BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

CHANNEL (BLACKER) RISH, Claimant, v. THE HOME DEPOT, INC., Employer, and INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA, Surety, Defendants.	**IC 2005-011806** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** Filed September 23, 2015

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Industrial Commission assigned the above-entitled matter to Referee Douglas A. Donohue who conducted a hearing in Idaho Falls on August 26, 2014. Paul Curtis represented Claimant. W. Scott Wigle represented Defendants. The parties presented oral and documentary evidence. Post-hearing depositions were taken. The parties submitted briefs. The case came under advisement on June 3, 2015 and is now ready for decision.

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 Claimant is medically stable, and, if so, on what date;
4. Whether and to what extent Claimant is entitled to benefits for
   (a) Permanent partial impairment;
   (b) Disability in excess of PPI including 100% total and permanent disability;
   (c) Medical care; and

(d) Attorney fees;

5. Whether Claimant is entitled to total and permanent disability under the odd-lot doctrine; and

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

In post-hearing briefing Claimant added a new issue claiming 12 weeks of unpaid temporary disability benefits. Claimant abandoned the issues of total permanent disability and odd-lot disability.

Additionally, the parties represent that Commissioner Baskin represented Defendants in this matter prior to accepting appointment to the Commission.

CONTENTIONS OF THE PARTIES

The parties agree Claimant suffered a compensable accident at work on October 30, 2005. Surety paid medical and TTD benefits for a time.

Claimant contends she twisted her knee at work and injured it. After medical treatment including three knee surgeries, she still had pain and swelling. She was prematurely deemed to be at MMI by Casey Huntsman, M.D., in August 2007. Her actual MMI date should be no earlier than January 28, 2009, the date Christian Gussner, M.D., performed his second IME. Regardless of MMI date, Claimant still needs medical treatment for debilitating knee pain. Her condition has evolved to CRPS. She is entitled to medical care benefits to the date of the hearing and in the future. Surety stopped paying medical benefits in April 2009. Physicians generally agree a 5% PPI is appropriate. Claimant's disability should be found in a range of 40% to 60%. Defendants should be ordered to pay attorney fees; they acted unreasonably by paying TTDs untimely, cutting off medical benefits prematurely, and denying an evaluation at University of Utah.

Defendants contend they have paid all appropriate TTD and PPI benefits due Claimant.

Medical benefits were discontinued after expert medical opinions in 2009. Subsequent pain management treatment, including narcotics and a spinal stimulator, was not reasonable or necessary and was harmful to Claimant. Claimant failed to show an objective basis for her claim of permanent disability in excess of PPI. Claimant has failed or refused to cooperate in physicians' recommendations to achieve maximum recovery. Defendants' have acted reasonably throughout the course of this claim.

EVIDENCE CONSIDERED

The record in the instant case included the following:

1. Oral testimony at hearing of Claimant and her mother;
2. Claimant's exhibits 1 through 23 and B1 through B16 admitted at hearing;
3. Defendants' exhibits A through P admitted at hearing;
4. Depositions of physiatrist Gary Walker, M.D., pain management physician Jason Poston, M.D., neuropsychologist Carol V. Anderson, Ph.D., and vocational experts Mary Barros-Bailey, Ph.D., and Kent Granat.

Objections in posthearing depositions are OVERRULED; EXCEPT the following objections are SUSTAINED:

Dr. Walker's deposition at pages 33-35; and
Mr. Granat's deposition at page 15.

Claimant's proposed exhibits 24 through 31 were acknowledged by the parties to be merely duplicative and were not admitted. The record was held open post-hearing to allow the parties to review these documents further and move to admit specific documents within the set which were not duplicative, if any were found. No party moved for the admission of any document within this group.

The Referee submits the following findings of fact and conclusions of law for the approval of the Commission and recommends it approve and adopt the same.

FINDINGS OF FACT

1. Claimant worked for Employer on October 30, 2005. She slipped on a floor mat but did not fall. She twisted her knee. She was 26 years old.

2. While still in her recovery period, Casey Huntsman, M.D., released Claimant to full-duty work. As temporary restrictions, he recommended she avoid kneeling and that she take a 15 minute break every two hours. About January 25, 2006 Claimant returned to work. She worked until May 16, 2006. She has not worked since.

Medical Care Beginning October 30, 2005

3. Claimant visited Eastern Idaho Regional Medical Center (EIRMC) ER that day. Examination was compromised by pain complaints. Where discernible upon examination, no abnormalities were noted. X-rays were normal. No specific diagnosis was made.

4. On November 1 Claimant visited Barry Bennet, M.D., at Southeast Idaho Family Practice. Dr. Bennet is a partner of Kay Christensen, M.D., Claimant's regular physician since childhood. Dr. Bennet noted, "Any realistic exam is hampered by severe pain." He diagnosed a sprain and prescribed Lortab. Throughout Claimant's course of treatment for this injury, additional unrelated visits for various ailments were attended by Dr. Christensen or nurse practitioner Cathy Arvidson, F.N.P.

5. On November 8 Claimant visited Casey Huntsman, M.D. Claimant reported her knee "gets worse with bending the knee and walking and twisting. It gets better with Hydrocodone." His examination found "trace" effusion. He noted, "I cannot do a good examination because of how tender she is." Beyond the trace swelling, he found no objective symptoms. He considered possible meniscal or ACL tears and recommended an MRI.

6. A November 17 MRI could not "absolutely exclude" a possible subtle meniscus tear, but no objective basis for her pain complaints was visible.

