BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

EDWARD JORDAN, Claimant, v. DEAN FOODS, Employer, and ACE INSURANCE and INDEMNITY INSURANCE COMPANY OF NORTH AMERICA, Sureties, Defendants.	**IC 2006-005687** **IC 2010-001650** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** Filed April 13, 2015

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 July 18, 2013. Claimant was present at the hearing and represented by Justin Aylsworth of Boise. W. Scott Wigle of Boise represented the Employer (referred to herein as "Meadow Gold") and both Sureties. The parties presented oral and documentary evidence and three post-hearing depositions were taken. Post-hearing briefs were filed, and the matter came under advisement on

February 4, 2015. The undersigned Commissioners have chosen not to adopt the Referee's recommendation and hereby issue their own findings of fact, conclusions of law and order.

ISSUES

By agreement of the parties at the hearing, the issues to be decided are:

1. Whether Claimant's cervical spine condition for which he underwent a tri-level disc decompression and fusion surgery on June 6, 2012 is a compensable workplace injury related, in whole or in part, to his industrial accidents on May 16, 2006 and/or January 12, 2010;

2. Whether and to what extent Claimant is entitled to benefits for:

    a. Medical care;

    b. Temporary total disability (TTD);

    c. Permanent partial impairment (PPI); and

    d. Disability in excess of impairment;

3. Whether any of Claimant's claims are barred by operation of the statute of limitations provided in Idaho Code § 72-706;

4. Whether any of the benefits to which Claimant may be entitled are subject to apportionment under Idaho Code § 72-406; and

5. Whether Defendants, or any of them, are liable for attorney fees pursuant to Idaho Code § 72-804.

CONTENTIONS OF THE PARTIES

Undisputed. It is undisputed that Claimant suffered workplace accidents on May 16, 2006 and January 12, 2010, while working for Meadow Gold, that resulted in injuries to his neck. Claimant timely reported these injuries, and Surety provided benefits for treatment.

Following the 2006 injury, Claimant was temporarily placed on light duty work. After conservative treatment, including physical therapy, Claimant was deemed medically stable on September 1, 2006, and he returned to full-duty. Following the 2010 injury, Claimant continued to work full-duty. After a short course of physical therapy, he was deemed medically stable on February 16, 2010, even though he still had what he described as a knot and burning sensation in his right periscapular area.

Claimant did not seek additional treatment for his neck until summer 2011. Thereafter, on June 6, 2012, Claimant underwent a tri-level cervical spine fusion by Dr. Doerr.

Surety denied benefits based on an independent medical evaluation (IME) opinion by Dr. Friedman that the surgery was not causally related to either industrial accident; rather, it was the result of degenerative disc disease. Claimant worked full-duty at Meadow Gold until an assistant was assigned to his route, about two weeks before his cervical spine surgery. He has not been employed since his surgery because he believes he is physically unable to work at jobs for which he is otherwise qualified.

Claimant's position. Claimant contends that his cervical spine fusion was required solely as a result of the 2010 injury. Therefore, he is entitled to benefits for medical care, permanent impairment, temporary disability, and permanent disability of 31% of the whole person inclusive of PPI. Claimant also seeks an award of attorney fees because he claims Defendants failed to provide reasonable medical care following the 2006 and 2010 industrial accidents. Further, Claimant asserts that Defendants denied his claim for additional benefits without a reasonable medical basis. He relies upon the medical opinions of Drs. Foutz, Doerr, and Verska, and the vocational opinion of Douglas Crum, CDMS.

Defendants' position. Defendants counter that Claimant has failed to meet his burden of proving that either of the industrial accidents is causally related to his June 2012 cervical spine surgery. They focus upon foundation problems with the opinion evidence of Drs. Foutz, Doerr, and Verska, arguing that Dr. Friedman's opinion is the most credible because it is the only medical opinion which considers all of Claimant's relevant medical facts. They deny Claimant is entitled to any additional benefits and that he has any basis for an award of attorney fees.

OBJECTIONS

All pending objections preserved at the hearing and post-hearing depositions are overruled.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The pre-hearing depositions of:
    a. Claimant taken July 24, 2012; and
    b. Michael Foutz, M.D., taken June 26, 2013;
2. Claimant's testimony taken at the hearing;
3. Claimant's Exhibits (CE) A through X admitted at the hearing;
4. Defendants' Exhibits (DE) 1 through 3 admitted at and following the hearing by stipulation of counsel; and
5. The post-hearing depositions of:
    a. Joseph Verska, M.D., taken November 22, 2013;
    b. Douglas N. Crum, CDMS, taken July 25, 2014; and
    c. Robert H. Friedman, M.D., taken October 16, 2014.

FINDINGS OF FACT

BACKGROUND

1. Claimant was 48 years of age at the time of the hearing and residing in Long Beach, Washington. He had a childhood generally unmarked by significant physical problems, although he did break his leg when he was ten.

2. Claimant enlisted in the United States Navy when he was 17, obtaining his GED during the next year. In the Navy, Claimant took a couple of college-level courses. He served as a gunner's mate for more than ten years, then served his final ten-year span as a career counselor, assisting sailors in determining their qualifications for career advancement programs, and helping prepare applications for those programs. In preparation for this position, Claimant attended the Navy's career counseling school, where he learned to review manuals to determine eligibility requirements. He also obtained a commercial driver's license while enlisted. Claimant accumulated various merit and service honors through the time of his honorable discharge and service retirement in 2003.

3. Upon his retirement from the Navy, Claimant moved to Mountain Home, Idaho and worked in a call center for three months. Thereafter, in August 2003, Claimant was hired as a full-time milk delivery driver at Meadow Gold, doing heavy work such as moving multiple cases of milk at once, stacking pallets, and other activities.

MILITARY SERVICE MEDICAL TREATMENT AND DISABILITY ASSESSMENTS

4. While in the Navy, Claimant received treatment primarily for low back pain with radiculopathy (treated with epidural steroid injections; surgery was discussed but Claimant declined), headaches (including migraines), ear problems, and left knee symptoms (for which he

underwent arthroscopic surgery in 2000). He was also treated for seasonal illnesses (like sinus ailments, for example), as well as a stress fracture to his left foot in 1985, vasectomy in 1987, and excision of a salivary calcification from his left submandibular gland in 1999.

5. On a few occasions, Claimant was treated for upper extremity and/or thoracic spine symptoms:

- In August 1999, Claimant sought treatment for what he thought was a pinched nerve in his neck. He thought onset had occurred when he opened up a tent flap, and that it had happened several times before. Claimant reported bearable pain, at about "1" on a ten scale, that would increase to "7" or "8" with backward neck movement. A couple of weeks later, he sought a Motrin prescription to treat his persistent sore neck. He was instructed to seek additional treatment if his pain worsened, which he apparently did not do.

