

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

JAMIE DARNELL,

Claimant,

v.

DAVE SMITH MOTORS, INC.,

Employer,

and

LIBERTY NORTHWEST INSURANCE
CORP.,

Surety,

Defendants.

IC 2009-030881

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

**FILED
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INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Alan Taylor, who conducted a hearing in Coeur d'Alene, Idaho on April 24, 2012. Claimant, Jamie Darnell, was present in person and was represented by Stephen J. Nemecek, of Coeur d'Alene. Defendant Employer, Dave Smith Motors, Inc., and Defendant Surety, Liberty Northwest Insurance Corp., were represented by E. Scott Harmon, of Boise, Idaho. The parties presented oral and documentary evidence. Post-hearing depositions were taken and briefs were later submitted. The matter came under advisement on September 18, 2012.

ISSUES

The issues to be decided by the Commission are:

1. Whether Claimant's cervical spine condition is caused by the industrial accident;
2. Whether Claimant is entitled to medical care; and
3. Whether Claimant is entitled to temporary disability benefits.

CONTENTIONS OF THE PARTIES

Claimant contends that on November 24, 2009, she "suffered injuries to her cervical spine at C5-6 and C6-7 as a result of her industrial accident in the form of two disc herniations" while at work. Claimant's Opening Post-Hearing Brief, p. 7. As a result of the cervical disc injuries, she seeks cervical surgery. In addition, Claimant asserts that she has been unable to work as a result of the pain caused by her injuries and is entitled to temporary disability benefits for the time she was and will be off work during her period of recovery.

Defendants acknowledge Claimant's accident at work on November 24, 2009, but assert that the accident only resulted in a temporary injury to Claimant's right wrist, and did not cause her cervical injuries. Defendants argue that they have paid all related medical and temporary disability benefits owed to Claimant as a result of the accident.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The Industrial Commission legal file;
2. The testimony of Claimant taken at the April 24, 2012 hearing;
3. Claimant's Exhibits 1-12, admitted at hearing;
4. Defendants' Exhibits A-M, admitted at hearing;
5. The post-hearing deposition of Zafar Khan, M.D., taken by Claimant on May 21, 2012; and

6. The post-hearing deposition of Spencer D. Greendyke, M.D., taken by Defendants on June 21, 2012.

All pending objections are overruled. After having considered 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

1. Claimant was born in 1966 and was 46 years old at the time of the hearing. She earned her GED in 1999 and has worked since that time, primarily in sales.

2. Claimant's upper extremity complaints were first documented on June 23, 2003, when she presented to Harry Downs, M.D., reporting left shoulder pain that had persisted for three months. She denied any injury. On exam, Dr. Downs found mild tenderness over her biceps tendon with spasm in her neck, upper trapezius, and back. He noted good reflexes and strength in her upper extremities. He diagnosed left shoulder pain and prescribed Naprosyn and Soma.

3. On October 4, 2004, Claimant presented to Kevin R. Marsh, D.C., complaining of "mild to moderate left lower neck symptoms which was [sic] dull in character." Defendants' Exhibit C, p. 32. Claimant also reported left lower neck pain radiating from the left lower neck to the left posterior forearm. Dr. Marsh recorded objective findings including positive foraminal compression bilaterally and moderate spasm in the cervico-thoracic region bilaterally, worse on the left. He diagnosed cervical somatic dysfunction and thoracic somatic dysfunction. Dr. Marsh treated Claimant with manipulation and moist heat. His final chart note directed Claimant to return in one week, suggesting that Dr. Marsh expected to provide additional treatment. At hearing, Claimant stated that her left-sided neck and arm pain were the result of cradling the

telephone receiver between her ear and shoulder, and that once she obtained a headset, she had no further problems. Dr. Marsh's records do not discuss the cause of Claimant's neck and shoulder complaints and contain no recommendation that she use a headset.

4. In August 2006, Claimant presented to Richard Caldwell, M.D., complaining of work-related¹ left hand pain, including burning and tingling that bothered her most at the end of her day. Claimant was then working as an account executive, primarily using a telephone and keyboard. Dr. Caldwell diagnosed overuse syndrome. In particular, he noted that the distribution of her left hand pain was not entirely consistent with median nerve distribution and carpal tunnel syndrome, but that perhaps she was exhibiting both overuse syndrome and mild carpal tunnel syndrome. Suggested treatment options included time off from work and use of a telephone headset to reduce her left hand involvement. Dr. Caldwell referred Claimant to hand specialist Peter Jones, M.D. Dr. Jones diagnosed carpal tunnel syndrome, and sent Claimant for EMG studies to confirm his diagnosis. Those studies were read as showing borderline to mild left carpal tunnel syndrome. Claimant testified that she followed her doctor's advice to change jobs, minimize her computer work, and take a month off.