7. On a November 29 visit to Dr. Huntsman Claimant was much better. She reported only mild tenderness. Upon examination, Dr. Huntsman noted mild crepitus and a McMurray's test positive for pain although without a "click." Otherwise the examination found no abnormalities. He assessed a probable ACL sprain with a medial meniscus contusion. He prescribed Lodine XL. Claimant refused physical therapy.

8. A December 2 EIRMC ER record states Claimant had returned to work for three days but her knee complaints were worse. "She is out of her pain medications . . . and she needs something to get through the weekend." Claimant reported tenderness. No swelling was noted.

9. On December 14 Casey Huntsman, M.D., examined Claimant prior to performing arthroscopy. Claimant reported "a lot of swelling," but Dr. Huntsman observed "trace effusion." He noted Claimant's knee had "improved dramatically." His patellar grind test was positive; Claimant reported pain with a McMurray's test, but again no click was noted. Her knee was otherwise normal. Upon diagnostic arthroscopy, he confirmed that no meniscal tear had occurred. A plica band and fat pad in her knee were shaved. All else was in "excellent condition." His post operative diagnosis: right knee medial plica band syndrome.

Medical Care—2006

10. On January 24 Dr. Huntsman released Claimant to return to full-duty work. He cautioned against kneeling and recommended allowing a 15-minute break every two hours.

11. Physical therapy notes begin May 25. The record recites multiple no-shows.

12. A July 5 MRI showed a new low-grade sprain. Increased signal at the posterior horn of the meniscus was still present. This indicator previously suggested a possible meniscal tear, but arthroscopy showed no tear was present. The radiologist considered the findings

consistent with a mild injury of the posterior cruciate ligament.

13. Dr. Huntsman did not see Claimant again until July 18. On that date she complained of right index finger pain. At this visit no mention of knee pain is noted.

14. On August 16 Dr. Huntsman performed another arthroscopy. He observed some chondromalacia and a flap tear beneath the patella. He again debrided the fat pad and plica band of her right knee and removed some scar tissue.

15. A follow-up visit about August 29 revealed no objective findings although claimant reported some soreness and swelling at night. He prescribed Relafen and Darvocet. He recommended she remain off work for one more month.

16. At a September 26 visit Dr. Huntsman noted crepitus, "a small click," with knee motion, but the examination was otherwise entirely normal. He recommended temporary work restrictions including no kneeling, squatting, or lifting over about 20 pounds.

17. At an October 24 visit Claimant reported a flare-up without any precipitating event which began two weeks prior. She had stopped attending physical therapy. On examination Dr. Huntsman noted the click "is inconsistent with motion." He injected the knee with Medrol and Marcaine. On a November follow-up visit she reported that injections had not helped, neither analgesic nor steroidal. Dr. Huntsman sought consultation from his partner, Gregory Biddulph, M.D.

18. On December 18 Dr. Biddulph expressed concern about the click but also noted, "Again, she has pain out of proportion to physical findings in the posterior, medial, and lateral compartments as well. . . . I think one of Channel's biggest problems is her smoking. The smoking has been proven to perpetuate inflammation in the joint and cause persistent inflammation. However, in addition to this I also think she does have patellofemoral pain. . . I

think the first thing we have to do before any further surgeries are accomplished, that she does have to stop smoking."

Medical Care: January 1 – August 9, 2007

19. On January 18 Dr. Huntsman's nurse noted Claimant reported she had been taking Mobic as directed, but the pharmacy reported she had not refilled the prescription since October. In February and March Dr. Huntsman performed three Synvisc injections. These did not help.

20. On March 29 Claimant visited with Nurse Arvidson about Claimant's request for antidepressants. Nurse Arvidson prescribed Lexapro. By history, Claimant identified Lunesta and other prescriptions, not including narcotics and muscle relaxers, as part of her regular medication regimen.

21. On May 18 Drs. Huntsman and Biddulph performed a third arthroscopic surgery. They observed chondromalacia, lateral patellar compression, and some synovial fibrosis in the lateral gutter. Other areas of concern about the knee showed no abnormalities. They performed a lateral release.

22. On June 28 Dr. Huntsman rated Claimant's finger at a 2% whole person PPI based upon range of motion. He also examined her knee and found it entirely normal and without crepitus. He noted his assistant physicians "have given her the last Hydrocodone prescription today."

23. On July 18 Claimant first visited Holly Zoe, M.D., for pain management. Claimant reported continuing knee pain after arthroscopic surgery nine weeks earlier. Claimant reported Hydrocodone did not help. Dr. Zoe's examination notes identify no objective knee pathology. Dr. Zoe began by prescribing a Lidocaine patch, Percocet, and Flexeril.

Dr. Zoe relied upon her physician's assistants often. The records are not clear when Dr. Zoe versus an assistant observed or opined. Because Dr. Zoe's notes routinely recite language of prior notes, it is difficult to determine which language actually pertains to the visit on the date of a note. Where possible, the date on which the first mention of a remarkable fact occurs is used below.

24. At Claimant's August 2 visit Dr. Zoe recorded mild swelling, positive varus/valgus stress test, and a positive Perkin's test as objective findings in addition to tenderness and limited range of motion. Claimant also exhibited limited range of motion in her low back, reportedly from pain. Dr. Zoe noted the Lidocaine patch had been ineffective and prescribed a Fentanyl patch. Dr. Zoe considered possible CRPS as a diagnosis. She changed from Percocet to Lortab.

25. On August 9 Dr. Huntsman opined Claimant was medically stable and rated her knee at 3% whole person for "having had a partial medical meniscectomy and some patellar chondral damage." He recommended continued pain management with Dr. Zoe.