- In November 2000, Claimant reported upper thoracic spine pain with referred pain to his neck. On exam, Claimant had reduced range of motion in his neck, but no upper extremity paresthesias or radiculopathy. He had been diving earlier in the day and was wearing his tank and dive belt when he took a step down and felt a "pinch." DE-370. According to the chart note, Claimant reported this had happened every two to three months, for years. Then, while brushing his teeth at night, he bent over and felt burning between his shoulder blades along with pain while turning his neck. His pain subsided with conservative treatment, including Naproxen and ice/heat, and he returned to full-duty work.

- In December 2000, Claimant still had upper thoracic spine pain radiating to his neck. His pain had increased during the prior week, and his wife had "cracked" his back to release it. DE-369. She did so again before and after two short dives over the weekend. On exam, Claimant had knots right of T5 and left of T4, with tender points. He had no paresthesias or weakness into his arms. He was diagnosed with somatic dysfunction at the thoracic spine level and offered a marcaine trigger point injection, which Claimant declined.

- In November 2001, following a rear-end collision, Claimant was evaluated for pain in his mid-back and neck, along with shoulder stiffness. He did not evidence upper extremity paresthesias or radiculopathy.

6. Claimant believes his prior cervical problems were related to muscle strains that fully healed before he began working at Meadow Gold.

7. On discharge, Claimant was assessed a 40% service-related disability, including 10% related to hearing loss (ringing in the ears), 10% related to left knee surgery, and 20% related to lower back and right leg radiculopathy. In October 2006, Claimant's headaches were also determined to be service-related. Claimant is entitled to medical treatment through the Veteran's Administration (VA) related to these service-related conditions and disabilities.

8. Claimant had no history of cervical spine radiculopathy prior to May 2006.

DR. FOUTZ

9. Claimant established care with Michael Foutz, M.D., as his family physician, in November 2004.

10. Once each in 2006 and 2007, Dr. Foutz assessed Claimant for depressive disorder. In 2008, he assessed an acute upper respiratory infection, and evaluated Claimant's complaints concerning being "sore everywhere," joint problems, ear discomfort, sinusitis, headache, and lumbago. In June 2010, Dr. Foutz assessed a bout of infectious diarrhea. CE 21. The record contains no narratives to elucidate these assessments.

11. Claimant's further treatment by Dr. Foutz is described in chronological order, below.

MAY 16, 2006 INDUSTRIAL INJURY

12. On May 16, 2006, Claimant had sudden onset of neck and shoulder pain, with numbness down his arms, when he bent into an awkward position to move product around in the back of his truck. Claimant also experienced some low back pain. After a few more deliveries, Claimant had numbness and tingling down his right arm into his hand, with weakness, causing

him to drop a gallon of milk. Claimant notified his supervisor, who helped him finish his delivery route.

13. Later that day, Claimant sought emergent treatment at St. Luke's Regional Medical Center, where he reported low back pain and lower cervical pain with numbness and tingling to his hands, worse on the right. Claimant was diagnosed with cervical and lumbar spine strains.

14. On the following day, Claimant sought treatment at St Luke's Occupational Health, Meadow Gold's designated medical care provider. He held his right arm flexed at the elbow, across his chest, and reported, among other things, burning in his cervical musculature with numbness and tingling in his right upper extremity. On exam, Claimant reported increased pain in the right cervical musculature with muscle loading at the right upper extremity, significant pain with palpation of the upper right trapezius muscle, mild edema, and palpable spasms with range of motion. Claimant's cervical range of motion was limited in forward flexion and extension, and he had increased pain when turning his head to the right and bending his head to the left. Claimant was diagnosed with cervical and lumbar muscle strains, prescribed with a muscle relaxer medication, and provided with home care instructions.

15. On May 22, 2006, Claimant underwent a cervical spine x-ray. The reading radiologist reported, "Mild degenerative disk disease at C5-6 and C6-7 with mild bilateral foraminal narrowing at these levels. No fracture or malalignment." CE 118. He also noted some minimal early osteophyte formation at C5-6 and C6-7, with no evidence of prevertebral soft tissue swelling.

16. On May 25, 2006, Claimant underwent a cervical spine MRI to rule out right radiculopathy from C4-6. The reading radiologist concluded, "There is C3-7 degenerative disk disease with a small to moderate-sized central posterior C4-5 protrusion with cephalic migration, smaller posterior bulges/protrusions at the other levels and foraminal/spinal canal narrowing...." CE 122. Regarding the narrowing at C4-5, "The spinal canal is mildly narrowed but probably adequate. The neural foramina are normal." *Id.* At C5-6 there was mild left and mild-to-moderate right foraminal narrowing. At C6-7, there was mild bilateral foraminal narrowing.

17. On June 2, 2006, Claimant was again evaluated at St. Luke's Occupational Health. He still had consistent pain, mainly between his shoulder blades, and "sensory changes subjectively to the C5-6 distribution on the right." CE 124. His attending physician, Ralph Sutherlin, D.O., noted Claimant's MRI evidence of a small-to-moderate central posterior C4-5 protrusion. He recommended two chiropractic sessions, physical therapy, and completing a Predisone taper.

18. On June 9, 2006, Dr. Sutherlin noted Claimant's neck and thoracic spine pain had improved, but he still had tingling to the median nerve distribution to his right hand. Dr. Sutherlin ordered an EMG to rule out carpal tunnel syndrome. Michael Weiss, M.D., performed a nerve conduction study on Claimant's right upper extremity on June 14, 2006. He concluded that there was no electrodiagnostic evidence of neuropathy or myopathy in the areas sampled, which included right upper extremity and cervical paraspinal muscles, and multiple nerves.

19. On June 19, 2006, Dr. Sutherlin noted Claimant's cervical symptoms had greatly improved, though Claimant still reported some tenderness. On July 12, 2006, Claimant's neck

and back pain had resolved, but "with certain positions and movements he will get a pins and needles aching feeling to his entire arms below his elbows." CE 133. Claimant was "quite aggravated" by this. *Id.* Dr. Sutherlin opined Claimant's residual bilateral upper extremity paresthesias "may be secondary to an acute functional lesion versus peripheral vascular obstruction versus muscle contractures." *Id.*

20. Claimant's bilateral upper extremity paresthesias persisted. As of July 24, 2006, Dr. Sutherlin still did not know if they were industrially related, so he referred Claimant for a neurological evaluation.

21. On July 25, 2006, Claimant described his persistent arm paresthesias to Jana Thompson, Intermountain Claims, during a recorded telephone interview. His shoulder area pain had subsided, but his arms and hands were still going completely numb:

> Q. Arms and hands go numb. And from the numbness is it from the finger tips up to what?
>
> A. Uh, it actually goes from the back of the arms, you know, from the upper arms, it's not…
>
> Q. The biceps area?
>
> A. Yeah. It's pretty light but as it goes down it gets a lot heavier and then you get pins and needles in the hands [*sic*] you know where it hurts. You know, like when your foot falls asleep and when it first starts waking up.
>
> Q. Uhum.
>
> A. But that's what it constantly does.
> …
> A. …it comes and goes constantly. Um, like when I'm working, you know, I pick something up, you know, you move it you set it back down so I don't have a problem. Now, if I hold something for a while, yes it will do it.
> …

> A. …[it lasts] until I move my arm and just get it in the right position to get it uh, you know, the blood flow or whatever it is to release and, you know, start working again.