5. In January 2007, Claimant began working for Dave Smith Motors (Smith Motors). Her duties included extensive telephone and computer work taking deposits on sales, evaluating trade-ins, and putting deals together. She worked 50 to 70 hours per week. In April 2009, she left Smith Motors for other employment; however, in September 2009, she returned to work at Smith Motors.

6. On November 23, 2009, Claimant contacted her primary care physician, Richard

¹ This incident is the subject of a separate workers' compensation claim from the instant matter.

Samuel, M.D., who recorded Claimant was “having more/increased hand pain & weakness & wants to be re-evaluated.” Defendants’ Exhibit H, p. 83.

7. On November 24, 2009, Claimant was putting things away at the end of her workday. She reached down with her right hand, opened the file drawer in her desk, and felt what she described as:

... like lightning hit my arm and my fingers tingled, and I just – “Wow, that really hurt.” And it went all the way up to my neck, and I unlocked my door, and everyone was in – because it was 6:00, everyone was leaving. And so I caught my ride home, and then I could barely move these three fingers [middle, ring, and little fingers on right hand].

Transcript, p. 16, ll. 2-7. There is no assertion the desk drawer was difficult to open.

8. Claimant reported the incident to Smith Motors and presented to Dr. Samuel the next day reporting that she: “was working yesterday and was pulling out a drawer when she felt a snap and [sic] her wrist with sudden pain that emanated from this location up her arm and down into her hand.” Defendants’ Exhibit H, p. 83. Dr. Samuel recorded Claimant’s complaints of “parasthesia and pain extending into her third and fourth digits, right hand.” Defendants’ Exhibit H, p. 83. He recorded no report of right fifth finger complaints. Dr. Samuel found positive Tinel’s sign at the right wrist and at the ulnar groove. He believed that Claimant had suffered an acute onset of right side carpal tunnel syndrome as a result of the November 24 incident, though he did not discount the possibility that she might have ruptured her palmaris tendon. Dr. Samuel referred her to Dr. Jones for re-evaluation of her pre-existing left upper extremity symptoms, and evaluation and treatment of her new right upper extremity symptoms. The chart note mentioned that Claimant had also noted increasing problems with her left hand, was taking two ibuprofen with two Tylenol with slight improvement, was reopening her 2006 claim, and had asked to be re-evaluated by Dr. Jones.

9. On December 11, 2009, Claimant presented to Dr. Jones, who recorded her complaints of bilateral hand pain and numbness and that her hands “go to sleep at night and when she drives.” Defendants’ Exhibit G, p. 76. Dr. Jones diagnosed bilateral carpal tunnel syndrome, noting positive Tinel’s and Phalen’s tests for both upper extremities. He sent Claimant to neurologist James Lea, M.D., for nerve conduction studies to confirm his diagnosis.

10. On February 17, 2010, Dr. Lea performed EMG and nerve conduction testing that revealed: “No evidence of right median or ulnar entrapment neuropathy. No evidence of right cervical radiculopathy resulting in axonal injuries.” Defendants’ Exhibit I, p. 86.

11. On February 23, 2010, Dr. Jones described Claimant’s EMG results as “surprisingly negative.” Defendants’ Exhibit G, p. 77. Given the results of her nerve conduction tests, Dr. Jones considered the possibility that Claimant’s bilateral upper extremity complaints could be caused by cervical radiculopathy. He sought authorization for a full neurological consultation. Also, because Claimant’s 2006 EMG testing was mildly positive for left carpal tunnel syndrome, and the February 2010 test was negative, Dr. Jones sent Claimant back to Dr. Lea for an explanation of the discrepancy.

12. On April 13, 2010, Claimant presented to Dr. Lea, who advised that her EMG and nerve conduction tests showed no evidence of carpal tunnel syndrome or cervical radiculopathy. Regarding the apparent discrepancy between the 2006 and 2010 nerve conduction studies, Dr. Lea noted that he would have read the 2006 studies as negative.² Dr. Lea reported: “I think this lady at most has repetitive use type syndrome. Certainly she does not have any evidence of a peripheral nerve problem. She does not have an entrapment neuropathy or cervical

² The 2006 EMG was administered by Joav Kaufman, M.D. The 2010 EMG was administered by Dr. Lea. Dr. Kaufman and Dr. Lea practiced together at the time of Claimant’s diagnostic testing.

radiculopathy clinically or neurophysiologically [sic].” Defendants’ Exhibit I, p. 88. He recommended an independent medical evaluation and case closure. Dr. Lea sent Claimant back to Dr. Jones, who sent her back to Dr. Samuel.

