BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

EUGENIA LANDEROS, Claimant, v. CROOKHAM COMPANY, INC., Employer, and IDAHO STATE INSURANCE FUND, Surety, Defendants.	**IC 2014-029584** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** March 9, 2018

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee John Hummel, who conducted a hearing in Boise, Idaho on February 15, 2017. Clinton Miner, of Middleton, represented Claimant Eugenia Landeros, who was present. Neil McFeeley of Boise represented Employer, Crookham Company, and Surety, Idaho State Insurance Fund. The parties presented oral and documentary evidence, took post-hearing depositions, and submitted briefs. The matter came under advisement on July 7, 2017.

ISSUES

The issues[1] to be decided are as follows:

1. Whether Claimant's condition is due in whole, or in part, to a preexisting condition and/or subsequent injury/condition;

[1] The Notice of Hearing included two additional issues requested by Defendants, as follows: determination of Claimant's average weekly wage and whether Claimant was entitled to disability benefits under the holding of *Diaz v. Franklin Building Supply* 2009 IIC 0652 (November 20, 2009). The parties stipulated at hearing that they had resolved the average weekly wage issue. Tr., 15:8-16. The parties did not argue or brief the *Diaz* issue; it is deemed abandoned. In any event, the fact that Claimant became a U.S. Citizen in 2014 is undisputed. Tr., 19:17-19.

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

a. Medical care;

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

c. Permanent partial impairment (PPI); and

d. Disability;

3. Whether Claimant is entitled to attorney's fees pursuant to Idaho Code § 72-804; and

4. Whether Defendants are entitled to reimbursement for medical benefits paid for non-industrial conditions and overpayment of PPI benefits.

CONTENTIONS OF THE PARTIES

Claimant argues that her industrial wrist injury caused Complex Regional Pain Syndrome (CRPS) in her right upper extremity. She seeks an order requiring Defendants to pay for prospective ketamine treatment and payment of past medical bills relating to her diagnosis of CRPS. Claimant contends she is not at maximum medical improvement (MMI) and is therefore entitled to TTD payments from the date payment ceased until she is medically stable. If the Commission finds Claimant is at MMI, she argues that she is totally and permanently disabled or, in the alternative, has disability inclusive of impairment in excess of 50%. Further, if Claimant is at MMI, she contends that the recent holding of *Rish v. Home Depot* 161 Idaho 702, 390 P.3d 428 (2017) requires Defendants to provide ongoing palliative care. Claimant also requests attorney's fees because she alleges that Defendants unreasonably relied on the opinion of Dr. Chong when they denied further benefits.

Defendants argue that Claimant suffered a minor wrist sprain and that all her treating physicians released her without restrictions. They seek reimbursement for surgeries they contend

are unrelated to the industrial accident and for PPI paid for a non-industrially related condition. Defendants assert there is no basis for a diagnosis of CRPS. Further, they contend that they acted reasonably in relying on their independent medical examination (IME) by Dr. Chong and medical records to deny further medical treatment and, therefore, there is no basis for an award of attorney fees.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant taken at hearing.

2. Claimant's Exhibits A-NN admitted at hearing.

3. Defendant's Exhibits 1-8 admitted at hearing.

4. The post-hearing depositions of Daniel Marsh, M.D., taken on March 13, 2017, and Dennis Chong, M.D., taken on March 17, 2017.

All pending objections are overruled. Claimant's motion to strike[2] the reference in Dr. Chong's supplemental report that Dr. Toomey agreed with his findings is denied. Similarly, Defendants' motion to exclude[3] Dr. Marsh's causation testimony is denied. The medical records and testimony are subject to whatever weight is deemed appropriate.

After having considered all the above evidence and briefs of the parties, the Referee submits the following findings of fact and conclusions of law for review by the Commission.

FINDINGS OF FACT

1. **Claimant's Background**. Claimant was 31 years of age and resided in Caldwell as of the date the hearing. Tr., 18:13-14; 88:17-19.

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[2] Claimant's Reply Brief at 9.
[3] Defendants' Post Hearing Brief at 20.

2. Claimant was born in the Michoacan state of Mexico and completed the ninth grade there. Tr., 18:15-18, 23-25; 19:1-2. She had no further training or education prior to the industrial accident. *Id*. at 19:20-23.

3. Claimant's predominant language was Spanish, however, at the time of hearing, Claimant was taking classes in English at the College of Western Idaho. *Id*. at 19:3-10, 22-25. Claimant testified through a translator at hearing. *Id.* at 18:1-2.

4. Claimant immigrated to the United States in 2005. *Id.* at 19:11-13. In 2014, she became a U.S. citizen. *Id.* at 19:17-19.

5. **Employment**. Claimant began working for Employer in July of 2005. *Id.* at 21:13-15. She worked seasonally for Employer; she would work during an agricultural season, be laid off for a few months, then she would return to Employer once the work resumed. *Id.* at 21:16-22:9; 24:4-11. She also worked intermittently performing agricultural work for other employers, but always returned to Employer when work was available. *Id*.

6. Claimant's entire work experience has been manual labor in the agricultural industry. When Claimant began working for Employer, her first agricultural job was "selfing" corn – putting bags on the tops of corn stalk flowers to self-pollinate hybrid corn. *Id*. at 20:24-21:11. Claimant moved from selfing to processing corn crops on assembly lines for Employer; she also packaged peaches and apples and cut hops for other employers;. *Id*. at 21:23-22:9; 23:12-21.

7. **Industrial Accident**. In October of 2014, Claimant was cleaning corn on an assembly line. *Id.* at 24:17-21. Occasionally the machine would not fully remove parts of the cornhusk; she would manually remove those portions. *Id.* at 24:22-25:13. Claimant described the

removal process as follows: "[W]ith one hand you'd take it and with the other hand you'd take that end part and you'd pull it out." Tr., 25:19-21.

8. On October 4, 2014, Claimant was removing an end part of a cornhusk when she felt pain in her right wrist just under her thumb. *Id*. at 26:17-22. The pain radiated up to her elbow. *Id.* at 27:18-24. She reported it to her supervisor and finished her shift. *Id.* at 28:3-6; 30:23-25.

9. Claimant took ibuprofen after her shift and went to work again the next day, October 5, 2014. *Id*. at 31:7-11; 32:19-20. Her wrist had developed a bruise that she showed to her supervisor. *Id.* at 34:2-7.

10. Claimant's supervisor filed a first report of injury dated October 10, 2014. Ex. 1:1.

11. **Medical Care and Post-Accident Events**. On October 12, 2014, Claimant sought medical care at St. Alphonsus Urgent Care. Ex. A:3. She saw Charles Anstrand, PA, who assessed forearm injury and wrist strain. *Id*. He recorded tenderness along the forearm and decreased extension in the wrist; he prescribed NSAIDs (non-steroidal anti-inflammatory drugs) and a splint, and referred her to Occupational Medicine. *Id.*

12. The next day Claimant saw Kevin Chicoine, M.D., of St. Alphonsus Occupational Medicine. Ex. C:15. Dr. Chicoine diagnosed right wrist sprain and right hand strain; he issued restrictions including no use of the right hand. *Id.* On exam, Dr. Chicoine noted tenderness along the thumb joint, but no bruising or swelling or other abnormal findings. *Id.* at 17. He ordered right hand and wrist X-rays, which were negative for acute findings. *Id.* at 18-19.

13. Dr. Chicoine next saw Claimant on October 20, 2014. *Id.* at 20. He noted mild tenderness along the thumb and anterior deltoid and a mildly positive Finkelstein test. *Id.* at 21.

Claimant complained of "soreness in the right shoulder that has also been there" since the injury and stated she was "no better." Ex. C:21. Dr. Chicoine diagnosed "De Quevains [sic]," right shoulder strain, and right wrist strain. *Id.* at 20. He referred Claimant to physical therapy. *Id.*

14. Occupational Therapist Matt Woodruff saw Claimant October 21, 2014. Ex. F:41. He measured Claimant's range of motion (ROM) and strength in the wrist and shoulder, and recorded reduced ROM and strength on the right side compared to the left side. *Id*. Claimant reported pain in her shoulder, wrist, and thumb, numbness in her arm, and a "cold sensation" in her wrist. *Id*.

15. Claimant saw Dr. Chicoine again on October 28, 2014; she reported that her pain was worse and radiated into a "different area" of her arm. Ex. C:24. He speculated that "perhaps we are dealing with … radial tunnel." *Id.* at 25.

16. On that same day, Mr. Woodruff noted that Claimant had made progress with physical therapy, had "radial nerve pain," and continued to have reduced ROM in her shoulder, but not her wrist. Ex. F:47.

17. On November 3, 2014, Claimant reported her pain had changed, was worse, and was "shooting from the wrist up to the shoulder." Ex. C: 27. Dr. Chicoine noted that both he and her physical therapist believed her symptoms best fit with a cervical issue and that he would request an MRI. *Id*. at 28.