CE 335-336. Claimant also confirmed that he had never experienced these symptoms before his May 2006 industrial accident.

22. Following a second EMG on August 8, 2006, Richard Wilson, M.D., neurologist, opined that Claimant had bilateral carpal tunnel syndrome. Given this information, Dr. Sutherlin opined Claimant's residual numbness in his hands was not industrially-related, but instead was due to non-industrial carpal tunnel syndrome. He drew this conclusion even in light of Dr. Weiss's negative nerve test results and his own clinical testing on September 1, 2006, when he noted, "He does not have any significant sign of carpal tunnel syndrome, other than the history of the numbness to his hands. The patient has been using his wrist splints. The patient has negative Tinel's, negative Phalen's sign." CE 138. On that day, Dr. Sutherlin also noted that Claimant's hand numbness was worsening. He opined that Claimant had reached maximum medical improvement (MMI) even though Claimant's hand numbness was worsening because he attributed that condition to non-industrial carpal tunnel syndrome:

> The patient has fully resolved from his severe muscle strain from 05/16/06. He has had maximum medical improvement and the case will be closed. The patient does appear to have carpal tunnel syndrome, which appears to have been an insidious onset of numerous years, which may be greater than 3 years. The patient is complaining more of the worsening numbness, which appears to be worse in the evening. I did discuss that the patient should continue with his stretching type of program, as well as wearing the splints at night. Followup is not required at this clinic and the case will be closed.

CE 138. Claimant was not assessed any permanent work restrictions and he resumed his full-duty work.

INTERIM PERIOD BETWEEN INDUSTRIAL ACCIDENTS

23. Following his discharge from care by Dr. Sutherlin, Claimant continued to work, full-duty. "I was still having occasional pain, but overall it was feeling a lot better. …just occasional light pain and a little numbness depending on a position or something. " HT 58-59. Claimant received no further treatment related to his neck or arm symptoms until January 12, 2010 (see below). Similarly, Dr. Doerr's records indicate that Claimant told him in August 2011 that he had experienced bilateral arm radiculopathy, worse on the right, and cervical spine pain, since his 2006 industrial injury. He did not mention the 2010 injury, below, let alone attribute any residual symptoms to it. Claimant attributed his symptoms to non-industrial carpal tunnel syndrome.

JANUARY 12, 2010 INDUSTRIAL INJURY

24. On January 12, 2010, Claimant had onset of cervical symptoms when he was moving a dolly into position to hook up a set of very heavy steel duals. He testified, "I had pain in my neck, in my shoulder, a real terrible burning going across my shoulders. I got numbness in the arms, you know, the right one worse than the left, but numbness." HT 62-63.

25. Claimant testified that his symptoms were more severe and more persistent than those he experienced in May 2006, and that they were radiating from the same general location as his 2006 cervical injury. Nevertheless, Claimant made his delivery run to Pocatello on the day of the injury.

26. On January 13, 2010, after notifying his supervisor, Claimant sought treatment at St. Luke's Occupational Health, reporting pain and burning in his neck and right shoulder area and right hand numbness, worse in his fourth and fifth fingers. He was evaluated by Paige W.

Cline, PA-C. According to the chart note, he denied pain down his right arm. He also denied any prior neck or shoulder pain.

27. Claimant's neck exam revealed full range of motion with some pain at the endpoints of flexion and left lateral flexion. He had no spinal tenderness, but some paraspinal tenderness in the mid to lower cervical region, more on the right than left, with mild hypertonicity. Claimant's shoulder exam revealed mild swelling in the posterior right shoulder as compared to the left. His range of motion was limited by pain. He had tenderness to palpation over the outer clavicle region, the supraspinatus region, and just between the spine and shoulder blade. He also had a positive Hawkins test. PA Cline ultimately diagnosed cervical, thoracic, and right shoulder strains. She referred Claimant to physical therapy, prescribed medication, recommended icing several times a day, and restricted Claimant's lifting and reaching. She did not order any imaging.

28. Claimant followed up with PA Cline on January 25, 2010. According to the chart note, his muscle strains had improved, but he still had mild endpoint pain with neck rotation and shoulder abduction/flexion. He also had paraspinal tenderness medial to his right scapula with hypertonicity. His impingement testing was negative, supraspinatus strength and sensation intact, and his grip strength was symmetric. He denied finger numbness and neck problems, and had stopped taking Flexeril. The only remaining pain, he reported, was between the spine and shoulder blade on the right side. He had been working full-duty. PA Cline diagnosed persistent rhomboid/thoracic strains. She continued Claimant on ibuprofen 800 mg, twice per day, and a TheraCane self-massage device, discouraged lifting heavy weight overhead, and moved him from physical therapy to home exercises after a couple more sessions.

29. On February 16, 2010, Claimant followed up with Cody Heiner, M.D., at St. Luke's Occupational Health. He noted, "Most of his symptoms have resolved with the exception of one specific spot in the right periscapular area where he describes a "knot" and a burning sensation. This is rated at 0-3 out of 10 and worse with inactivity and better with stretching or massage. He is no longer taking any medications and doing fine in full-duty capacity." CE 157. On exam, Dr. Heiner noted normal cervical and right shoulder range of motion in all directions, and a tender spot near the superomedial border of the right scapula where a slight nodule was palpated. He had a negative Spurling's test and his upper extremity sensory function, motor function, and deep tendon reflexes were normal. He had no evidence of rotator cuff tendonitis or tear.

30. Dr. Heiner administered a trigger point injection to treat Claimant's remaining spot of persistent pain/spasm. Claimant noticed a slight improvement. Dr. Heiner counseled Claimant that his residual pain did not indicate significant pathology and that it should resolve gradually over time. He returned Claimant to full-duty work and continued his ibuprofen, as needed, his home exercise program, and heat.

31. On March 22, 2010, Dr. Heiner formally discharged Claimant from care via telephone. The corresponding chart note indicates Claimant was asymptomatic, tolerating full and normal activities, including work, and that Claimant did not request further evaluation.

32. Claimant continued to work full-duty until approximately May 24, 2012, when an assistant was assigned to his route. Thereafter, he worked until June 6, 2012, when he underwent tri-level cervical fusion surgery (see below).

INTERIM PERIOD BETWEEN 2010 ACCIDENT AND SURGICAL RECOMMENDATION

33. On November 29, 2010, Claimant sought treatment from Dr. Foutz for a number of conditions, none of which involved his arms, hands, or cervical spine. For example, Claimant complained of low back pain without radiculopathy and a persistent sore throat that he thought may be related to smoking.[1] Claimant also reported no worsening of his heartburn. On exam, Claimant's paraspinal muscles were tender to palpation bilaterally from the thoracic to the lumbar spine, but his neck exam was normal and there is no mention of any problem with his cervical spine. Under the heading, "Problem List," Dr. Foutz included calcium deposits in salivary gland, left knee meniscus removal, vasectomy (1987), left leg fracture (apparently), and migraine headaches. Dr. Foutz diagnosed backache, unspecified, and acute pharyngitis. He provided a medical excuse from work, predated to November 26 and extending through December 2.