13. On April 28, 2010, Claimant returned to Kevin Marsh, D.C., complaining of moderate to severe bilateral posterior upper shoulder symptoms, moderate to severe diffuse bilateral anterior hand symptoms, and moderate to severe bilateral chest symptoms. After examining Claimant, Dr. Marsh opined that she was suffering from thoracic outlet syndrome secondary to overuse syndrome.

14. On May 12, 2010, board certified orthopedic surgeon Spencer Greendyke, M.D., examined Claimant at Defendants’ request to evaluate her right upper extremity industrial injury. Dr. Greendyke also reviewed the medical records from Drs. Jones, Lea, and Samuel. Claimant reported “pain from the right small finger and ring finger that radiates to the elbow and neck on the right side. She also complained of numbness to the dorsal aspect of her right forearm that goes to the small and ring fingers.” Defendants’ Exhibit L, p. 102. Dr. Greendyke’s records make no mention of any report by Claimant of symptoms in her right third finger. On exam, Claimant’s range of motion, strength, reflexes, and sensory discrimination were normal and symmetric bilaterally. Dr. Greendyke noted that Claimant’s response to Phalen’s test was negative bilaterally; but that her response to median nerve testing was non-anatomic—right wrist compression produced tingling in the small finger and ring fingers, whereas the distribution of the median nerve encompasses the thumb, index, and middle fingers. Further, regarding Tinel’s testing, Dr. Greendyke explained:

The other finding was that when I did the same exam, the Tinel’s test at the elbow, at the cubital tunnel, she stated instead of—the normal finding for that in a positive test would be tingling in the ring and small finger where you tap on

their elbow along the ulnar nerve, and she stated that it produced a sharp pain in her shoulder, like it went up instead of down, and that's not physiologic.

Greendyke Deposition, p. 14, l. 22 through p. 15, l. 4.

15. Based on his review of Claimant's records, her history, and his exam and testing, Dr. Greendyke opined that Claimant's subjective right hand sensory complaints were unsupported by objective findings and EMG and nerve conduction studies. He found no evidence of either nerve entrapment or cervical radiculopathy in May 2010. Absent evidence of a neurological cause for her right upper extremity complaints, Dr. Greendyke opined that Claimant's November 2009 accident caused a minor mechanical twist injury resulting in transient positional impingement of her right median nerve that had resolved within a matter of hours. He compared it to a person hitting her "funny bone." Dr. Greendyke agreed that the transient impingement was the result of the November 24, 2009 industrial injury, but opined that no further treatment was needed and that Claimant was medically stable, suffered no permanent impairment, and could return to work without restrictions. On May 24 and 26, 2010, respectively, Drs. Lea and Jones agreed with Dr. Greendyke's findings and opinions.

16. In July 2010, Claimant returned to Dr. Samuel, complaining of continuing bilateral upper extremity pain, left worse than right. Dr. Samuel recommended occupational therapy and requested authorization from the surety on Claimant's 2006 injury for the treatment.

17. On August 11, 2010, J. Craig Stevens, M.D., examined Claimant in relation to her 2006 injury. He opined that Claimant's symptoms were somewhat consistent with carpal tunnel syndrome, but also were consistent with C-8 radiculopathy. He concluded that Claimant needed no further treatment for her 2006 injury, but that a cervical MRI might be appropriate to help diagnose a non-work-related cervical spine problem. Dr. Stevens noted that if the MRI did reveal a cervical disc problem, it was not related to any overuse injury of her hands.

18. On August 23, 2010, Claimant presented at the emergency department and was examined by Charles B. Foe, M.D. Claimant complained of pain from her neck down both of her arms, but reported no discrete injury. Dr. Foe found Claimant's strength and reflexes normal, but recorded: "By history, though, the patient is probably describing cervical radiculopathy." Defendants' Exhibit F, p. 69. Dr. Foe's impression was cervical radiculopathy. He prescribed ibuprofen and tramadol and encouraged Claimant to follow up with Dr. Samuel.

19. In September 2010, Claimant moved from Idaho to California to live with family. In California, she worked for a car dealership. She continued to complain of upper extremity problems, in particular decreased grip sensation, which caused her to drop objects. Claimant left the dealership after five months.