26. On August 30 Dr. Hunsman responded to ICRD questions and approved Claimant's return to her preinjury work without restrictions, effective August 9. He acknowledged Claimant's significant residual subjective complaints.

Medical Care: August 30 – December 31, 2007

27. On August 30 Dr. Zoe noted color and temperature changes, and sought approval for a nerve block to rule out CRPS. The exam notes for August 30 inaccurately dated Claimant's last knee surgery. It appears that Dr. Zoe may have intended to refer to the October 2005 accident which was two years prior, but the notes remain ambiguous or frankly inaccurate.

28. On September 14 Dr. Zoe performed a lumbar nerve block to alleviate knee pain.

29. On October 2 urinalysis lab data was essentially as expected given Claimant's medication regimen.

30. On October 4 Dr. Huntsman noted Claimant continued to complain as before the most recent surgery. He recommended an IME to determine "what her true functional status should be."

31. On October 23 Carol Anderson, Ph.D. performed a psychological evaluation prerequisite to placement of a spinal stimulator. By history, Claimant denied prescription drug abuse and mental health treatment prior to the accident. After interview and testing, Dr. Anderson opined Claimant possessed "cognitive capacity and judgment abilities" to decide about implantation of a spinal stimulator.

32. On October 30 Dr. Huntsman declined to impose permanent restrictions within six months of the last surgery. When Claimant visited him on November 29, he did not mention restrictions.

33. On December 4 Dr. Zoe, in a letter to Claimant's attorney, noted Claimant expressed a desire to discontinue narcotics, but her pain was too great. She expressed doubt that a spinal stimulator would help. Essentially, Dr. Zoe explained she (Dr. Zoe) needed to use pain medication as a treatment modality, which modality Claimant said she did not want. Dr. Zoe recommended she visit "another pain specialist to better treat her painful condition with better expertise."

Medical Care—2008 to October 2011

34. On January 9, 2008 Christian Gussner, M.D., and Robert Friedman, M.D., reviewed records and evaluated Claimant at Surety's request. Dr. Gussner opined Claimant's current condition was a right knee sprain which exacerbated a chronic knee condition

dating back to 1994. He noted her poor compliance with physical therapy and the absence of objective findings. He opposed a stimulator trial or opioid pump. He recommended additional evaluation by Dr. Burkes at University of Utah and conditional pain management treatment, possibly with Dr. Friedman. He opined Claimant was not yet at MMI. Dr. Friedman opined similarly, noting that Claimant's failure to report an accurate history of prior knee problems factored into unnecessary surgeries on her knee. He opined that no additional medical treatment was indicated, although in order to help return her to work his WorkFit program might help.

35. On February 10, 2008 Dr. Zoe recommended a spinal stimulator.

36. On May 30, 2008 Dr. Zoe performed another lumbar nerve block for knee pain.

37. On June 20, 2008, Dr. Zoe expressly noted on examination the absence of temperature or color changes, and no allodynia—all of which she later testified in deposition would be indicators of CRPS.

38. On July 9, 2008 Claimant visited Dr. Christensen about depression. Claimant claimed an allergy to Demerol and that Lexapro gave her migraines. Dr. Christensen prescribed Cymbalta. After about 30 days, Cymbalta was discontinued as ineffective. Claimant next tried citalopram.

39. On September 12, 2008 Dr. Zoe noted lab tests which reported negative for opiates, but positive for benzodiazepine. Claimant's prescribed Lortab (Hydrocodone) did not show up. Dr. Zoe ordered additional labs for confirmation. Testing of a September 12 sample showed results consistent with Claimant's medication regimen.

40. On November 7, 2008 Claimant asserted her Lortab was insufficient to alleviate pain. Dr. Zoe increased the dosage from 7.5 to 10 mg twice per day.

41. On December 4, 2008 Dr. Zoe noted "Pain seems to be more nociceptic rather

than neuropathic." She added Nortriptyline to the medication regimen.

42. On January 5, 2009 Dr. Zoe increased Claimant's Lortab to three per day instead of two.

43. On January 28, 2009 Michael McClay, Ph.D., evaluated Claimant at Surety's request. His involvement in this IME, Dr. McClay states, was part of a second IME by Drs. Gussner and Friedman. Dr. McClay opined she "has the elements of a Chronic Pain Syndrome" and noted symptom magnification and secondary gain issues. He questioned whether Claimant was "forthright" with him. His major recommendations was, "This patient needs to be out of the worker's compensation process as quickly as possible. Functional restoration can be considered as one component of this approach."

44. On February 5, 2009 Dr. Zoe decreased Claimant's Fentanyl patch dosage.

45. On June 4, 2009 Claimant visited Dr. Christensen after a 4-wheeler ran over her left ankle. The records do not show any follow-up regarding this accident.

46. On August 25, 2009 Claimant visited EIRMC ER. She was out of narcotics, seeking more. The ER physician administered two Hydrocodone but refused to provide more.

47. On August 26, 2009 Gary Cook, M.D., evaluated Claimant at her attorney's request. He reviewed records dated from November 2005 to the date of this IME and examined Claimant. He noted Claimant's pain responses prevented a thorough examination. He found some crepitus. Dr. Cook opined Claimant was not at MMI and needed a pain management program. Nevertheless, Dr. Cook rated Claimant's PPI using *AMA Guides*, 5th ed., and opined a 9% PPI related to Claimant's knee and 3% related to her right index finger. Also, she opined her prognosis was that her symptoms were unlikely to significantly change. Dr. Cook recommended unquantifiable limitations, conditional upon her response to a pain

management program and a change in her reported pain levels. He suggested psychological counseling. He recommended a home exercise program, weight loss, work hardening, discontinuation of narcotics, appropriate use of OTC analgesics, in-patient chronic pain management with, for example, Dr. Friedman, psychiatric treatment for depression, and smoking cessation. Other recommendations are obscured by a handwritten note disparaging Dr. Cook's recommendation for Dr. Friedman's pain program.