34. Dr. Foutz next treated Claimant on July 26, 2011, for right low back pain he'd been experiencing for years. Claimant also sought documentation of his condition for the VA. In the history section of the chart note, Dr. Foutz recorded, in detail, information he received from Claimant about his complaints, including at least one non-VA-related complaint, none of which included neck, arm, or hand problems.[2] The note states, among other things, that

[1] Along those lines, the chart note indicates Claimant has smoked two packs per day for 20-25 years. Other chart notes indicate one pack per day. By the time of the hearing, Claimant had apparently quit.

[2] Dr. Foutz noted low back pain due to facet arthropathy, for which surgery had been previously recommended; right leg radiculopathy to Claimant's knee and, sometimes, to his foot, aggravated by sitting for too long associated with his daily work routine; migraine headaches mostly controlled with Imitrex; non-migraine type headaches with sudden and more frequent onset; positional knee pain primarily on the left following meniscus removal aggravated by getting in and out of the truck at work. He also diagnosed and treated Claimant's impacted cerumen.

Claimant carried a diagnosis of thoracic or lumbosacral neuritis or radiculitis, unspecified. Also, Claimant reported he quit smoking one to three months previously.

35. As to Claimant's cervical spine, Claimant reported his pain was unchanged – "no better or worse." CE 26. On exam, Dr. Foutz palpated some cervical spine tenderness. Dr. Foutz ordered MRIs of Claimant's lumbar spine and left knee, and an x-ray of his cervical spine.

36. On August 8, 2011, Claimant advised an office worker calling on Dr. Foutz's behalf that he wished to discuss with Dr. Foutz his right knee condition, as well as concerns about what the July 26 chart note may convey. *See* CE 30. Claimant does not remember the call, but does not dispute that it occurred. According to the note, Dr. Foutz advised the office worker that he did not need to see Claimant again, and referred Claimant to Dr. Tadje for follow-up on his knee, back, and neck issues.

37. At his deposition in June 2013, Dr. Foutz testified that Claimant specifically sought treatment for cervical spine symptoms because he was having such a hard time with work. The Commission finds the chart note and telephone message from July 26, 2011 are more credible evidence of Claimant's stated concerns during that particular time period. Claimant did not report any changes or specific concerns regarding his cervical spine, arms, or hand conditions at that time.

38. *Dr. Doerr.* On August 18, 2011, Dr. Doerr evaluated, among other things, Claimant's "axial neck pain." CE 50. Dr. Doerr, a practice partner of Dr. Tadje, is an orthopedic surgeon who performs spine surgeries. Claimant presented with cervical neck pain and bilateral arm radiculopathy, worse on the right than on the left, for several years. According to Dr.

Doerr's chart note, Claimant attributed the onset of his radicular pain to his 2006 industrial injury:

> [Claimant] reports that he had an industrial injury about six years ago, at which time he began having pain radiating in the right greater than left arms. He had neck pain prior to this injury but no arm pain prior to the injury. He was treated with physical therapy but his symptoms never full [*sic*] resolved. He has some generalized weakness, as well as some numbness into both hands, which he was told at the time of his work comp evaluation, was secondary to carpal tunnel syndrome.

CE 47.

39. On exam, Claimant's cervical spine motion was moderately restricted. Light touch response was intact and symmetric from C-2 to S-2, with the exception of intermittent paresthesias into both hands.

40. Dr. Doerr opined that Claimant's August 2, 2011 cervical spine x-rays demonstrate some loss of the normal cervical lordosis (curvature) and degenerative disc space narrowing throughout the cervical spine, most significant at C4-5 and C5-6.

41. Dr. Doerr assessed likely cervical radiculopathy, prescribed medication, and ordered an MRI of Claimant's cervical and thoracic spine to evaluate his hyperreflexia. He notified Dr. Foutz of his diagnosis and imaging plan by letter dated August 18, 2011.

42. Dr. Doerr attributed Claimant's radiculopathy to his 2006 industrial injury. "Given that he reports that he has had no radicular arm symptoms prior to his industrial injury of 2006 it appears that this may be related to his previous industrial injury." CE 48.

43. On August 23, 2011, Claimant underwent a cervical spine MRI for "[n]eck pain radiating into the right arm for five to six years […with] [n]o known injuries." CE 37. The reading radiologist assessed, among other things, multilevel degenerative changes of the cervical

spine causing mild cord compression at C4-5 and C5-6 without abnormal cord signal and a broad-based disc/osteophyte complex affecting C3-6. He also identified neural foraminal stenosis from C3 through C7, as follows:

- C3-4: Mild, right.
- C4-5: Severe, right worse than left.
- C5-6: Severe, bilateral.
- C6-7: Mild, right worse than left.
- C7-T1: Normal for age.

"Compared with the previous examination there has been interval desiccation of the disc extrusion at C4-5 with slight flattening of this extruded disc material but interval progression of disc space narrowing and broad-based osseous ridging/disc bulging at C4-5 and C5-6 levels." CE 38. There was also a small right paracentral disc protrusion at C6-7 that did not directly abut the cord. The disc bulge was broad-based and there was mild, right-worse-than-left neural foraminal stenosis.

44. On August 25, 2011, Claimant followed up with Dr. Doerr, who also evaluated his cervical spine MRI. Dr. Doerr noted "broad based disc and osteophyte at C4-5 and C5-6 levels, resulting in mild cord compression with severe right greater than left C4-5 foraminal narrowing and severe bilateral C5-6 foraminal narrowing." CE 52. Claimant's thoracic spine MRI showed mild degenerative changes and very mild S-shaped scoliosis without significant central canal or neural foraminal stenosis.

45. Dr. Doerr diagnosed C4 to C6 stenosis with neck pain and right greater than left arm radiculopathy. Given Claimant's cervical spine MRI results, his "six year history of symptoms unresponsive to activity modifications and physical therapy," and his failure to

improve with oral steroid medication, Dr. Doerr recommended proceeding with a C4 to C6 anterior cervical decompression and fusion surgery. CE 52-53.

46. On September 1, 2011, Claimant underwent non-industrial left knee partial meniscectomy arthroscopic surgery by Dr. Doerr.