20. In early June 2011, Claimant was once again employed and had health insurance benefits. Her primary care physician, Thomas Kockinis, M.D., referred her to neurologist M. Michael Mahdad, M.D., for her upper extremity complaints. On August 5, 2011, Claimant presented to Dr. Mahdad who recorded: "she complains of bilateral arm/wrist/elbow/shoulder and neck pains and soreness—constant, and which increases at the end of the day. There is no significant numbness or paresthesia. There is occasional numbness in the right 3rd, 4th, & 5th digits. She denies any shooting-type pain." Claimant's Exhibit 5, p. 1. Dr. Mahdad noted that Claimant had previous repeated electro-diagnostic studies, none of which revealed evidence of nerve damage, carpal tunnel syndrome, or cervical radiculopathy. Dr. Mahdad's initial impression was, "[m]ost likely, tendinitis/overuse syndrome vs. fibromyalgia. It is very doubtful that the patient has any inherent neurological disease or 'pinched nerve.'" Claimant's Exhibit 5, p. 4. On August 15, 2011, Dr. Mahdad performed EMG and nerve conduction studies that showed mild bilateral C6-7 radiculopathies.

21. On August 22, 2011, a cervical MRI revealed:

C5-6: There is a prominent 5.0 mm left paracentral herniated disc with extradural compression over and complete effacement of the anterior subarachnoid space and moderate direct left-sided cord compression. This has caused mild to moderate left-sided central spinal stenosis without significant associated foraminal stenosis.

C6-7: There is a 2.0 to 3.0 mm central herniated disc without cord compression. There is no significant central spinal or foraminal stenosis.

Claimant's Exhibit 4, p. 9. Claimant did not see Dr. Mahdad following the nerve conduction studies or the MRI, and his records do not include any notes that discuss the test results in relation to his initial diagnosis.

22. Claimant returned to Dr. Kockinis, who then referred her to board certified orthopedic surgeon Zafar S. Khan, M.D. On September 8, 2011, Dr. Khan examined Claimant and reviewed the MRI and the EMG and nerve conduction studies. Dr. Khan noted: "she is a 45-year-old woman with a history of severe neck and bilateral arm pain. She has had it for two years. It is 8/10. It is sharp, stabbing, achy, throbbing, pins and needles, constant, and unpredictable." Claimant's Exhibit 3, p. 6. Dr. Khan commented that Claimant's MRI showed the prominent left paracentral disc protrusion at C5-C6; he made no mention of the smaller C6-7 central disc herniation also revealed by the MRI. Dr. Khan diagnosed cervical radiculopathy and discussed treatment options, including surgery, epidural steroid injections, and physical therapy. His notes from that visit make no mention of the November 2009 accident.

23. On September 29, 2011, Claimant returned to Dr. Khan. He recorded:

She continues to have severe back [sic] and bilateral pain. She has a lot of questions about her findings on her MRI as well as options. I went over all these in great detail. At this point, I do think that the disc protrusion is the result of her injury from a [sic] November 24, 2009. She was involved in a work related accident. Apparently, she was opening the door at work and the pain shot up into her arm and neck. Based upon the way she describes, it does seem to be that the source and cause of her accident and this is a work related injury.

Defendants' Exhibit J, p. 92.

24. In October 2011, Claimant moved back to Idaho to pursue the instant claim. In December 2011, she commenced work as a housekeeper, but quit after three months because of increasing pain.

25. Having observed Claimant at hearing and compared her testimony with other evidence in the record, the Referee finds that Claimant is not an entirely reliable historian. Claimant's reported symptoms have varied over time as reflected in the notes of different examiners. At hearing, Claimant testified that at the time of her accident she experienced symptoms in her third, fourth, and fifth digits which still persisted. However, when examined by Dr. Samuel the day after the accident, she reported only symptoms in her right third and fourth digits. When examined by Dr. Greendyke in May 2010, she only reported symptoms in her fourth and fifth digits. When examined by Drs. Mahdad and Khan in 2011, she reported symptoms in her third, fourth, and fifth digits. The presence or absence of symptoms in the third digit may be significant as Dr. Khan noted that carpal tunnel syndrome—involving compromise of the median nerve at the wrist—generally produces symptoms in the first, second, and third digits, whereas symptoms in the fourth and fifth digits generally involve the ulnar nerve and indicate cervical radiculopathy. Additionally, when examined by Dr. Mahdad in August 2011, Claimant denied shooting pain, but at hearing she testified that sometime after her November 2009 accident she began having shooting pain up and down her arms and in both hands when she would pull on a jacket and that this shooting pain became more frequent and consistent when she worked as a housekeeper in 2012. Transcript, p. 33. Additionally, Dr. Greendyke's May 12, 2010 record documents that on at least two occasions Claimant's responses to medical testing were non-anatomic and not credible.

DISCUSSION AND FURTHER FINDINGS

26. 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).