48. On November 10, 2009 Dr. Christensen noted crepitus of the patella, an objective finding, upon examination. On other visits, examination notes include pain, tenderness, or other subjective complaints which are mentioned without objective signs or symptoms of knee problem. Dr. Christensen began prescribing Tylenol #3 with codeine for knee pain.

49. Throughout 2010 Dr. Christensen continued to attend Claimant's various ailments. Few subjective and no objective knee findings are included in Dr. Christensen's 2010 examination notes. Various medication changes and additions were made, but narcotics continued. In an October 13, 2011 note Dr. Christensen mentioned the possibility of fibromyalgia. On February 29, 2012 fibromyalgia was ruled out because Claimant's pain was only in her knee. An ANA IFA screening was negative for autoimmune disorders and negative for rheumatoid factors.

50. On July 8, 2010 Claimant first visited Joseph Liljenquist, M.D. On examination he noted patellar "catching," mild crepitus, and a positive grind test. All other objective symptoms and tests were normal. X-rays showed no abnormalities, acute or chronic. Dr. Liljenquist was unable to discern significant degenerative changes in the knee. He recommended against surgery and for strengthening exercises. On September 1 he suggested she see a new pain management specialist, Jason Poston, M.D.

51. On July 16, 2010 Daniel McLaughlin, M.D., in Dr. Christensen's office, examined Claimant for right foot pain after a fall. He noted some bruising.

52. On September 2, 2010 Jason Poston, M.D., at Pain Specialists of Idaho, examined Claimant. He noted some crepitus without other objective findings. He noted Claimant reported swelling and weakness in her knee, but he found none. On September 17 Dr. Poston performed a nerve block. Thereafter, he proceeded to treat Claimant using a primary diagnosis of CRPS/RSD. He performed additional nerve blocks on September 22 and 30, and October 7, 2010 with an eye toward recommending a spinal cord stimulator. On October 29 Dr. Poston's exam noted some swelling in Claimant's right knee.

53. On December 14, 2010 Dr. Poston began a Medtronic spinal cord stimulator trial. This was obtained through Medicaid. Three days later, upon Claimant's representations that her pain had decreased from a "7" to a "3" on a ten-point scale, Dr. Boston recommended permanent implantation.

54. On January 19, 2011 Stephen Marano, M.D., performed the implantation surgery. His PA, James Cook, attended follow-up visits.

55. On February 19, 2011 Dr. Poston recorded that Claimant showed "improved swelling and decreased color changes and decreased allodynia." He anticipated possible return to work two months after the date of permanent implantation. Visits in June and July 2011 showed no objective improvement in function despite Claimant's representations that her pain is usually decreased by the stimulator. She reported continued swelling and weakness of the knee. She reported her pain worsens "after the stimulator is on for a long time." She reported that, for about the last three weeks, her pain sometimes worsened with use of the stimulator. She reported her pain was spreading to her left leg.

56. On August 22, 2011 Michael O'Brien, M.D., reviewed records and examined Claimant neurologically at Claimant's request. She reported the stimulator relieved her pain only intermittently. Examining her pain response Dr. O'Brien noted, "This pain seems totally out of proportion to the type of injury that she sustained." He noted swelling in the knee "without any real pathology." He recommended a rheumatology consult. He opined he was "not totally convinced" she suffered CRPS. He rated PPI at 5% as a residual from and causally related to the 2005 accident, despite an absence of pathology. He acknowledged Claimant's subjective limitations and cautioned against prolonged standing and walking, but he imposed no specific restrictions.

Medical Care: October 2011 - Hearing

57. In October 2011 Claimant's fiancé passed away. Essentially the next day, Claimant moved herself and her two children into Claimant's parents' home. They have lived there since. Claimant's mother has become the *de facto* primary caregiver to Claimant's two sons and has substantially resumed her role watching over Claimant.

58. On November 2, 2011 Claimant reported to Dr. Poston that her pain was "constant" and "throbbing" with continued knee swelling and pain in multiple joints and muscle groups. She requested a diagnosis of fibromyalgia. She requested additional pain medications. Dr. Poston recorded no objective findings upon examination. Dr. Poston advised her that opioids do not help fibromyalgia. On December 7 Dr. Poston increased her Neurontin dosage. He recorded, "Worker's compensation want her to get a bone scan completed, but I explained that CRPS is a clinical diagnosis and cannot be tested through diagnostic testing. . . . Channel absolutely has CRPS; this is a clinical diagnosis and requires no confirmatory diagnostic testing for CRPS."

59. On January 9, 2012 Dr. Poston and a Medtronic representative reprogrammed Claimant's stimulator. She reported left leg pain also and described it as being "like nerve pain."

60. On January 24, 2012 a physical therapist saw Claimant regarding *left* leg symptoms radiating from low back pain. Although not the focus of physical therapy, Claimant's right knee symptoms were also noted. Claimant cut treatment short that day, asserting she needed to retrieve a child from school, "but then stood > 30' & told me about her fiancé's death & some of the emotional aspects." After four visits, Claimant's low back and left leg pain had significantly decreased.