47. Dr. Doerr again evaluated Claimant's cervical spine on September 15, 2011. His chart note reiterates Claimant's report of persistent symptoms since his May 16, 2006 industrial injury. It also memorializes Dr. Doerr's recent review of Claimant's medical records pertaining to his treatment for that injury in 2006 which, he opined, supported the likelihood that Claimant's May 2006 industrial injury was the cause of his persistent cervical spine radiculopathy. First, Claimant's prior reports of his symptoms were consistent with onset at the 2006 industrial injury:

> He had symptoms documented consistent with his current symptoms of neck pain with predominately [*sic*] right arm radicular symptoms on his initial evaluation on 05/17/06 as well as subsequent evaluations on 05/26/06 and 06/02/06. Occupational Health Services on 07/24/06 documented that he had not had any tingling or similar radicular symptoms in his arm prior to the initial industrial injury. The patient reports that his symptoms never ever completely resolved and he was again seen at Occupational Health Services on 01/12/10 with similar predominately [*sic*] right arm radicular complaints.

CE 60-61. Second, a comparison between Claimant's 2011 and 2006 cervical spine MRIs supports this conclusion:

> Edward had an MRI of the cervical spine on 05/25/06, which is compared to his most recent MRI. The MRI of 05/25/06 revealed moderate size central disc protrusion at C4-5 with extradural defect on the cord. In addition, there was some right moderate foraminal narrowing at the C5-6 level. Although there has been some progressive degeneration since the MRI on 05/25/06, the patient's symptoms appear to be clearly related to this industrial injury, therefore I believe that it is medically more probable than not that his need for C4 to C6 anterior cervical decompression and fusion is directly related to his industrial injury of 05/16/06.

Id.

48. On September 27, 2011, Dr. Doerr wrote a letter to Surety's third party claims administrator, apparently seeking authorization to perform surgery. He provided a detailed description of Claimant's cervical spine radiculopathy symptoms beginning in 2006 and opined, "Although there is some progressive degeneration since the MRI on 05/25/06, the patient's symptoms appear clearly related to his industrial injury and I believe medically more probable than not his need for a C4 to C6 anterior cervical decompression and fusion is related to his industrial injury of 05/16/06." CE 64.

49. On October 3, 2011, Claimant underwent non-industrial right knee partial meniscectomy arthroscopic surgery by Dr. Doerr. Following his knee surgeries, Dr. Doerr released Claimant to work, without restriction, on October 18, 2011.

50. On November 17, 2011, Dr. Doerr wrote a second letter seeking authorization to perform cervical spine surgery. This time, he asserts that Claimant's cervical radiculopathy was initially caused by his May 2006 industrial accident, and then was permanently aggravated by his January 12, 2010 industrial injury.

> Edward had an industrial injury on 05/16/06, which resulted in neck pain with predominately [*sic*] right arm radicular symptoms. He was then treated nonoperatively and had a second injury on 01/12/10, at which time he was moving a very heavy dolly and had onset of neck pain radiating into his right shoulder with numbness down into his right hand.
>
> In summary, I do believe that Edward's initial injury on 05/16/06 resulted in his C4-5 and C5-6 injuries causing neck pain with radiculopathy. His 01/12/10 injury resulted in a traumatic event with permanent aggravation of his initial preexisting injury. I have recommended a C4 to C6 anterior cervical decompression and fusion.

CE 77. Dr. Doerr's notes do not provide any further insight into his reason(s) for revising his causation opinion, and he was not deposed in these proceedings.

51. *Dr. Friedman.* On December 22, 2011, Claimant underwent an IME by Robert Friedman, M.D., a physiatrist. He reviewed a selection of Claimant's medical records from May 2006 through September 2011, provided by both Claimant and Surety, and examined Claimant in preparation to render his opinion. In his December 22, 2011 report, Dr. Friedman opined that Claimant had reached medical stability and that the surgery Dr. Doerr performed was reasonable to treat his cervical spine degenerative disease, cervical spine stenosis, and intermittent radiculopathy. He also opined that 1) Claimant's May 2006 cervical spine herniation had healed, and 2) Claimant's January 2010 industrial accident had temporarily exacerbated his cervical spine pain, but had not permanently aggravated the underlying condition for which he underwent surgery. Therefore, "I would not relate this to his injury of 05/2006, or subsequent "aggravation" of 01/2010, but would, on a more probable than not basis, relate this to his preexisting cervical degenerative disease as evidenced by his radiologic studies at or about the time of his 05/2006 injury." DE-757.

52. Surety denied further benefits based upon Dr. Friedman's opinion.

53. On January 19, 2012, after reviewing additional medical records and the January 13, 2010 First Report of Injury, Dr. Friedman supplemented his report with a letter to Surety. The new information did not change his opinion. "It remains my medical opinion that his need for his decompression is, on a more probable than not basis, related to the normal natural history, and progression of his preexisting condition." DE-762.

54. On March 16, 2012, Claimant's wife left a message generally referencing a letter to the VA to be authored by Dr. Foutz and Claimant's neck condition. On that same day, Dr. Foutz wrote an open letter to "Evaluating Physician" at the VA in which he attributed a significant portion of Claimant's neck pathology to his time in the service:

> …He had an MRI in 2006 which showed evidence of neural foraminal stenosis and this is likely the anatomical origin of many of his symptoms. It is unlikely that this developed over less than five years as the findings are consistent with arthritic changes. In his case, where there is not an inflammatory arthropathy involved and overuse is the most likely cause, years of wear and tear would be the moist likely causative trigger, much of which he incurred in military service.

CE 44.

55. In March 2012, Claimant and his wife placed their home on the market. They closed the sale in April. Claimant was still working full-time without restrictions or assistance, but he anticipated that he would soon be unemployed.

56. Dr. Foutz's attribution of Claimant's neck problems to his military service was roundly refuted by John K. Dudek, M.D., Navy staff physician, on May 9, 2012:

> Courts have held that medical opinions based on incomplete information have no value. As such, Dr. Foutz's medical opinion letter dated 3/16/2012 cannot be considered. He did not have any access to the c-file which is devoid of any neck pathology except for one visit 8/28/1999 for neck pain which was treated with motrin and after which veteran did not follow-up. Veteran was seen in Nov-Dec 2000 for neck pain that was felt to be due to "somatic dysfunction" in the T-spine with palpable "knots" there. There was no other medical care sought for neck issues in service, no mention of neck issues at separation, and no care sought for any neck issue with [*sic*] a year of separation.
>
> Veteran's neck symptoms clearly started in 2006…. In fact, veteran has pursued his neck and radicular symptoms as a work-related injury since 5/2006. Veteran's c-spine MRI showed some mild-moderate pathology in 2006 and this has significantly worsened as of the 2011 MRI. However, none of this can be blamed on military service. It is far more likely due to work-related issues.

CE 317.

57. Beginning on approximately May 24, 2012, Claimant had a helper to assist him on his delivery route. Until then, Claimant had been working full-duty, unrestricted, while managing his cervical spine condition, as well as other conditions, including his nonindustrial knee and low back problems.

58. On May 25, 2012, Claimant underwent a preoperative cervical spine MRI which demonstrated no significant changes compared to his August 23, 2011 imaging.

