

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

MICHELLE STROPE,

Claimant,

v.

KOOTENAI MEDICAL CENTER, INC.,

Employer,

and

LIBERTY NORTHWEST INSURANCE
CORPORATION,

Surety,

Defendants.

IC 2011-003968

**ORDER ON MOTION FOR
RECONSIDERATION AND/OR
REHEARING**

Filed September 9, 2016

On July 12, 2016, Claimant filed a Motion for Reconsideration and/or Rehearing with supporting memorandum, regarding the Industrial Commission's decision filed June 22, 2016, in the above-captioned case. On July 26, 2016, Kootenai Medical Center, Inc. and Liberty Northwest Insurance Corporation (Defendants) filed Defendants' Response opposing Claimant's Motion for Rehearing and/or Reconsideration. Claimant filed a reply on August 4, 2016.

BACKGROUND

It is undisputed that Claimant injured her back in August 2011 while in the course of her employment. On February 28, 2011 Claimant received a lumbar MRI and in June 2011, Claimant underwent an L5-S1 discectomy, which Defendants paid for. Dr. Larson, Claimant's surgeon, opined that Claimant attained medical stability on September 2, 2011.

At hearing, Claimant contended that she has not reached maximum medical improvement (MMI) and is entitled to additional medical treatment, including a lumbar MRI. Defendants argue that Claimant was declared medically stable by Dr. Larson on September 2, 2011 and thus, is not entitled to any additional medical or temporary disability benefits.

The Commission found that although Dr. Dirks recommended a lumbar MRI for Claimant, and related Claimant's need for such study to her industrial accident, he acknowledged that he could not determine whether Claimant's symptoms are actually related to her industrial accident or to another cause until the MRI is performed.

The Commission concluded that Claimant has not proven that her current need for a lumbar MRI and potential additional medical treatment of her lumbar spine are due to her 2011 industrial accident.

In her motion for reconsideration, Claimant argues that the Commission failed to consider the "key causal evidence" in rendering its decision. According to Claimant, since the Findings of Fact, Conclusions of Law and Recommendation did not specifically discuss several relevant medical records, it follows that they were not considered in reaching a decision. Claimant also contends that there is new evidence in the form of additional analysis by Dr. Dirks following a February 24, 2016 MRI, originating after the hearing and the filing of the decision, which is relevant to causation.

Defendants contend Claimant's motion is based upon her disagreement with the Commission's determination of the weight given to the facts presented and conclusions drawn from those facts, rather than upon legal error. Defendants aver Claimant's motion requests the Commission reweigh the evidence and presents no new legal or factual information. While

Claimant did submit new evidence with her motion, Defendants argue that the new evidence that Claimant requests the Commission review consists of medical evidence that Claimant could have, and should have, adduced in support of her claim in time for the underlying hearing. She should not be allowed to present this evidence now, only after having received an unfavorable ruling. (*See* Defendants' Response to Claimant's Motion for Rehearing and/or Reconsideration at page 4).

AUTHORITY

Under Idaho Code § 72-718, a decision of the commission, in the absence of fraud, shall be final and conclusive as to all matters adjudicated; provided, within twenty (20) days from the date of filing the decision any party may move for reconsideration or rehearing of the decision. . . and in any such events the decision shall be final upon denial of a motion for rehearing or reconsideration of the filing of the decision on rehearing or reconsideration. J.R.P. 3(f) states that a motion to reconsider "shall be supported by a brief filed with the motion."

On reconsideration, the Commission will examine the evidence in the case, and determine whether the evidence presented supports the legal conclusions. The Commission is not compelled to make findings on the facts of the case during a reconsideration. *Davison v. H.H. Keim Co., Ltd.*, 110 Idaho 758, 718 P.2d 1196. The Commission may reverse its decision upon a motion for reconsideration or rehearing of the decision in question, based on the arguments presented, or upon its own motion, provided that it acts within the time frame established in Idaho Code § 72-718. *See, Dennis v. School District No. 91*, 135 Idaho 94, 15 P.3d 329 (2000) (*citing Kindred v. Amalgamated Sugar Co.*, 114 Idaho 284, 756 P.2d 410 (1988)).

A motion for reconsideration must be properly supported by a recitation of the factual findings and/or legal conclusions with which the moving party takes issue. However, the Commission is not inclined to re-weigh evidence and arguments during reconsideration simply because the case was not resolved in a party's favor.

DISCUSSION

Claimant contends the Commission failed to consider all of the evidence in the record because the Findings of Fact, Conclusions of Law, and Recommendation did not specifically reference all of the “key causal evidence” submitted by Claimant. While Claimant clearly does not agree with the conclusion, the Commission is under no obligation to reference every piece of evidence submitted by the parties. The Commission reviewed all the evidence submitted by the parties and considered all the pertinent facts in its analysis.