61. Dr. Poston or his PA Matt Nelson attended follow-up visits as Claimant reported increasing and more constant pain bilaterally. Claimant described swelling at the stimulator battery site which Dr. Poston could not confirm upon examination. Oddly, a note of her May 7 visit states, "She has not lost work time because of it." By that point Claimant had not worked for about six years, a detail which was expressly included in a note of her May 15 visit. Also, these May visits recorded she walked with a "shuffle" or a "limp." These are the first indications of a gait disturbance since the days immediately after the reported accident. At a June 14 visit Claimant's gait had returned to normal. By August 9 her limp had returned.

62. Physical therapy records for Summer 2012 appear not to have been significantly contributory, clinically or forensically. If anything, her reports of pain increased with therapy.

63. A lumbar CT taken August 16, 2012 showed a left L4-5 disc herniation compressing the left L5 nerve root along with generalized lumbar stenosis and facet degeneration.

64. Dr. Poston's office scheduled a lumbar epidural steroid injection. On September 25, the injection was performed. The injection merely increased her pain.

65. At a January 8, 2013 visit to Dr. Poston's office, Claimant asserted her left leg pain was gone but her right knee was worse. She had no limp. Dr. Poston's office refused to prescribe medications unless Claimant agreed to random drug monitoring. Claimant was advised her function, not her self-reported pain score, would be the basis for additional opioids. On January 31 she limped. A February 18 note represents Claimant's first report of decreased sensation in her right knee. On several prior visits sensation was expressly reported as normal. Another lumbar ESI, this time on the right and at L5-S1, was performed on February 26. By March 14 Claimant reported constant back and upper back pain among her symptoms. Her gait was normal. On July 8 another lumbar ESI was performed at L5-S1 on the right. On July 24 she reported increased pain from the ESI and again limped. On July 29 and August 12 genicular nerve blocks were performed as a precursor to a possible radiofrequency ablation of the nerve. Per Claimant's August 28 report to Dr. Poston's office, the nerve blocks did not help.

66. Claimant sought attention in Hamilton, Montana. Brent Bender, M.D., reviewed records and evaluated Claimant before beginning a program of pain management in October 2013. He diagnosed CRPS 1 and "chronic pain syndrome with psycho[so]cial features including depression and anxiety."

67. On October 29, 2013, on approximately the eight-year anniversary of Claimant's accident, Claimant was evaluated by Jason Dalling, M.D., from the offices of Drs. Biddulph and Huntsman, as a new patient. Claimant reported her pain had progressively worsened since the third arthroscopic procedure. On examination Dr. Dalling noted the knee click but found no other objective signs despite Claimant's reports of exquisite global knee pain. X-rays revealed mild osteoarthritis. He diagnosed chondromalacia of the patella and prescribed home exercises.

68. In early 2014 physical therapy failed to produce positive results.

69. On February 4, 2014 a CT for the right knee showed "slight spurring" at an edge of the patella and slight joint swelling.

70. On February 24, 2014, Gary Walker, M.D., reviewed records and examined Claimant at Surety's request. He opined Claimant's pain complaints were out of proportion to objective evidence of her knee condition. His examination could not pinpoint a cause or source for her pain complaints. He opined that no objective basis existed for imposition of restrictions. He noted that by temporal coincidence, Claimant's ongoing, persistent pain complaints seemed causally related to the industrial accident. On April 18, 2014, Dr. Walker amplified his IME report. He opined she showed no objective findings which would support being off work. In deposition, Dr. Walker retracted his written opinion that the narcotics and stimulator were "not work related" because these were prescribed in response to her complaints of knee pain.

71. Claimant's regular visits to Dr. Poston's office continued. By June 2014 an issue arose once again of Claimant's compliance with opioid prescriptions. Dr. Poston's notes of record discontinue by the end of June 2014.

Prior Medical Care

72. Medical records reference care provided for epilepsy, psychological/behavioral issues and other conditions as early as age 13. The earliest available medical record dates to January 1989 when Claimant was age nine. Dr. Christensen was her primary physician during her teenage years. One note dated April 13, 1994 records a complaint of intermittent chronic knee pain. A knee immobilizer was prescribed. There are no follow-up notes. The next mention of her right leg is dated June 24, 2002. It reported muscle tenderness in posterior

calf and medial thigh which was thought to be possible phlebitis.

73. Claimant underwent right index finger surgery on January 15, 2005. Significant physical therapy did not reduce pain complaints for at least four months after surgery. She reported pain levels in the same ranges for her finger before her knee injury as she did for her knee afterward. She reported swelling which physicians were unable to confirm.

74. Claimant's first medical office visit after the knee injury shows she had been taking the sleep medication, Lunesta, before the accident.

Vocational Factors

75. Claimant's time-of-injury wage was $8.50 per hour.

76. Claimant returned to work on January 26, 2006 upon recommendation from Dr. Huntsman. She stopped working on May 16, 2006 and has not worked since.

77. From April through September 2007 ICRD consultant Kari Rohrbach assisted Claimant. Claimant was unreliable about maintaining contact and attending appointments; it took more than a month of rescheduling to obtain an initial evaluation with Claimant. In the initial evaluation Claimant stated her prior right finger injury was a barrier to employment.

78. On August 30, 2007 Dr. Huntsman responded to ICRD inquiry and stated, "Objectively, there are no work restrictions." He went on to identify Claimant's self-reported and self-imposed limitations. He opined Claimant medically stable as of her last visit on August 9, 2007.

