never significantly improved would unjustly undermine Claimant's right to medical care benefits under workers' compensation law.

84. As set forth in *Sprague*, Idaho Code § 72-432 requires, "The employer **shall** provide...**reasonable** medical...treatment...as may be required by the *employee's* physician." (Emphasis in original). Claimant is entitled to reasonable diagnostic and rehabilitative treatment, with reasonableness viewed prospectively as opposed to the hindsight review applied in *Sprague*, even though his condition did not improve. At the time of Dr. Kadyan's opinion on April 22, 2010, Claimant had tried chiropractic care, physical therapy, pain injections into his interspinous ligaments at C6-7, C7-T1 and T1-2 on two occasions and medications. Yet, he continued to suffer pain. On May 13, 2010, Dr. Brus disagreed that he was medically stable, concurred in Dr. Kadyan's recommendation for a rheumatological evaluation and further recommended a

⁹ None of the other *Sprague* factors are at issue.

physiatry consultation. On July 7, 2010, Claimant still reported pain and Dr. Sant credibly posited that his facet joints were the problem. He recommended facet injections primarily for diagnostic purposes, while acknowledging that they should also bring Claimant some temporary relief. Along with this new diagnosis, Dr. Sant also recommended further physical therapy. Dr. Sant's new diagnosis, which related Claimant's pain to his industrial injury, bestowed Claimant with renewed reasonable prospects for permanent relief from his pain. Thus, the care proposed by Dr. Sant, Claimant's physician, was medically reasonable. Further, during Dr. Sant's treatment, his condition could reasonably be expected to improve. Dr. Kadyan's initial opinion that Claimant should be evaluated by a rheumatologist to determine the underlying nature of his pain also supports the conclusion that he was not medically stable as of April 22, 2010. Dr. Kadyan opined that the evidence before him was inadequate to support an opinion, to a reasonable medical probability, that Claimant's industrial accident aggravated the suspected underlying disorder. However, Dr. Kadyan's opinion also demonstrates that the evidence he relied upon in concluding that Claimant was medically stable was inadequate to rule *out* the likelihood that it was related to the workplace accident. How could Dr. Kadyan opine to a medical probability that the industrial accident did not permanently aggravate Claimant's underlying disease process if he did not know what it was? Dr. Kadyan did not explain his reasoning in this regard. The evidence establishes that Dr. Kadyan recommended additional diagnostic treatment, without which the relationship between Claimant's industrial injury and his ongoing symptoms could not be ascertained. Further, past Commission cases are replete with medical opinions claiming that a traumatic event ignited previously silent symptoms of an underlying arthritic condition, so this is a significant weakness in Dr. Kadyan's otherwise thorough, well-reasoned opinion, in terms of Claimant's medical stability as of April 22, 2010.

85. The Referee finds Claimant was not yet medically stable as of April 22, 2010, and that the earliest date on which Claimant became medically stable was the day on which Dr. Sant released him from care (April 19, 2011).

86. Claimant argues that he cannot be deemed medically stable before May 2, 2011 because no other opining physician was adequately qualified to rule out surgery as a treatment option. It is true that Dr. Frizzell is the only surgeon to opine in this case. However, Idaho Workers' Compensation Law does not require a surgeon to provide an opinion in every case. Sufficient medical evidence may establish that a condition is non-surgical, whether or not it is proffered by a surgeon. Claimant may not reap a windfall in medical or compensation benefits via an extension of the medical stability date by simply waiting, then obtaining an IME surgeon's opinion that concurs with an earlier opinion that surgery is not warranted, when Defendants have elected not to obtain a surgical opinion in reliance upon other sufficient medical evidence.