Idaho Code § 72-432(1) mandates that an employer shall provide for an injured employee such reasonable medical, surgical or other attendance or treatment, ... as may be reasonably required by the employee’s physician or needed immediately after an injury and for a reasonable time thereafter. The fact that Claimant suffered a covered injury to a particular part of her body does not make the employer liable for all future medical care to that part of the employee’s body, even if the medical care is reasonable. *Henderson v. McCain Foods, Inc.*, 142 Idaho 559, 130 P.3d 1097, (2006). The Commission’s decision addressed this exact issue and we find no reason to review the analysis again.

Claimant is critical of the Commission’s finding that the opinions of Dr. Dirks were not founded on a complete understanding of Claimant’s medical history. Dr. Dirks testified that he did not review, and his opinions were not based on, the numerous documents provided to him

immediately prior to his deposition, and which constitute deposition Exhibit 1. Claimant has offered Exhibit A to the affidavit of Mr. Kelso as proof that Dr. Dirks actually has reviewed the majority, if not all, of the pre-injury medical records relevant to Claimant's low back condition. According to Mr. Kelso, these documents were delivered to Dr. Dirks by Mr. Kelso on November 9, 2015, the day before Dr. Dirks' November 10, 2015 examination of Claimant. Of course, the fact that the documents comprising Exhibit A may have been provided to Dr. Dirks prior to his examination of Claimant does nothing to support a conclusion that he reviewed those documents, or that his opinions were somehow informed by those prior medical records. Indeed, Dr. Dirks confirmed that while he did have some of Claimant's prior medical records at the time of his November 10, 2015 evaluation, his opinion was largely based on Claimant's self-reported history and his examination of Claimant. (Dirks Deposition 21/1-22/16). Therefore, Exhibit A to Mr. Kelso's affidavit cures none of the problems with the foundation of Dr. Dirks' opinion previously noted by the Commission in the underlying decision.

The principal thrust of Claimant's argument is that the Commission ignored medical records tending to establish that the surgery performed by Dr. Larson on June 6, 2011 was not successful in resolving her lower extremity radiculopathy, and that if Claimant continued to suffer from that condition as of the date of hearing, it follows that she has ongoing radiculopathy related to the industrial accident for which she is entitled to further treatment, at the very least, the MRI recommended by Dr. Dirks. According to Dr. Dirks, the only way to verify whether or not Claimant has residual problems at L5-S1 referable to the subject accident is to perform another MRI evaluation of Claimant's lumbar spine.

In support of this argument, Claimant notes that on or about July 19, 2011, Dr. Larson

prescribed for Claimant a TENS unit. Claimant suggests that the only reason a TENS unit would be prescribed for Claimant by Dr. Larson is for the treatment of “radiculopathy” and, therefore, it follows that on July 19, 2011, Claimant must have had objective findings consistent with a radiculopathy. In fact, Dr. Larson’s note of July 19, 2011, reflects that Claimant had no pain with straight leg raising, and that her buttock pain was reduced. While Dr. Larson did prescribe a TENS unit on that date, there is no indication in his report that he did so on the basis of an extant radiculopathy. Nor is the Commission aware of anything in the record that would support Claimant’s statement that TENS units are only prescribed where there is evidence of an active radiculopathy. Finally, there is nothing in the medical record, certainly nothing in Dr. Larson’s notes, that reflects that buttock pain equates to “radiculopathy”.

In connection with Dr. Larson’s chart note of September 7, 2011, Claimant argues that this note too demonstrates the existence of an active radiculopathy as of that date. That note simply reflects that Claimant had no pain with straight leg raising, but did have complaints of pain radiating into the upper portion of her left buttocks. On September 7, 2011, Dr. Larson also prescribed lifetime use of a TENS unit for Claimant. Again, nothing in this note supports Claimant’s assertion that Claimant had an active radiculopathy on September 7, 2011. There is no medical evidence that radiation of pain into the buttocks represents the compromise of a nerve root causing radiculopathy. In other words, Claimant assumes that it is appropriate to equate “radiation” with “radiculopathy” in the absence of medical evidence establishing that they are one and the same.

It is true that when Claimant was evaluated by Dr. Sealy on September 28, 2011, Dr. Sealy noted that Claimant presented with pain radiating to the left hip in addition to low back

pain. Dr. Sealy's impression was that Claimant suffered from left sciatica and he recommended MRI evaluation of Claimant's lumbar spine. (*See* Claimant's Exhibit D at 70-73).