79. On June 1, 2012 vocational expert Kent Granat met and evaluated Claimant. He reviewed medical records. His report is dated August 10, 2012. Using three different approaches to calculate loss of labor market access, he averaged results of 87.5%, 45.4% and 45.1%. Similarly considering two disparate approaches to potential wage loss, he estimated it at

6.4% to 13.3%. Mr. Granat—in the absence of specific, physician-imposed, permanent restrictions—relied upon Claimant's oral reports of her self-imposed restrictions; he adjusted these supposed restrictions to discount what he considered to be Claimant's hyperbole. He used these self-determined restrictions to perform his disability analysis. He referred to general statements in medical notes to derive specific limitations. His evaluation assumed a 20-pound lifting restriction, limitations about bending and stooping, and an inability to be on her feet for more than two hours. Claimant also reported a prior, right-hand injury which would limit grasping. He rated Claimant's disability in a range of 33 to 36 percent, inclusive of PPI.

80. Mary Barros-Bailey opined that Claimant's earning history suggests short-term full-time or longer-term part-time employment for about nine of 11 years before the accident. Claimant's two full-time years of employment were 1999 and 2001 when she earned $11,928 and $12,341 respectively. Dr. Barros-Bailey reviewed medical records and noted physician's general suggestions. She opined that the absence of physician-imposed restrictions should preclude any vocational expert from having a foundation upon which to opine about disability. Physicians' notes about Claimant's subjective limitations were not endorsed by the respective physicians and cannot substitute for medical opinions. Dr. Barros-Bailey was unable to do more than speculate about Claimant's disability and declined to do so. Such speculation would violate the standards of her profession. She opined that to the extent some physicians have opined Claimant has no permanent restrictions, there can be no disability; to the extent other physicians have generally discussed limitations without imposing specific restrictions, Dr. Barros-Bailey has no foundation upon which to perform a disability analysis.

Medical Opinions

81. Medical opinions differ about whether a diagnosis of CRPS (or RSD) is

appropriate here. Some physicians include this diagnosis without specifically identifying all of the objective bases prerequisite to such a diagnosis. Other physicians recite the canon of objective bases and opine Claimant's condition does not qualify for the diagnosis. Different physicians found and did not find clinical support for the diagnosis despite their examinations being merely days apart. Dr. Poston proclaims himself an expert in the diagnosis and asserts that his word is sacrosanct without corroborating diagnostic evidence.

82. During his examination of Claimant, Dr. Walker looked for evidence of CRPS—skin discoloration, temperature changes, hypersensitivity to touch, hair and nail changes—and found none. In deposition he explained that the absence of response to a sympathetic nerve block does not dispositively preclude CRPS, but a positive test would have been consistent if CRPS were present. CRPS remains a vague and inconsistently applied diagnosis within the medical community. Its cause is not well established. CRPS is an uncommon condition which has become a common diagnosis for chronic pain despite the absence of the objective markers which define CRPS. Moreover, in treating hundreds of patients, Dr. Walker has never seen CRPS arise in relation to a knee injury or mechanical knee pain. Dr. Walker pointed out a note of Dr. Poston's which reported most objective indicators of CRPS were absent when Dr. Poston examined Claimant. Dr. Walker questioned how Claimant's examinations by Dr. Poston should inconsistently report appearing and disappearing objective indicators in a short amount of time. Dr. Walker acknowledged that symptoms of CRPS may wax and wane but not that they may appear, disappear, and reappear.

83. Dr. Walker made a "generic diagnosis" of chronic knee pain. There is no pathology in Claimant's knee which would explain her complaints. Diagnostic imaging ruled out significant arthritis.

84. Dr. Walker opined that a spinal stimulator is not used for mechanical knee pain; it may be used for CRPS. He noted Claimant's response to the spinal stimulator has been "a mixed bag." Sometimes it actually has increased her pain complaints. It has not helped increase her function. Initially, he opined that neither the spinal stimulator nor the opioid medication were work related; rather, they were a function of the chronicity of her unsupported complaints. However, he clarified his opinion by stating that although continued narcotics and/or the spinal stimulator were neither reasonable nor necessary medical care for Claimant, they were prescribed as a result of her continuing complaints following the work injury.

85. Dr. Walker opined Claimant would be most helped by discontinuation of narcotics and by increase of activity; psychological counselling or therapy might help her understand the pain she reports does not represent an injury; weight loss and stress control techniques could help as well. Activity should be increased gradually because she is so deconditioned after such a long period of inactivity. Hypothetically, this might involve recommending medium or light work at first.

86. In deposition Dr. Poston recalled that Claimant, upon examination, showed sensitivity to light touch, swelling, color and temperature changes; all are indicators of CRPS. He opined Claimant exhibited a "severe" reaction to a "more moderate" case of CRPS. Claimant's CRPS has improved; objective indicators have ameliorated with treatment. Dr. Poston's causation opinion is expressly predicated upon Claimant's representations of her history and recollections of her subjective complaints before he first examined her. Dr. Poston opined Claimant will require lifelong psychological care as well as treatment for her chronic pain. Dr. Poston testified he is not in a position to opine about whether her need for psychological care is predominantly related to the industrial accident. Dr. Poston opined

Claimant "needs to go back to work." He has not imposed permanent restrictions. He opined she should be weaned from all narcotics, but identified the practical difficulties involved.

87. Dr. Poston noted Claimant failed two urine tests; she twice showed positive for nonprescribed Hydrocodone instead of the prescribed Oxycodone. His June 19, 2014 note reflects that he addressed the issue with Claimant. When she denied knowledge of why the discrepancy arose, he changed her prescription to the Hydrocodone she preferred. He ordered drug testing for every future visit. These drug tests were expected to occur weekly and were to have constituted a prerequisite to approval of an opioid refill.