18. At her physical therapy appointment on November 7, 2014, Rich Moore, MPT, recorded Claimant's complaints of paresthesia, burning, and increased pain with neck movement. Ex F:53. Moore noted "it is somewhat difficult to ascertain the origin of her symptoms." *Id.*

19. Claimant met with Dr. Chicoine for the last time on November 17, 2014. Ex C:30. He observed, “still unclear etiology of pain.” *Id.* at 31. He referred Claimant to Dr. Kevin Krafft of Northwest Physical Medicine and Rehabilitation. Ex. H:66.

20. Claimant first saw Kevin Krafft, M.D., on December 3, 2014 *Id.* Claimant reported that if she used her right hand, she had constant numbness in her right thumb and the radial[4] aspect of her wrist. *Id.* On exam, Dr. Krafft recorded pain with testing at the neck, elbow, and wrist; he also noted “fasciculations in her right forearm and tremors in her wrist.” *Id.* at 67. Dr. Kraft continued her work restrictions, prescribed physical therapy and Gabapentin, and ordered an EMG, the results of which were normal. *Id.* at 67, 70.

21. On December 15, 2014, Dr. Krafft recorded diminished sensation on the right and bicipital tendinitis. *Id.* at 73. Claimant reported burning, “pins and needles,” and that her arm was “very cold” at times. *Id.* Her second physical therapist, Rulin Hawks, reported that she was making gains with therapy, but that it increased her pain. Ex. J:116. He recorded similar complaints from Claimant (arm was cold and numb) and noted her right arm was “unremarkable. I still do not see any swelling, discoloration, skins changes, or atrophy in the right arm.” *Id.*

22. Claimant saw Dr. Krafft again on December 29, 2014. Ex. H:76. He documented decreased sensation, pain in her arm, neck, and shoulder, and a positive Finkelstein’s test; Claimant reported an “itchy” feeling along her forearm and hand and numbness. *Id.*

23. On January 20, 2015, Dr. Krafft recorded that Claimant still had pain in her arm and wrist and decreased sensation; he recorded that medication helped for about a week but “that is it.” *Id.* at 79. Dr. Krafft anticipated MMI by Claimant’s next visit. *Id.* at 80.

[4] “Anatomically, if when one looks at the wrist, the radial side of the wrist is where the thumb is, and the ulnar side of the wrist is where the little finger is.” Chong Dep. 10:13-16.

24. Employer laid Claimant off on February 11, 2015. Ex. 1:3. Claimant remained unemployed until June 2015. *Id*. She received unemployment benefits during this time period and did not perform any other work. Tr., 47:11-18.

25. On February 12, 2015, Claimant's physical therapist wrote a report to Dr. Krafft that stated in pertinent part as follows:

> She continues to have right arm pain that, according to her, is as bad now as it was when she started therapy because of the small increase in weight on Feb 6th. I find it difficult to believe such a small change in her program could cause such a significant deterioration in her condition. There are no supporting objective findings that would indicate her condition has deteriorated as significantly as she is reporting. Her right arm ROM and strength have not decreased … To me, she appears to have some minor inflammation of her rotator cuff and APL/EPL tendons in her wrist. There is significant disparity between her physical/objective findings and her subjective complaints.

Ex. J:146.

26. Claimant returned to Dr. Krafft on February 13, 2015. Ex. H:82. He recorded substantially the same symptomatology as prior appointments: the pain started in the radial aspect of her wrist and spread to her shoulder, "pins and needles," and pain with cold. *Id.* Claimant reported the medication was not helping and that therapy was no longer helping. *Id.* He again noted decreased sensation. *Id.* Dr. Krafft ordered an MRI of the wrist. *Id.*

27. The February 19, 2015 MRI findings, as read by Shane McGonegle, M.D., were as follows:

> Full thickness rupture of the extensor carpi ulnaris tendon with a residual distal tendon fragment inserting on the fifth metacarpal base. Proximal fragment not identified in the field-of-view, will attempt to have the patient return for additional imaging of the forearm to identify the proximal tendon fragment.
>
> Focal defect at the scaphoid insertion of the scapholunate ligament central membranous component may represent focal detachment or iatrogenic change as this occurs at the location of the injection site.

> Focal defect in the ulnar collateral [sic] ligament-ulnar joint capsule allowing a contrast collection to form along the distal ulna. Intact TFC articular disc.

Ex. H:85.

28. On March 4, 2015, Dr. Krafft saw Claimant and noted her MRI results showed an ECU tendon rupture. *Id.* at 87. He noted that Claimant "continues to have right hand and arm symptoms which seem to be escalating … She is not sure her medications are helping." *Id.* He referred her to T. Clark Robinson, M.D., a hand surgeon with St. Alphonsus Medical Group. *Id.*

29. Claimant saw Dr. Robinson on March 16, 2015. Ex. A:5. He recorded her reports of pain on the radial aspect of her wrist. *Id.* He noted the MRI "indicates a possible injury to the extensor carpi ulnaris tendon," nevertheless "with specific questioning the patient has no ulnar-sided wrist pain. She denies previous injury." *Id.* Dr. Robinson conducted a physical exam where he documented that Claimant exhibited radial wrist tenderness, a positive Finkelstein's, but that she had no discoloration and was "otherwise neurovascularly intact." *Id.* at 6. Dr. Robinson wrote: "I think the MRI findings are not consistent with her work injury and I do not believe it is the source of her pain. I do not believe treatment is necessary for this condition." *Id.* He assessed de Quervain's tenosynovitis and injected lidocaine. *Id.*

30. Claimant followed up with Dr. Krafft on April 1, 2015. Ex. H:90. She reported that the shot she received from Dr. Robinson did not change her pain. *Id.* Dr. Krafft noted numbness on exam and a positive Finkelstein's test. *Id*. He noted that after she had completed therapy, "we may need to consider a FCA given her noted illness conviction." *Id.* at 88.[5]

31. Claimant returned to Dr. Robinson on April 16, 2015. Ex. A:10. Claimant reported her wrist pain improved with the shot and continued to deny ulnar-sided pain. *Id.*

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[5] Exhibit H appears to be out of order from pages 87-98; Dr. Krafft's second page of notes does not correspond with his first page of notes.

Claimant wanted to know why she hadn't had wrist surgery and why an MRI of her shoulder had not been performed. Ex. A:10. Dr. Robinson noted as follows:

> I discussed with the patient that the ECU tendinitis noted on her MRI does not correlate with her exam findings and there is no indication for surgery. She is now complaining of shoulder pain which she claims began at the same time as her wrist injury in October. I've discussed that she does have some signs of impingement but MRI imaging is not warranted at this time.

Id. at 11. To treat her shoulder pain, Dr. Robinson injected lidocaine. *Id.*

32. Dr. Krafft saw Claimant again on April 21, 2015. Ex. H:93. She reported the same symptoms but increased pain in her thumb and middle finger and again reported no relief from lidocaine; she also reported redness at the site of the injection with movement. *Id.*

33. On May 12, 2015, Dr. Krafft noted in pertinent part as follows:

> Eugenia continues to have right shoulder, wrist, and arm symptoms. Dr. Robison [sic] has not recommended surgery. She has tenderness over the right bicipital tendon … Her right shoulder is not part of her initial injury so she will follow up with her PCP [primary care physician] regarding a right shoulder MRI arthrogram. Given her findings on her MRI study and her persistent symptoms, she is interested in a second opinion. I will have her see Dr. Boyer …

Ex H:96.

34. On June 10, 2015, Claimant returned to work with Employer after a period of five months of unemployment. Ex. 1:3. When she returned, Employer assigned her to a nursery to perform selfing work on corn. Tr., 47:2-18.

35. Claimant saw Jeffrey Boyer, M.D., on June 17, 2015. Ex. P:283. He noted that her right hand was sometimes cold when compared with her left, a small pale spot on the first dorsal compartment area, tenderness, and sensitivity to light touch along her thumb and carpal tunnel area. *Id.* Claimant reported increased sweating generally and purple discoloration with physical therapy. *Id.* at 284. Dr. Boyer diagnosed de Quervain's tendinitis and noted there were no indications for surgery. *Id.* at 283. He noted that "if her pain becomes localized, she may benefit

from a first dorsal compartment release … However, her main issue is now pain throughout the right upper extremity that is unexplained from the injury itself and is most likely explained by complex regional pain syndrome.” Ex. P:283. He deferred further treatment to Dr. Krafft. *Id.*

36. On June 22, 2015, Claimant saw Dr. Krafft to discuss her visit with Dr. Boyer. Ex. H:99. He noted as follows:

> I discussed the possibility of CRPS, but her presentation does not seem to fit with this. She cannot understand why we can’t find anything in her hand since she always has pain. I explained that the hand surgeons do not find a correlation between the MRI findings and her pain presentation. She has requested an MRI of her shoulder and elbow. She finds it impossible there is nothing that correlates with her pain. I recommend a bone scan and … If her bone scan is negative, then she is likely at MMI.

Ex. H:100.

37. Surety denied the bone scan. *Id*. at 102. Claimant met with Dr. Krafft again on July 13, 2015. *Id*. at 101. He determined that she had reached MMI. *Id*. at 102. He assessed a 6% upper extremity impairment for both Claimant’s de Quervain's and ECU tendon rupture, explaining the basis for the rating as follows:

> Permanent impairment evaluation is performed in accordance with the AMA’s *Guides to the Evaluation of Permanent Impairment, Sixth Edition*. She fits into Class 1 for her ECU tendon rupture and de Quervain’s. Her functional grade modifier is 3 based on her Quick*Dash* score, but is not consistent with her objective presentation and is reduced to a 2. Physical exam grade modifier is 1. This results in an impairment of 6% of the upper extremity.

