BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

SUSAN D. OAKES, Claimant, v. COEUR D'ALENE SCHOOL DISTRICT #271, Employer, and IDAHO STATE INSURANCE FUND, Surety, Defendants.	**IC 2008-025143** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** Filed March 16, 2015

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Industrial Commission assigned the above matter to Referee Douglas A. Donohue who conducted a hearing in Coeur d'Alene on September 23, 2013. Starr Kelso represented Claimant. H. James Magnuson represented Defendants. The parties presented oral and documentary evidence. Post-hearing depositions were taken. Claimant filed a motion to allow posthearing rebuttal testimony. A telephone hearing on the motion was held July 15, 2014. As described below, the Referee denied the motion. The parties submitted briefs. The case came under advisement on November 4, 2014 and is now ready for decision. 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

According to the Notice of Hearing, the issues are as follows:

1. Whether the condition for which Claimant seeks benefits was caused by the alleged industrial accident;
2. Whether Claimant's condition is due in whole or in part to a subsequent intervening cause;
3. Whether and to what extent Claimant is entitled to benefits for:

    a) Temporary disability;
    b) Permanent partial impairment;

c) Disability in excess of PPI; and
d) Medical care; and

4. Whether apportionment of permanent disability for preexisting conditions are appropriate under Idaho Code § 72-406.

CONTENTIONS OF THE PARTIES

The parties agree Claimant, working as a special education paraprofessional, was injured when an autistic student headbutted her (the "2008 headbutt"). The claim was accepted. She received some temporary disability benefits and medical treatment.

Claimant contends she is entitled to additional medical care, specifically treatment for jaw and dental conditions and for treatment and counselling for traumatic brain injury and psychological injuries, arising from the 2008 headbutt. Consideration of PPI and permanent disability is premature, as Claimant has not reached medical stability. If found to be medically stable, Claimant is totally and permanently disabled as a result of her physical and psychological injuries. Claimant's treating physicians and experts are in a better position to diagnose and opine than are Defendants' experts.

Defendants contend they have paid all medical benefits due Claimant. She is medically stable and rates no permanent impairment or disability. Claimant failed to show that any additional treatment is likely related to the 2008 headbutt. She received reasonable medical care, returned to work for Employer, and worked satisfactorily for more than two years before she was terminated for reasons unrelated to the 2008 headbutt.

EVIDENCE CONSIDERED

The record in the instant case included the following:

1. Oral testimony at hearing of Claimant, Lake City High School special education teacher Tim Buzolich, Canfield Middle School special education teacher Virginia Welton, Canfield Middle School intensive behavior intervention therapist Jacqueline Nichole Wilson, and Coeur d'Alene School District history teacher Tracy Turrell;

2. Claimant's exhibits A through N admitted at hearing;

3. Defendants' exhibits 1 through 41 admitted at hearing (see below for a discussion about exhibit 28 which is admitted as a Claimant's exhibit upon foundation provided by posthearing deposition);

4. Depositions of Claimant's brother Russell Wyatt Oakes, vocational expert Dan Brownell, oral surgeon Darlene Chan, D.D.S., and psychologists Edward Deatherage, Ph.D., and Craig Beaver, Ph.D.

Objections in posthearing depositions are OVERRULED.

After the taking of the posthearing deposition of Darlene Chan, D.D.S., Claimant moved to reopen the record to allow Claimant to offer rebuttal testimony about whether and to what extent Dr. Chan actually examined Claimant. At a telephone conference, upon Claimant's offer of proof that Claimant would deny that Dr. Chan actually examined Claimant, Claimant's motion was denied. Here, finality of the record and timeliness of decision are deemed to outweigh a minor dispute which can be assumed to fall in Claimant's favor without affecting the outcome of this case.

At hearing, Defendants withdrew their proposed exhibit 28, a report by Dr. Deatherage. Claimant objected and requested its inclusion. The Referee held this document pending posthearing deposition testimony by Dr. Deatherage. In their brief, Defendants move to strike testimony of Dr. Deatherage because he is not qualified to offer testimony about psychiatric diagnoses and/or impairment. Defendants' motion to strike is hereby denied; their argument goes to the weight to be assigned to the testimony. The posthearing deposition testimony and exhibit 28 are admitted to the record.

FINDINGS OF FACT

The 2008 Headbutt

1. Claimant worked as a paraprofessional with developmentally disabled children. On July 29, 2008 a boy in middle school headbutted her just under the left eye. She sought

immediate medical treatment and was diagnosed with an orbital fracture.

2. Claimant returned to work in September 2008 for a few weeks. She stopped working about mid-October.

3. Claimant again returned to work in January 2009. She continued to work until terminated in May 2011 for reasons unrelated to the 2008 headbutt.

Initial Medical Care: 2008

4. On July 29 Claimant visited Kootenai Medical Center ("KMC") ER. She reported the headbutt and denied she had been knocked unconscious. David Barnes, M.D., found bruising and a small amount of swelling about the left orbit with tenderness in the left maxillary sinus. He noted her eye, nose, teeth, and jaw were normal. X-ray showed a "possible" orbital floor fracture. Dr. Barnes in the ER note diagnosed an orbital fracture, but in the work release sent to Employer he diagnosed an orbital contusion. He allowed a return to "modified" work effective July 31; the only restriction noted was "avoid further trauma/contact." During her three-hour ER stay a nurse's note expressed concern about Claimant's medication requests; particularly, Claimant reported usually taking two Darvocet per dose. The nurse's concern was that such dose represented an overdose of acetaminophen.

5. On the date of the 2008 headbutt Barbara Daugharty, M.D., was and for years had been Claimant's primary physician, along with Dr. Daugharty's nurse practitioner Valerie Kastens. Most medical notes show a copy of the report of each X-ray, CT scan, MRI, etc., was sent contemporaneously to Dr. Daugharty.

6. On July 31 Claimant was examined by Chad McCormick, M.D. Claimant reported left eye pain with questionable diminished vision, left mid-facial numbness, nausea, and left headache. She denied jaw pain "but feels as if her occlusion may be slightly off."

Her dentist made bite impressions two weeks ago. Exam showed some bruise and swelling below her left eye. "Marginal malocclusion . . . appears to be her native bite." Diminished sensation of the second division of left cranial nerve V. Dr. McCormick's impression: left facial trauma with probable inferior blowout fracture. He recommended a CT scan.

7. An August 1 a CT scan showed a "subtle fracture" with approximately a 2 mm depression.

8. On August 8 Dr. McCormick noted multiple subjective complaints; Claimant was noncompliant about getting an eye exam despite her continuing vision complaints; she claimed memory loss and blamed her failure to heed reminders to obtain an eye exam on that memory loss. On exam Dr. McCormick noted the bruise and swelling were healing.

9. On August 15 Claimant visited Dr. Daugherty in follow-up. Claimant reported residual nausea, dizziness, and "having trouble connecting mentally." Dr. Daugherty examined her, but noted no objective findings.

10. On August 21 Claimant visited KMC ER for a headache which she reported had persisted since the 2008 headbutt. She also complained of nausea, vomiting, and vision change "a little bit." Warren Keene, M.D., examined her eye, nose, mouth, and jaw and found all normal. He noted she reported some mild neck muscle discomfort, but found no objective corroboration. He noted by history a left orbital fracture. He diagnosed a headache and neck muscle strain.