27. **Causation.** The primary issue is whether either of Claimant's cervical disc herniations was caused or permanently aggravated by her November 2009 industrial accident. Idaho Code § 72-432(1) mandates that an employer shall provide for an injured employee 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). Of course, the employer is only obligated to provide medical treatment necessitated by the industrial accident. The employer is not responsible for medical treatment not related to the industrial accident. Williamson v. Whitman Corp./Pet, Inc., 130 Idaho 602, 944 P.2d 1365 (1997). Hence, a claimant must prove not only that he or she suffered an injury, but also that the injury was the result of an accident arising out of and in the course of employment. Seamans v. Maaco Auto Painting, 128 Idaho 747, 751, 918 P.2d 1192, 1196 (1996). 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). The claimant must establish a probable,

not merely a possible, connection between the injuries alleged and the industrial accident. Dean v. Dravo Corporation, 95 Idaho 958, 511 P.2d 1334 (1973). It is also well settled that “an employer takes an employee as it finds him or her; a preexisting infirmity does not eliminate the opportunity for a worker's [sic] compensation claim provided the employment aggravated or accelerated the injury for which compensation is sought.” Spivey v. Novartis Seed Inc., 137 Idaho 29, 34, 43 P.3d 788, 793 (2002), citing Wynn v. J. R. Simplot Co., 105 Idaho 102, 104, 666 P.2d 629, 631 (1983).

28. In the present case, Drs. Lea and Jones diagnosed Claimant with borderline left carpal tunnel syndrome in 2006, believed to be related to her work for her prior employer. Claimant was advised to find a job that did not require so much keyboarding. She changed jobs and did well until she started working for Smith Motors in another position requiring a great deal of keyboarding. In the fall of 2009, Claimant's left hand symptoms worsened, prompting her to seek additional treatment for her left upper extremity. Claimant's left hand complaints that first arose in 2006 are not a part of the instant claim; however, her November 24, 2009 industrial accident occurred only one day after she had contacted her primary care physician reporting increasing left-sided complaints. Thereafter, Claimant's long-standing left side complaints, symptoms, tests, and treatment begin to merge with her right side complaints, symptoms, tests, and treatments. Close examination of events and chronology establishes that the causal connection between Claimant's C5-6 and C6-7 disc herniations and her November 2009 industrial accident is attenuated. The records and opinions of Drs. Lea, Khan, and Greendyke are most helpful in analyzing the instant claim.

29. Dr. Lea. Following Claimant's 2009 industrial injury, Dr. Lea performed EMG testing on both of her upper extremities in February 2010. The testing showed no evidence of

median or ulnar entrapment neuropathy and no evidence of cervical radiculopathy in either extremity. Dr. Lea's physical exam of Claimant on April 13, 2010, was entirely normal in respect to her upper extremities. He concluded that she most likely had a repetitive use-type syndrome, and decidedly did not show any evidence of nerve entrapment or radiculopathy in either upper extremity.

30. Dr. Khan. Dr. Khan is the only physician who has opined that Claimant's 2009 industrial accident caused her cervical disc injuries. He examined Claimant in September 2011, and had the benefit of the cervical MRI, EMG, and nerve conduction testing ordered by Dr. Mahdad. The MRI showed a prominent 5.0 mm left-sided disc herniation at C5-6 causing left-sided central spinal stenosis, and a smaller 2.0 to 3.0 mm central disc herniation at C6-7 causing no significant central spinal or foraminal stenosis. The August 2011 EMG and nerve conduction testing showed "mild neurogenic changes in bilateral C6/7 innervated muscles. These changes are suggestive of: BILATERAL C6/7 RADICULOPATHIES, mild in degree electrically" Defendants' Exhibit K, p. 96. These results suggest that Claimant's left upper extremity complaints could be related to her herniated discs. However, although the August 2011 EMG and nerve conduction testing documented mild bilateral radiculopathy, Dr. Khan agreed in his post-hearing deposition that Claimant's complaints of right upper extremity pain in late summer and fall of 2011 were not consistent with radiculopathy.

31. The existence of Claimant's cervical disc herniations is clearly established by her cervical MRI. At issue is the validity of Dr. Khan's conclusion linking Claimant's right upper extremity complaints, her industrial injury, and the radiological evidence of left-sided C5-6 and central C6-7 disc herniations. Dr. Khan's initial causation opinion was offered on September 28, 2011:

At this point, I do think that the disc protrusion is the result of her injury from a November 24, 2009 [sic]. She was involved in a work related accident. Apparently she was opening the door at work and the pain shot up into her arm and neck. Based upon the way she describes, it does seem to be that the source and cause of her accident [sic] and this is a work related injury.

