**BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO**

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| ROBERT E. MEAD,<br><br>Claimant,<br><br>v.<br><br>SWIFT TRANSPORTATION,<br><br>Employer,<br><br>and<br><br>ACE AMERICAN INSURANCE COMPANY,<br><br>Surety,<br><br>Defendants. | **IC 2008-027385**<br><br>**FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER**<br><br>Filed September 11, 2015 |

## INTRODUCTION

Pursuant to Idaho Code § 72-506, the above-entitled matter was assigned to Referee LaDawn Marsters, who conducted a hearing on November 3, 2014 in Lewiston, Idaho. Claimant was present in person and represented by Starr Kelso of Coeur d'Alene. Employer (Swift) and Surety (collectively referred to as Defendants) were represented by Emma R. Wilson of Boise. Oral and documentary evidence was admitted, and post-hearing depositions were taken. Subsequently, Exhibit 19 to Dr. Dirks' deposition was admitted into evidence pursuant to the Order entered on December 9, 2014, and the post-hearing deposition of Brenda Elliff, R.N., was admitted pursuant to the Order entered on February 23, 2015.[1] Briefing was completed and the matter came under advisement on July 9, 2015. The case is now ready for decision. Referee

[1] Claimant filed three post-hearing evidentiary motions, on December 5 and 22, 2014, and January 14, 2015, to which Defendants timely responded. Following the entry of orders thereon, Claimant filed motions for reconsideration on two of the orders, on February 25, 2015 and March 10, 2015. Both motions to reconsider were dismissed by the Commission, by separate orders, each dated April 7, 2015.

Marsters submitted her recommendation on July 23, 2015, and left for new employment on July 24, 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

The parties seek adjudication of the following issues:

1. Whether Claimant's claim for additional benefits is barred by Idaho Code § 72-706;

2. Whether the conditions for which Claimant seeks benefits were caused by the industrial accident; and

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

    a. Medical care; and

    b. Temporary disability.

## CONTENTIONS OF THE PARTIES

There is no dispute that Claimant suffered a low back injury at Swift on June 9, 2008 for which he received medical benefits for treatment including two surgeries – one on October 10, 2008 by Dr. Dirks and one on April 12, 2012 by Dr. Larson – as well as indemnity benefits. It is also undisputed that Surety never filed any notices of claim status as required by Idaho Code § 72-806 in adjusting this claim.

Claimant contends that his lumbar spine condition has deteriorated since his second surgery such that he is entitled to additional diagnostic treatment by Dr. Dirks and, potentially, a third low back surgery which Dr. Dirks opines will likely be necessary. Claimant relies upon the medical opinion of Dr. Dirks and strongly argues that Dr. Larson is not a credible witness because he improperly induced Claimant to allow him to perform surgery in April 2012 after

performing an evaluation of Claimant at Surety's request. Further, it appears that Dr. Larson's surgery may be defective. Claimant also asserts entitlement to temporary disability benefits related to his 2008 industrial low back injury due to his inability to work after his temporary disability benefits related to his August 2013 neck injury ceased on July 2, 2014.

Defendants counter that Claimant's symptoms for which he seeks additional treatment are unrelated to his 2008 industrial injury and, therefore, they are not liable for additional benefits. Further, they assert that any further temporary disability benefits are barred by Idaho Code § 72-706. Defendants primarily rely upon the medical opinions of Dr. Larson.

## EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The prehearing deposition testimony of Claimant and Misty Coates taken October 22, 2014;
2. Claimant's Exhibits (CE) lettered "A" through "W";
3. Defendants' Exhibits (DE) numbered "1" through "6", "8" through "18", and "20" through "23" (or, "1" through "23" excepting "7" and "19");
4. The testimony of Claimant taken at the hearing; and
5. The post-hearing deposition testimony of:
    a. Bret A. Dirks, M.D., taken November 4, 2014 and supplemented on December 10, 2014;
    b. Jeffrey J. Larson, M.D., taken December 8, 2014; and
    c. Brenda Elliff taken March 27, 2015.

## OBJECTIONS

Mr. Kelso's limited objection at the hearing to the admission of portions of the 2013 prehearing deposition of Claimant are overruled; Claimant's testimony therein will be afforded the weight it deserves on each issue at bar. Defendants' objection to CE "V" is deemed waived since no motion was filed following the hearing. Similarly, the legal disputes that arose during the deposition of Misty Coates pertaining to privileged information on sticky notes are deemed waived since the parties proceeded to briefing without first seeking a ruling from the Commission, either via separate motion prior to briefing, or by motion incorporated into briefing. All other pending objections are overruled.

## FINDINGS OF FACT

### *BACKGROUND*

1. Claimant was a few weeks shy of his fortieth birthday and residing in Lewiston at the time of the hearing. He attended high school through the first half of his senior year, and later obtained his GED. Claimant began working at Swift in 1996, where he obtained experience and certifications in various fields of mechanical work. At one point, he moved to Texas where he worked as a shop manager for Swift. He moved back – still in Swift's employ as a mechanic – before 2008.

2. Claimant has a history of continuing to work or otherwise function following injuries. For example, in high school, he was on the football team in the first play of the game when he broke three ribs and ruptured his spleen. He continued to play until halftime. When he worked as a logger prior to his full-time employment with Swift, he broke his hand in a non-industrial accident. TR-37. When he realized he could not do his job wearing the cast, he took it off and worked without it. Prior to 2008, Claimant injured his neck while working out at

the gym. He continued to work at Swift, thinking the pain would resolve. When it did not, Claimant sought treatment and learned that he had herniated one or more discs in his cervical spine. He improved with conservative treatment including prescription pain medication, physical therapy, and epidural steroid injections. Claimant took his prescription pain medication at night to help him sleep, and continued to take it through the time of his 2008 industrial low back injury.

***INDUSTRIAL INJURY AND FIRST SURGERY***

3. On June 9, 2008, Claimant suffered a low back injury at Swift when he lifted a six-foot tall, 130-pound spring onto a cart. He felt a pinch in his back followed by low back pain with pain and numbness down his left leg into his calf and foot. There is no dispute that Claimant provided timely notice to Swift of this accident and injury.

4. Claimant received medical benefits for treatment by Christy Norwood, F.N.P., who ordered an MRI on August 14, 2008, among other things. Ultimately, NP Norwood referred Claimant to Bret Dirks, M.D., a neurosurgeon. Dr. Dirks diagnosed a herniated disc at L5-S1 and performed a left-sided microdiscectomy and laminectomy on October 10, 2008.

5. At a follow-up appointment on November 18, 2008, Claimant asked to be returned to regular duty even though he was not yet back to his pre-injury condition. According to Claimant, Dr. Dirks advised that he would never again be completely symptom-free. Claimant believed the pain he was experiencing was reasonable, given his surgery, and he felt significant improvement compared to his presurgical condition. Also, Swift was laying off employees, and Claimant had demonstrated in physical therapy that he could perform his job requirements. Dr. Dirks released Claimant to return to full-duty work, without restrictions, on

December 2, 2008. He also prescribed physical therapy. Claimant continued to take prescription pain medication at night to control his residual pain and help him sleep.