59. Claimant explained at the hearing that his cervical symptoms remained constant, and progressively worsened, after he was discharged from care in early 2010. He had good and bad days, worsening with increased activity. He was also experiencing nonindustrial pain related to his knee and low back. Nevertheless, he sought no further cervical spine-related treatment and missed no work until his cervical spine surgery in June 2012.

CERVICAL SPINE SURGERY

60. On June 6, 2012, Dr. Doerr performed a tri-level discectomy and fusion with instrumentation, the reasonableness of which is undisputed, to alleviate Claimant's C4-5 and C5-6 central and bilateral foraminal steonsis and his right C6-7 herniated nucleus pulposus/stenosis.

61. Claimant recovered from his cervical spine surgery. At the hearing, he described the improvement in his symptoms. "I don't have the pain I was having, you know, at the time of the surgery. I do still have a little bit of occasional neck pain and that's coming up from the muscles in my shoulder." HT 69.

62. Dr. Doerr returned Claimant to work on August 1, 2012 with restrictions including lifting limited to no more than five pounds; no pushing, pulling, repetitive neck movements, or repetitive overhead activity; and no overhead lifting.

INDUSTRIAL CAUSATION OPINIONS

63. *Dr. Verska.* On August 3, 2012, Claimant underwent an IME by Joseph M. Verska, M.D., an orthopedic surgeon whose practice focuses exclusively on the spine. He estimates that he has performed 300 to 400 surgeries to treat tri-level disc disease. Prior to completing his report of the IME, Dr. Verska interviewed and examined Claimant. He also reviewed Claimant's MRI imaging and reports, as well as medical records from May 16, 2006 through May 25, 2011. By the time of Dr. Verska's deposition, on November 22, 2013, he had reviewed additional medical records from the VA and St. Luke's Occupational Health.

64. Dr. Verska ultimately opined that Claimant's May 2006 industrial injury had resolved prior to his January 2010 industrial injury, which caused Claimant's cervical radiculopathy and necessitated surgery. Specifically, "It is my professional opinion on a more probable-than-not basis that the 2010 injury caused him to have disc herniations at C5-C6 and C6-C7 and aggravated the preexisting degenerative changes at C4-C5 requiring him to have surgery at C4-c5, C5-c6, and C6-C7 by Dr. Timothy Doerr." CE 107. Similarly, at his deposition, Dr. Verska opined that "the industrial accident aggravated a pre-existing disc herniation at C4-5, and also caused him to have nerve root compression at 5-6 and 6-7, eventually requiring treatment and surgery. So there was a specific event that resulted in specific symptoms that did not resolve with conservative care." Verska Dep. 18.

65. Dr. Verska further opined that nothing in Claimant's 2011 MRI specifically evidenced a new acute injury. However, "there are some alignment problems that could have come on acutely. If we look at the findings under "General," there is retrolisthesis between C4 and 5 and 5-6. And certainly a strain or event could have caused that to have happened." Verska

Dep. 31. In addition, Dr. Verska opined that the 2012 MRI demonstrates no worsening in the C5-6 and C6-7 disc herniations as compared to the 2011 MRI, but significant worsening as compared to the 2006 MRI.

66. On August 28, 2012, Dr. Doerr increased Claimant's lifting limit to 20 pounds, effective the following day. He also referred claimant for physical therapy and assessed Claimant's complaints of right shoulder and upper arm pain. Following examination, Dr. Doerr opined these symptoms were secondary to right shoulder impingement. He did not relate these symptoms to any industrial cause.

67. On September 19, 2012, Dr. Doerr wrote a letter to Claimant's attorney positing that, following rehabilitation therapy, Claimant would be permanently restricted from lifting more than 50 pounds, overhead lifting, and repetitive twisting and bending of his neck. He further opined that Claimant would not be able to return to his prior job with these restrictions. He also recommended job retraining. On October 9, 2012, Dr. Doerr issued additional interim restrictions, lifting his then-current lifting limit to 30 pounds.

68. On November 1, 2012, Dr. Doerr opined Claimant had reached MMI and assessed whole person PPI of 8%, as per the *Guides to the Evaluation of Permanent Impairment, Sixth Edition*.

69. Due to his lifting restrictions, Meadow Gold deemed Claimant unable to perform all of the essential functions of his job. Further, there was no reasonable accommodation that would allow him to perform those functions. As a result, Claimant's employment was terminated on November 6, 2012.

70. Surety provided benefits related to Claimant's 2006 and 2010 industrial injuries through March 2010. However, it denied benefits related to Claimant's subsequent treatment related to his cervical spine, beginning in 2011 and including his 2012 cervical spine surgery.

71. After meeting with Claimant and his counsel, Dr. Foutz wrote a second letter, on June 10, 2013, addressed to Claimant's attorney, to clarify his position. He explained that he was unaware of Claimant's 2010 injury when he authored the 2012 letter. "At the time of the composition of that letter, I had only reviewed Mr. Jordan's neck MRI done in 2006 two days prior to composing the letter and was not aware of a new injury to the neck in 2010, nor did I have any documents or images after to [*sic*] this new injury except what was done by Dr. Doerr following my referral to him in 2011." CE 45. In fact, Dr. Foutz wrote, he first learned of the 2010 injury during his meeting with Claimant and his attorney in early June 2013. Dr. Foutz also wished to "point out that he'd had some difficulty for years, worsened by the injury sustained in 2006 which had continued through 2012." *Id.* Dr. Foutz understood that Claimant had a high tolerance for pain and needed to keep working, so he put off treating his various problems for as long as he could.

72. On June 25, 2013, Dr. Foutz wrote a third letter, addressed to Claimant's attorney. This letter appears to be an edited draft of the prior June 2013 letter, notably omitting the phrases advising that Dr. Foutz was unaware of the 2010 injury until June 2013.

73. On October 16, 2014, at his deposition, Dr. Friedman confirmed his earlier opinions.

> …I thought his clinical findings fit the slow but steady progression of his natural underlying degenerative process of his neck; that the findings on the MRI of August of 2011 did not show any particular acute findings; that it was all consistent with ongoing degeneration; and I didn't see any ongoing degeneration -

> - how do I say this? (Pause.) The findings of 2006 simply are identical to the findings in the 2011 MRI, with the exception that they have progressed as I would have expected them to over five years.

Friedman Dep. 17.

74. Dr. Friedman also elaborated on his endorsement of Dr. Doerr's surgery recommendation. Regardless of what a patient's imaging studies may show, Dr. Friedman would not recommend surgery in the absence of symptoms consistent with those studies. "…I don't send people to have surgeries because I see something on an X-ray study. … It's when what I see on an X-ray study is consistent with what the patient is complaining of and their clinical exam, then it says to me, "We may need to do something." Friedman Dep. 33. In Claimant's case, his complaints were consistent with the pathology demonstrated on his radiologic studies, so Dr. Friedman opined surgery was reasonable.

75. Dr. Friedman further opined that Claimant was at higher risk for an exacerbation of cervical spine symptoms than someone who did not have degenerative disease in his cervical spine or someone who did not do heavy physical labor with his upper extremities.