32. Claimant's Exhibit 4, p. 5. The only disc protrusion mentioned in Dr. Khan's notes was the left-sided C5-6 protrusion. Dr. Khan's causation opinion in September 2011 was based solely on Claimant's subjective report, and her belief that her disc herniations were the result of her work accident, which Dr. Khan's note did not accurately describe.

33. In February 2012, Claimant's counsel wrote Dr. Khan about Claimant's case, reviewing the course of Claimant's medical care following her November 2009 industrial accident, and providing copies of medical records and Dr. Stevens' report. Counsel then posed written questions to which Dr. Khan responded:

[Q] 1. Based on the chronology of events discussed above and your own prior examinations of the claimant and her medical records, are you able to state on a more likely than not basis (51% or greater) as to whether the claimant herniated the disc at C5-6 while reaching to open a drawer with her right hand?

[A] Based on her history both prior to and since the industrial injury in November of 2009, I think it is likely (greater than 51%) that the industrial injury as reported in November [sic] of 2009 caused her current symptoms which are the result of cervical radiculopathy. The symptoms she reported are entirely consistent with radiculopathy. In my experience, it is very common for patients to complain of shooting arm pain or electrical sensations at the time of injury. Again, this is entirely consistent with her symptoms. In fact, in the IME report of Dr. Stevens, he seemed also to suspect cervical radiculopathy as the cause of her symptoms. Additionally, it is not uncommon for radicular symptoms to progress into the contralateral arm if the pathology worsens and it is left untreated.

....

[Q] 3. Please comment on any other items or issues you deem relevant.

[A] It seems clear to me that her injury explains her current symptoms. I think it is unfortunate that an MRI of her cervical spine was not obtained at the time of the injury. Despite that, her [sic] description of the symptoms, the

mechanism of the injury and her progression all lead me to believe that the injury caused (or at least worsened and/or aggravated) her cervical radiculopathy.

Claimant's Exhibit 4, p. 1.

34. In his post-hearing deposition, Dr. Khan reiterated his earlier opinion, describing Claimant's right upper extremity symptoms as entirely consistent with radiculopathy. However, on cross-examination he agreed that Claimant's right upper extremity complaints were not radicular in nature. Dr. Khan's statement that "it is not uncommon for radicular symptoms to progress into the contralateral arm if the pathology worsens and it is left untreated" (Claimant's Exhibit 4, p. 1) is as supportive of Defendants' assertion that Claimant's cervical disk herniations pre-existed her 2009 industrial accident as it is of Claimant's assertion that her prominent left-sided cervical disc herniation could produce right upper extremity symptoms. Dr. Khan reiterated that as early as 2010, Dr. Stevens had suspected cervical radiculopathy at C-8³ as the cause of the left upper extremity complaints Claimant had been reporting since before 2006. However, Claimant's August 2011 MRI revealed no pathology at C7-T1.

35. Dr. Khan provided little additional explanation of the causal relationship between Claimant's disc herniations and her 2009 industrial accident in his May 2012 deposition. He agreed that Claimant's left-sided disc herniation correlated with her left upper extremity complaints that pre-existed her 2009 industrial accident. He disagreed with Dr. Greendyke's opinion that Claimant's 2009 industrial accident was just a minor wrist injury—pointing to the 2011 EMG results as evidence that her right side complaints confirmed cervical radiculopathy. But then he admitted that Claimant's symptoms as reported to Dr. Mahdad in 2011, which led to the EMG and nerve conduction testing to which he referred, were not consistent with

³ Described by Dr. Greendyke as C7-T1.

radiculopathy.

36. Dr. Khan lamented that Claimant did not obtain an MRI promptly following her November 2009 accident. However, an MRI immediately after her accident would not have clarified the status of her cervical spine before the 2009 accident, providing no basis for “before and after” comparison. Dr. Greendyke testified that a single MRI study provides little evidence of chronology absent an earlier or later additional study for comparison. Claimant’s 2011 MRI clearly shows a prominent left-sided C5-6 disc herniation, and a small central C6-7 disc herniation, but does not reveal when those herniations occurred, or whether they are acute or degenerative.

37. Per Dr. Mahdad’s 2011 EMG and nerve conduction testing, the only cervical radiculopathy identified is bilateral at C6-7. The record lacks objective confirmation of C5-6 radiculopathy. Dr. Khan’s explanation of right sided radiculopathy from the left-sided C5-6 herniation is not persuasive. Presuming the small C6-7 central disc herniation produces bilateral C6-7 radiculopathy, it does not necessarily follow that such relates to Claimant’s 2009 accident. Claimant testified she felt only right-sided symptoms when opening her desk drawer on November 24, 2009. She has never alleged that she simultaneously experienced left-sided shooting pain. To the contrary, Claimant testified that she first began to notice bilateral shooting arm and hand pain sometime after her November 24, 2009 accident, when she would pull on a jacket. This testimony suggests that Claimant’s bilateral cervical radiculopathy did not commence with her industrial accident, but rather sometime thereafter. This conclusion is consistent with the absence of cervical radiculopathy on EMG testing in February 2010.