***IMPAIRMENT RATING***

6. Surety sought an impairment rating from Dr. Dirks, who declined because he does not do them. So, in February 2009, Claimant underwent a medical evaluation at Surety's request by Jeffrey Larson, M.D., another neurosurgeon. Claimant still had low back pain. Dr. Larson assessed 6% whole person PPI following guidance from the Sixth Edition of the *AMA Guides to the Evaluation of Permanent Impairment*. According to Claimant, Dr. Larson did not examine Claimant's back.

> I went into his office and he told me, "Most places you go, they're gonna do an exam on you, but honestly, it's really just a bunch of BS."
>
> And he told me, "In the end, I'm going to go in this book, which is the AMA Guide to Impairment, and it's gonna say that you had this done, and I can rate you between here and here. I will give you closer to the top of it."

TR 104-105.

***CONTINUING LOW BACK AND LOWER EXTREMITY SYMPTOMS***

7. Claimant continued to work with low back and left leg radiculopathy treated by prescription medication that was managed by NP Norwood. She repeatedly noted Claimant's continuing low back and radiculopathy symptoms, on March 11, 2009, and on many occasions in 2010 and 2011.

8. On February 2, 2010, NP Norwood treated Claimant for lower back, right testicle, and groin pain that had persisted for two weeks. The pain was constant but waxed and waned in intensity. NP Norwood ordered an MRI (see below) and prescribed a Toradol injection and physical therapy. In physical therapy, Claimant was diagnosed with a right upslip,

which the therapist repaired via a manual manipulation. He had no right testicle trouble after that procedure, but his groin pain, low back pain, paravertebral spasm, and lower extremity radiculopathy persisted.

9. Claimant left employment at Swift, in or around August 2010 through September 2011, to work for Clearwater Paper because he thought the new job would be easier on his back. However, he ended up primarily driving a forklift on 12-hour shifts, which exacerbated his back and leg pain about as much as his work at Swift did. Claimant received medical treatment for his back pain and lower extremity symptoms before, while, and after he worked at Clearwater Paper. Because the Clearwater job was no easier on his back, and he preferred his work at Swift, Claimant returned to employment as a mechanic and trailer foreman at Swift on September 6, 2011. A few days later, he reported right greater than left leg pain.

10. Claimant kept a current CDL while he worked at Swift. It was not a requirement, but it was convenient to be able to move trucks if he had to. In order to maintain his interstate CDL, he had to maintain a medical card, which carried a limitation that he must wait 12 hours to drive a commercial truck after taking his pain medication. So, Claimant took his pain medication upon returning home from work in the evening. At some point, however, he began needing his medication at work, so he renewed his CDL as an in-state-only license (intrastate) to avoid the medical card requirement and, consequently, the 12-hour limitation.

11. In late 2011, Claimant again sought treatment from Dr. Dirks. "It was getting to the point where my legs were hurting all the time. I was - - had a lot of pain in my low back, down through my butt, down the back of my leg into my calf, the outside of my foot was going numb all the time - - the pinky toe side of my foot and, occasionally, my heal was going numb, and I was having a lot of weakness issues." TR-44, 45. Claimant was also experiencing right

lumbar radiculopathy, which Dr. Stoutin, at Interventional Pain Consultants (IPC), opined was due to his L5-S1 discectomy. Claimant's symptoms interfered with his ability to climb stairs and he became concerned about climbing on the 14-foot scaffolding to work on trailers. Dr. Dirks ordered an MRI, taken October 31, 2011 (see below), and administered an epidural steroid injection in November. Claimant underwent another injection in December. Claimant recalled that Dr. Dirks anticipated at this time that another surgery may be necessary; however, Dr. Dirks' notes do not address that issue.

12. At Surety's request, on January 11, 2012, Claimant was again evaluated by Dr. Larson, who agreed that a second surgery was reasonable because Claimant's symptoms and imaging were consistent with disc space collapse at L5-S1 and spondylosis compressing the L5 nerve root. He also opined that the procedure was required as a result of his June 2008 industrial injury. At his deposition, however, Dr. Larson took back his opinion when defense counsel advised during questioning that Claimant had been treated for leg pain while driving a forklift at Clearwater Paper. On cross-examination, Dr. Larson admitted that he did not know anything about the forklift job that would, on a more-probable-than-not basis, change his causation opinion. But, because there was the suggestion of the potential for additional injury, he was backing away from his earlier opinion.

13. According to Claimant, Dr. Larson advised it was unethical to say so, but he (Dr. Larson) was the only surgeon in the area qualified to perform the needed surgery, which he proposed was a minimally invasive fusion procedure. "Basically, from what I got from what he was telling me, is that it was unethical for him to take a patient away from Dr. Dirks when he was just supposed to be doing the medical evaluation." TR-47-48. Dr. Larson testified that he never said this. He recalled that Claimant had complained about Dr. Dirks because he had done

a poor job on Claimant's wife's back surgeries. Claimant's testimony on this point is persuasive in terms of what he understood Dr. Larson to say and why he elected Dr. Larson to perform his fusion surgery. *See* TR 47-50.

14. NP Norwood continued to prescribe pain and nerve medications into February 2012, when Claimant returned to Dr. Stoutin for further pain management. Dr. Stoutin was Claimant's pain physician prior to his 2008 industrial injury, and she had again begun treating Claimant in October 2011. Earlier that year, Claimant and NP Norwood had a misunderstanding about his pain medications, which they worked out. More recently, Claimant and his wife had both called for a hydrocodone refill, so provider and patient parted ways. Claimant later admitted he was addicted to the medication and had tried to wean himself off of it, unsuccessfully. In any event, Dr. Stoutin resumed her role as Claimant's pain physician, and she treated him, along with other care providers at IPC, through the time of the hearing. Claimant was taking approximately six hydrocodone per day in and around February 2012. Like NP Norwood, the care providers at IPC continued to note and treat Claimant's low back and radiculopathy symptoms.

***SECOND SURGERY***

15. Claimant underwent minimally invasive surgery by Dr. Larson on April 12, 2012 to fuse and decompress his L5-S1 disc space. Dr. Dirks testified at his deposition that he was qualified and able to perform this procedure. The operative report describes Dr. Larson's procedure:

> The left L5 nerve root was completely decompressed by opening the foramen. The left S1 nerve root was completely decompressed by opening the foramen. Disk osteophyte compex was identified on the left. The disk space was opened with a 15-blade and then distracted open using a series of paddle distracters. The

> disk space was severely compressed and distraction required osteotomy of the osteophytes. The disk space was opened to 8 mm . . . .

DE 584-585.

16. Following surgery, Claimant began physical therapy. Claimant's condition improved post-surgery. Following physical therapy, he had "good days and bad days," but did not feel he needed to return for more.