88. Dr. Poston's records are difficult to navigate. Extensive use of boilerplate, including repetition of typographical errors, makes it hard to determine whether Claimant's reports, the physician's examination, and the physician's comments or findings are actually related to the date of the various follow-up visits. Except as described in findings of fact regarding specific visits above, the presence or absence of indicators of CRPS, Claimant's progress or lack of it, and Dr. Poston's attempts at treatment are difficult to distinguish from visit to visit.

89. In deposition, Dr. Anderson described Claimant's neuropsychological evaluation which was prerequisite to the spinal stimulator. Because Dr. Anderson was unaware of any pre-injury mental health treatment, she opined Claimant's depression and need for antidepressant medication was likely related to the industrial accident.

DISCUSSION AND FURTHER FINDINGS OF FACT

90. 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). However, facts 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).

91. Claimant presents a claim highly dependent upon the accuracy of her representations of subjective, unverifiable complaints, conditions, and abilities. Claimant's demeanor at hearing was often inconsistent with the content of her testimony. For example, Claimant made the following statements:

> But I don't want to be on it (opiod medication), period. . . . And I just - - I don't want to be on it anymore. . . .
>
> I feel like - - I almost feel like a bad mother because I feel like I'm only giving a certain percent, a small percentage, to my kids; and they deserve so much more and - - because I can't go out and do what they want when they want. And sometimes they want to go out to the park, or they want to go play baseball, or they want to just go. And I can't just do that; and, you know, I can't take them to do the things that we used to do. And so that makes me feel bad. . . .

These supposedly emotionally charged statements were delivered with a casual nonchalance—without any indication by Claimant that she felt any more emotion about them than the emotion which she showed when reciting her work history. At these and other instances in her testimony, Claimant's demeanor was inconsistent with the content of her representations.

92. By contrast, when Claimant spoke about the death of her fiancé, she showed natural emotion, within the range one would expect when a person recalls such an event. Claimant is not a stoic person. If anything, her overall demeanor was consistent with an intelligent teenager; that is, she talked and gestured demonstratively, almost floridly, and so seemed significantly younger than she is. At times throughout her testimony, where one would expect it, she exhibited voice inflection, gestures, and body posture consistent with a

likeable storyteller. Other times she was appropriately informative. Her range of demeanor when discussing general, informative, historical facts starkly contrasted with the casual unaffectedness with which she described her pain, quality of life, and desires to return to work. These findings do not attempt to discern Claimant's state of mind; rather they attempt to describe some of the foundation for the actual finding—which is that Claimant's demeanor was, at material times, inconsistent with the content of her testimony.

93. Further, Claimant's testimony about a history of consistent employment and hard work, occasionally involving two jobs at a time, is inconsistent with her Social Security earnings record. For the twelve years reported, 1995-2006, including her two best years 1999 and 2001, her average annual income was $5,890.83; excluding those two years, her annual average was $4,642.10. Claimant's year of injury wage was $5,747.00, down from $7,972 the year before, and, after the accident, her 2006 wage was $4,328.

94. Additionally, Claimant's testimony shows a failure of memory. First, Claimant testified that ICRD consultant Ms. Rohrbach could not find a job for Claimant within her physician-imposed restrictions. Ms. Rohrbach's notes show Claimant had no work restrictions but was uncooperative; it was Claimant who believed she could not perform any work despite Ms. Rohrbach's identification of several possible jobs. Second, Claimant testified that in the end Dr. Zoe gave her 150 Hydrocodone tablets and said she did not want to see Claimant anymore. Dr. Zoe's last note, dated May 1, 2009, discusses releasing Claimant from her care after they titrate down her medication over a several-week reduction period with follow-up appointments; it states that Claimant "started screaming." Claimant denied that she screamed at Dr. Zoe. Claimant did not make or attend any follow-up appointments to cooperate with attempts to wean her from her opiate addiction.

95. In testimony Claimant describes her job goals:

> If I had the opportunity to work from home where I could do - - you know, like sit, stand, take a bath when I needed to, I would be more than happy to do that, more than happy.

Claimant and her mother testified Claimant takes four to six hot baths, each lasting up to one hour or more, every day.

96. Where contemporaneously made written evidence is inconsistent with her testimony, the written evidence receives more weight.

Causation

97. 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).

98. In the few months before the October 30, 2005 incident Claimant had been receiving regular treatment for a lingering, right index finger injury. She reported significant pain. She reported significant swelling which was unconfirmed upon multiple examinations. She received opiate analgesics to relieve the pain she reported.

99. Within about 24 hours after the alleged incident, Claimant had undergone examinations by two separate physicians who found no objective abnormalities in her knee. Both noted that her pain responses prevented a complete examination of the knee. Narcotics were prescribed to alleviate knee pain.

100. Diagnostic imaging failed to demonstrate an objective condition requiring treatment.

101. Three arthroscopic surgeries failed to show a basis for Claimant's asserted level of pain and lack of function. Nevertheless, some mild irritation and scar tissue resulting from the first arthroscopic surgery was surgically treated in the second and third arthroscopic surgeries.

102. The preponderance of medical opinions supports a probable causal link between the October 30, 2005 accident and a possible sprain of the ACL—or perhaps PCL, depending upon which physician is consulted—ligament in Claimant's right knee. Additionally, some scarring under the patella was a compensable consequence of the first arthroscopic surgery. Regardless of exact diagnosis, medical testimony and records consistently demonstrate Claimant has exaggerated her pain and claims of other symptoms.