38. As discussed above, the credibility of Claimant’s reported complaints is subject to question. Her subjective complaints are the only basis for evidence of her alleged cervical

radiculopathy between her November 24, 2009 accident and the first objective evidence of cervical radiculopathy found by Dr. Mahdad on EMG testing in August 2011. Dr. Khan expressly acknowledged that his causation opinion was based upon Claimant's history and her description of her symptoms. Claimant's briefing alleges that she suffered no left hand symptoms for more than a year prior to her November 2009 accident. However, Dr. Samuel's records reveal that the day before her November 24, 2009 accident, she contacted his office complaining of increasing left upper extremity pain and seeking additional medical care for her symptoms. Additionally, Claimant denied any shooting pain when examined by Dr. Mahdad in August 2011. Yet in September 2011, she told Dr. Khan that she had suffered stabbing pain of 8/10 severity for two years since opening a door at work. It is not surprising Dr. Khan concluded that her November 2009 accident caused the C5-6 disk protrusion as referenced in his September 29, 2011 note, and caused her cervical radiculopathy, as referenced in his February 20, 2012 letter and post-hearing deposition.

39. Dr. Khan has practiced in California for at least eight years, treated thousands of patients with cervical symptoms, and performed more than one thousand cervical surgeries. However, Dr. Khan's opinion does not discuss why Claimant had no radiculopathy in either of her upper extremities as evidenced by EMG and nerve conduction testing in February 2010. Neither does it explain how a non-strenuous maneuver of her right arm would cause a prominent left-sided cervical disc herniation and a central cervical disc herniation.

40. Dr. Greendyke. In May 2010, Dr. Greendyke examined Claimant for evaluation of her right upper extremity complaints. After reviewing the medical records and test results, and taking a history and examining Claimant, Dr. Greendyke found no objective evidence of any neurological entrapment or cervical radiculopathy in Claimant's right upper extremity. The only

findings he recorded were non-anatomic: median nerve compression resulting in ulnar nerve distribution symptoms, and ulnar nerve compression resulting in non-anatomic shoulder pain.

Both Drs. Jones and Lea agreed with Dr. Greendyke's opinion.

41. In February 2012, Surety provided Dr. Greendyke additional medical records, including the results of the August 2011 EMG and nerve conduction testing done in California and the images from the August 2011 cervical MRI. Dr. Greendyke then opined, by letter dated February 28, 2012:

In light of the new clinical information obtained, I would recommend modifying the diagnoses list provided in the initial IME dated 05/12/2010. The changes are as follows:

Cervical spondylosis, with left-sided upper extremity discomfort, dating back to 2004, pre-existing, not industrially related to work related incident of 11/24/2009 on a more likely than not basis

MRI-documented (08/22/2011) mild to moderate left-sided central C5-6 HNP, and a small central C6-7 HNP, likely pre-existing back to 2004, not industrially related on a more likely than not basis

Left upper extremity EMG/NCV, 2006, documenting a borderline left carpal tunnel syndrome and no evidence of left cervical radiculopathy, pre-existing, not industrially related on a more likely than not basis

Right upper extremity EMG/NCV, 02/17/2010, documenting no evidence of right median or ulnar nerve peripheral entrapment neuropathy or cervical radiculopathy, not industrially related on a more likely than not basis

Bilateral upper extremity EMG/NCV, 08/15/2011, documenting suggestion of mild chronic bilateral C6-7 radiculopathy, not industrially related on a more likely than not basis

Status post minor mechanical right wrist injury at work, pulling a drawer with the right hand, 11/24/2009, with temporary right wrist discomfort, resolved, industrially related on a more likely than not basis

Defendants' Exhibit M, pp. 114-115 (emphasis in original).

42. Dr. Greendyke discussed his conclusions, noting in particular that Claimant's documented cervical pathology is predominately left-sided, with left-sided neck and left upper extremity symptoms dating back to 2004. Claimant had no evidence of right side cervical radiculopathy per EMG or nerve conduction testing in 2006 or 2010. Her August 2011 EMG and nerve conduction testing demonstrated mild bilateral chronic radiculopathy at C6-7, which was a level below the larger left-sided disc herniation at C5-6. Therefore, Dr. Greendyke concluded that the right side radiculopathy was a new finding developing after Claimant's February 2010 EMG testing and after her May 2010 IME.