17. Claimant followed up with Dr. Larson's assistant, Mary Eggleston, N.P., on May 23, 2012 and July 11, 2012. Curiously, in May, Ms. Eggleston insisted to Claimant that he had only undergone a discectomy, and not a fusion. Also, Claimant's recollection of the amount of pain medication he was taking differed from the information in her chart notes. Claimant was taking 12 hydrocodone pills plus 2 oxycodone pills per day, prescribed by Dr. Larson, following his surgery. He believed six hydrocodones plus two oxycodones would be sufficient, but Ms. Eggleston would not refill the oxycodone because it was just for post-surgical breakthrough pain. Ms. Eggleston/Dr. Larson instead prescribed 12 hydrocodones. Claimant tried to go down to six hydrocodones, alone, prescribed by the pain clinic, as he had been taking before his April 2012 surgery. However, this was insufficient to control his pain. When Claimant's pain clinic prescription ran out, he called Ms. Eggleston for a refill. When she learned of Claimant's pain clinic prescription, she was alarmed, but ultimately she advised that Dr. Larson had approved Claimant's refill request.

18. Claimant does not recall Ms. Eggleston performing an examination in either May or July 2012, although her chart note indicates she did.

19. As to the July 11, 2012 visit, the chart note is signed by Dr. Larson, who testified that he performed an examination that day. Claimant, however, testified that he was attended by

Ms. Eggleston, who did not examine him. According to Claimant, he had a conversation with Dr. Larson in the office hallway on July 11, in which he told Dr. Larson that he was doing alright and wanted to get back to full-duty work as soon as possible. On that same day, Dr. Larson wrote to Surety, advising that Claimant was medically stable. Along those lines, Dr. Larson testified:

> I remember a conversation with him where he was very pleased with his situation. In fact, he was somewhat ecstatic about he hadn't felt this good in a long time.
>
> He was only taking three hydrocodone per day, which was less than it had been previously, and he'd been on it chronically. He was hoping to get off of it.
>
> But despite that, I remember telling him, if I do your impairment rating, if they ask me to, be ready. And if you do, you know what they're going to ask for is that you have - - your impairment will likely stay the same, but I'm going to ask that you have maintenance hydrocodone prescribed.

Larson dep., pp. 22-23.

20. On July 16, 2012, Surety requested an impairment rating from Dr. Larson, which he provided via report dated July 20, 2012. Dr. Larson opined that Claimant had not incurred any additional permanent impairment – he still had 6% whole person PPI – and that no medical restrictions were necessary. Dr. Larson further opined that Claimant agreed with his assessment, which Claimant strongly disputes, since Dr. Larson never discussed it with him. Dr. Larson wrote that Claimant was taking three hydrocodones per day, but Claimant recalls that he was still taking six.

21. Claimant found out about Dr. Larson's impairment rating sometime later, when he called Surety wondering when this would be done. He was surprised to learn that Dr. Larson had already addressed this issue. "I told them, 'I have never seen Dr. Larson for an impairment rating, and I have no idea what you're talking about.'" TR-61. Surety provided Claimant with

Dr. Larson's report. "Sure enough, I got the paperwork and it said that I received a zero percent impairment rating and that I was - - I think he puts in there "basically pain-free" or whatever and that I agreed with him. None of that took place." *Id.*

22. Surety paid for the treatment by Dr. Larson. However, it never filed any related notices of change in claim status with the Commission, and issued no summary of benefits paid from the end of November 2011 through July 2012. Defendants confirm that the last indemnity benefit they paid was on July 13, 2012. Claimant filed his Complaint on October 10, 2013.

***CONTINUING SYMPTOMS***

23. A few weeks after he returned to work, Claimant again began to have significant pain in his low back and down his left leg into his buttock and calf. A month or two later, he tried to step up and felt severe pain such that he could not do it. "You know it was really, really weird because I can deal with a lot of pain, and I would have thought that, you know, there wasn't much that could stop you from being able to lift your leg, if you really wanted to, but I couldn't pick it up." TR-64. That evening, he had to drag his leg into his pickup with his hand. The next day, it happened on his right leg. Thereafter, he experienced similar symptoms every two weeks to a month for a day or two. "I remember one particular incident where I was going to step up on the curb to go into the store and my daughter was with me in the pickup, and I just planted it face first in the grass there because I couldn't lift up my leg to step up on the curb." TR 64-65.

24. Around this time (September 2012), Claimant sought treatment at IPC for a deep ache in his left leg that woke him up at night, severe aching in his right thigh to his knee, right leg burning, and numbness in the ball of his left foot and toe. In December 2012, he reported right leg numbness and weakness.

25. Claimant's leg pain, weakness, and numbness in his foot continued. So, in December 2012, he followed up with Dr. Larson. Claimant recalled that Dr. Larson advised that he (Dr. Larson) had not done anything wrong, that Claimant was fine, and that Claimant should make another appointment if he continued to have problems. This greatly frustrated Claimant, so he decided he would never go back to Dr. Larson. "So I went back to work, and I figured that I'll just deal with it. I'll take painkillers, whatever, I'll take muscle relaxers and whatever it is, is what I get, basically. I continued to work that way and I continued to have the pain to deal with." TR-67. Dr. Larson testified that he found no new neurological problems on exam, and scheduled a two-week follow-up. Then, Claimant called and cancelled the appointment, saying he was feeling better.

26. Claimant continued to report and obtain treatment for his symptoms. For example, he reported at IPC that his low back pain was stable in March 2013, and he again planned to wean himself off of his pain medication. However, he developed right leg pain into his ankle and, on exam, he demonstrated a positive straight leg raise prompting his physician to recommend a right steroid injection at L5-S1 and, potentially, a spinal cord stimulator.

***NECK INJURY, SURGERY, LOW BACK SYMPTOMS, AND LEAVE OF ABSENCE***

27. In August 2013, Claimant injured his neck, he asserts, in a separate industrial accident at Swift. Dr. Dirks treated Claimant's neck injury, eventually performing surgery, and he also evaluated Claimant's persisting low back complaints, which Claimant felt increased as his activity level dropped.

28. Claimant was a little sheepish about returning to Dr. Dirks.

> When I went back to Dr. Dirks, I was a little bit embarrassed that I never contacted him, you know. He was supposed to do my back surgery.

> Dr. Larson had told me things that I wanted to hear to the point that I chose him over Dr. Dirks, and so I felt pretty guilty about just leaving him high and dry when he was my doctor, he'd been good to me, he had done a great job in the past.
> …
> I explained to him, you know, what had transpired, and I told him that I was really sorry and that was kind of a shady thing for me to do.
>
> He told me that he didn't blame me whatsoever and that we needed to do something to get my back fixed.

TR 69-70.

29. Following his cervical surgery, Claimant began experiencing bilateral leg symptoms and low back pain that he attributed to lack of movement. Claimant described that his right leg pain "comes across my butt and around the front part of my leg above my knee, and that's something that has been new in the last year or so." TR-88.