11. On August 26, NP Kastens examined Claimant. She expressly noted Claimant's memory was intact, as was balance and gait. She provided a restricted duty work release.

12. On September 5 a brain MRI was normal. It showed no change from a CT scan taken in December 2007.

13. On September 16 Dr. McCormick noted Claimant had obtained the eye exam which showed no objective abnormality. On exam he found a slight bruise on her lower eye lid. He noted multiple subjective complaints.

14. On September 16 another CT scan of Claimant's face showed no evidence of swelling; the fracture was no longer visible; her jaw and temporomandibular joints (TMJ) were normal.

15. From August 20 to September 10 Thomas Creed, D.D.S., treated Claimant for dental pain. He performed two root canals.

16. On October 14 Dr. Daugharty's office saw Claimant in follow-up. Claimant "is asking for work restrictions." NP Kastens allowed work as tolerated. She was still waiting on a neurological consultation and suggested a visit to an ophthalmologist. She approved a job site evaluation with modification and noted, Claimant "is able to work when her (dizziness, nausea) symptoms are not present, not to run, move quickly. Needs frequent rest periods, no climbing."

17. On October 28 Claimant falsely reported to NP Kastens that "she has not worked at all because the workers comp insurance can not place her in a job with restrictions."

18. On November 11 Daniel Cullum, D.D.S., examined Claimant on referral from Dr. Creed. He found "no gross abnormality" and noted "slight splaying on occlusion with crowding and cross bite of tooth #27." He did not opine about causation.

19. On November 12 Will Fagan, O.D., opined Claimant needed a "mild prescription change." He noted Claimant attributed persisting eye discomfort to the 2008 headbutt and opined that the new prescription "should alleviate" it.

20. On November 20 Linda Wray, M.D., reviewed medical records and examined Claimant at Defendants' request. By history Claimant alleged she had been knocked out by the headbutt and had not returned to work. Claimant endorsed an ongoing history of a number of complaints which were not supported by objective findings at this exam. Claimant's reports of symptoms upon examination were inconsistent with her physical responses and upon repeated attempts at examination. Dr. Wray diagnosed:

1) Left facial contusion, with slight fracture of the infraorbital rim, and contusion of the infraorbital sensory nerve, healed, related to the injury of July 29, 2008.
2) Prior history of migraine, with multiple emergency room visits, preexisting, and unrelated to this industrial claim.
3) Multifocal complaints, without objective findings, no organic diagnosis.
4) Normal neurologic examination.

Dr. Wray opined: "There are no objective findings on clinical examination or imaging studies to support her multiple subjective complaints." She opined Claimant was medically stable; no further treatment was necessary; no permanent impairment related to the 2008 headbutt; no work restrictions should be imposed.

21. On November 24 Claimant visited a Montana hospital ER after a car accident. A spine X-ray showed something the radiologist termed a T11-12 end plate irregularity from childhood but the ER physician termed a suggested minimal compression fracture. A knee X-ray showed degeneration in her left knee. A pelvic X-ray showed no fracture.

22. On November 29 Claimant visited KMC ER in follow-up to the car accident, seeking additional analgesics. Anthony Russo, M.D., examined her. He noted she reported cervical and thoracic paraspinal muscle tenderness without objective findings. His exam also noted, "HEENT: Normocephalic and atraumatic. . . . Cranial nerves intact."

23. Claimant continued frequent visits to Dr. Daugharty's office for various complaints.

24. On December 4 thoracic and lumbar X-rays were normal, noting prior longstanding findings.

25. On December 12 a pelvic X-ray was normal.

26. On December 22 a lumbar MRI was "unremarkable," with some mild degeneration at T11-12 and the longstanding scoliosis.

Medical Care: 2009

27. On January 5 NP Kastens, with a checkmark, agreed with the opinions of the November 2008 IME.

28. On January 21 Claimant reported to NP Kastens that she felt able to work. NP Kastens' examination showed concerns about lingering spinal complaints. Multiple follow-up visits to Dr. Daugharty's office in the Spring focused on back pain complaints arising after the November 2008 car accident rather than to complaints from the 2008 headbutt.

29. Claimant visited KMC ER on March 25 and April 15. Medical records do not suggest any physician linked those complaints to the 2008 headbutt.

30. On March 13 Jeffrey McDonald provided a neurosurgical consultation for persistent low back and hip pain from the November 2008 car accident with exacerbation arising recently at work. A lumbar MRI was normal.

31. A March 25 CT head scan was normal.

32. On March 17 and April 10 Clamant underwent bilateral SI joint injections for pain.

33. On April 20 Dr. McDonald provided a neurosurgical follow-up for bilateral hip pain. X-rays were normal.

34. On June 9 Dr. Daugharty's office examined Claimant's left hand. X-ray showed no fracture. Claimant complained about lingering symptoms from the 2008 headbutt. NP Kastens recorded, "I explained she has had a neurological workup throught [sic] her workmans comp, that her symptoms are subjective and I see no objective evidence so she should seek out a specialist to further eval."

35. On July 10 William Boggs, D.D.S., at Willamette Dental examined Claimant's teeth. He noted "discomfort is involving premaxilla area and is too indiscrete [to] be of dental origin." In a later report he linked her pain with sinus infection. Neurologic consultation was recommended.

36. On November 3 Claimant first visited Edward Deatherage, Ph.D., for psychological counseling. Dr. Deatherage is not licensed to practice psychology or counseling in Idaho, but counsels clients under a religious exemption waiver. At the initial visit, Claimant noted "Blue Cross" should be billed. Claimant attended essentially weekly counseling sessions until late March 2010. They met less frequently thereafter. Dr. Deatherage's notes do not clearly separate his opinions from Claimant's reports. For example, a 4/27/10 visit notes PTSD from the car accident as well as the 2008 headbutt; from it one cannot discern whether this is Claimant's belief or Dr. Deatherage's opinion.

37. On December 2 X-rays of Claimant's knees showed some left knee degeneration. Dr. Daugharty's (or her nurse practitioner's) handwritten note on this report identified "pseudo gout." An ultrasound of Claimant's knee was normal.

38. On December 14 Claimant visited Kootenai Urgent Care for finger pain which she related to an April 1 injury. A complete examination including a neurological and psychological assessment found no abnormalities. An X-ray showed no fracture of the left hand.

Medical Care: 2010—Present

39. On January 5, 2010 Claimant visited Kootenai Urgent Care for sinus congestion. Diagnosis: sinusitis.

40. On January 29, 2010 Peter Jones, M.D., provided a consultation for Claimant's hand injury from May 2009. Upon examination Dr. Jones found a positive grind test, Tinel's, and Phalen's signs. An X-ray showed posttraumatic degenerative changes. He diagnosed posttraumatic arthritis with some evidence of carpal tunnel syndrome. He noted that Claimant seeks surgery. Surgery was performed February 10, 2010.

41. On June 1, 2010 Dr. McCormick examined Claimant for ongoing left facial pain and dental pain; he noted multiple complaints in reviewing her systems. Upon exam he noted no objective findings: "Her symptoms are not completely consistent with trigeminal neuralgia."