43. Dr. Greendyke noted no objective evidence of a radicular component to Claimant's left side complaints until the August 2011 EMG. Dr. Greendyke emphasized that the 2010 EMG testing following the subject industrial accident was negative for median and ulnar nerve entrapment and cervical radiculopathy in her right upper extremity.

44. Dr. Greendyke acknowledged that Claimant had C5-6 and C6-7 disc herniations, although he disagreed with Dr. Khan as to the extent the herniated discs were impacting the exiting nerves. Dr. Greendyke demonstrated a clear understanding of the chronology of Claimant's complaints as they correlated to test results, and clearly separated Claimant's pre-existing neck and left upper extremity issues from the right upper extremity complaints that are the subject of this proceeding.

45. Dr. Greendyke was asked by Claimant's counsel if mild radiculopathy could exist and be manifest as arm pain, yet evade detection on EMG or nerve conduction testing. Dr. Greendyke was skeptical, but readily acknowledged that he did not know the answer and indicated that was a question for a neurologist. The record is otherwise silent on this critical question. However, two neurologists—Dr. Lea and Dr. Mahdad—have evaluated Claimant's

condition. After EMG and nerve conduction testing in February 2010, Dr. Lea agreed with Dr. Greendyke's opinions and conclusions that Claimant did not have cervical radiculopathy in May 2010. Dr. Mahdad recited Claimant's history of negative electrodiagnostic test results and stated it was "very doubtful" that she had cervical radiculopathy in August 2011. Both neurologists' conclusions imply they did not expect EMG testing would fail to detect cervical radiculopathy if Claimant actually suffered therefrom. This tends to confirm Dr. Greendyke's skepticism and suggests that Claimant's condition materially changed sometime between May 2010 and August 2011, during which time Claimant moved out of state and worked in two different jobs.

46. Dr. Greendyke's opinion is more consistent with the clear evidence of Claimant's long-standing neck and upper extremity symptoms, the benign nature of her November 2009 industrial accident, the significant passage of time between her 2009 accident and the first objective evidence of cervical radiculopathy on EMG testing in August 2011, and the objectively documented absence of radiculopathy in February 2010 testing than Dr. Khan's opinion. Dr. Khan's imprecision and failure to explain how Claimant's documented left-sided disc pathology could produce right-sided symptoms further undermine his opinion.

47. The Referee finds Dr. Greendyke's opinion concerning the cause of Claimant's C5-6 and C6-7 disc herniations and radiculopathy more persuasive than that of Dr. Khan. While it is undisputed that Claimant suffered an injury to her right hand and wrist on November 24, 2009, Claimant has failed to establish that her accepted 2009 industrial injury caused or aggravated her cervical disc herniations.

48. **Additional medical and temporary disability benefits.** Having failed to prove a causal relationship between Claimant's 2009 industrial accident and her undisputed cervical disc herniations, all other issues are moot.

CONCLUSIONS OF LAW

1. Claimant has failed to establish that her accepted 2009 industrial injury caused or aggravated her cervical disc herniations.

2. All other issues are moot.

RECOMMENDATION

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

DATED this ___3rd___ day of January, 2013.

INDUSTRIAL COMMISSION

_____/s/_____
Alan Reed Taylor, Referee

ATTEST:

_____/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the ___11th__ day of __January_____, 2013, 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:

STEPHEN J NEMEC
1626 LINCOLN WAY
COEUR D'ALENE ID 83814

E SCOTT HARMON
PO BOX 6358
BOISE ID 83707-6358

kh

_____/s/_____

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

JAMIE DARNELL,

Claimant,

v.

DAVE SMITH MOTORS, INC.,

Employer,

and

LIBERTY NORTHWEST INSURANCE
CORP.,

Surety,
Defendants.

IC 2009-030881

ORDER

**FILED
JAN 11 2013
INDUSTRIAL COMMISSION**

Pursuant to Idaho Code § 72-717, Referee Alan Reed Taylor submitted the record in the above-entitled matter, together with his recommended findings of fact and conclusion 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 conclusion of law as its own.

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

1. Claimant has failed to establish that her accepted 2009 industrial injury caused or aggravated her cervical disc herniations.
2. All other issues are moot.

DATED this __11th__ day of __January_____, 2013.

INDUSTRIAL COMMISSION

_____/s/_____
Thomas P. Baskin, Chairman

_____/s/_____
R.D. Maynard, Commissioner

_____/s/_____
Thomas E. Limbaugh, Commissioner

ATTEST:

_____/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the _11th_ day of ___January_____, 2013, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

STEPHEN J NEMEC
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kh

_____/s/_____