30. On November 19, 2013, Dr. Dirks prescribed additional diagnostic care, including EMG nerve conduction testing and an MRI, to investigate Claimant's persisting low back and leg symptoms. Dr. Dirks faxed an approval request to Surety on November 21, 2013. Surety neither denied nor approved the recommendation. Claimant's medical insurance carrier would not cover the costs without a denial from Surety. As a result, Claimant had no immediate coverage for the recommended procedures. Dr. Dirks faxed another request on January 10, 2014. Ultimately, Surety approved coverage for an EMG/nerve conduction study (performed on May 28, 2014) and a low back MRI (taken on June 9, 2014).

31. On January 14, 2014, Dr. Larson evaluated Claimant with respect to his neck injury. However, the purpose of the visit was only clear to Dr. Larson after a fair amount of confusion and a call by him to Surety. In a February 2014 letter responding to questions posed

by Surety, Dr. Larson opined that Claimant "did not demonstrate any low back problems when showing the alleged mechanism of injury to his neck." DE-621. Further:

> In each scenario Mr. Mead noted improvement to the treating physician but then went on to complain of further problems and seek treatment from another surgeon. According to Dr. Dirks [*sic*] recent notes Mr. Mead worsened after the lumbar fusion surgery. The medical records document otherwise. CDA Spine office visit dated 7/11/2012 shows ODI [Oswestry Disability Index] 28 with patient complaining of very little discomfort and no radicular pain. He was taking 3 hydrocodone tablets/day but had been taking hydrocodone chronically for the prior 4-5 years. Muscluloskeletal exam and neurologic exam was normal. The patient himself requested that he return to work without restrictions. It appears Mr. Mead had a similar scenario following the original discectomy performed by Dr. Dirks before he went on to seek further treatment.

DE-621.

32. When questioned about this at his deposition, Dr. Larson expounded upon his recollections from the January 14 cervical spine evaluation:

> A. … In demonstrating to me the - - the degree of acrobatics he could do with his low back and everything else but his neck during that examination to show me how he injured his neck, allegedly, was incredible. And I was sitting there watching and just observing that there's no problem with his low back.
>
> He was on his hands and knees, flipping over a hypothetical board that was on a hypothetical pickup bed, or a bed of some kind, and, you know, turning and twisting each way, and getting on and off the exam table without difficulty, each way and onto his hands and knees, back and forth.
>
> I haven't – I have not – did not otherwise examine his low back in any way since 2012. …
>
> …
>
> Q. Okay. And so with what you observed on January 14th, 2014, this on the ground demonstrating something, did you see any low back abnormalities?
>
> A. No.

Larson dep., pp. 34-35.

33. Brenda Elliff, R.N., attended, observed, and took notes at the January 2014 evaluation (as well as at other appointments) at Claimant's request. In the mid-1990's, Ms. Elliff worked as a nurse consultant for Claimant's attorney. She has many educational degrees and certifications – among them, nurse case manager. She is a solo practitioner nurse consultant contracted by attorneys and insurance companies regarding various medical issues. At her deposition, Ms. Elliff persuasively testified that she did not observe Claimant get onto his hands and knees during the examination. Further, she has never observed a patient get onto hands and knees on the floor during any examination. She explained her recollection of how Claimant demonstrated and described his neck injury to Dr. Larson at the January 2014 evaluation and, later, at an evaluation in July 2014:

> Dr. Larson asked him what was he [*sic*] doing at the time of the injury that he felt caused the pain. So Mr. Mead was sitting in the chair in the exam room. And he described the work history to Dr. Larson. And as he was describing it he would turn his body in the chair to describe it as well as when he was on the examination table. He would lift himself up and turn his whole body to describe the work he was doing. And it had to do with lifting some boards, or a trailer, or moving something heavy.
> …
> And would turn his body in like one plane, like a stiff board, and would show that he would have to have his hands over his head, or above his head. He would put his hands up slightly above his head with his elbows flexed. And then he would describe that he would have to turn the board and he would there again using his legs to kind of turn his body to the other side and say I would have to turn this heavy piece of equipment.

Elliff dep., pp. 17-18.

34. Claimant's primary care provider at Valley Medical Center noted that Claimant was improving in February 2014. He was exercising and trying to stay active. However, his low back pain and right leg symptoms had worsened by May.

35. Claimant next saw Dr. Dirks on June 10, 2014. Claimant still had bilateral leg pain. His EMG/nerve conduction studies demonstrated chronic radiculopathy at L4 and L5 bilaterally, among other things, and his MRI showed what Dr. Dirks thought was the fusion cage backed out into the canal and causing compression. He ordered a plain x-ray and CT scan to further assess this.

36. On June 18, 2014, after undergoing the plain x-rays and MRI, Claimant was again evaluated by Dr. Larson at Surety's request. Following examination and review of Claimant's imaging and EMG/nerve conduction study results, Dr. Larson opined that "there is no further treatment for Mr. Meads [*sic*] low back that will change his outcome. He is at MMI." CE-282. According to Dr. Larson, Claimant had a normal gait, no pain on straight leg raise bilaterally, no pain on Patrick's test, slightly diminished left Achilles reflex, paralumbar region pain at or below his healed incisions, groin pain on external hip rotation bilaterally, normal neurological testing, and normal strength. Dr. Larson opined that the groin pain reproduction on hip pain rotation was the only exam finding that supported Claimant's many complaints. However, on further questioning regarding Claimant's diminished left Achilles reflex, he confirmed that this could evidence S1 nerve root compression:

> Q. And what is the significance of the left Achilles having being [*sic*] slightly diminished?
>
> A. It's an S1 reflex. It isn't - - and there's no clinical significance to that. He's had surgery around that nerve root. There's scar tissue around that nerve root. There was a disk herniation compressing that nerve root in 2008. There's no S1 findings to go along with it, and no clinical significance.
>
> You might - - if you were concerned about it, you might get an image to see if there's compression of the S1 nerve root.

Larson dep., pp. 40-41. Dr. Larson also opined that Claimant's nerve conduction testing was not diagnostic for pain, but only for motor deficits.

37. Claimant underwent a CT scan on July 28, 2014 (see below).

38. On August 5, 2014, Dr. Dirks opined that Claimant's CT scan showed neural foraminal encroachment at L5-S1 and that Claimant's previous surgery was only a fusion and not a decompression. On that day, Claimant again reported back pain and bilateral leg pain, left worse than right. Dr. Dirks recommended conservative treatment. Surety approved physical therapy and steroid injections. By August 7, 2014, Claimant was in physical therapy and had undergone the first of two sets of two injections (one on each side of his spine).

39. At some point, someone from Dr. Dirks' office notified Claimant that Surety had denied further coverage. No notice of change in claim status was filed by Surety. Thereafter, Claimant continued to treat with Dr. Dirks, with coverage by his medical insurance provider.

40. Claimant was anxious to get back to work because his job at Swift would only be held for him for twelve months while he recovered from his neck and back injuries. Ultimately, Claimant was unable to return to his employment, and he was discharged on August 26, 2014. Swift notified him of this fact by letter dated September 18, 2014.