Id. He noted that she was working “full time, full duty” and released her to return to her pre-injury work without restrictions. *Id.* He observed that Claimant had persistent symptoms of tendinitis and that he would assist her with pain management. *Id.*

38. Claimant’s counsel referred Claimant to Jeremy Toomey, M.D., who reviewed Claimant’s records and examined her on September 25, 2015. Tr., 49:11-15; Ex. R:287. She reported pain from the radial aspect of her wrist that spread into her arm and that the previous

shot to her wrist worsened her symptoms. Ex. R:287. On exam, Dr. Toomey noted tenderness and a mildly positive Finkelstein maneuver, but did not observe any other abnormalities. *Id.* at 288. Dr. Toomey discussed surgical and non-surgical options; Claimant chose a first dorsal compartment release. Regarding the proposed surgery, Dr. Toomey noted as follows:

> I explained to her at least 4 times during the encounter that my goal for the surgery would be relief of the pain that is around the radial aspect of her wrist. I explained to her that this procedure would do nothing to address both the elbow and shoulder pain that she is having. This was explained to her on multiple occasions and she stated understanding.

Id.

39. On October 7, 2015, Employer laid off Claimant again. Ex 1:3. Claimant received unemployment benefits until January 2016; she did not work thereafter through the date of hearing. Tr., 51:8-11; 75:2-4.

40. On October 8, 2015, Dr. Toomey performed the right first dorsal compartment release surgery. Ex. R:289. Claimant followed up with Dr. Toomey on October 21, 2015 and reported pain and throbbing around the incision, but that the pain she had complained of prior to the surgery was gone. *Id*. at 292. Claimant reported pain in the ulnar side of her wrist. *Id.* Dr. Toomey released her to work without restrictions. *Id.* at 293.

41. On November 4, 2015, Claimant returned to Dr. Toomey and reported improvement from before the surgery but continued pain on the ulnar side of her wrist. *Id*. at 294. On exam, Dr. Toomey noted Claimant was sensitive to palpation along the ECU tendon and radial tunnel. Dr. Toomey noted as follows:

> I reiterated to her at least 4 times during the encounter that my goal for the previous surgery was simply to relieve the radial sided wrist symptoms that she was having and that her 1st dorsal compartment release was not going to address the other constellation of symptoms that she is having. She stated multiple times that she understood this but then continued to progress [sic] me on further interventions to alleviate all the other symptoms that she was having. I explained

> to her that she is [sic] had a very thorough workup to this point with negative EMGs and evaluations by 2 other hand surgeons who not feel that she had any operative indications or offered her 1st dorsal compartment release which she declined at the time. After discussing things with her, I splint [sic] her I did feel that she has some symptoms of radial tunnel.

Ex. R:294. Dr. Toomey gave Claimant a diagnostic injection of lidocaine in the radial tunnel. *Id*.

42. Claimant returned to Dr. Toomey on November 11, 2015 and reported the lidocaine shot had provided relief to her forearm and some of her shoulder pain, but that her ulnar-sided wrist pain and some shoulder pain were not relieved by it. *Id.* at 296. Based on these results, Claimant and Dr. Toomey decided to proceed with a radial tunnel decompression; Dr. Toomey advised Claimant that the proposed surgery would not resolve all of her pain complaints, but only those that the lidocaine shot had relieved. *Id*. at 296.

43. Dr. Toomey performed a radial tunnel decompression on Claimant on November 16, 2015. *Id.* at 298. He recorded multiple points of nerve compression. *Id.* at 300. Claimant followed up with Dr. Toomey on December 2, 2015. *Id.* at 302.

44. Claimant reported that her arm was "much better" but she still had the same shoulder and forearm pain that had not resolved with the lidocaine injection. *Id*.

45. On February 3, 2016, Claimant met with Dr. Toomey again. *Id*. at 304. She reported the radial tunnel surgery helped with a lot of her symptoms in that area, but complained of pain running from the ulnar side of her wrist into her shoulder and from her thumb into her neck; she stated that her arm was "useless." *Id*. Dr. Toomey noted her exam was "difficult to interpret as she has a significant amount of pain even with light touch." *Id.* He explained that her ECU tendon rupture was too old to repair and that he needed to consider whether further surgical intervention would help her; he released her back to work to use her right upper extremity "as tolerated." *Id.*

46. Claimant returned to Dr. Toomey again on February 24, 2016; she had the same pain complaints as the previous appointment and continued to consider her arm useless. Ex. R:305. Dr. Toomey referred Claimant to his associate, Dr. Johnson, based on her continued complaints of radiating shoulder pain. *Id.* Dr. Toomey noted as follows:

> "In terms of her ulnar-sided wrist pain, hand pain and forearm pain I do not have a definitive cause that links all this together … I am left with either a debridement type procedure or nothing … I also explained to her that there is a good chance that I would make her worse or no better with surgery … At this point, I have no further surgical interventions to offer her … She may benefit from a work hardening program and a functional capacity evaluation."

Id.

47. On March 11, 2016, on referral from her attorney, Claimant met with Daniel Marsh, M.D. Ex.V:364; Marsh Dep., 6:9-12. Claimant signed a document entitled: "Irrevocable Assignment of Benefits, Instruction and Authorization for Direct Payment to Physician" written in English. Ex. V:362. During this appointment, Claimant reported for the first time that she sustained a second injury to the ulnar side of her wrist. *Id.* at 364. Dr. Marsh recorded her pain complaints as constant, worse with any use, and spreading from her wrist into her elbow; further, she could not laterally deviate her wrist due to pain.[6] *Id*. at 365. Dr. Marsh recommended further imaging and noted that Claimant was "a very complex historian with a complex history via a translator." *Id*. It is not clear what records Dr. Marsh reviewed at this time other than the MRI of Claimant's wrist; he noted that he wanted to see her again for a "complete records review." *Id.*

48. Claimant self-referred to Michael Daines, M.D., on March 31, 2016 for her shoulder pain. Ex. X:424. He documented positive impingement tests and an otherwise normal shoulder exam. He assessed cervicalgia and ordered a cervical MRI. *Id.*

[6] It is unclear from Dr. Marsh's notes whether he personally observed Claimant's inability to deviate or if it was self-reported.

49. On April 7, 2016, Claimant met with Dennis Chong, M.D., at Defendant's request for an IME. Ex. 6:20. Dr. Chong performed a complete records review, interviewed Claimant, and conducted a physical exam. *Id.* at 21-33. He noted that Claimant reported no relief with the first surgery performed by Dr. Toomey and some relief with the second surgery. *Id.* at 26. Dr. Chong recorded that Claimant stated she was unable to deviate her wrist ulnarly when asked, but did so "without examiner instruction" to show where her pain and swelling were present. Ex. 6:29. He noted no temperature differential between her left and right hand, 5/5 with manual muscle testing, no muscle atrophy, no swelling, and no discoloration. *Id.* Dr. Chong diagnosed a "nonspecific right wrist sprain" and opined that Claimant did not have de Quervain's tenosynovitis, did not have CRPS, did not have thoracic outlet syndrome, but did have "post-operative iatrogenic disability" since October 2015. *Id*. at 31.

50. Because of his disagreement with Dr. Krafft's diagnoses, Dr. Chong calculated his upper extremity impairment based upon a diagnosis of "nonspecific right wrist sprain, without proximate documentation to illuminate a more specific pathological diagnosis, related to the industrial event of October 4, 2014." He concluded as follows: "At the most, per the AMA *Guides for the Evaluation of Permanent Impairment*, 6th Edition, page 395, Table 15-3, Wrist Regional Grid Upper Extremity Impairment, I would have recorded her a default class 1, grade C 1 percent impairment of the right upper extremity for sprain." *Id.* at 32-33.

51. Claimant presented at the West Valley Medical Center ER, where Brett Bemis, PA, examined her on April 15, 2016. Ex. L:191. PA Bemis prescribed Ketorolac and Cyclobenzaprine for Claimant, and released her that same day. *Id*. at 212; 192-193. He noted as follows: "no acute injury by history. Pt [sic] may have complex regional pain syndrome and would match her history. Strength adequate so doubt hardware failure." *Id.* at 212.

52. Claimant returned on April 19, 2016 to Dr. Daines. He explained her cervical MRI had no significant findings . Ex. X:428.

53. Claimant saw Dr. Marsh again on May 10, 2016. Ex. V:382. Dr. Marsh recorded Claimant's pain complaints and noted an absent Brachioradialis reflex with distraction. *Id.* He assessed neck pain, CRPS, and cervical radiculopathy. *Id.*

54. Claimant returned to Dr. Toomey on May 25, 2016. Ex. R:307. She explained that Dr. Marsh had sent her to Dr. Toomey again because he had observed an abnormal area on the volar aspect of her wrist.[7] *Id.* Dr. Toomey noted that this area did not seem to bother her the last time he saw Claimant; he documented the results of the visit as follows:

> She states that there is some swelling on the volar aspect of her wrist. When I compare her left and right wrist side-by-side there is no swelling in either neutral, flexion or extension. She points to an area that is tender to palpation. This is the distal pole of her scaphoid. She states that it gets red with activity. There are no color changes that I can appreciate today. The remainder of her incisions are nicely healed. She does not retract or react with fairly significant palpation of the tender area.