42. Claimant visited KMC ER on July 23, 24 and 26, 2010. Michael Ettner, M.D., examined her, noted diffuse abdominal tenderness with no objective findings. He noted she appeared anxious and expressly included "No mental illness" in his note. X-rays were normal except that her longstanding lumbar scoliosis now showed some degenerative changes. Subsequent visits reported nothing new. A CT of her abdomen and pelvis was consistent with prior normal CT scans.

43. On August 6, 2010 Claimant underwent a colonoscopy. Dr. Toelle opined it normal.

44. On August 18, 2010 Claimant underwent a gastroscopy. Dr. Toelle opined it normal, except for a small hiatal hernia and diffuse erythema.

45. Claimant visited KMC ER on August 23, 2010. She attributed her persistent abdominal complaints to eating fried oysters on July 28. This represents her first such mention of the event in medical notes. She also complained of having fainted three days ago. "She was informed that the anxiety was possibly responsible for a large proportion of her symptoms."

46. On August 24, 2010 Claimant visited Dr. Daugharty. Among multiple complaints, she reported a seizure with loss of consciousness. Dr. Daugharty examined her and noted no objective findings. Dr. Daugharty noted Claimant had suffered a head injury in the last year, ordered a neurological consultation and a CT scan.

47. On August 25, 2010 another CT scan of Claimant's head was normal.

48. On August 26, 2010 Claimant underwent a pharyngeal dynamic study. Dr. Daugharty noted a single episode of transient laryngeal penetration during swallowing which was not repeated with additional swallowing, otherwise normal. A chest X-ray was negative.

49. Chiropractic notes show treatments from July 14 through September 1, 2010 for complaints including TMJ, neck, right arm, lower lumbar, headaches, and face pain separate from her jaw. On examinations, Charles Swayze, D.C., also found complaints and treated her thoracic spine, trapezius, and rhomboids. At the September visit, Claimant complained she was worse than when chiropractic treatments began. This comment is inconsistent with the up to "2%" improvements Dr. Swayze recorded after earlier visits.

One more chiropractic treatment occurred on March 21, 2011 after Claimant was wrestling with her son.

50. Claimant underwent an EEG on September 3, 2010. James Lea, M.D., opined it normal but for beta activity related to sedative medication.

51. Also on September 3, 2010 Claimant underwent an esophagram. It showed some reflux.

52. On September 13, 2010 Claimant visited Kootenai Urgent Care for a cough. No objective findings on exam except nasal congestion. Sinusitis was the diagnosis.

53. On October 27, 2010 Claimant visited KMC ER complaining of chest pain worsening with jaw movement. An EKG was normal. A chest X-ray was suggestive of chronic obstructive pulmonary disease.

54. On December 22, 2010 Dr. Jones performed a surgical excision of DuPuytrens contracture of Claimant's left index finger.

55. On March 8, 2011 Claimant visited KMC ER for chest pain. The examination showed no objective findings. An EKG and X-rays showed no abnormality.

56. On March 10, 2011 Claimant visited Sacred Heart ER for chest pain. No objective findings were reported on examination. An EKG and X-rays showed no abnormality.

57. On March 25, 2011 Claimant visited KMC ER for chest pain radiating into her jaw. Her examination showed no objective findings. An EKG, X-rays, and CT of her abdomen were normal.

58. On May 10, 2011 Claimant visited KMC ER for chest pain radiating into her jaw. Her examination was negative. An EKG and X-ray were negative.

59. On June 7, 2011 X-rays of Claimant's abdomen were "unremarkable."

60. On June 8, 2011 an ultrasound of Claimant's abdomen was normal. Oddly, it reported Claimant's gallbladder as normal and made express findings. Claimant's gallbladder was removed years before.

61. On June 14, 2011 Claimant visited KMC ER for right-sided abdominal pain. Dr. Ettner considered questionable the possibility of whether she had a urinary tract infection and prescribed medication. A CT urogram showed scattered diverticuli without diverticulitis and some spinal degenerative changes, otherwise normal. Dr. Ettner cut off receipt of pain medications sought through the ER and referred her to her primary physician, Dr. Daugharty.

62. On June 19, 2011 Claimant visited KMC ER for right side pain. Chest X-ray was negative with some gas present. Urinalysis was positive for urinary tract infection, still present despite medication since her last ER visit.

63. On July 11, 2011 Claimant visited KMC ER for right upper quadrant pain. Her examination was normal, her chest X-ray negative.

64. On July 18, 2011 an ultrasound looking for a hernia failed to find one.

65. On August 1, 2011 Claimant visited Kootenai Urgent Care for nasal congestion. An examination noted she reported tenderness about her maxillary sinuses, but made no objective findings. Sinusitis was the diagnosis.

66. On September 28, 2011 Claimant's last visit to Dr. Daugharty's office was recorded. Claimant's subsequent involuntary psychiatric admission and threats against Dr. Daugharty prevented further contact.

67. On March 19, 2012 Claimant visited KMC ER for a cough with rib pain for one month. A chest X-ray showed no rib fracture and was normal.

68. On May 18, 2012 Claimant visited KMC ER stating, "I need to be admitted to the hospital, or I might kill myself." She attributed complaints to the 2008 headbutt. (The ER history noted she misidentified it as occurring in 2007.) She reported no specific symptoms, but generalized pain. Her examination showed COPD and "body habitus is consistent with a chronic emphysematous-type smoker" but otherwise made no objective findings; "HEENT: Head is normocephalic. . . . Tympanic membranes are normal. Oral cavity is unremarkable." An EKG was normal. Lab data showed "[no] remarkable abnormalities." A toxicology screen showed positive for marijuana. Claimant was admitted to Kootenai Behavioral Health unit.

69. On May 21, 2012, Dr. Ettner cleared Claimant for involuntary admission to Kootenai Behavioral Unit. He noted Claimant's assertion linking her condition to the 2008 headbutt (again inaccurately represented as occurring in 2007.) Claimant alleged she was "markedly disabled" and suffers from PTSD. She threatened that if she committed suicide she would take her primary physician, Dr. Daugharty, with her. Physical findings on examination were negative but for a urinary tract infection. She was diagnosed with "depression/suicidal with homicidal statements."

70. A July 2, 2012 note from nurse practitioner J. Roye Ely requests Claimant be allowed to keep her companion dog with her. Notes of treatment visits with Nurse Ely are dated November 7 and December 28, 2012, and January 23 and July 8, 2013.

71. Admitted as a psychiatric inpatient from May 21 through 30, 2012 Claimant was primarily treated by Nicole Carlberg. Records identify her as a "D.O." or "M.D." within the same document. Dr. Carlberg provided significant attention and psychiatric care. Upon discharge, Dr. Carlberg noted, "I do not see symptomatology associated with a posttraumatic

stress disorder. I do, however, see symptomatology associated with a generalized anxiety disorder at this time, which is not inconsistent with somebody who has been exposed to a traumatic incident."

72. On October 12, 2012 Claimant visited KMC ER. She reported having been punched in the nose by a frightened customer at Silverwood Theme Park's Halloween offering. She reported her nose did not bleed; her jaw was "a little sore" but without malocclusion. An examination was normal and showed no evidence of trauma. Expressly noted by the physician to have been taken as a precaution in anticipation of litigation, an X-ray showed no nasal fracture.

73. On November 15, 2012 Claimant visited KMC ER for leg pain. An examination showed no objective findings. Ultrasound of the leg was normal.