87. Like Drs. Sant, Kadyan and Brus before him, Dr. Frizzell opined that Claimant's condition does not warrant surgery. Dr. Brus referred Claimant for a surgical consultation, but only as a result of Claimant's request, because Dr. Brus doubted surgery would prove efficacious. The only new evidence Dr. Frizzell reviewed before rendering his opinion was a cervical spine x-ray which provided no new significant information. Dr. Frizzell's opinion adds nothing to Dr. Sant's and, thus, is no more credible and no more persuasive. No other physician has recommended further treatment, other than palliative care. The Referee finds Dr. Sant's opinion as to when Claimant reached medical stability is most persuasive. Claimant was medically stable as of April 19, 2011.

88. Dr. Sant's nonobjection to Dr. Brus's referral to Ms. Thompson, who evaluated Claimant on April 22, 2011, does not constitute a recommendation for further treatment that would extend Claimant's medical stability date.

89. No physician has opined, to a reasonable medical probability, that Claimant's depression is related to his industrial injury and Claimant has not sought treatment from a psychological health professional related to this condition. Facts pertaining to Claimant's depression are not relevant to a finding of medical stability in this case.

90. Claimant is entitled to medical care benefits through April 19, 2011, the date on which he reached medical stability. He is not entitled to additional medical care for pain relief because he has failed to prove by a preponderance of evidence that the pain he experienced after that date is related to his industrial accident. To the extent, if any, that Defendants have failed to pay medical benefits through April 19, 2011, Claimant is entitled to immediate payment of the amount owing.

91. All other issues are moot.

CONCLUSIONS OF LAW

1. Claimant has proven that he sustained cervical and thoracic spine sprain/strains as a result of his October 16, 2009 industrial injury.

2. Claimant has proven that he reached medical stability as of April 19, 2011.

3. Claimant has proven that he is entitled to reasonable medical care for his industrial injuries through April 19, 2011.

4. Claimant has failed to prove that he has sustained any permanent conditions as a result of his industrial accident and injuries, or that he is entitled to benefits for permanent impairment or permanent disability.

5. All other issues are moot.

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 25th day of June, 2012.

INDUSTRIAL COMMISSION

/s/
LaDawn Marsters, Referee

ATTEST:

/s/
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 13th day of July, 2012, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

DANIEL J LUKER
GOICOECHEA LAW OFFICES
PO BOX 6190
BOISE ID 83707-6190

JAMES A FORD
ELAM & BURKE, P.A.
PO BOX 1539
BOISE ID 83701-1539

sjw

/s/

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

WADE LYNN,

Claimant,

v.

PROCORE PROPERTY SOLUTIONS, LLC,

Employer,

and

STATE INSURANCE FUND,

Surety,

Defendants.

IC 2009-027777

ORDER

July 13, 2012

Pursuant to Idaho Code § 72-717, Referee LaDawn Marsters submitted the record in the above-entitled matter, together with her recommended 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 recommendations of the Referee. The Commission concurs with these recommendations. Therefore, the Commission approves, confirms, and adopts the Referee's proposed findings of fact and conclusions of law as its own.

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

1. Claimant has proven that he sustained cervical and thoracic spine sprain/strains as a result of his October 16, 2009 industrial injury.
2. Claimant has proven that he reached medical stability as of April 19, 2011.
3. Claimant has proven that he is entitled to reasonable medical care for his industrial injuries through April 19, 2011.

ORDER - 1

4. Claimant has failed to prove that he has sustained any permanent conditions as a result of his industrial accident and injuries, or that he is entitled to benefits for permanent impairment or permanent disability.

5. All other issues are moot.

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

DATED this 13th day of July, 2012.

INDUSTRIAL COMMISSION

/s/
Thomas E. Limbaugh, Chairman

/s/
Thomas P. Baskin, Commissioner

/s/
R.D. Maynard, Commissioner

ATTEST:

/s/
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 13th day of July, 2012, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

DANIEL J LUKER
GOICOECHEA LAW OFFICES
PO BOX 6190
BOISE ID 83707-6190

JAMES A FORD
ELAM & BURKE, P.A.
PO BOX 1539
BOISE ID 83701-1539

sjw

/s/_____