Id.

55. Dr. Marsh saw Claimant again on June 2, 2016, and Claimant signed another document entitled "Irrevocable Assignment of Benefits, Instruction and Authorization for Direct Payment to Physician" written in English. Ex. V:384. Dr. Marsh noted an absent Brachioradialis reflex, paresthesias, and hyperpathia in Claimant's right forearm. *Id*. at 386. He started[8] Claimant on Tramadol. *Id.*

56. On referral from Dr. Toomey, Jared Johnson, M.D., evaluated Claimant's right shoulder on June 22, 2016. Ex. R:309. He ordered and read X-rays of her shoulder that same day, which were normal. *Id.* at 311. He also ordered a shoulder MRI. *Id.*

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[7] There is no reference to this abnormality in Dr. Marsh's notes, nor in Dr. Marsh's instruction to see Dr. Toomey.
[8] Dr. Marsh referred to both starting and continuing Claimant on Tramadol during this appointment.

57. James H. Bates, M.D., performed a second upper extremity EMG on Claimant on June 30, 2016. The results were normal. Ex. GG:471.

58. On July 26, 2016, Claimant returned to Dr. Marsh. Ex. V:401. He started[9] her on Lyrica and wrote "the patient clearly has neuropathic pain as she has had virtual elimination of apin [sic - pain] withlyrica [sic]." *Id.* Dr. Marsh recorded, in an identical notation to his June 2, 2016 note, an absent Brachioradialis reflex, paresthesias, and hyperpathia in Claimant's forearm. *Id*.

59. As ordered by Dr. Johnson, Claimant had a shoulder MRI on July 27, 2016. Ex. R:313. On August 17, 2016, Dr. Johnson noted that her MRI was "unremarkable" and that he recommended no surgical invention. *Id.* at 316.

60. Claimant followed-up with Dr. Marsh on August 26, 2016. Ex. V:407. She reported that with medications she felt she could return to work. *Id.* Dr. Marsh entered an identical note to his previous note that Claimant had virtual elimination of pain with Lyrica. *Id.* He started Claimant on Cymbalta, continued Claimant's three other prescriptions, and wrote that after Cymbalta he would start Claimant on a work hardening program. *Id*. at 408. Claimant signed a document entitled: "Patient Financial Agreement" written in English. *Id.* at 409.

61. On September 29, 2016, Dr. Marsh conducted a physical exam and noted the following: numbness with shoulder retraction, positive adverse neurodynamic tension, hyperesthesia to pinprick in a non-dermatomal distribution, and normal strength and reflexes. *Id.* at 411. He noted that Claimant had pictures of her hands that showed edema and hyperemia on the right side. *Id.* Dr. Marsh continued her medications, ordered physical therapy, and assessed "neuropathic paineither [sic] CRPS or Thoracic outlet syndrome." *Id.* at 412.

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[9] Again, it is unclear from Dr. Marsh's notes if he continued or started Claimant on this medication.

62. Claimant underwent additional physical therapy with Rulin Hawks, her same physical therapist while under the care of Dr. Kevin Krafft. Ex. J:153. Mr. Hawks examined Claimant on October 4, 2016, exactly two years after her industrial accident. *Id.* He noted her thoracic outlet tests were positive and stated: "I did not observe any diaphoresis or swelling in the arm or hand. I did notice after my evaluation that her right hand turned red and was noticeably discolored as compared to her left hand." *Id.* Claimant received treatment from Hawks for three weeks and 11 sessions; he released her from care on October 27, 2016 with the following notation: "Due to lack of progress, I do not think she would benefit from additional therapy at this time." *Id*. at 167. He did not observe any discoloration or swelling at that time. *Id.*

63. Claimant returned to Dr. Marsh that same day, October 27, 2016. Ex. NN:493. Two more identical notations appear regarding Dr. Marsh's physical examination and assessment. *Id.* He noted that physical therapy did not help Claimant and that Mr. Hawks "agrees adn [sic] would likt [sic] the TOS [sic - thoracic outlet syndrome] worked up." *Id.*

64. Claimant underwent an MRI of the brachial plexus on November 11, 2016 that yielded normal results. Ex. V:415.

65. Dr. Chong performed a records review at the request of Defendants on December 29, 2016. The review was of interim medical records created since his IME of April 7, 2016. Ex. DD:462. Dr. Chong opined that none of the interim records changed his previous conclusions. He concluded that the treatment Claimant had received after his IME was not industrially-related, because Claimant had been medically stable since July 2015, per Dr. Krafft. *Id*. at 465. He concluded his report with the following observation:

> Ms. Landeros appears to be on a mission to pursue a "pain syndrome" diagnosis, in the absence of objective findings, and this mission, appears to be enabled by her pain doctor, Dr. Marsh. This is unfortunate, as this simply perpetuates her

> disability conviction. The best rehabilitation for Ms. Landeros, would be a return to gainful employment.

Ex. DD:466.

66. Claimant saw Dr. Marsh again on January 5, 2017 for the results of her brachial plexus MRI. Ex. NN:495. Dr. Marsh conducted a physical exam in which he noted Claimant had a "video of the hand with fasiculations [sic - fasciculations],"[10] numbness, "parasthesias" with light touch, and pain in the arm from testing her cervical ROM. *Id.* Dr. Marsh entered another identical note assessing CRPS or thoracic outlet syndrome; he stopped Claimant's Lyrica prescription. *Id*. at 496.

67. Claimant saw Dr. Marsh again on February 2, 2017. He transcribed an identical physical exam note from January 5, 2017. *Id.* at 497. Dr. Marsh continued Claimant on her three prescriptions and wrote that he would check her toxicology screen for compliance with the patient treatment agreement. *Id.* at 498.

68. **Vocational Assessment**. Delyn Porter assessed Claimant's employability for Defendants in a report dated January 16, 2017. Ex. 8. The Commission is familiar with Mr. Porter's qualifications. Mr. Porter reviewed Claimant's medical records, ICRD records, and Claimant's responses to interrogatories; he did not interview Claimant. *Id.* at 73-74. He concluded that Claimant had 0% disability in excess of impairment because no physician had issued permanent restrictions or limitations relating to her industrial injury. *Id.* at 93.

69. **Claimant's Condition at Hearing**. Claimant described her condition at hearing in pertinent part as follows:

> Q. [By Mr. Miner]: Let me ask you this question, how are you feeling today?
>
> A: I have pain.

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[10] It is unclear from Dr. Marsh's note whether he viewed this video or not.

Q: Tell us today where you're experiencing pain.

A: Right now I have about four or five percent of pain, because I am moving my arm - - my hand even though I did took my medication for my pain before coming here.

…

Q: You're talking four or five on a scale of one to ten?

A: Correct.

Q: And where is it you're experiencing that pain? Point to it and describe where you're experiencing it.

A: So on the side, on top, under, and the side of my neck, and back of my shoulder.

Referee: Let the record reflect that the witness was pointing to her right arm and lifting her right arm as she described where the pain was.

Tr., 43:1-9;12-23.

70. Claimant proceeded to describe in detail that her right-sided pain was present on the top of her forearm, on the back of her wrist and in the entire wrist when she moved her fingers, where her neck and shoulder meet, her shoulder blade, neck, and along the elbow into her middle finger. *Id.* at 44-45. She recounted that she experienced redness, burning, pins and needles, and spasms. *Id.* at 53:4-5; 58:1-9. Claimant stated that she did not experience any other accident in 2014 or 2015. *Id.* at 46:18-20. She believed that the first surgery by Dr. Toomey helped her somewhat. *Id.* at 49:17-22.

71. Regarding her ability to work, Claimant expressed that she felt physically incapable of working without restrictions but acknowledged that no doctor had assigned her work restrictions, as follows:

Q: [By Mr. Miner]: Has Dr. Marsh given you any physical restrictions?

> A: No. If I feel like I'm able to work and I told him that yes, because I'm tired and I need to work, and so he told me that he was going to test me by going through therapy and that the therapists were the ones that were going to me the restrictions and not him.
>
> Q: Did you go through that therapy?
>
> A: Correct, yes.
>
> Q: And did they communicate any restrictions to you?
>
> A: So they said that they couldn't do much for me, because they were doing some sort of ultrasound in the area and it was a lot of pain.
>
> …
>
> Q: What restrictions do you have right now?
>
> A: To be honest, *I don't have any restrictions right now*. He hasn't told me anything, but myself, I don't feel that I can work without restrictions, because, of course, medications tell you once you take the medications, you're not allowed to drive, not allowed to work a machine.

Tr., 64:3-17; 72:2-8 (emphasis added).

72. Claimant's perceived limitations in her activities of daily living included the inability to use her right arm to vacuum, do dishes, put on make-up, cut vegetables, sweep, or write. *Id.* at 68:1-5; 72:11-73:10.