74. On December 26, 2012 Claimant visited KMC ER. An examination showed no objective findings. Chest X-rays were normal.

75. A September 18, 2013 Millon Clinical Multiaxial Inventory—III ("MCMI—III") report is of record as a separate exhibit. It expressly cautions that clinical correlation by an expert is required to interpret its findings.

Prior Medical Care

76. Medical records beginning October 1989 show Claimant sought medical attention for multiple conditions and symptoms, often at hospital emergency rooms and urgent care facilities, often without objective findings upon examination, as follows:

> 10/17/89 KMC ER: low back pain after lifting patient at work six days ago. X-ray showed lumbar scoliosis. Diagnosis: possible lumbar strain. 10/20/89 office follow-up: better, work release given.
>
> 10/3/90 KMC ER: Knee and ankle pain after injury while hiking. X-rays normal. Diagnosis: ankle sprain, possible medial meniscus injury.

3/12/92 KMC ER: Twisted ankle while walking dog. X-ray normal. Diagnosis: ankle sprain.

7/27/92 KMC: Twisted right ankle. Some swelling. X-ray normal.

9/27/92 KMC ER: Mid-back and left side pain without history of trauma. Chest X-ray normal. Diagnosis: bronchitis.

4/3/95: impacted wisdom teeth removed.

9/14/95 KMC ER: abdominal pain, right lower quadrant radiating into leg. Diagnosis: possible ovarian cyst.

9/14/95 KMC ER: patient returns with persistent pain. No history of trauma. Diagnosis: uncertain cause for pain.

9/15/95 KMC ER: ultrasound normal. Pain has moved from front of leg to back of leg. Diagnosis: follow-up visit for pain.

12/12/95 KMC ER: tripped on carpet at work, ankle pain. X-rays normal. Diagnosis: Right ankle sprain. At a 1/11/96 follow-up exam Claimant was released to full duty.

9/28/96 KMC ER: worried about meningitis exposure, headache, photophobia, sore throat, generalized malaise for 5-6 days. Lab data normal. Treatment: reassurance given. Diagnosis: viral syndrome.

4/30/97 KMC ER: wrist pain after doing back handsprings. Exam: tenderness, subjective loss of motion, no objective findings. Diagnosis: bilateral tendinitis of hands.

5/21/98 KMC ER: left hip and buttock pain persists four months after a fall; increasing discomfort radiating into leg to toes for the last two days. Exam: exquisite tenderness, no objective findings. X-rays normal. Diagnosis: Contusion, four months old, with sciatica symptomatology.

1/12/00 Dr. Daugharty: vascular headaches, daily, since adolescence. "Possible myofascial pain syndrome with chronic low back pain. Doubt that she has fibromyalgia."

From 2001 forward Dr. Daugharty regularly monitored Claimant's lab data and gynecological care. These records do not contribute to analysis of any aspect of this claim. Although not separately summarized here, multiple visits for headache or abdominal pain are also of record.

1/12/01 James Lea, M.D.: neurological referral for headaches. History of headaches associated with nausea and vomiting. She noted recent job as teacher's aide and florescent lights at work. Exam normal. Diagnosis: migraine. Occasional follow-up visits to July 2001.

2/28/01 KMC ER: upper abdominal pain with bloody stool. Lab confirmed trace blood in stool. Diagnosis: question etiology. Consultation by Stanley Toelle, M.D.: suspect ulcer, hemorrhoids. (3/2/01) Colonoscopy showed internal hemorrhoids, distal polyps, occasional diverticula; Gastroscopy showed two 8 mm ulcerations.

3/20/01 Dr. Toelle: pathology report of stomach biopsy showed gastritis, possible ulcer without helicobacter.

5/24/01 North Idaho Imaging Center ("NIIC"): normal ultrasound upon complaint of epigastric pain.

6/1/01 NIIC: upper GI/SB for epigastric pain normal

6/14/01 KMC: CT of abdomen normal. Dr. Toelle performed gastroscopy with biopsy. Impression: "Nothing on this exam would account for her symptoms." Sigmoidoscopy shows internal hemorrhoids.

6/29/01 NIIC: Pelvic ultrasound found one fibroid cyst, 4 cm. in size.

7/5/01 North Idaho MRI: MRI of abdomen "normal exam except for very small left, tiny right pleural effusions."

7/27/01 KMC: radionuclide gallbladder scan: gallbladder not seen, "nonspecific and could be related to either acute or chronic cholecystitis."

August 2001: gallbladder removed (operative report not found).

8/15 and 8/27/01 NIIC: bloody discharge from right nipple not confirmed on X-ray, ultrasound, or mammogram.

8/28/01 KMC: biliary colic. ERCP showed a pair of tiny air bubbles vs. small stones in distal common bile duct. Surgery identified "Two separate 2 to 3-mm distal common bile duct filling defects." Dr. Toelle noted these were "consistent with small stones."

9/20/01 NIIC: headache. CT of head normal.

10/31/01 KMC ER: lifted student, hurt back. X-ray of T-spine showed "Schmorl's nodes at T11 and T12 with slight loss of disk space height and some mild scoliosis." Diagnosis: Trapezius strain/spasm. Claimant filed a workers' compensation claim.

11/8/01 KMC ER: slipped, injured left foot about 10 days ago. Exam: "remarkable tenderness" but no objective findings. X-rays normal. Diagnosis: left foot sprain.

3/15/02 Dr. Daugharty's office: Complaints of right ear pain, face pain, and teeth pain. Diagnosis: sinusitis.

3/18/02 KMC ER: dizziness, headache with recurrence; she believes related to propane exposure. Exam normal. Diagnosis: migraine headache after fume exposure.

4/10/02 KMC ER: headbutted twice, then grabbed by hair and neck twisted by autistic child at work (the "2002 headbutt"). Complaints of short-term memory loss, nausea, vomited once. Exam: tenderness and swelling at bridge of nose; no hematoma, mild neck tenderness. X-rays of neck normal. Head CT normal. Diagnosis: Closed head injury; clinical nasal fracture. Claimant filed a workers' compensation claim.

4/13/02 KMC ER: headaches persist with "vague visual complaints." Exam noted forehead tenderness but no objective findings. Diagnosis: post-concussive syndrome.

4/18/02 KMC ER: headaches continue with blurry vision and dizziness. Exam: normal. "She felt that she was told that she had swelling of her brain. I indicated to her that I felt that that was incompatible with outpatient care on initial injury." Treatment: medication and "encouragement."

5/09/02 KMC ER: daily headaches, dizziness, slowed thinking, general malaise. Exam normal.

5/18/02 KMC ER: autistic student struck her on left forearm; she fears pain may be more significant than a contusion. Exam normal. X-ray normal. Diagnosis: contusion. Claimant filed a workers' compensation claim.

6/26/02 NIIC: breast lumps. X-ray and ultrasound show benign.

8/20/02 KMC ER: recurrent headaches with nausea and photophobia. Exam normal. Diagnosis: headache.

10/14/02 KMC ER: headache with nausea and photophobia. Exam normal. Diagnosis: headache.

10/25/02 KMC ER: 3rd grader tried to bite her, scratched her knuckle, she wants a tetanus shot. Exam: abrasion. Tetanus shot given. Claimant filed a workers' compensation claim.