Following the June 6, 2011 surgery, Claimant was referred by Dr. Larson for physical therapy at Pinnacle Physical Therapy. Therapy evidently commenced on June 27, 2011, as reflected in the physical therapy initial evaluation of that date. (*See* Claimant's Exhibit X at 558). The physical therapy intake evaluation reflects that Claimant reported an increase in discomfort over the prior weekend while doing yard work. Claimant also reported that as the result of driving over a speed bump in her car she experienced an increase in symptoms. The physical therapy intake evaluation reflects that Claimant's chief complaints were of low back and hip pain. She also reported some radicular symptoms past her knee, relieved with stretching. The record reflects that Claimant underwent six weeks of physical therapy commencing on or about June 27, 2011. When he pronounced Claimant medically stable on September 7, 2011, Dr. Larson's note of that date reflects that he did so only after conferring with Claimant's physical therapist. As noted above, Dr. Larson did not note the presence of any radicular complaints as of September 7, 2011. The puzzling thing about the June 27, 2011 physical therapy intake evaluation is the space provided at the bottom of that evaluation for the physician's response. (*See* Claimant's Exhibit X at 559). That response, signed by Dr. Larson, reflects that he agreed with the plan of care described by the physical therapist on June 27, 2011. However, his agreement with the plan is dated October 10, 2011. In the original Findings of Fact, Conclusions of Law and Recommendation, the Commission concluded that Dr. Larson's October 10, 2011 concurrence represented his agreement that Claimant required six additional weeks of physical therapy, i.e. six weeks of additional therapy subsequent to October 10, 2011. Further review of

the aforementioned documents leaves the Commission to conclude that Dr. Larson's October 10, 2011 agreement with the June 27, 2011 treatment plan lends no support to the proposition that he endorsed yet another six weeks of physical therapy to treat ongoing symptoms after medical stability.

As noted in the original Decision, Claimant presented to Dr. Stoddard on or about March 7, 2012 with complaints of increased discomfort which she related to working around her house. Another flare-up of symptomatology occurred in July of 2012 when Claimant was involved in an automobile accident.

On or about December 13, 2012, Claimant presented for evaluation at Dr. Larson's office, where she was seen by Nurse Practitioner Moore. Claimant reported to Nurse Practitioner Moore that she noted an increase in symptoms after doing some home improvement chores. Objective findings on exam suggested the presence of an L3 radiculopathy, for which Nurse Practitioner Moore recommended further evaluation in the form of an MRI. As noted in the original decision Dr. Dirks originally concluded that the distribution of Claimant's symptoms represented an L4-5 radiculopathy.

None of the medical records referenced above and others parsed by Claimant in her motion, persuade the Commission to a different conclusion than that reached in the original Decision. There is, however, certain new evidence which must be discussed before concluding this analysis.

In the underlying Decision, Claimant was denied the MRI recommended by Dr. Sealy, N.P. Moore, and Dr. Dirks, because she was unable to demonstrate that it was more probable than not that her need for such evaluation was related to the subject accident. Subsequent to the

Commission's Decision, Claimant was able to obtain the recommended study by accessing other insurance she obtained after the hearing. That study was performed on February 24, 2016.

The study led to the generation of other records by Dr. Dirks, also included in Exhibit B to the affidavit of Mr. Kelso. Defendants object to consideration of this evidence, arguing that Claimant should have come to hearing with all the evidence necessary to support her claim. Prior to hearing Surety refused to authorize the MRI, and the fight at hearing was over whether surety should be required to pay for the study. For Defendants to now challenge the MRI on the basis that Claimant should have obtained this evidence in time for the original hearing ignores what has gone before and borders on the disingenuous.

The radiologist who read the February 24, 2016 MRI did not have the opportunity to compare it against the two previous MRIs of record. In general, the study revealed marked multi-level degenerative changes from L2 through S1. In addition to a copy of the MRI report, Claimant has offered additional records from Dr. Dirks, although there is reason to believe that not all of Dr. Dirks' 2016 records have been submitted. Claimant has provided a copy of a May 17, 2016 chart note as well as a copy of a July 12, 2016 letter to Mr. Kelso. Also included are procedure reports from March 22, 2016 and April 21, 2016 for L3-L4 and L4-L5 epidural steroid injections. No chart notes pre-dating those procedures, nor any chart notes associated with those procedures have been provided, although it seems likely that such documentation exists. The May 17, 2016 chart note reflects that the epidural steroid injections were not successful in relieving Claimant's discomfort. Dr. Dirks noted that Claimant suffered from severe lumbar spondylosis at L3-L4, L4-L5 and L5-S1. He recommended that she is a candidate for surgical intervention at L3 through S1, surgery to include lumbar laminectomies and facetectomies at