73. During Claimant's direct examination, counsel for Defendants made the following record regarding Claimant's physical actions during the hearing:

> My request for the record so that the Referee will recognize this is that the Claimant is not just pointing with her other hand, but is actually physically showing the Referee or showing Mr. Miner, turning her hand, showing her hand, lifting her hand. She is with her left hand, the other hand, rubbing her arm where she's indicating that it hurts. She is constantly resting her left arm - - left hand on her right wrist and on her forearm. She's bending her arm and rubbing, if you will, motioning, gesturing with her other hand on the actual physical skin of her right hand where she's contending it hurts, so, again, it's difficult I understand from the written record to show this, but I think it's important that the Referee has this on the record the indications that she's touching her right hand and she's

> gesturing with her right hand and that her left hand has been resting on the right upper extremity.

Tr., 55:12-56:3. Claimant's counsel agreed with this description and added that Claimant had never lifted her arm above the shoulder level. *Id.* at 56:7-15.

74. On cross-examination, Claimant agreed that she was wearing a long-sleeved sweater and that physical therapy had not helped her. *Id*. at 76:19-77:20. On re-direct, Claimant stated driving was difficult because she could only use her left hand, that the movement of her sweater on her skin caused numbness up her arm, and that she'd be happy to be off the medications she was currently on for pain. *Id*. at 80:3-9; 81:7-12; 83:4-6.

75. **Post-Surgery Employment**. Claimant did not return to work with Employer after her second surgery by Dr. Toomey in November 2015. She recalled as follows: "I took the documents and I could go back to work, but with restrictions and a person that was in the office, her name is Julia, so then they told me that they didn't have a position for me, that they had hired somebody else." *Id*. at 50:20-24. As of the date of the hearing, Claimant had not worked since her last period of employment with Employer because "practically" she could not work due her right upper extremity pain. *Id.* at 51:11-12.

76. **Dr. Marsh Deposition.** Dr. Marsh is a physiatrist who is board certified in pain management. Marsh Dep., 4:15; 5:2. He described the history Claimant gave him, including the mechanism of her first injury and that "she got another injury to her wrist on the ulnar border." *Id.* at 7:22-23. He explained that he did not do a physical exam during their first appointment because her history took a long time. *Id.* at 11:22-25. Dr. Marsh found her initial lack of brachioradialis reflex significant but stated it would need to be repeated over time to confirm an absent reflex. *Id.* at 13:5-20.

77. Dr. Marsh assessed CRPS based on her abnormal presentation and history. Marsh Dep., 15:11-17; 16:7-8. He described CRPS as a "challenge" to diagnose because it is a clinical diagnosis based on patterns, not necessarily on objective imaging. *Id*. at 17:13-18:9.

78. Dr. Marsh agreed that Claimant's presentation fit with the first component of the AMA *Guides* for CRPS, i.e. "a continuing pain which is disproportionate to the inciting incident." *Id.* at 18:18-24. When asked about the inciting incident Dr. Marsh replied: "could have been the injury, could have been the surgery. You have to look back in the timeline whether it was before the surgery or after surgery that she had these strange symptoms. I didn't see her. I mean, it's been going on since 2014." *Id*. at 19:2-6. He stated the inciting incident for CRPS can be "extremely minor," such as a sprained ankle or injection. Dr. Marsh discussed the fourth criteria, that there is "no other diagnosis that better explains the signs and symptoms," and described his process for ruling out thoracic outlet syndrome. *Id.* at 19:16-24; 20:22-21:8. He stated that there were no further diagnostic studies he would order at this time. *Id.* at 21:20-21.

79. Dr. Marsh read through the second and third *AMA Guides* criteria for CRPS. *Id*. at 23-27. The second criteria required the patient to report three out of four types of symptoms; the third criteria required the diagnosing doctor to observe at least one[11] of the four same types of "signs." *Id*. at 25:12-17. The four types of signs were: sensory changes, vasomotor changes, sudomotor changes, and motor/trophic changes. *Id.* at 23:20-24:11. Dr. Marsh recalled that Claimant had reported "pain to silly, light little touches" and paresthesias (sensory); skin color changes (vasomotor); and motor dysfunction, trembling, and tremors (motor/trophic). *Id.* at 26:4-12. He stated he had personally observed hyperesthesia and allodynia (sensory); skin color changes (vasomotor); and tremors/trembling (motor/trophic). *Id.* at 26:13-19. He described her

[11] The *AMA Guides* actually requires one sign in two or more categories.

pain as localized in the fingers, hand, wrist, forearm, shoulder, and chest. Marsh Dep., 27:9-19. He also described phenomena he related to CRPS as follows:

> Q: [By Mr. Miner]: So there's stimuli that goes on up the arm and into her shoulder and - -
>
> A: And the opposite is true. If you stimulate up here, it will go down here too (indicating).
>
> Q: And are those findings consistent with your understanding of CRPS?
>
> A: They are consistent, yes. And they are very consistent in their presentation. She's had the same presentation from day one.

Id. at 27:21-28:4.

80. Dr. Marsh concluded that Claimant had CRPS and that his opinion was within a reasonable degree of medical probability. *Id.* at 26:22-27:1.

81. Dr. Marsh opined that Claimant could not return to work with Employer, but that "there is work that she could be trained to do." *Id.* at 29:2-11. He further noted in pertinent part as follows: "[S]he doesn't have one of those severe types [of CRPS] that is going to leave her at bed rest … She's in pain, her life is disrupted, but she functions … she's not ever going to be able to return to manual labor." *Id.* at 29:14-17, 20-21.

82. Dr. Marsh discussed treatment options at length including: sympathetic nerve blocks, "ketamine protocol," spinal cord simulators, and low dose naltrexone. *Id.* at 29-32. He explained that because Claimant wanted to get off pain meds, his next treatment step would be an opiod blocker (naltrexone) and sublingual ketamine, and if that didn't work, he would recommend ketamine therapy. *Id.* at 32:3-22.

83. When asked specifically about how Claimant's CRPS relates to the industrial injury, Dr. Marsh replied as follows:

Q: [By Mr. Miner]: Doctor, do you have an opinion as to the relationship between the accident injury and the CRPS?

A: Yeah. Again, I have to go back and look in the history of 2014 and 2015 as to whether or not the inciting event was the injury, or whether it was the surgery, or what exactly it was, but I think it's - - I'm convinced it's work related. I mean it's related to the whole injury.

Q: And do you hold that opinion to a degree of medical probability?

A: I do.

Q: So just to recap, it sounds like you believe it's either from the initial incident or from the surgery; is that correct?

A: That's correct.

Marsh Dep., 34:10-24.

84. On cross-examination, Dr. Marsh explained his understanding of the document entitled "Irrevocable Assignment of Benefits, Instruction and Authorization for Direct Payment to Physician" was that if Claimant did not have insurance coverage, he could "recover some of my fees if and when she settles her case." *Id.* 36:17-18.

85. Regarding certain signs/symptoms of CRPS, Dr. Marsh stated as follows:

Q: [By Mr. McFeeley]: And as I understand, that allodynia and hypersensitivity is that just touching the skin causes pain, and even the pressure of - -

A: Clothing.

Q: - - of clothing causes problems; is that correct? Is that kind of the symptoms?

A: Yes, that's true.

Id. at 43:19-25.

86. Dr. Marsh confirmed that he had personally observed color changes and tremors in Claimant's upper right extremity. *Id.* at 52:10-13.

87. On redirect, Dr. Marsh opined that fluctuating symptoms are typical of CRPS. Marsh Dep., 58:3-4. He stated that someone who sees her repeatedly, such as a physical therapist, would be best positioned to opine on a CRPS diagnosis due to the shifting nature of CRPS and that he had seen her six or eight times. *Id.* at 57:22-25. Regarding allodynia, Dr. Marsh confirmed that it meant pain to light touch, and when asked whether that specific symptom could wax or wane, he replied as follows: “I mean, in CRPS it can, but it’s going to be pretty consistent. And I think in her case, it’s pretty consistent.” *Id.* at 58:24-59:5.

88. **Dr. Chong Deposition**. Dr. Chong is board certified in Physical Medicine and Rehabilitation and has specialized training in CRPS. Chong Dep. 5:23-6:19; Ex. 6.

89. Dr. Chong elaborated on his criticism of Dr. Krafft’s impairment rating from his IME report as follows:

> “A careful review of Dr. Krafft’s rating process is that he rated Ms. Landeros for the extensor carpi on the wrist tendon rupture as well as far [sic - for] de Quervain’s disease … According to the AMA *Guides* as to the evaluation of permanent impairment, you rate for the disease condition that’s causally related to the injurious event. And since there was no injury and no symptomatic presentation to the ulnar wrist, this should not have been considered. Now, with respect to the de Quervain’s disease, I would have to concede that this is with the benefit of hindsight, which Dr. Krafft did not have. After he had declared Ms. Landeros at maximum medical improvement … she pursued additional treatment and actually had both injections and surgical treatment for de Quervain’s disease. The surgical report actually shows successful surgery for such a condition if it were to exist, yet Ms. Landeros continued to complain of radial wrist pain. What this tells me then is that the presumptive diagnosis of de Quervain’s … was not probably the correct diagnosis.”

Id. at 16:13-17:18.