3/9/03 Dr. Lea: right lower rib discomfort, symptoms suggestive of shingles but without rash. Conservative treatment with Neurontin. 4/9/03: Dr. Lea refused to further treat Claimant based upon her noncompliance.

4/18/03 KMC ER: abdominal distress after eating tacos; history of "fibromyalgia" (quotation marks in original). Exam: appears uncomfortable, epigastric tenderness, no objective findings. Lab data showed slightly elevated lipase. Diagnosis: gastritis, fibromyalgia.

4/18-25/03 KMC ER: patient returns. X-rays nonspecific. White count up a bit. Admit for observation. She reports having been hospitalized in Salt Lake City three days ago for partial bowel obstruction, gastroscopy without findings, got better. Earlier-reported lipase elevation now normal. Diagnosis: gastroenteritis, fibromyalgia. During admission, pain migrated to pelvis. Gynecological consult. Multiple imaging tests: normal, with preexisting fibroid cyst. Exam inconsistent with fibroid as cause for pain. Gynecologist's diagnosis: possible resolving small bowel obstruction versus mild pancreatitis. Procedure: endoscopy, findings all normal. Discharge diagnosis: gastroparesis.

6/5/03 KMC ER: abdominal cramping with vomiting and diarrhea. Exam: vague tenderness, no objective findings. Treatment: "reassured and released."

6/13/03 KMC: pelvic pain, cyclic. Surgery: given cancer risk, prophylactic hysterectomy and salpingo-oophorectomy performed. No malignancy seen.

3/27/04 KMC ER: abdominal cramping. Exam and lab data normal.

10/24/04 KMC ER: right nipple pain with radiation into neck. Exam: no objective findings.

12/8/04 KMC ER: abdominal cramping with nausea, constipation. Exam: tenderness, no objective findings. X-rays normal.

12/15/04 Dr. Daugharty: facial pain, cold symptoms. Diagnosis: sinusitis.

2/8/05 KMC: Stress echocardiogram. Normal.

2/28/05 KMC: Stress Echo. Same findings as 2/8 test.

3/4/05 KMC ER: chest pain. Exam: normal. Chest X-ray: normal. Diagnosis: noncardiac chest pain.

*2/8/05 KMC: Echocardiogram. Stress test, met heart rate goal without chest pain. Normal results, no ischemia. (*Based upon dates of dictation (3/30), transcription (3/30), and authentication (4/5), compared to a pattern of prompt dictation, transcription, and authentication in other KMC records, this test possibly was performed later than the stated date.)

5/3/05 KMC ER: abdominal pain. Exam: tenderness in right upper quadrant, less so in right lower quadrant; otherwise normal; no objective findings. Lab data nondiagnostic. No evidence of appendicitis. Cautioned about Lortab usage exacerbating irritable bowel syndrome. "The patient became somewhat upset at this suggestion and was insistent that this discomfort is not related to her irritable bowel syndrome."

5/5/05 Timothy Quinn, M.D.: "She left the office somewhat upset that I was not going to take out her appendix."

5/8/05 KMC ER: intermittent right side pain; does not want to wait for scheduled colonoscopy (5/12), seeks admission for gastrointestinal consultation. Exam objectively normal. Not admitted, sent home.

5/12/05 Dr. Toelle: colonoscopy showed no new findings.

10/13/05: Willamette Dental: crossbite identified. Bridge recommended.

1/11/06 KMC ER: right sided abdominal pain, vomiting, diarrhea. Exam: abdominal tenderness, no objective findings. CT scan abdomen and pelvis: no appendicitis, small amount of free fluid in right pelvis.

1/15/06 KMC ER: Chest pain woke her, shortness of breath, nausea, diaphoresis, a novel sensation for her, pain radiating to right shoulder. EKG normal. Pain worsened despite nitroglycerin treatment. Admitted overnight for coronary care observation. Enzymes and EKGs normal. Exam: mild right lower quadrant discomfort, otherwise normal.

1/23/06 John Pennings, M.D.: exploratory laparoscopy with biopsy and appendectomy.

2/22/06 KMC ER: struck hand at work on coworker's elbow. Exam: Right hand tender and swollen. X-ray normal. Diagnosis: Right hand contusion, acute. Claimant filed a workers' compensation claim.

5/18/06 KMC ER: persistent left foot pain. Kickboxing a bag. No bruise. Exam: tenderness at mid-foot at the base of the metatarsals, mid-tarsal zone and arch, small amount of swelling. X-ray declined. Diagnosis: strain and contusion.

10/10/06 Daugharty's office: headache, facial pressure. Diagnosis: sinusitis.

9/7/07 KMC ER: chest pain, onset nonexertional. She has noticed decreasing exercise tolerance and increasing shortness of breath, radiation into arm and back. Arrived by ambulance; nitroglycerine administered; complete resolution upon arrival. Exam normal. EKG nondiagnostic, normal. X-ray normal. Discomfort resumed. Diagnosis: coronary syndrome; unstable angina. Admit. Claimant filed a workers' compensation claim.

9/7/07 KMC: admit from ER. Exam: hyperlipidemia. EKG: sinus bradycardia. Diagnosis: symptoms suggestive of myocardial ischemia, with prevalent family history. Cardiologist consult: angiogram, heart catheterization, ventriculography, arteriography. Diagnosis: early stage coronary disease; chest pain noncardiac.

10/30/07 KMC: cough, chest pain. Pulmonary function test shows clinical diagnosis of asthma. Chest X-ray normal.

12/22/07 KMC ER: headache, nausea, vomiting, blurred vision, "feels stoned," used chemical called "Goof Off" for 3 days. Exam normal. Narcotic injection given at patient's request; she stated, "Pills will not work." Diagnosis: unclear etiology of dysphoria and headache; possible mild toxic chemical exposure.

12/23/07 KMC ER: headache, also tinnitus, blurred vision. Forgot to report at yesterday's ER visit that last Thursday she was hit in the head by a basketball. Requesting pain medications. Exam normal, no evidence of trauma. CT head normal.

4/12/08: Claimant reported a hip injury after bumping it while coaching children's gymnastics. Claimant filed a workers' compensation claim.

6/24/08 KMC ER: face hurts; 10-year-old son (actually, per her deposition, her grandson) threw a baseball two days ago. Pain under right eye persists. Mild nausea. "WAS KNOCKED UNCONSCIOUS THOUGH WHEN IT HAPPENED, BUT DOES NOT KNOW HOW LONG." (all caps, ours). Exam: bruise, very tender; no neurologic symptoms. CT scan normal, some mucosal thickening. Diagnosis: right facial contusion.

77. These records further indicate Claimant has upon occasions reported a history of conditions, including fibromyalgia, irritable bowel syndrome, and small bowel obstructions. Later, some physicians have adopted these "diagnoses." No physician of record made an

original diagnosis of any of these conditions prior to Claimant's representations of having been previously so diagnosed.

78. These records refer to a history of depression, anxiety, and hyperlipidemia. Lab data supports lipids rising over time.

79. These records show Claimant alleged she was attacked by school children on at least three occasions prior to the 2008 headbutt. The records do not indicate whether she ever failed to seek emergency room treatment after contact by a student.

80. In deposition Claimant reported a history of sensitive teeth and tooth removal requiring bridgework before the 2008 headbutt.