76. Although Claimant's cervical spine surgery improved his neck symptoms, Claimant has not found any employment he believes he can do due to his residual neck pain. "…it causes me to not be able to do a whole lot. A lot of motion, movement, driving. I had maintenance done on my truck and just trying to dry it off after they ran it through the car wash, I mean that causes that muscle to, you know, cause my neck to hurt." HT 75. Claimant takes Tylenol to treat his neck pain.

DISCUSSION AND FURTHER FINDINGS

The provisions of the 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). However, the Commission is not required to construe facts 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).

77. 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).

78. 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. Dravo Corporation*, 95 Idaho 958, 560-61, 511 P.2d 1334, 1336-37 (1973). See also *Callantine*, *Id*.

79. 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).

80. As noted by the parties, the principle issue before the Commission is whether the need for Claimant's June 6, 2012 cervical spine surgery is referable to one or both of the subject accidents. HT 7/4-9/9; Defendants' Brief 1; 15-16. On this issue, a number of conflicting opinions have been adduced from treating/evaluating physicians. As will be seen, these opinions depend to a greater or lesser degree on the history of onset given by Claimant to such physician, or the history that such physician was asked to assume in rendering his opinion.

81. Dr. Foutz ultimately declined to offer an opinion on the question of whether or not, or to what extent, the accidents of 2006 and 2010 contributed to Claimant's need for cervical spine surgery. Foutz Dep. 26/24-27/21. Claimant has testified that following the accident of January 12, 2010, he experienced the sudden onset of neck and upper extremity symptomatology. Though he completed treatment on February 16, 2010, he testified that his symptoms did not abate, as promised. Instead, they progressively worsened to the point that he was always in pain by the time he saw Dr. Foutz on July 26, 2011. HT 65/7-66/7. However, when Claimant saw Dr. Foutz on July 26, 2011, he did not give Dr. Foutz a history of either the 2006 or 2010 accidents, even though he complained of static neck pain. Moreover, Dr. Foutz was asked either by Claimant, or his wife, to prepare a letter to the Veteran's Administration endorsing the proposition that Claimant's degenerative disease of the spine was causally related to his time in the Navy. CE 43. The March 16, 2012 letter addresses Claimant's cervical spine and makes it clear that Dr. Foutz considered Claimant's cervical spine condition to be somehow

related to Claimant's naval service. CE 44; Foutz Dep. 22/15-17. At the time of his deposition Dr. Foutz confirmed that at the time he authored his letter of March 16, 2012, he was unaware that Claimant had suffered a work accident on January 12, 2010. It is difficult to square Claimant's current insistence with the history he gave to Dr. Foutz, and upon which Foutz relied in proposing that Claimant's naval service figures in the etiology of his cervical spine condition. Claimant has testified that the January 12, 2010 accident was a signal event, and that he has gone downhill ever since, and yet, he failed to mention this event when discussing the etiology of his problems with Dr. Foutz.

82. Dr. Doerr saw Claimant on referral from Dr. Foutz. Dr. Doerr's deposition was not taken, but from his medical records it is relatively easy to appreciate the history upon which he relied in rendering his various opinions on the etiology of Claimant's complaints. In fact, Dr. Doerr's records illustrate the central importance of Claimant's history of injury in informing judgments about the cause of Claimant's objective injuries.

83. Claimant was first seen by Dr. Doerr on August 18, 2011, over a year and a half subsequent to the January 12, 2010 accident. However, Claimant said nothing to Dr. Doerr about the 2010 accident, instead relating his several years history of neck and upper extremity problems to an industrial accident occurring about six years prior to the August 18, 2011 evaluation. *See* CE 47. This history caused Dr. Doerr to relate Claimant's cervical spine injuries to the 2006 industrial accident, and he lobbied the surety on the risk for the 2006 accident to authorize the cervical spine surgery he proposed in order to address Claimant's objective deficits:

> I am treating Edward for a C4 to C6 stenosis with neck pain with right greater than left arm radiculopathy. Edward has had a six year history of symptoms after

> an industrial injury on 05/16/06, which is unresponsive to activity modifications, physical therapy and oral steroids. He had an MRI of the cervical spine on 08/23/11 that revealed a broad-based disc/osteophyte at C4-5 and C5-6 resulting in mild cord compression with severe right greater than left foraminal narrowing at C4-5 and server bilateral C5-6 foraminal narrowing. Having failed six years of conservative treatment, I am recommending a C4 to C6 anterior cervical decompression and fusion. I have reviewed Edward's previous records from his industrial injury on 05/16/06. He had symptoms documented, which were consistent with his current symptoms of neck pain with predominately right arm radicular symptoms on his initial evaluation on 05/17/06 as well as subsequent evaluation on 05/25/06 and 06/02/06. Occupational Health Services on 07/24/06 documented that he had not had any tingling or similar symptoms in his right arm prior to his industrial injury. The patient reports that his symptoms never completely resolved and he was again seen at Occupational Health Services on 01/12/10 with similar predominately right-sided radicular complaints. Edward had an MRI on 5/25/06, which was compared to his most recent MRI of 08/23/11. The MRI on 5/25/06 revealed moderate central disc protrusion at C4-5 and extradural defect on the cord in addition, there is some right moderate foraminal narrowing at the C5-6 level. Although there is some progressive degeneration since the MRI on 05/25/06, the patient's symptoms appear clearly related to his industrial injury and I believe medically more probably than not his need for a C4 to C6 anterior cervical decompression and fusion is related to his industrial injury of 05/16/06.

CE 64.

84. Therefore, the objective medical evidence, correlated with Claimant's history and clinical findings on exam led Dr. Doerr to conclude that the 2006 accident is responsible for Claimant's need for cervical spine surgery. The importance of the Claimant's history to Dr. Doerr in this synthesis is illustrated by the about face Dr. Doerr was forced to execute when alerted to the fact that there was a second accident of January 12, 2010. Compare Dr. Doerr's September 27, 2011 letter quoted above to Dr. Doerr's letter of November 17, 2011:

> I have been treating Edward for C4 to C6 stenosis with neck pain and right greater left arm radiculopathy. Edward had an industrial injury on 05/16/06, which resulted in neck pain with predominately right arm radicular symptoms. He was then treated nonoperatively and had a second injury on 01/12/10, at which time he was moving a very heavy dolly and had onset of neck pain radiating into his right shoulder with numbness down into his right hand.

> In summary, I do believe that Edward's initial injury on 05/16/06 resulted in his C4-5 and C5-6 injuries causing neck pain with radiculopathy. His 01/12/10 injury resulted in a traumatic event with permanent aggravation of his initial preexisting injury. I have recommended a C4 to C6 anterior cervical decompression and fusion.

CE 77.

85. It is apparent that at some point in time between September 27, 2011 and November 17, 2011 Claimant came to Dr. Doerr with a new history of the January 12, 2010 accident, a history that he had never previously shared with Dr. Doerr. Why, if Claimant's testimony at hearing is to be believed, would Claimant fail to immediately advise Dr. Doerr of the accident to which he now attributes his unrelenting and progressively worsening neck and upper extremity pain?