90. Dr. Chong considered a diagnosis of CRPS and tested for it during his physical exam. *Id.* at 22:6-9. He explained that one of the diagnostic criteria for CRPS is the inability to use the affected limb and that a lack of use has observable, measurable consequences, namely, muscle loss. *Id.* at 23:4-11. He stated that in measuring her arm and forearm, he observed no

muscle loss, and that her right side had greater muscle mass than her left. Chong Dep., 22:21-23:15. He explained this was significant because: “in fact, the dominant side, the right upper limb, continues to have greater muscle mass than the non-dominant side, which informs me that she certainly had no functional disability to the right upper limb, which would be required both as a consequence and as an objective findings.” *Id*. at 23:13-18.

91. Dr. Chong reiterated his IME findings that he observed no swelling, no temperature asymmetry, no abnormal perspiration, no discoloration, no abnormal sensation, and no dystrophic (hair, skin, fingernail) changes in Claimant’s upper right extremity. *Id*. at 24:3-25:25. Dr. Chong stated CRPS requires an affirmative diagnosis. A lack of pathological explanation for pain is not enough to diagnosis the condition; a physician must observe positive signs of the disease. *Id.* at 26:13-18. He clarified that he was not saying Claimant did not feel pain, but that she did not qualify for a diagnosis of CRPS. *Id.* at 28:18-24.

92. Dr. Chong opined that the methodology of conducting an EMG, insertion of needles in the subject extremity, was not consistent with a diagnosis of CRPS because any person with a “true diagnosis” of CRPS would refuse to have it performed. *Id.* at 33:9-20. He observed that wearing a long-sleeved sweater was not consistent with a diagnosis of CRPS of the upper extremity because a typical CRPS patient would experience pain or abnormal sensation from normal textures, especially clothing. *Id*. at 36:19-37:21.

93. Dr. Chong critiqued Dr. Marsh for intermingling signs and symptoms of CRPS, i.e., what he, as a physician observed, and what his patient was reporting to him. *Id.* at 35:4-10. He disagreed with Dr. Marsh that a trivial injury could lead to CRPS. *Id.* at 43:10-25. Regarding ketamine therapy, Dr. Chong did not discount it entirely as a treatment for CRPS, but stated that even assuming Claimant had CRPS, ketamine therapy would be inappropriate because her

alleged CRPS was mild and there are numerous other treatment options that should be attempted first. Chong Dep., 40:4-41:10. He opined that Claimant did not need ongoing palliative care. *Id.* at 44:10-12.

94. Under cross-examination, Dr. Chong stated it would be highly unusual for a wrist strain or sprain to cause CRPS. *Id*. at 47:12-14.

95. **Claimant's Credibility**. Based upon her testimony and demeanor at hearing, the Claimant was a credible witness. She believably recounted her pain symptoms and perceived physical limitations. Nevertheless, there are numerous inconsistencies between Claimant's testimony and the medical records, which were further complicated by the language barrier that was apparent throughout Claimant's treatment. Where Claimant's testimony conflicted with the medical records, the medical records carry greater weight in these findings.

DISCUSSION AND FURTHER FINDINGS

96. The provisions of the Idaho Workers' Compensation Law should be liberally construed in favor of the employee. *Haldiman v. American Fine Foods*, 117 Idaho 955, 956, 793 P.2d 187, 188 (1990) (retraining benefits statute liberally construed to permit payment of travel-related retraining expenses rather than requiring claimant to pay them from his subsistence-level temporary disability benefits). Facts, however, need not be construed liberally in favor of a claimant when evidence is conflicting. *Aldrich v. Lamb-Weston, Inc.*, 122 Idaho 361, 363, 834 P.2d 878, 880 (1992) (substantial evidence supported Commission's finding that the industrial accidents did not cause claimant's breathing problems, where medical evidence was conflicting).

97. **Causation**. Claimant has the burden of proving that the condition for which she seeks compensation is causally related to an industrial accident. *Callantine v Blue Ribbon Supply*, 103 Idaho 734, 734-735, 653 P.2d 455, 455-456 (1982) (alleged industrial accidents neither

caused nor aggravated claimant's thoracic outlet syndrome). There must be evidence of a medical opinion, whether by physician's testimony or written medical record, supporting the claim for compensation to a reasonable degree of medical probability. 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, 901 591 P.2d 143, 148 (1979) (physician's testimony supported finding that industrial accidents caused claimant's condition). Claimant must establish a probable, not merely a possible, causal connection between an injury and a claimed condition. *Dean v. Dravo Corporation*, 95 Idaho 558, 561, 511 P.2d 1334, 1337 (1973) (physician's testimony raised an ambiguity whether there was a possibility rather than a probability of a causal connection, requiring remand for rehearing).

98. The Commission, as the fact finder, is free to determine the weight to be given to the testimony of a medical expert. *Rivas v. K.C. Loggin*g, 134 Idaho 603, 608, 7 P.3d 212, 217 (2000) (Commission acted within its discretion in determining claimant's impairment, where five physicians concurred in a 1% impairment as opposed to claimant's doctor who found a 14% impairment). "When deciding the weight to be given an expert opinion, the Commission can certainly consider whether the expert's reasoning and methodology has been sufficiently disclosed and whether or not the opinion takes into consideration all relevant facts." *Eacret v. Clearwater Forest Industries,* 136 Idaho 733, 737, 40 P.3d 91, 95 (2002) (Commission as fact finder acted within its discretion in relying upon physician's opinion in determining that apportionment for a preexisting condition was inappropriate).

99. The parties do not dispute that Claimant suffered an accident and injury on October 4, 2014. They dispute whether her alleged CRPS is related to that accident and whether

she suffered de Quervain's tendinitis casually related to the accident. Additionally, the medical record raises an issue whether her ECU tendon rupture is industrially related.

100. ***CRPS***. Dr. Krafft saw Claimant within two months of her injury and treated her for over seven months; he took a history and performed a physical examination at each appointment. Dr. Krafft was best positioned to observe Claimant's symptoms over time. Dr. Boyer specifically requested that Dr. Krafft consider a diagnosis of CRPS after his single exam of Claimant, but Dr. Krafft rejected this diagnosis based on Claimant's presentation. Dr. Krafft never recorded any observations similar to Dr. Boyer's reports of a temperature differential or a small pale spot. He opined that her pain was the result of persistent symptoms of tendinitis, not CRPS, and released her without restrictions.

101. Dr. Chong was the only doctor who had access to all of Claimant's medical records for review. At deposition, he cogently explained his methodology and conclusions regarding Claimant's proposed diagnosis of CRPS. During his exam, he found no symptoms of CRPS and actually found contraindications for CRPS including greater muscle mass on the affected side and movement/touching inconsistent with that diagnosis.

102. Other than Dr. Marsh, only two physicians suggested a possible diagnosis of CRPS: Dr. Boyer and PA Bemis. Both physicians saw Claimant only once and did not have her complete records. Their opinions regarding a diagnosis of CRPS carry no weight.

103. Both the record as a whole and his own deposition testimony do not support Dr. Marsh's opinion regarding Claimant's CRPS. Dr. Marsh was unable to identify whether Claimant's CRPS was caused by her initial industrial injury or either surgery with Dr. Toomey, but stated he could "probably tell just by looking at the history in detail." Marsh Dep., 35:1-2.

104. Dr. Marsh did not review all of Claimant's medical records; he stated at deposition that the records contained in his notes were the extent of his file. Marsh Dep., 61:21-23. Notably missing from Dr. Marsh's review were the following: all of the records of Dr. Chicoine, Claimant's initial treating physician; all but one of Dr. Krafft's notes, her rating physician; Dr. Toomey's records, her surgeon; and all of the physical therapy records. Ex. V, NN.

105. Dr. Marsh could only opine that he was convinced that Claimant's condition was work related. His inability to identify on a more probable than not basis an "inciting incident" or the cause of her CRPS is fatal to his opinion.

106. Dr. Marsh's office practices also undercut his opinion. The document entitled "Irrevocable Assignment of Benefits, Instruction and Authorization for Direct Payment to Physician" is an unenforceable assignment of benefits pursuant to Idaho Code § 72-802 and the Commission decision of *The Industrial Commission v. Oasis Legal Finance* 2012 IIC 003. The document states in pertinent part as follows:

> In consideration for the professional services provided to me by Dr. Daniel R. Marsh, MD, doing business as Exodus Pain Center (hereinafter "Provider"), I hereby *assign my cause of action and right of recovery* on any settlement claim, judgment or verdict as a result of the accident/injury dated herein.

Ex. V:362 (emphasis added).

107. Idaho Code § 72-802 provides as follows:

> *No claims for compensation under this law*, including compensation payable to a resident of this state under the worker's compensation laws of any other state, *shall be assignable*, and all compensation and claims therefor shall be exempt from all claims of creditors, except the restrictions under this section shall not apply to enforcement of an order of any court for the support of any person by execution, garnishment or wage withholding under chapter 12, title 7, Idaho Code.

(Emphasis added.)