41. Claimant followed up with Dr. Dirks on September 30, 2014. Claimant's first set of bilateral injections had provided him with temporary but significant relief for his leg pain, so Dr. Dirks prescribed another set, which was administered on October 7, 2014. Claimant's strength in his lower extremities was adequate and he was ambulatory, with a slight limp, and possible slight weakness in dorsiflexion. He opined that Claimant was incapable of returning to work because he could not fulfill any job requirements and suggested that Claimant apply for

SSDI benefits. Dr. Dirks attributes Claimant's inability to work primarily to his 2008 industrial low back injury.

42. Claimant's testimony is internally consistent, and it is also consistent with the weight of the evidence in the record. His testimony is not consistent with Dr. Larson's medical records or testimony on certain points; however, the Referee found Claimant's testimony more consistent with the balance of the evidence in the record than Dr. Larson's and, therefore, is more credible with respect to the factual issues on which they differ. Further, Ms. Eggleston did not testify at the hearing. Therefore, Claimant's testimony that no examination was performed during either the May or July 2011 visit is persuasive. Claimant is admittedly not good at remembering the dates on which some relevant events occurred. Otherwise, his testimony is both observationally and substantively credible. The Commission finds no reason to disturb the Referee's findings and observations on Claimant's presentation or credibility.

## DISCUSSION AND FURTHER FINDINGS

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

### *CAUSATION*

44. 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).

45. The claimant has the burden of proving that 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*. A claimant must prove not only that he or she suffered an injury, but also that the injury was the result of an accident arising out of and in the course of employment. *Seamans v. Maaco Auto Painting,* 128 Idaho 747, 918 P.2d 1192 (1996). Proof of a possible causal link is not sufficient to satisfy this burden. *Beardsley v. Idaho Forest Industries*, 127 Idaho 404, 901 P.2d 511 (1995). A claimant must provide medical testimony that supports a claim for compensation to a reasonable degree of medical probability. *Langley v. State, Industrial Special Indemnity Fund*, 126 Idaho 781, 890 P.2d 732 (1995). "Probable" is defined as "having more evidence for than against." *Fisher v. Bunker Hill Company*, 96 Idaho 341, 528 P.2d 903 (1974). An employee may be compensated for the aggravation or acceleration of a preexisting condition, but only if the aggravation results from an industrial accident as defined by Idaho Code § 72-102(18)(b).

46. 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). The Industrial Commission, as the factfinder, 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, 7 P.3d 212 (2000). The Commission can accept or reject the opinion of a physician regarding impairment. *Clark v. City of Lewisto*n, 133 Idaho 723, 992 P.2d 172 (1999). The Commission's conclusions as to the weight and credibility of expert testimony will not be disturbed unless such conclusions are clearly erroneous. *Reiher v. American Fine Food*s, 126 Idaho 58, 878 P.2d 757 (1994). "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, 40 P.3d 91 (2002). Unless a decision to render no weight to a medical expert opinion was clearly erroneous, it will be affirmed. *Id.*

***MEDICAL OPINIONS***

47. Drs. Dirks and Larson are both neurosurgeons, and each performed a low back surgery on Claimant. Each is qualified to render medical opinions in Claimant's case, and each were deposed. Both opined, through the time of the hearing, that Claimant's initial surgery (by Dr. Dirks) and follow-up surgery (by Dr. Larson) were medically reasonable and necessitated by the 2008 industrial injury.[2]

48. Dr. Dirks believes Claimant continues to suffer low back pain and radiculopathy as a result of his 2008 industrial injury, while Dr. Larson does not. Dr. Dirks believes additional

[2] There is insufficient evidence upon which to find that Claimant suffered a subsequent low back injury, and Dr. Larson does not opine that he did. Therefore, Dr. Larson's earlier opinion – that Claimant's fusion surgery was causally related to his 2008 industrial low back injury – is more persuasive than his changed opinion at his deposition.

diagnostic treatment will likely lead to ameliorative treatment – most likely including surgery – that will improve Claimant's condition, while Dr. Larson does not. Dr. Dirks finds Claimant credible, but Dr. Larson characterizes him as a patient who exaggerates his symptoms and who bounces between care providers, bad-mouthing previous ones to each new one.

49. The foundation for each physician's opinion is based largely upon Claimant's imaging studies taken over the years, his 2014 nerve testing, and his clinical presentation. Each physician is verbose and articulate in explaining why his own respective interpretation is correct, and why the other's is not. A brief summary of their interpretations of Claimant's imaging, nerve testing, and clinical presentation follows:

a. Imaging. Claimant had MRIs taken on August 14, 2008 (ordered by NP Norwood), February 12, 2010 (ordered by NP Norwood), October 31, 2011 (ordered by Dr. Dirks), and June 9, 2014 (ordered by Dr. Dirks). He also had a CT scan taken on July 24, 2014, ordered by Dr. Dirks. He had various x-rays, as well. Claimant's imaging was taken without contrast after February 12, 2010 because it was discovered on that date that he is allergic to gadolinium.

· MRI w/o contrast - August 14, 2008 – *Reading radiologist:* "Large disc extrusion at L5-S1 compromising the left descending S1 nerve root very likely related to the patient's radicular symptoms." CE-1. *Dr. Dirks and Dr. Larson agree:* Shows herniated disc at L5-S1 with very minimal disc degeneration throughout the rest of the lumbar spine. X-rays are consistent. Herniation is due to June 2008 industrial accident.

· MRI w & w/o contrast - February 12, 2010 – *Reading radiologist:* "Post-surgical changes at L5-S1 with a very small amount of granulation tissue touching the descending left S1 nerve root. Correlation with radicular symptoms would be warranted. There is no evidence of recurrent disc. There is mild right and moderate left neural foraminal narrowing at this level due to degeneration." CE-8. *Dr. Dirks and Dr. Larson agree:* Severe disc degeneration with some mild recurrent disc and neural foraminal encroachment to L5-S1. Remaining lumbar spine fairly similar to prior imaging. Industrially related.

· MRI w/o contrast - October 31, 2011 – *Reading radiologist:* "Stable as when compared with the preceding exam. Post-op changes at L5-S1 left side. Bulge of annulus at that level out into the left neural foramen more than right, with mild narrowing of that foramen." CE-11. *Dr. Dirks and Dr. Larson agree*: No significant changes from prior MRI.

· MRI w/o contrast - June 9, 2014 – *Reading radiologist:* (Very little detail in this one-page report.) "L5-S1 fusion with some mild neural foraminal narrowing at L4-5 and L5-S1… ." CE-15. *Dr. Dirks:* Central disc bulge at L4-5 and either recurrent disc or scarring on the left with persistent stenosis at L5-S1. It is difficult to determine which without contrast. Claimant's left-sided complaints are consistent with a recurrent disc at L5-S1. Changes at L4-5 with neural foraminal encroachment are presumably due to accelerated degeneration related to the fusion surgery. X-rays taken the next day are consistent with these findings. Opines that the MRI demonstrates that the second surgery was only a fusion and not a decompression. *See* Dirks dep., pp. 21-25 and Exhibits 17 and 19 thereto. *Dr. Larson:* Shows a normal disc at L4-5 (similar to 2008 imaging) and neural encroachment but no recurrent or residual disc herniation or clinically significant stenosis at L5-S1. Agrees that he only did a partial facetectomy, as complete removal was not necessary or prudent.