Vocational Factors

81. Claimant did not graduate high school, but obtained a GED. She has since obtained an A.A. degree in human services and a one-year certificate as a mental health technician. She has a certified nurse's assistant ("CNA") certification.

82. For most of Claimant's adult life she has worked with children with developmental disabilities. She has also worked as a school lunch worker, "outside duty," substitute teacher, CNA in home health care, as a spray tanning technician, and cheerleading and gymnastic coach. She has worked retail during Christmas shopping seasons and as a mall Santa's helper. She worked as a laborer for a tile company the summer of 2008.

83. Claimant's work at various positions with Employer since 2002 shows she was well liked by coworkers. Among supervisors, opinions of her work are somewhat more variable.

84. Claimant was allowed to return to work by Dr. Barnes almost immediately after the 2008 headbutt. About one month later, on August 29, 2008 Dr. Daugharty restricted Claimant to light duty, no lifting over 20 pounds, no climbing, no prolonged standing; these

restrictions seem to arise as a result of Claimant's ongoing complaints—particularly of nausea and vomiting—which are of an uncertain relationship to the injury. On October 10, 2008 NP Kastens recommended continued modified duty work when Claimant's dizziness and nausea were present. She recommended neurology and ophthalmology consultations be performed soon.

85. By September 3, 2008 Claimant had returned to work for her normal six-hour shifts; some absenteeism occurred, a little more than once per week, until October when she began to work less. She stopped working about mid-October but remained on the schedule for at least another two weeks.

86. On September 4, 2008 ICRD began providing services. She was then working for Employer at modified duty. On February 9, 2009 upon opinions of stability without restrictions from Dr. Wray and Claimant's 30-day return to work for Employer, ICRD services were discontinued.

87. On December 26, 2008, Surety discontinued TTD benefits based upon Dr. Wray's evaluation and opinion that Claimant had reached medical stability and required no restrictions.

88. Claimant's prior attorney for this workers' compensation claim notified Employer of his representation on January 15, 2009. He visited Dr. Daugharty's office on January 28. He sent notification of his withdrawal from representation on February 2. The Commission makes no findings related to any implications associated with these facts.

89. Claimant again worked for Employer beginning January 2009 and continued until terminated for an event occurring in May 2011. She earned $12.57 per hour on a 30-hour work week at termination.

90. In her 2012 application for Social Security Disability, Claimant alleged her disability began July 10, 2010.

91. On July 9, 2013 Robert Cornell performed a vocational evaluation at Mr. Brownell's request. Mr. Cornell's data was neither self-explanatory nor well explained; the data appear subjective. Mr. Cornell concluded that the evaluation, her postaccident vocational history, and anxiety problems indicate Claimant is likely unemployable. In follow-up correspondence to Claimant's attorney apparently faxed on September 17, 2013 Mr. Cornell responded to some of Dr. Beaver's and Dr. Deatherage's comments. He softened his opinion slightly by stating that Claimant might work part time for a "very understanding and flexible employer."

92. On September 13, 2013 Mr. Brownell provided a vocational evaluation. Giving greater weight to the opinions of Drs. Creed, Deatherage and Mr. Cornell, he opined Claimant was unemployable and attempts to seek work would be futile unless Drs. Creed and Deatherage are allowed to treat her further. Mr. Brownell is not shown to have the qualifications to choose which physicians are more believable or right. In his report and deposition, Mr. Brownell does not well explain the underlying facts and bases for his opinions. Rather, he relies upon a resort to his general knowledge and authority. It is difficult to assign significant weight to such opinions.

Medical Opinions

93. An undated, unsigned document (Defendants' 25, page 647) purportedly received from Willamette Dental refers to Surety "dragging its feet" as noted in posthearing briefs. It goes on to expressly note "we are not able to identify source of pain."

94. On October 2, 2008 Thomas Creed, D.D.S., noted: "Susan Oakes is in pain from injuries sustained on July 29, 2008. Upon review I feel that the pain is such that she is unable to fully function in the duties of her job until further treatment to stop the pain is completed." On October 29, Dr. Creed summarized his treatment of Claimant which began one month postaccident. He reported the two root canals and Claimant's continued pain complaints. He opined he was "at a loss to explain these pain symptoms." On January 31, 2011 without further records review or examination and upon a summary of history provided by Claimant's attorney, Dr. Creed, with a checkmark, signaled his agreement with the proposition that Claimant suffered TMJ dysfunction which probably was caused by the 2008 headbutt. In undated correspondence "to whom it may concern" Dr. Creed again opined TMJ syndrome was caused by the 2008 headbutt based upon Claimant's reported history and the absence of recording TMJ problems when he examined her in 2005.

95. On July 29, 2009 Dr. Boggs reported to Dr. Daugharty about his July 10 examination. He opined Claimant's tooth discomfort was "too indiscriminate and involves normally appearing tissues to be comfortable attributing to tooth origin." He cautioned against tooth extraction.

96. On October 9, November 2 and 18, 2009 neuropsychologist John Wolfe, Ph.D., evaluated Claimant upon referral from Claimant's primary physician, Dr. Daugharty. By history, Claimant reported that after the 2008 headbutt, she fell and hit her face on the floor. She reported she suffered an orbital blowout fracture. She denied any previous losses of consciousness. She reported she had quit smoking for 15 years but resumed after the 2008 headbutt. Dr. Wolfe interviewed Claimant and administered a battery of psychological tests. Testing suggested some caution about validity and effort. Her performance on testing

was below that expected for her education and career experience. Her pattern is inconsistent with traumatic head injury. Depression is consistently indicated.

97. On January 20, 2011 Joseph Paventy, D.M.D., evaluated Claimant at her request. Dr. Paventy opined dental pain and headaches were consistent with bilateral TMJ disorder. Dr. Paventy expressly denied having any opportunity to evaluate Claimant before the 2008 headbutt, but based upon the history she provided, diagnosed TMJ disorder and opined "trauma to the head or neck is one cause of TMJ disorder." He recommended a removable orthotic with periodic adjustments.

98. On March 8, 2011 Darlene Chan, D.D.S., reviewed records at the request of the attorney for the autistic student's parents who were defending themselves in a related tort suit brought by Claimant. She opined Claimant suffered a left facial contusion related to the 2008 headbutt and opined it fixed and stable with no impairment. She opined there was no evidence of dental injury. She opined that malocclusion with crossbite and migraine headaches preexisted the 2008 headbutt and were unaffected by it; crepitus in the TMJ was also preexisting and unrelated to the 2008 headbutt; no objective basis supports performing root canals on teeth 7 through 10, although a change of sensation in that area could arise from compression of a branch of the 5th cranial nerve.

99. On January 24, 2012 Dr. Chan evaluated Claimant by reviewing additional records, including X-rays, and taking a history personally from Claimant; Claimant made a pain drawing at that time. The pain drawing describes the injury as including being knocked out and hitting her face on the floor. Neither of these facts are supported by medical records made contemporaneous to the 2008 headbutt. As described by the offer of proof above, Claimant disputes whether Dr. Chan examined her. Among other things, Dr. Chan's report notes she

used a stethoscope to listen for jaw crepitus. Dr. Chan opined Claimant's crossbite, overbite, missing teeth, headaches, and anxiety are all preexisting and unrelated to the 2008 headbutt. She opined Claimant did not suffer TMJ injury or TMJ syndrome, that Claimant's TMJ complaints were related to her missing teeth and partial dentures; root canals were unrelated to the 2008 headbutt.