86. While Claimant initially gave Dr. Doerr a history that related Claimant's complaints to the 2006 accident, he gave an entirely different history to Dr. Verska. Dr. Verska saw Claimant on August 3, 2012, and took a history from Claimant to the effect that Claimant's problems with his neck and upper extremity resolved following the 2006 accident, but did not resolve following the 2010 accident. Verska Dep. 15/20-16/5; 29/22-30/6. These underlying assumptions led Dr. Verska to conclude that the 2006 accident was not significant in explaining the condition for which surgery was required in 2012, but that the 2010 accident was:

> Q. Would you please briefly set forth those findings for the Commission?
>
> A. Yes. So in kind of summary, the patient had, it looks like, two injuries; one in 2006 where his neck symptoms resolved, and they resolved with conservative care and he went back to gainful employment and was without any problems or symptoms until his industrial accident of 2010.
>
> And there was a specific injury and a specific event that caused him to have specific symptoms that never resolved. So in reviewing the MRIs and his

> symptoms, it appeared that this caused -- an event or injury and symptoms of January 2010 caused Mr. Jordan to have the need for treatment and eventually surgery.

Verska Dep. 17/23-18/11.

87. Finally, Claimant was evaluated by Dr. Friedman on or about December 22, 2011, at the instance of Defendants. Dr. Friedman had the opportunity to review Claimant's medical records and conduct an exam. In reviewing the May 25, 2006 MRI, Dr. Friedman testified that it clearly demonstrated multilevel degenerative changes predating the accident of May 16, 2006. However, at C4-5, Dr. Friedman noted a disk protrusion with cephalic migration which he felt was, at the very least, consistent with the accident of May 16, 2006. Interestingly, however, a second MRI of August 23, 2011, demonstrated that the C4-5 lesion had significantly resolved, and that Claimant's most significant problems were progressive degenerative changes at C5 through C7. Per Dr. Friedman, the 2011 MRI failed to demonstrate the presence of any findings that were only consistent with an acute injury. Most of Claimant's findings on exam were consistent with the C5-6 dermatome, suggesting impingement at that level. While Dr. Friedman did not disagree with Dr. Doerr's decision to perform cervical spine surgery, he was unable to relate the need for such surgery to either the 2006 or the 2010 accidents: Although he conceded that the 2006 accident might be responsible for producing a disk bulge at C4-5, that lesion had healed by the time of the 2011 MRI. With respect to the 2010 accident, the 2011 MRI failed to demonstrate the existence of any acute injury that could be related to that accident. Dr. Friedman was of the view that the most likely explanation for the problems leading to Claimant's June 6, 2012 surgery was the normal progression over time of degenerative changes, well documented by the 2006 and 2011 MRI studies.

88. As demonstrated above, whether one accepts one of these opinions over another as being a more credible explanation of the need for Claimant's cervical spine surgery depends, in significant part, on understanding the true history of the development and progression of Claimant's symptomatology following the accidents of 2006 and 2010. Since this matter was heard before Referee Marsters instead of the Industrial Commission, the Industrial Commission has neither the freedom, nor the ability, to make some judgment concerning Claimant's "observational credibility" on the stand. However, while Referee Marsters' proposed recommendation found that Claimant was not credible, she did so on the basis that Claimant lacked "substantive credibility," that is, Claimant's testimony is irreconcilable with other testimony and facts of record. The Commission has exactly the same information before it that was before the Referee, and also concludes that Claimant's testimony concerning the history and cause of his symptoms following the 2006 and 2010 accidents lacks substantive credibility. Claimant's testimony inherently conflicts with medical records establishing that he gave different stories to his providers/evaluators about the cause of his symptoms over the years. This is a determination that is well within the province of the Industrial Commission. *See Stevens-McAtee v. Potlatch Corp.*, 145 Idaho 325, 179 P.3d 288 (2008). Between the time he was last treated in September of 2006 for the effects of the 2006 accident, and the date of the accident of January 12, 2010, Claimant insists that he had minimal symptoms. Compare this to the history recorded by Dr. Doerr, referenced above, to the effect that Claimant's problems following the 2006 accident never relented. Claimant insists that on January 12, 2010 he suffered an accident which caused the sudden onset of neck and upper extremity symptoms. He now contends that his symptoms have been unrelenting since that date. However, Claimant gave no such history to

either Dr. Foutz or to Dr. Doerr, at least initially. Claimant, or his wife, appears to have at one point been interested in attempting to assign some responsibility for his cervical spine condition to events pre-dating the 2006 accident.

89. It is understandable that the physicians who have rendered opinions in this case have come to different conclusions based on certain facts they have assumed concerning the development and course of Claimant's symptomatology. Claimant bears the burden of proving the existence of a causal relationship between his need for cervical spine surgery and one or both of the subject accidents. As demonstrated above, the opinions rendered in this case by treating/evaluating physicians rely in large part on what that physician assumes to be the correct history of the nature of onset and progression of Claimant's symptoms. The many inconsistencies and factual conflicts in the record leave the Commission unable to ascertain the nature and extent of Claimant's symptoms following each of the subject accidents. Since a correct understanding of this history is important to ascertaining the cause of Claimant's cervical spine complaints, we are unable to accept the opinions rendered by Drs. Verska or Doerr. The most credible opinion is that of Dr. Friedman, who offered a cogent opinion that while the 2006 accident might have caused a C4-5 disk bulge, that lesion had healed by the time of the 2011 MRI and cannot fairly be said to be implicated in the need for Claimant's cervical spine surgery. By the same token, the conditions for which surgery was actually required, i.e. Claimant's well-documented multilevel degenerative changes, were years in the making, as evidenced by the 2006 and 2011 MRI studies, and cannot fairly be said to be the product of the 2010 accident.

90. From the foregoing we conclude that Claimant has failed to meet his burden of proof with respect to both the 2006 and 2010 accidents; Claimant has failed to demonstrate that the need for surgery is more probably than not related to one or both of the subject accidents.

91. All other issues are moot.

CONCLUSIONS OF LAW AND ORDER

1. Claimant has failed to prove by a preponderance of evidence that his 2012 cervical spine surgery was necessitated, in whole or in part, by either the 2006 or 2010 industrial accidents. As a result, he has failed to prove his entitlement to additional benefits or attorney fees as a result of those accidents.

2. All other issues are moot.

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

DATED this 13th day of April, 2015.

INDUSTRIAL COMMISSION

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

_/s/_____
Thomas E. Limbaugh, Commissioner

_/s/_____
Thomas P. Baskin, Commissioner

ATTEST:

_/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 13th day of April, 2015, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** was served by regular United States Mail upon each of the following:

JUSTIN AYLSWORTH
PO BOX 6190
BOISE ID 83707-6190

W SCOTT WIGLE
PO BOX 1007
BOISE ID 83701-1007

_/s/_____