· July 24, 2014 CT scan w/o contrast – *Reading radiologist:* "1. Posterior lumbar spine fusion L5-S1 noted, hardware appropriately placed, degenerative disk disease and loss of disk space height noted as well. 2. Possible bony encroachment of the neural foramen at L5-S1, especially on the left, recommend clinical correlation for any left L5 nerve root symptoms. 3. At the L4-5 level, mild to moderate neural foramen encroachment is seen, left greater than right, recommend clinical correlation for any L4 nerve root symptoms for significance, especially on the left." CE 18-19. *Dr. Dirks:* Shows severe neuroforaminal encroachment and disc degeneration at L5-S1 bilaterally. Neural foraminal encroachment also at L4-5. *Dr. Larson:* Mild neural foraminal encroachment into L5-S1 space, but no encroachment at L4-5. No nerve compression. *Both:* Discussed and marked on printed images from the CT scan during their respective depositions to illustrate their divergent opinions.

b. EMG/nerve conduction study - May 28, 2014 (ordered by Dr. Dirks). J. Craig Stevens, M.D., a physiatrist, performed the study. He recorded Claimant's symptoms as "pain radiating from the low back into the left buttock with at times dysesthesia noted laterally beyond the knee on the left." CE-12. "He also describes episodic sharp pain within both groins, most apparent if he attempts to rise from a seated position. This can occur on the left or the right side." CE-13. Dr. Stevens concluded,

"Symptoms and physical examination findings are consistent with the demonstrated multiple levels of lumbar radiculopathy as noted." *Id.* *Dr. Dirks:* The study shows bilateral L4 radiculopathy (correlates with the L4-5 area), L5 and S1 radiculopathy (consistent with Claimant's left leg complaints). *Dr. Larson:* The study only evidences chronic findings bilaterally at L4, L5, and S1. The only acute findings were consistent with adhesions in the musculature at Claimant's surgical sites. It also showed ankle reflex absent on the left, which is related to the S1 nerve distribution. The test showed no L5 deficit, which would relate to Claimant's reports of left lateral calf and top of foot numbness, but some L4 and S1 deficit, among other things.

c. Clinical exams. *Dr. Dirks:* Claimant's subjective complaints are supported by objective findings. *Dr. Larson:* Claimant's subjective complaints are exaggerated and not supported by objective findings related to the industrial accident. For example, groin pain is associated with the L3 nerve root.

50. Each party posits reasons why the other is not providing an accurate interpretation of Claimant's post-fusion medical evidence (the CT scan, in particular). Claimant asserts that Dr. Larson is biased against Claimant because agreeing with Dr. Dirks' opinion would require him to also agree that there is a potential problem with Dr. Larson's fusion surgery, which would be contrary to Dr. Larson's own interests, and also because of Dr. Larson's employment relationship with Surety, demonstrated by his retention by Surety to perform evaluations on Claimant before and after the fusion surgery. On the other hand, Dr. Larson opines that the imaging shows no problem with the fusion surgery. He asserts that Dr. Dirks is not reading the imaging correctly because, when Claimant's spinal curvature is

considered, all of the imaging is consistent with a successful fusion surgery with no evidence of residual spinal compression.

51. When considering the weight of evidence in the record, Dr. Dirks' opinion is built upon a stronger foundation than Dr. Larson's and, therefore, is more persuasive on the points on which they differ. Some reasons why:

Dr. Dirks is capable of interpreting a CT scan.

Dr. Dirks relies upon Claimant's reports of persistent symptomatology following relatively brief periods of improvement following his surgeries; whereas, Dr. Larson generally discounts them. Claimant has established that he has experienced persistent low back and left leg symptoms following his 2008 industrial injury, and that he later developed right leg and groin symptoms. Other than with respect to dates, the Referee found Claimant to be a credible witness with a high pain tolerance and a demonstrated desire to continue working. Again, the Commission finds no reason to disturb the Referee's findings and observations on Claimant's presentation or credibility. Contrary to Dr. Larson's opinion, Claimant's testimony regarding his symptoms over time is persuasive and consistent with his medical records. He testified that he improved after each surgery, but never healed to the point where he was asymptomatic. Also, after each surgery, his symptoms gradually worsened. When his low back pain and left leg radiculopathy following his first surgery became too severe, Claimant returned for treatment, which Dr. Larson agreed was reasonable. He did not assert that Claimant was exaggerating, then. Now that Claimant's symptoms have again worsened, this time after Dr. Larson's surgery, Dr. Larson has opined that he is exaggerating. However, Dr. Larson's opinion (based in part on findings of Waddell's signs on one examination in 2014), does not rebut the weight of evidence regarding Claimant's credibility with respect to his symptom reports, including but not limited to

Dr. Stevens' opinion that Claimant's symptoms are consistent with his nerve study results, and the suggestion by the radiologist who read Claimant's CT scan that the imaging may evidence radiculopathy symptoms.

Dr. Larson's opinions appear to be predicated upon a position of advocacy, conscious or unconscious, for Defendants. His testimony regarding Claimant's "acrobatics" during the January 2014 examination is rebutted by Claimant's and Ms. Elliff's testimony, as well as the inference to be drawn from his omission of any mention of these particular observations in his prior reports, chart notes, or letters to Surety, and it is not credible. Also, Dr. Larson reversed his long-held opinion that Claimant's second surgery was required as a result of his 2008 industrial injury based only upon Defendants' suggestion that he had driven a forklift at another job in 2011 and had sought treatment for leg pain. Even though Dr. Larson admitted he did not know whether Claimant had experienced another accident or injury, or what such injury may have entailed, he nevertheless reversed his opinion. This casts doubt upon whether Dr. Larson's opinions regarding Claimant's condition and prognosis were appropriately based on likely medical facts or, instead, were susceptible to suppositions or unquantified possibilities.

Dr. Larson's admission that Claimant has chronic L4 radiculopathy evidenced by his EMG/nerve conduction testing appears to be inconsistent with his opinion that Claimant has no nerve compression at L4-5. Dr. Dirks' opinion appears more consistent with the weight of the evidence on this point.

Claimant is not unreasonably critical of either Dr. Dirks or Dr. Larson. Claimant has returned to both physicians following his surgeries by each. He was unhappy with his treatment by Dr. Larson in December 2012, but his explanation of the circumstances surrounding that visit and his reaction are reasonable. Moreover, Claimant returned to Dr. Larson and cooperated in

subsequent visits arranged by Surety. The record establishes that Claimant's medical condition is difficult, but he is a cooperative patient motivated to improve. Dr. Larson's view of Claimant's character in this regard is unwarranted based upon the weight of evidence in the record. Citing this unsupported fact as a reason why no further treatment is reasonable for Claimant weakens the foundation for his opinion.