those levels, along with multi-level fusion. One might guess that since Dr. Dirks ordered epidural steroid injections to be performed at L3-L4 and L4-L5, he thought that these must be Claimant's symptomatic levels. Of course, it is only the L5-S1 level that is implicated in connection with the subject accident. At any rate, from Dr. Dirks' note of May 17, 2016 it is impossible to understand whether he believes the subject accident is implicated in Claimant's need for multi-level lumbar spine surgery. However, any doubt about Dr. Dirks' opinion in this regard is resolved by his July 12, 2016 letter to Mr. Kelso. In that letter, Dr. Dirks stated:

As documented in the radiologist's report, and my personal review of the MRI, Ms. Strobe has neuroforaminal narrowing, greater on the left, that is causing her to suffer a left L5 radiculopathy. This radiculopathy is at the site of her June 6, 2011 surgery and it is clearly the result of the fact that her surgery did not resolve the injury she suffered at work on January 13, 2011. I am recommending surgery to correct this condition and in order to do so, I will have to address her other lumbar issues at L3-L4 and L4-L5.

Therefore, contrary to what could be suggested by Dr. Dirks' recommendations for epidural steroid injections at L3-L4 and L4- L5, his July 12, 2016 letter places all the blame for Claimant's symptomatology on the L5-S1 space. Next, he explains that because the accident requires further surgical intervention at L5-S1, he must necessarily address her "other lumbar issues" at higher levels.

This case bears a remarkable similarity to *Amber Lawson v. Addus Healthcare, Inc.*, 2016 IIC 0003. In that case, too, the Commission denied MRI evaluation requested by claimant, reasoning that claimant had failed to demonstrate that the need for such treatment/evaluation was related to her accident. In that case as well claimant obtained the MRI in question from other sources following the Commission decision. On review of that MRI, a physician involved with the case proposed that the MRI findings suggested that claimant needed surgery related to the

subject accident. Counsel moved the Commission to reconsider its decision on the basis that failure to consider the new evidence would constitute a manifest injustice under Idaho Code § 72-719. The Commission agreed, and provided defendants with additional time to adduce medical evidence to controvert the new evidence adduced by claimant. Ultimately, consideration of the new medical evidence did not persuade the Commission to change the original outcome of the case.

Here, the provisions of Idaho Code § 72-719 are not technically applicable, since Idaho Code § 72-719(3) provides that the Commission may review a case to correct a manifest injustice within five years following the date of accident. Here, that five-year period has expired. Even so, this matter comes to us on a timely motion for reconsideration and the Commission has considerable leeway to grant the motion, deny the motion, or re-hear the case. *See* Idaho Code § 72-718.

Since it was the principal thrust of Claimant's argument at hearing that a new MRI would reveal all, we believe it only fair to test that proposition now that this hoped for study has finally been obtained. Dr. Dirks suggests that the MRI establishes that Claimant requires surgery referable to the subject accident although, as developed above, even Dr. Dirks' records raise some questions about his conclusions. Since we believe it is important to consider the study, now that it has been accomplished, we conclude, as we did in *Lawson*, that the record should be re-opened to allow the parties to adduce additional medical evidence on the narrow question of whether the February 24, 2016 MRI evaluation is compensable, and if so, whether it supports a conclusion that Claimant requires further treatment referable to the subject accident. The Commission will not entertain a rehashing of other evidence/arguments previously submitted for

consideration. Therefore, **IT IS HEREBY ORDERED** that the February 24, 2016 MRI report is admitted into evidence, along with the other records attached as Exhibit B to the July 12, 2016 affidavit of Starr Kelso.

Further, the parties are allowed 90 days from the date of this Order within which to provide the Commission with such additional medical evidence and argument as the parties would have the Commission consider on the following narrow issue: Are Defendants liable for the payment of the expenses associated with the February 24, 2016 MRI, and if so, what does that study add to analysis of the question of whether or not Claimant is entitled to further medical treatment referable to the subject accident?

DATED this 9th day of September, 2016.

INDUSTRIAL COMMISSION

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

_____/s/_____
Thomas E. Limbaugh, Commissioner

_____/s/_____
Thomas P. Baskin, Commissioner

ATTEST:

_____/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on 9th day of September, 2016, a true and correct copy of the foregoing **ORDER ON MOTION FOR RECONSIDERATION AND/OR REHEARING** was served by regular United States Mail upon each of the following:

STARR KELSO
PO BOX 1312
COEUR D ALENE ID 83816

LEA KEAR/MATTHEW VOOK
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_____/s/_____