100. In posthearing deposition Dr. Chan well explained her bases for her opinions. Significantly, the absence of supporting contemporaneous medical records shortly after the 2008 headbutt suggests Claimant did not have TMJ or other dental or jaw problems then, and that if any arose later, they were unrelated to the 2008 headbutt. She opined that such problems, if related to the 2008 headbutt, would have manifested almost immediately. Dr. Chan admitted records prior to the 2008 headbutt did not describe the jaw malocclusion or overbite.

101. On October 3 and 4, 2011 Craig Beaver, Ph.D., evaluated Claimant at Defendants' request. He interviewed Claimant, administered a comprehensive neuro-psychometric test battery, and reviewed her records. Upon testing, indicators for validity were equivocal, suggesting an exercise of caution about whether she put forth maximum effort. Symptom magnification and somatization was indicated by testing. Personality assessment tests indicated defensiveness to the point of invalidity. Dr. Beaver diagnosed as follows:

AXIS I:	Dysthymic disorder; anxiety disorder NOS; pain disorder associated with psychological factors and medical condition; benzodiazepine dependency.
AXIS II:	Strong somatization and dependency issues.

Dr. Beaver opined while it is likely the 2008 headbutt temporarily exacerbated some of her underlying psychological difficulties—particularly anxiety and depression—there is no evidence of permanent exacerbation; no permanent neuropsychological changes were caused by the 2008 headbutt; no psychiatric condition was caused by the 2008 headbutt; there is

no evidence of lingering postconcussive syndrome or of residual neurocognitive deficits; no neuropsychological restrictions or PPI are related to the 2008 headbutt.

102. On August 16, 2012 Gerald Gardner, Ph.D., performed a psychological assessment for Idaho Department of Labor Disability Determinations Service Division. He reviewed records of her involuntary psychiatric admission and interviewed Claimant. He opined she suffered from an anxiety disorder but not from PTSD. He diagnosed depression. He considered a closed head injury but needed medical information to confirm it. He suspected cluster B personality traits.

103. On August 21, 2013 Dr. Deatherage opined Claimant suffered from PTSD, depression, and anxiety. He opined the 2008 headbutt was the "straw that broke the camel's back" resulting in disability.

104. On September 10, 2013 Dr. Beaver analyzed and criticized Dr. Deatherage's opinions. He disagreed with a PTSD diagnosis. He disagreed with the causation analysis.

105. On October 3, 2012 after review of additional and recent medical records, Dr. Beaver upgraded a portion of his AXIS I diagnosis from dysthymic disorder to major depressive disorder, recurrent; he discussed possible inclusion of cluster B personality disorder.

106. On August 19, 2013 after review of vocational experts' reports, Dr. Beaver opined that the tests administered by Mr. Cornell were vulnerable to manipulation. They were not reflective of an acquired injury, rather, they showed longstanding abilities and limitations. Moreover, the history provided by Claimant upon which Mr. Cornell based his opinions was inaccurate.

107. In posthearing deposition Dr. Beaver more strongly adopted his inclusion of cluster B personality disorder. He well explained his analysis and bases for his opinions,

including his opinion that PTSD is an inappropriate diagnosis for her condition.

DISCUSSION AND FURTHER FINDINGS OF FACT

108. 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).

109. Referee Donohue found that Claimant's manner, body posture, gestures, and use of voice contributed to a demeanor that seemed overdramatic and disingenuous. During Claimant's psychiatric admission in 2012, Dr. Carlberg used the terms "egocentric" and "manipulative" in her early assessments of Claimant. Upon review of the entire record, Referee Donohue could make no finding about whether her demeanor was related to willfulness or to her longstanding personality disorder. However, as is evident in Dr. Carlberg's records, like Dr. Carlberg the Referee became more sympathetic to Claimant's unfortunate psychological condition as more information became available. The Referee prefers to believe that Claimant's inconsistent statements and beliefs are largely beyond her control. The Commission finds no reason to disturb the Referee's findings and observations on Claimant's presentation or credibility.

110. Claimant admits to issues of memory loss and distortion. Where contemporaneously made medical records report medical matters inconsistent with Claimant's memory or testimony, the records are afforded greater weight.

Causation

111. A claimant has the burden of proving the condition for which compensation is sought is causally related to an industrial accident. *Callantine v Blue Ribbon Supply*, 103 Idaho 734, 653 P.2d 455 (1982). Further, there must be evidence of medical opinion—by

way of 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, 591 P.2d 143 (1979); *Roberts v. Kit Manufacturing Company, Inc.*, 124 Idaho 946, 866 P.2d 969 (1993). 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 558, 560-61, 511 P.2d 1334, 1336-37 (1973), *overruled on other grounds by Jones v. Emmett Manor*, 134 Idaho 160, 997 P.2d 621 (2000), *See* also *Callantine, Id*.

112. Multiple separate conditions must be examined for causation, including physical injury to the orbit, possible dental issues, possible TMJ syndrome, possible traumatic brain injury, possible PTSD, and possible other physical and/or psychological conditions.

113. Claimant has suffered a number of other traumatic events in her life. In 2002 she reported being headbutted by a student; for a month afterward she reported short-term memory loss, nausea, vomiting, and vague visual complaints. Most notably, she was knocked out by a baseball thrown by a 10-year-old boy just one month before the 2008 headbutt. Another particularly notable trauma occurred just four months after the 2008 headbutt when she was in a frontal car crash in Montana. Claimant's frequent medical visits—including many X-rays, CT scans, MRIs, and other diagnostic imaging tests—throughout her life provide a more comprehensive picture of her conditions before and after the 2008 headbutt and before and after other traumatic events.

114. Claimant was not knocked out by the 2008 headbutt but misremembers having been so. Similarly, her after-acquired "memory" of hitting her jaw on the floor is

inconsistent with contemporaneous medical records.

115. In reporting her medical history, Claimant's representations to treating physicians have often been inconsistent. On more than one occasion she has provided a history, been treated, and just days later provided a different history. For example, she underwent significant treatment in August 2010 for gastrointestinal complaints and identified a relatively short duration of symptoms preceding her decision to seek treatment; after multiple diagnostic procedures—almost one month later—she suddenly "remembered" her symptoms began after eating oysters one month earlier. For another example, in December 2007 Claimant visited an emergency room on consecutive days with a primary complaint of headache; on the first visit she gave a history of possible chemical exposure; on the next day she said she "forgot" to mention the day before that she had been hit in the head by a basketball a few days prior.

Physical Injury to the Orbit

116. The 8/1/08 CT scan confirmed a "subtle fracture" just below the left orbit. According to Dr. Chan, the fact that the CT scan from September 16, 2008 no longer showed a "discontinuity defect" is evidence that any injury was minimal.

117. The weight of medical evidence, especially the timely treatment in July and August together with the evaluation of Dr. Wray on November 20, 2008 shows it likely that the 2008 headbutt caused the fracture which healed entirely sometime before Dr. Wray's examination.

Dental Issues

118. Medical records among treating physicians and among opinions of evaluating physicians disagree about whether dental issues such as loose teeth, damaged teeth, and/or

injury to a branch of cranial nerve V exist. The controversy is more sharply defined when the possibility of the 2008 headbutt as a cause is considered.