52. Dr. Dirks opined:

> When you review everything, clearly Mr. Mead has what I think is neural foraminal encroachment at the L5, S1 area, which just means that the area where the nerves come out from the bones there appears to be bone compressing onto the nerve root. That's at both the left and the right sides. And the L5, 5 [*sic*] area has started to show accelerated degeneration, presumably as a result of the fusion that was done at L5, S1. And probably correlates with a lot of the symptoms that Mr. Mead is currently having.

Dirks dep., pp. 24-25.

53. Dr. Stoutin also supports Dr. Dirks opinion. Dr. Stoutin concluded that Claimant's right lumbar radiculopathy was due to his L5-S1 discectomy. Based on the foregoing, the Commission finds Dr. Dirks' opinion more persuasive. Claimant has established that, more likely than not, his persistent low back pain and his lower extremity radiculopathy symptoms are related to his 2008 industrial injury.

***MEDICAL CARE***

54. Idaho Code § 72-432(1) obligates an employer to provide an injured employee reasonable medical care as may be required by his or her physician immediately following an injury and for a reasonable time thereafter. It is for the physician, not the Commission, to decide whether the treatment is required. The only review the Commission is entitled to make after such treatment has already been rendered is whether the treatment was reasonable. *See Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989). A claimant must provide

medical testimony that supports a claim for compensation to a reasonable degree of medical probability. *Langley v. State, Industrial Special Indemnity Fund*, 126 Idaho 781, 890 P.2d 732 (1995). "Probable" is defined as "having more evidence for than against." *Fisher v. Bunker Hill Company*, 96 Idaho 341, 344, 528 P.2d 903, 906 (1974).

55. The Commission must consider the totality of circumstances in a particular case when determining whether the treatment required or recommended by Claimant's physician is reasonable. *Chavez v. Stokes,* 2015 Op. No. 64 (July 7, 2015).

56. Due to symptoms of low back pain and radiculopathy, Claimant resumed pain management treatment with Dr. Stoutin in October 2011. Dr. Stoutin has conscientiously monitored Claimant's prescription drug use, and has shown her willingness to terminate treatment for non-compliance. Dr. Stoutin resumed her role as Claimant's pain physician, and she treated him, along with other care providers at IPC, through the time of the hearing. Dr. Dirks has recommended further diagnostic and palliative care for Claimant's low back pain and radiculopathy, focusing on the nature and extent of Claimant's nerve damage. Dirks dep., pp. 25-26.

57. Given Claimant's credible testimony that he continues to have symptoms of low back pain and radiculopathy and Dr. Dirks' persuasive testimony that these symptoms are industrially related, the Commission finds Dr. Stoutin's and Dr. Dirks' treatment to be reasonable under the totality of the circumstances. Claimant has shown he is entitled to further reasonable diagnostic and palliative care as recommended by Dr. Dirks and Dr. Stoutin, because Claimant has proven that following his 2012 fusion surgery, he continued to experience low back pain and lower extremity radiculopathy, with objective evidence of nerve compression and nerve damage at the time of the hearing. Claimant is entitled to reimbursement for the diagnostic and

palliative care he received from Dr. Dirks, Dr. Stoutin, and others following July 2012, when Dr. Larson deemed him medically stable from his fusion surgery, through the date of the hearing.

***ADDITIONAL MEDICAL TREATMENT***

58. The next question is whether Dr. Dirks' opinion is sufficient to support a determination that Claimant is entitled to a third surgery. Dr. Dirks has opined that Claimant will likely benefit from a third surgery. However, he was very cautious in his recommendation, calling for additional workup first:

> . . . . I would want to correlate again Mr. Mead, his exam, his history, talk to him again, review the C.T. scan, review the MRI and make certain that we have a reasonable chance of helping him. If it's a flip of the coin, 50/50, I would not do surgery. If it's at least 60, 70, 80 percent chance you are going to provide some benefit to him, you could at least offer that to him as a potential option.
>
> . . . .
>
> And at this time I think Mr. Mead's only hope - - let's say it this way, best hope of recovering function and getting rid of some of the back pain, would be to go in and do a decompression, particularly at the L5, S1 area, but possibly at the L4, 5 area. Again I would have to review those films in conjunction with what Mr. Mead is telling me to give him a chance of recovering function. Because right now the EMGs are indicative of nerve damage. It may be permanent and it may not recover. I don't know. So it's obviously a very complicated case because you have two different surgeons involved. You have lots of different testing that has been done. I think if you take out the two surgeons and you just look at the patient, he clearly has issues in his lower back. … So I think if you are going to give Mr. Mead a chance, you have to contemplate redoing the surgery Dr. Larson did. But is it a guarantee he is going to get better, absolutely not. So that's kind of where we are at.
>
> Dirks dep., pp. 26-27; 25-26/59.

Dr. Dirks is forthright in admitting the difficulties involved in determining whether another surgery is reasonable. If Claimant's nerve damage is permanent, then the proposed surgery will not relieve his symptoms. However, if Claimant's nerve damage is not permanent, then

decompressing the nerves should improve some of Claimant's symptoms. Dr. Dirks recommended further evaluation to make this determination.

59. Unless further evaluation supports a conclusion that Claimant's chances of improving are substantially above 50/50, the proposed surgery is not reasonable. However, Dr. Dirks was not prepared at the hearing to testify as to Claimant's actual chances of improving with surgery or, consequently, whether he presently recommends it. This is because he is not yet convinced that Claimant's symptoms are not the result of permanent nerve damage.

60. Under these circumstances, the Commission finds that Claimant has failed to prove by a preponderance of the evidence that another low back surgery is reasonable. Although it is quite possible Dr. Dirks will endorse future treatment options, including a third surgery, the Commission does not advocate for a particular outcome. Simply, at this point, Claimant has not met his burden of showing that a third surgery is reasonable care.

***NOTICE***

61. Pursuant to Idaho Code § 72-604, where employer "willfully fails or refuses" to file a report as required by Idaho Code § 72-806, the limitations prescribed in Idaho Code § 72-701 and Idaho Code § 72-706 are tolled until such report is filed. Idaho Code § 72-806 requires written notice within fifteen (15) days of any change of status or condition including, but not limited to, the denial, reduction or cessation of medical and/or monetary compensation benefits, which directly or indirectly affect the level of compensation benefits to which the work might presently or ultimately be entitled.

62. The Idaho Supreme Court has held that the word "willful" implies a purpose or willingness to commit the act or make the omission referred to. While it does not require an intent to violate the law in the sense of having an evil or corrupt motive or intent, it does imply a

conscious wrong. It is more nearly synonymous with "intentionally," "designedly," "without lawful excuse," and, therefore, not accidental. It refers to those who purposely, intentionally, consciously or knowingly fail to report, not those whose omission is accidental because of negligence, misunderstanding or other cause. See*, Meyer v. Skyline Mobile Homes*, 99 Idaho 754, 589 P.2d 1240 (1079); *Bainbridge v. Boise Cascade Plywood Mill*, 111 Idaho 79, 721 P.2d 179 (1986).