108. Dr. Marsh's patient agreement violates Idaho Code § 72-802 and encourages mischief. It gives Dr. Marsh a vested interest in Claimant's successful pursuit of litigation, much more so than a fee for service relationship typical of an IME doctor. As he stated in deposition, if and when she settles her case he gets paid; Claimant cannot "settle her case" without medical evidence/opinion of a compensable injury/disease, which Dr. Marsh provides here.

109. Further undermining Dr. Marsh's opinion was his habit of copying and pasting notes from one of Claimant's appointments to another, misspellings included, and his practice of signing his office notes months after the fact.[12]

110. Claimant did not develop CRPS as a result of the industrial accident of October 4, 2014. Claimant has failed to establish causation for this condition.

111. ***De Quervain's***. Dr. Chicoine, Claimant's first treating physician, suspected "de Quevains [sic]" within three weeks of the accident. Ex. C:20. Dr. Krafft rated Claimant for de Quervain's when he released her from care. All three hand specialists, Dr. Robinson, Dr. Boyer, and Dr. Toomey, her surgeon, diagnosed de Quervain's and related it to her industrial injury. Only Dr. Chong opined that Claimant did not have de Quervain's, and he based that opinion on her wrist MRI and Claimant's report at the IME where she stated she had reduced symptoms from the second surgery but not the first. Nevertheless, she reported relief from the surgery to her surgeon, Dr. Toomey, and at hearing. Furthermore, four of the five doctors who opined she had de Quervain's had access to the MRI (Robinson, Krafft, Boyer, and Toomey) and still reached the conclusion that Claimant had de Quervain's.

112. Claimant's de Quervain's was more probably than not related to her industrial accident of October 4, 2014.

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[12] Dr. Marsh's electronically signed his office notes dated 3/11/16, 5/10/16, 7/26/16, 8/26/16, and 9/29/16 on October 3, 2016. Dr. Marsh's signed his 6/2/16 note on February 1, 2017 and his 10/27/16, 1/5/17, and 2/2/17 notes on February 7, 2017.

113. ***ECU Tendon Rupture***. The only evidence that Claimant's ECU tendon rupture was work related is in Dr. Marsh's notes stating she had a second injury to that side of her wrist. Nevertheless, no such claim is before the Commission, nor does the record reflect that Claimant's ECU tendon rupture was related to the industrial accident. Both Dr. Robinson and Dr. Boyer observed Claimant was asymptomatic on the ulnar side of her wrist. Dr. Toomey only recorded ulnar-sided wrist pain after her first surgery, and further opined that her ECU tendon rupture was too old to repair. Finally, Dr. Chong opined that the ECU tendon rupture was an incidental finding and preexisting.

114. Claimant's ECU tendon rupture was not industrially related.

115. **Medical Care**. Idaho Code § 72-432(1) requires an employer to provide medical care that is related to a compensable injury, as may be reasonably required by the employee's physician or needed immediately after an injury or manifestation of 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. A reasonable time to provide medical treatment generally includes the period of recovery. *Harris v. Independent School District No. 1*, 154 Idaho 917, 928, 303 P.3d 604, 615 (2013) (substantial evidence supported Commission's finding that claimant reached medical stability and was not entitled to medical care thereafter). The employer's obligation to provide medical care may or may not extend to palliative care that does not result in functional improvement to an employee's condition following medical stability, depending upon the totality of facts and circumstances. *Rish v. Home Depot* 161 Idaho 702, 706, 390 P.3d 428, 432 (2017) (Commission erred in determining post-MMI palliative care was not reasonable because it did not improve claimant's functionality).

116. Claimant bears the burden of proving that medical expenses are due to an industrial injury and must produce medical testimony that supports a claim for compensation to a reasonable degree of medical probability. *Langley v. State of Idaho, Industrial Special Indemnity Fund*, 126 Idaho 781, 785, 890 P.2d 732, 736 (1995) (medical testimony failed to demonstrate an industrial cause of damage to claimant's knee). A physician, not the Commission, must determine whether medical treatment is required; the Commission's role is to determine whether, based upon the totality of the circumstances, the medical treatment determined required by a physician is reasonable. What constitutes reasonable medical care is to be determined by a totality of the circumstances approach. *Chavez v. Stokes*, 158 Idaho 793, 798, 353 P.3d 414, 419 (2015) (bill for medical helicopter transport of claimant following his finger injury was reasonable medical care).

117. Claimant requests that Defendants pay for her diagnostic procedures relating to her CRPS, her pain medications, and ketamine therapy. As discussed *supra*, however, the record does not support Dr. Marsh's diagnosis of CRPS. Therefore, Claimant's request for diagnostic procedures and ketamine therapy relating to CRPS is rejected. Nevertheless, further discussion is warranted for her request for pain treatment for her industrially-related diagnosis of de Quervain's tendinitis.

118. Dr. Krafft opined that Claimant was at MMI on July 13, 2015, but further stated that he would assist Claimant with her pain management due to her persistent symptoms of tendinitis. Pursuant to *Rish*, 161 Idaho at 706, 390 P.3d at 432, a finding of medical stability does not preclude additional palliative medical treatment, including pain medications, for tendinitis.

119. Given Claimant's ongoing reports of pain and Dr. Krafft's recommendation for pain management, Claimant is entitled to palliative care as reasonably required by Dr. Krafft or

any physician he might refer her to for pain management of tendinitis. Claimant is not entitled to reimbursement for any pain management provided by Dr. Marsh.

120. **Temporary partial/total disability payments.** Claimant has been medically stable since July 13, 2015. Claimant is not entitled to further temporary partial or total disability payments.

121. **Permanent partial impairment (PPI).** Permanent impairment is any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved and which abnormality or loss is considered stable at the time of evaluation. Idaho Code § 72-422. While utilizing the advisory opinions of physicians, the Commission is the ultimate evaluator of impairment. *Urry v. Walker & Fox Masonry Contractors*, 115 Idaho 750, 755, 769 P.2d 1122, 1127 (1989) (opinion of claimant's treating physician that he did not suffer any additional impairment after second injury not binding on Commission).

122. Dr. Krafft found Claimant at MMI on July 13, 2015 and issued a PPI rating of 6% of the upper extremity for her ECU tendon rupture and de Quervain's. Dr. Chong agreed Claimant was at MMI in July 2015 and issued a PPI rating of 1% of the upper extremity for a wrist strain.

123. The record supports Dr. Krafft's decision to rate Claimant for her de Quervain's. Dr. Chong's opinion that Claimant did not suffer from industrially-related de Quervain's and his corresponding decision to rate Claimant's right upper extremity at only 1% PPI for a mere wrist strain are not supportable.

124. Dr. Chong's criticism of Dr. Krafft's impairment rating for Claimant's ECU tendon rupture, however, is well taken. No other physician opined that her ECU tendon rupture

was related to her October 4, 2014 accident.[13] The only indication Dr. Krafft related that injury to her accident is its inclusion in his PPI rating. Dr. Chong explained that the ECU tendon rupture was likely a preexisting condition based on the fact that there was no mechanism of injury and no symptoms on that side of the wrist until after her first surgery. Both Dr. Robinson and Dr. Boyer specifically opined that Claimant's ECU tendon rupture was unrelated to her industrial accident and symptoms. Claimant has not proven accident related impairment for her ECU tendon rupture.

125. Nevertheless, in issuing his rating, Dr. Krafft did not separate out his rating for Claimant's ECU tendon rupture and de Quervain's; he rated 6% impairment of the upper extremity for both conditions. Defendants adduced no evidence on how Claimant's impairment should be apportioned between her ulnar and radial wrist injuries, other than arguing that Dr. Chong's PPI rating should be adopted. As noted above, Dr. Chong's 1% PPI is unsupportable due to his rejection of a de Quervain's diagnosis. Therefore, Claimant is entitled to the full 6% PPI rating.[14]

126. Claimant is entitled to a 6% impairment of the right upper extremity.

127. **Permanent Disability.** "Permanent disability" or "under a permanent disability" results when the actual or presumed ability to engage in gainful activity is reduced or absent because of permanent impairment and no fundamental or marked change in the future can be

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[13] Dr. Marsh recorded a second injury to Claimant's ECU tendon and did not relate it to her original October 4, 2014 injury.

[14] The parties did not introduce the relevant chapter of the AMA *Guides*, 6th Ed., Chapter 15, "The Upper Extremity," into evidence, thus it is not a basis of the above findings on impairment. Nevertheless, it is interesting to note that Table 15-3 at page 395 of the *Guides* recognizes that either an initial diagnosis of wrist sprain/strain, followed by persistent pain without consistent objective findings at MMI, including the condition of de Quervain's disease, and a ruptured tendon of the wrist with residual loss, each separately qualifies for a Class 1 impairment range of 1 to 13%. Because the default grade is C, 5%, the net adjustment of 1 applied by Dr. Krafft in the case of either diagnosis yields a 6% impairment of the upper extremity. Thus, even if Dr. Krafft had not addressed the ECU tendon rupture in his impairment analysis, a 6% impairment of the upper extremity is justified under the *Guides* solely upon a diagnosis of de Quervain's disease, modified by the net adjustment applied by Dr. Krafft.

reasonably expected. Idaho Code § 72-423. Idaho Code § 72-425 provides that the evaluation (rating) of permanent disability is an appraisal of an injured employee's present and probable future ability to engage in gainful activity as it is affected by the medical factor of permanent impairment and by pertinent nonmedical factors provided in Idaho Code § 72-430.