119. At least as early as March 2002 Claimant had complained of face and teeth pain. This was diagnosed as symptomatic of sinusitis. This complaint and diagnosis recurred at least in 2006. Moreover, she was seen for dental issues as recently as two weeks preceding the 2008 headbutt. Afterward, Surety accepted responsibility for evaluation and some treatment related to evaluating whether a causal relationship existed. Surety's denial of additional and continuing treatment was reasonably based upon the medical records provided by treating physicians. The addition of subsequent information from treatment and evaluations shows Claimant's dental issues are not likely related to the 2008 headbutt.

TMJ Syndrome

120. Included within this condition is consideration of malocclusion and crossbite. Whether these are better served as dental issues or jaw issues is uncertain. Different physicians seem to categorize them differently. Regardless, Claimant's malocclusion and crossbite clearly preexisted the 2008 headbutt. Mere days after the 2008 headbutt, Dr. McCormick opined the condition "appears to be her native bite."

121. Medical records show a history of complaints of jaw pain associated with sinusitis and/or chest discomfort at various intervals before and after the 2008 headbutt. Physicians have not significantly documented an objective exacerbation of jaw dysfunction after the 2008 headbutt. Claimant's complaints about jaw issues in medical records were brief, sporadic, and significantly less than the way she describes them from memory later.

122. As to TMJ syndrome, treaters appear to disagree in medical records and experts opine inconsistently from one another. Claimant failed to show it likely she suffers from TMJ

syndrome and failed to show any jaw issue was caused or exacerbated by the 2008 headbutt.

Traumatic brain injury

123. Some medical records include mention and even diagnosis of postconcussive symptoms and/or closed head injury following the 2008 headbutt. To the extent that these refer to traumatic brain injury, reports of diagnostic imaging—MRIs and CT scans—fail to support its existence. Moreover, possible postconcussive symptoms were mentioned at least twice before the 2008 headbutt, once in relation to a 2002 headbutt. Again, the neurological evaluation by Dr. Wray is more consistent with medical records in the weeks following the 2008 headbutt. She was in a better temporal position to opine than later-appearing experts and treaters. The weight of diagnostic imaging, neurological examinations, and evaluations shows it likely Claimant did not suffer a traumatic brain injury.

PTSD

124. Under Idaho Code § 72-451, psychological conditions are compensable if certain conditions are satisfied. Of central importance, Claimant must demonstrate that the subject accident is the "predominant cause as compared to all other causes combined" of the psychological injury in question. Idaho Code § 72-451(3). Dr. Beaver's opinions carry greater weight than Dr. Deatherage's. Dr. Beaver's qualifications are better; his records review was more comprehensive; he relies less upon Claimant's fallible memory and more on contemporaneously made records; his opinions show better reasoning. Moreover, Dr. Carlberg opined Claimant's history and symptoms did not establish a PTSD diagnosis; other qualified physicians expressed doubt about the diagnosis of PTSD and about whether Claimant exhibited symptoms consistent with such a diagnosis.

125. Here, the evidence fails to establish causation per this elevated burden of proof. Claimant failed to show the 2008 headbutt was the predominant cause of PTSD or any similar psychological condition.

Other Psychological Conditions

126. As stated above, under Idaho Code § 72-451, psychological injuries are compensable if a claimant can demonstrate that the subject accident is the "predominant cause as compared to all other causes combined" of the psychological injury in question. Idaho Code § 72-451(3).

127. Claimant has longstanding issues related to anxiety and depression.

128. There is reasonable evidence of a causal relationship between these conditions and the 2008 headbutt. Dr. Beaver opined that it temporarily exacerbated them for a few months afterward. However, Dr. Beaver's opinion requires reliance upon Claimant's memory; her memory is inconsistent with contemporaneously made medical records. Dr. Deatherage's opinions are entitled to less weight. The preponderance of other psychological and neuropsychological opinions indicate little or no relationship between these conditions and the 2008 headbutt.

129. The weight of medical opinion is insufficient to show that Claimant's 2008 headbutt was the predominant cause of Claimant's psychological conditions, as opposed to the prior baseball-to-the-face event nor by the subsequent car accident. Even if Dr. Beaver's opinion was afforded the greatest weight about this issue, he further opined she was stable; she suffered no permanent impairment as a result.

Medical Care Benefits and Maximum Medical Improvement

130. An employer is required to provide reasonable medical care for a reasonable time.

Idaho Code § 72-432(1).

131. Medical care was approved and paid by Surety for conditions related to the 2008 headbutt.

132. Dr. Wray's opinion provided an appropriate date of medical stability. Claimant was medically stable as of November 20, 2008.

133. Regarding psychological issues, Dr. Beaver's opinion that Claimant is stable and needs no further treatment related to the 2008 headbutt is consistent with the preponderance of evidence.

Temporary Disability

134. Eligibility for and computation of temporary disability benefits are provided by statute. Idaho Code §72-408, *et. seq*. Upon medical stability, eligibility for temporary disability benefits does not continue. *Jarvis v. Rexburg Nursing*, 136 Idaho 579, 38 P.3d 617 (2001). An injured worker who is unable to work while in a period of recovery is entitled to temporary disability benefits under the statutes until he has been medically released for work and Employer offers reasonable work within the terms of the medical release. *Malueg v. Pierson Enterprises*, 111 Idaho 789, 727 P.2d 1217, (1986). The statute requires a five-day waiting period before temporary benefits become payable. Idaho Code § 72-402.

135. With a date of medical stability as of November 20, 2008, Surety appropriately continued to pay TTD benefits well into December 2008 due to a delay in receiving Dr. Wray's report. No further TTDs are due or payable related to the 2008 headbutt.

Permanent Impairment and Disability

136. Permanent impairment is defined and evaluated by statute. Idaho Code §§ 72-422 and 72-424. When determining impairment, the opinions of physicians are advisory only. The

Commission is the ultimate evaluator of impairment. *Urry v. Walker & Fox Masonry*, 115 Idaho 750, 769 P.2d 1122 (1989); *Thom v. Callahan*, 97 Idaho 151, 540 P.2d 1330 (1975).

137. Dr. Wray's and Dr. Beaver's opinions are consistent with the preponderance of evidence. Claimant suffered no permanent impairment—physically or psychologically—as a result of the 2008 headbutt.

138. Issues of disability and apportionment are moot.

CONCLUSIONS OF LAW AND ORDER

1. Claimant was injured in a compensable work accident on July 29, 2008;

2. She is entitled to medical care and temporary disability benefits which have been paid by Surety;

3. She had reached maximum medical improvement on or before November 20, 2008 and has not shown entitlement to medical care or temporary disability benefits beyond that already paid;

4. Claimant failed to show it likely that any lingering or permanent physical or psychological condition was caused by the 2008 headbutt;

5. Claimant failed to show she is entitled to permanent partial impairment or permanent disability; and

6. All other issues are moot.

DATED this 16th day of March, 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 16th day of March, 2015, a true and correct copy of FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER were served by regular United States Mail upon each of the following:

STARR KELSO
PO BOX 1312
COEUR D'ALENE ID 83816

H JAMES MAGNUSON
PO BOX 2288
COEUR D'ALENE ID 83816-1312

ka __/s/____________________________