63. Defendants argue that even in a compensable situation, Claimant's claim for additional indemnity benefits is barred by Idaho Code § 72-706(3). Defendants contend that the Commission's Claims and Benefits Department clarified its policy regarding notice of change of status (NOCS) reports, and did not order Defendants to send out a NOCS report following a review of the Claimant's file in 2009. Defendants assert that the failure to file the NOCS was inadvertent and does not rise to the level of being "willful." Claimant argues that Defendants willfully failed to file a NOCS report between April 29, 2009 and August 21, 2014, and that the statute of limitations is tolled.

64. Misty Coates, claims adjuster, testified on behalf of Defendants. Ms. Coates agreed that Defendants made their last payment to Claimant on July 13, 2012, and that there was a responsibility to send a NOCS following this last payment. Coates dep., pp. 73/12-16. Even though Ms. Coates was not personally assigned to Claimant's case in 2012, Ms. Coates believed that Claimant "had knowledge of the benefits" during the relevant timeframe; she did acknowledge that the case notes were unclear as to whether a NOCS was filed between June 25, 2009 and August 26, 2014. Coates dep., pp. 61/19-63/10; 64/10-65/7. The Commission finds that Defendants failed to file a NOCS report between April 29, 2009 and August 21, 2014.

65. As to "willfulness," Defendants argue that there is no evidence that the failure to file NOCS letters was consciously wrong or in any way deliberate. Defendants also contend that the Commission has changed their interpretation of the law regarding the NOCS, particularly since 2013. Defendants cite the Commission's Claims and Benefits Department's 2014 Guidance Memorandum and a 2009 review of Claimant's file in support of this argument.

66. The Claims and Benefits Department's 2014 Guidance Memorandum was issued *after* an event prompting the need for a NOCS, e.g., Dr. Larson's declaration of Claimant's medical stability in 2012, and could not have influenced Defendants' actions in 2012. Further, the 2014 Guidance Memorandum expressly recognizes that "the failure to provide notice of any change in status which directly or indirectly affects the payment of income or medical benefits will subject the surety to the consequences described in § 72-604, Idaho Code." C. Opening Brief, Ex. 1. Although Defendants are correct that some administrative practices changed with the issuance of the Guidance Memorandum, the statutory requirement to file NOCS letters remains was unaffected.

67. On July 6, 2009, the Claims and Benefits Department reviewed the summary of payments Defendants prepared in Claimant's file, and stamped the file with the following: "File examined and ordered retired: jurisdiction not retained beyond applicable statute(s) of limitations. INDUSTRIAL COMMISSION." DE 14, p. 759. A Commission Claims and Benefits Department employee signed underneath the stamped text.

68. IDAPA 17.02.06.021 requires of sureties that they file a "summary of payment" with the Commission within a time certain following the "termination of disability". This refers to the date upon which "the obligation of the employer/surety/adjuster becomes certain as to duration and amount whether by settlement, decision or periodic payments in the ordinary course

of claims processing". *See* IDAPA 17.02.06.021.01.e. Here, since there has been neither settlement nor decision of the Commission, a summary of payment would be required after the completion of periodic payments in the ordinary course of claims handling, e.g. the completion of TTD or PPI benefits. The purpose of the summary of payment is to allow the Commission to perform the ministerial task of confirming that on the basis of the information provided by employer/surety, benefits have been correctly calculated and paid. The review conducted by the Claims and Benefits department is not an adjudication, nor does approval of a summary of payments foreclose the possibility that additional benefits may be due and owing on a particular claim. The summary of payments is merely a snapshot of surety's unilateral assessment that it has paid what is owed on a particular claim. Just because the Commission gave its approval to the calculation of benefits as calculated by Employer/Surety, this in no wise constitutes an adjudication of Claimant's entitlement to further benefits, e.g. additional periods of time loss, disability over impairment, etc. Moreover, the information which the rule calls for Defendants to provide does not include information about notices of change of status. Therefore, the Commission's approval of the summary of payment at issue does not speak, one way or another, about Defendants' compliance with the provisions of Idaho Code § 72-806. Finally, Defendants put on no evidence tending to demonstrate that the adjuster assigned to this case concluded that a notice of change of status did not need to be filed because of some conclusion she drew from the approved summary of payments. Therefore, the Commission is not persuaded that the approved summary of payments has anything to do with excusing, or explaining, the employer's actions vis-à-vis the requirements of Idaho Code § 72-806.

69. The Commission finds that Defendants' actions were "willful" under the standard explained by the Idaho Supreme Court. Defendants were aware of the legal requirements of

Idaho Code § 72-806 at all times relevant to Claimant's claim. The record indicates that Defendants failed to submit a NOCS when there was a legal responsibility to do so. Pursuant to Idaho Code § 72-604, the statute of limitations is tolled.

***TEMPORARY TOTAL DISABILITY BENEFITS***

70. Defendants argue that Claimant is not entitled to temporary disability benefits related to his low back because he was not operating under any medical restrictions in July 2014. They also posit that Claimant was working full-duty through August 2013, after which he was on leave and no longer performing heavy work, so it is unlikely that his low back condition could have deteriorated to the point that he could not return to work solely due to his 2008 injury and/or 2012 fusion surgery.

71. As addressed, above, the evidence of record establishes the authenticity of Claimant's symptoms over time – he has lived and worked with low back pain and radiculopathy – to some degree, since 2008. However, it is insufficient to establish whether Claimant's condition is permanent and, if it is, when it became so. If Claimant's nerve damage is permanent, then no treatment is likely to permanently improve his condition, so his condition is medically stable. If, instead, his symptoms are the result of current nerve compression, then Claimant may not have been medically stable at the time of the hearing. Because the exact nature of Claimant's symptomatology has not been established, it cannot be determined whether Claimant reentered a period of recovery or, if he did, when he did so.

72. The medical evidence of record is insufficient to establish by a preponderance of the evidence that Claimant reentered a period of recovery following July 2012, when he was deemed medically stable following his lumbar spine fusion surgery. Therefore, Claimant has failed to prove his entitlement to additional temporary total disability benefits.

## CONCLUSIONS OF LAW AND ORDER

1. Claimant has proven that he continues to suffer pain and lower extremity radiculopathy symptoms related to his June 2008 industrial low back injury.

2. Claimant has proven that he is entitled to additional reasonable diagnostic and palliative treatment, as prescribed by Dr. Dirks, and pain management treatment with Dr. Stoutin.

3. Claimant has failed to prove that a third low back surgery constitutes reasonable treatment for his industrially-related symptoms.

4. Defendants failed to submit a NOCS when there was a legal responsibility to do so. Pursuant to Idaho Code § 72-604, the statute of limitations is tolled.

5. Claimant has failed to prove that he had reentered a period of recovery by the time of the hearing; therefore, he failed to establish that he is entitled to additional temporary disability benefits.

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

DATED this 11th day of September, 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 11th day of September, 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:

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__/s/_____