128. The test for determining whether Claimant has suffered a permanent disability is "whether the physical impairment, taken in conjunction with nonmedical factors, has reduced the claimant's capacity for gainful employment." *Graybill v. Swift & Company,* 115 Idaho 293, 294, 766 P.2d 763, 764 (1988) (claimant at time of hearing was earning a salary equal to his pre-injury employment and did not present significant evidence of disability). Idaho Code § 72-430(1) provides that in determining percentages of permanent disabilities, account should be taken of the nature of the physical disablement, the disfigurement if of a kind likely to handicap the employee in procuring or holding employment, the cumulative effect of multiple injuries, the occupation of the employee, and his or her age at the time of accident causing the injury, or manifestation of the occupational disease, consideration being given to the diminished ability of the affected employee to compete in an open labor market within a reasonable geographical area considering all the personal and economic circumstances of the employee, and other factors as the Commission may deem relevant. In sum, the focus of a determination of permanent disability is on the claimant's ability to engage in gainful activity. *Sund v. Gambrel*, 127 Idaho 3, 7, 896 P.2d 329, 333 (1995) (claimant's limitations preexisted industrial injury, thus he had no permanent disability).

129. The proper time for determining Claimant's disability under most circumstances is the time of the hearing. *Brown v. Home Depot,* 152 Idaho 605, 609, 272 P.3d 577, 581 (2012) (Commission's finding regarding disability was reached in error

because it was based upon his circumstances at time of medical stability rather than hearing). Claimant bears the burden of proving that she has suffered a disability. *Seese v. Ideal of Idaho, Inc.*, 110 Idaho 32, 34, 714 P2d 1, 3 (1985) (claimant failed to establish disability where her complaints of chronic back pain were not supported by an anatomical cause of her pain or physical evidence of injury). "[A] permanent disability rating need not be greater than the impairment rating if, after consideration of the non-medical factors in Idaho Code § 72–425, the claimant's 'probable future ability to engage in gainful activity' is accurately reflected by the impairment rating." *Graybill,* 115 Idaho at 294, 766 P.2d at 764.

130. In *Poljarevic v. Independent Food Corporation*, 2010 IIC 0001 (permanent work restrictions assigned to claimant by independent medical examiner were appropriate), the Commission observed as follows:

> In assessing Claimant's permanent partial disability, it is first helpful to understand whether Claimant's permanent impairment has caused a loss of functional capacity, which impacts his ability to engage in physical activity. Indeed, a loss of functional capacity figures prominently in all cases involving a determination of an injured worker's disability in excess of physical impairment. *Absent some functional loss, it is hard to conceive of a factual scenario that would support an award of disability over and above impairment*; if the injured worker is physically capable of performing the same types of physical activities as he performed prior to the industrial accident, then neither wage loss nor loss of access to the labor market is implicated.

Poljarevic, 2010 IIC 0001.7 (emphasis added). Thus, for Claimant to prevail, the medical evidence must demonstrate that the industrial accident caused a permanent impairment, together with a functional loss in her physical capabilities justifying permanent work restrictions.

131. Dr. Krafft released Claimant without restrictions related to her industrial injury. Dr. Toomey released Claimant back to work with use of her upper extremity "as tolerated" after her second surgery. Neither Dr. Marsh, nor Rulin Hawks, PT, issued restrictions for Claimant.

Delyn Porter, Defendant's vocational expert, opined that without restrictions, Claimant has no disability in excess of impairment.[15]

132. Claimant's reported self-limitations are significant. Nevertheless, there is no objective medical evidence that support her subjective limitations. Although Claimant has a documented permanent partial impairment, without evidence that the industrial accident caused a functional loss in her physical capabilities resulting from that impairment, she has failed to prove either permanent total disability or partial disability.

133. **Reimbursement.** Defendants request reimbursement of monies they assert are unrelated to Claimant's industrial injury. Specifically, they request reimbursement for all medical care Claimant received after Dr. Krafft released her and reimbursement for overpayment of Claimant's impairment rating.

134. The only authority in the Workers' Compensation Law that provides for recoupment of overpaid benefits is Idaho Code § 72-316, which provides as follows:

> Any payments made by the employer or his insurer to a workman injured or afflicted with an occupational disease, during the period of disability, or to his dependents, which under the provisions of this law, were not due and payable when made, may, subject to the approval of the commission, be deducted from the amount yet owing and to be paid as income benefits; provided, that in case of disability such deduction shall be made by shortening the period during which income benefits must be paid, and not by reducing the amount of the weekly payments.

135. Defendants are not in a position to take advantage of this statute; they have successfully argued Claimant has no permanent disability, either total or partial. Defendants owe Claimant no income benefits from which these costs could be deducted. There is no other provision in Title 72 that could apply to reimburse Defendants for any overpayment.

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[15] The attempts by Claimant's attorney in brief to calculate Claimant's loss of labor market and wage loss are without foundation. *See*, Claimant's Opening Brief at 18.

136. **Attorney's fees.** Claimant has requested attorney's fees pursuant to Idaho Code § 72-804, which reads as follows:

> If the commission or any court before whom any proceedings are brought under this law determines that the employer or his surety contested a claim for compensation made by an injured employee or dependent of a deceased employee without reasonable ground, or that an employer or his surety neglected or refused within a reasonable time after receipt of a written claim for compensation to pay to the injured employee or his dependents the compensation provided by law, or without reasonable grounds discontinued payment of compensation as provided by law justly due and owing to the employee or his dependents, the employer shall pay reasonable attorney fees in addition to the compensation provided by this law. In all such cases the fees of attorneys employed by injured employees or their dependents shall be fixed by the commission.

137. Claimant asserts Defendants unreasonably relied on Dr. Chong's IME report to deny benefits. Defendants' reliance on Dr. Chong was not unreasonable. Dr. Chong's opinion was well reasoned and based on Claimant's complete medical records. Claimant has not proven an award for attorney's fees.

CONCLUSIONS OF LAW

1. Claimant has not proven her that alleged CRPS is related to her industrial accident of October 4, 2014.

2. Claimant has proven that the industrial accident of October 4, 2014 caused her de Quervain's tendinitis.

3. Claimant's ECU tendon rupture is not industrially related.

4. Claimant is entitled to reasonable pain management for her industrial injury as required by her last treating physician, Dr. Krafft.

5. Claimant has not proven entitlement to additional TPD/TTD payments.

6. Claimant is entitled to permanent partial impairment (PPI) of her upper right extremity in the amount of 6%.

7. Claimant has not proven entitlement to either permanent partial or total disability.

8. Defendants have failed to prove they are entitled to a reimbursement for overpaid benefits.

9. An award of attorney fees to Claimant pursuant to Idaho Code § 72-804 is not justified.

RECOMMENDATION

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

DATED this _7th___ day of March, 2018.

INDUSTRIAL COMMISSION

_/s/______________________________
John C. Hummel, Referee

ATTEST:

_/s/______________________________
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the _9th_____ day of ___March_________, 2018, 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 persons:

CLINTON E MINER
MIDDLETON LAW
412 S KINGS AVE STE 105
MIDDLETON ID 83644

NEIL D MCFEELEY
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PO BOX 1368
BOISE ID 83701-1368

_/s/______________________________

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

EUGENIA LANDEROS, Claimant, v. CROOKHAM COMPANY, INC., Employer, and IDAHO STATE INSURANCE FUND, Surety, Defendants.	**IC 2014-029584** **ORDER** March 9, 2018

Pursuant to Idaho Code § 72-717, Referee John C. Hummel submitted the record in the above-entitled matter, together with his recommended findings of fact and conclusions of law, to the members of the Idaho Industrial Commission for their review. Each of the undersigned Commissioners has reviewed the record and the recommendations of the Referee. The Commission concurs with these recommendations. Therefore, the Commission approves, confirms, and adopts the Referee's proposed findings of fact and conclusions of law as its own.

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

1. Claimant has not proven her that alleged CRPS is related to her industrial accident of October 4, 2014.

2. Claimant has proven that the industrial accident of October 4, 2014 caused her de Quervain's tendinitis.

3. Claimant's ECU tendon rupture is not industrially related.

4. Claimant is entitled to reasonable pain management for her industrial injury as required by her last treating physician, Dr. Krafft.

5. Claimant has not proven entitlement to additional TPD/TTD payments.

6. Claimant is entitled to permanent partial impairment (PPI) of her upper right extremity in the amount of 6%.

7. Claimant has not proven entitlement to either permanent partial or total disability.

8. Defendants have failed to prove they are entitled to a reimbursement for overpaid benefits.

9. An award of attorney fees to Claimant pursuant to Idaho Code § 72-804 is not justified.

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

DATED this __9th____ day of ___March__________, 2018.

INDUSTRIAL COMMISSION

__/s/______________________________________
Thomas E. Limbaugh, Chairman

__/s/______________________________________
Thomas P. Baskin, Commissioner

__/s/______________________________________
Aaron White, Commissioner

ATTEST:

__/s/______________________________________
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the _9th__ day of ___March___________, 2018, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

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sjw

_______/s/_______________________