Medical Care Benefits and Maximum Medical Improvement

103. An employer is required to provide reasonable medical care for a reasonable time. Idaho Code § 72-432(1). A reasonable time includes the period of recovery, but may or may not extend to merely palliative care thereafter, depending upon the totality of facts and circumstances. *Harris v. Independent School District No. 1*, 154 Idaho 917, 303 P.3d 605 (2013). One factor among many in determining whether post-recovery palliative care is reasonable is based upon whether it is helpful, that is, whether a claimant's function improves with the palliative treatment. *Id.*; *see also*, *Sprague v. Caldwell Transp., Inc.*, 116 Idaho 720,

591 P.2d 143 (1979)(overruled on other grounds by Chavez v. Stokes, ___ Idaho ___, ___ P.3d ___, (July 7, 2015)).

104. To diagnose and treat Claimant's complaints of pain, medical care was reasonable from the date of the accident, October 30, 2005 through August 9, 2007. On that date, Dr. Huntsman—who had performed all three arthroscopic surgeries—opined Claimant to be at maximum medical improvement. His final diagnosis pertained to sequela of the surgeries rather than to any initial knee condition, contusion or sprain. He had, six weeks earlier, announced that his office was discontinuing Claimant's narcotics prescription.

105. In an ironic reversal of the usual arguments, Claimant asserts that her treating surgeon's—Dr. Huntsman's—opinion about the date of MMI is premature. She points to opinions of the panel IME, Drs. Gussner and Friedman, requested by Defendants in January 2008, and argues that these opinions should carry greater weight than Dr. Huntsman's. With almost the same breath, Claimant denigrates the perceived lack of neutrality of the panel because the suggested treatment included Dr. Friedman's own rehabilitation regimen. Dr. Gussner's other suggestion, an evaluation by a Dr. Burks at University of Utah, was precluded by Claimant herself, alleging insurmountable personal issues. Moreover, the panel physicians opined significant causation for the condition to a preexisting 1994 knee condition—an opinion which Claimant argues should not be considered persuasive.

106. When next they examined her on January 28, 2009, Drs. Gussner and Friedman, together with Dr. McClay, opined Claimant was medically stable. The preponderance of evidence fails to show an improvement in Claimant's condition between the dates of the two IME evaluations. The panel physicians do not identify any.

107. The preponderance of evidence shows physicians who treated Claimant after

August 9, 2007 merely provided, at best, palliative treatment which subjectively, temporarily, decreased Claimant's complaints of pain but did not provide any curative measures or restore function in a measurable way.

108. Dr. Huntsman was in the best position to evaluate Claimant at the most relevant times. He had performed the surgeries and actually observed Claimant's internal knee condition. His opinion that Claimant was at MMI as of August 9, 2007 carries the most weight.

109. About two weeks after being cut off from narcotics by Dr. Huntsman, by mid-June 2007 Claimant had secured a new narcotics prescription from Dr. Zoe. Dr. Zoe and all physicians thereafter provided only palliative care, hoping to reduce Claimant's reports of pain. But for a single recorded episode by Dr. Zoe in which she recounted that Claimant stated she did not want narcotics, Claimant asked for and received increasing amounts of narcotics. During the course of this lengthy pain management, Dr. Zoe recorded Claimant was noncompliant in limiting her narcotics. After nearly more two years of palliative care, primarily including narcotics, without objective indicia of any improvement in function, about May 1, 2009, Dr. Zoe informed Claimant she would begin a regimen to reduce and discontinue the narcotics. Claimant did not return to Dr. Zoe.

110. On September 2, 2010, Dr. Poston began his pain management, including narcotics. By June 2014 Dr. Poston recorded he would discontinue prescribing narcotics based upon Claimant's noncompliance. There are no more recent records from Dr. Poston in evidence.

111. Moreover, a significant amount of Dr. Poston's treatment included a spinal stimulator. The preponderance of evidence shows it failed to restore function in any objective way. Although still in recovery, Claimant returned to work in January 2006 and continued

to work into May 2006. She has not worked since. Testimony of Claimant's mother established that Claimant's activities of daily living have not improved since Claimant moved in with her in October 2011.

112. Considering the totality of facts and circumstances, Claimant's condition, related to the 2005 industrial accident reached MMI as of August 7, 2007. Medical care benefits thereafter were merely palliative and failed to restore function to any useful degree. Claimant has been actively uncooperative in assisting in her recovery and in improving her function post-recovery. Defendants did not act unreasonably in paying significant medical benefits into April 2009 and in refusing to pay additional medical benefits thereafter.

113. Claimant failed to show Dr. Poston's post-MMI palliative care was reasonable or probably related to the 2005 industrial accident or as a compensable consequence of it.

Temporary Disability

114. 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).

115. TTD benefits were identified as an issue in Claimant's Complaint. However, when Claimant requested a hearing in this matter she did not expressly identify a dispute over TTD benefits as being relevant for hearing. Her identification of a dispute over competing MMI dates does not, by itself, reasonably provide notice of an ongoing TTD dispute.

116. The Notice of Hearing did not identify TTD benefits as an issue for hearing. Often issues raised in a Complaint or Answer are resolved before hearing. A major purpose of issuance of a Notice of Hearing by the Commission is to provide the parties an opportunity to review and determine that all relevant issues will be addressed at hearing. Neither party sought the addition of an issue of TTD benefits.

117. No party raised an issue of TTD benefits at hearing.

118. The first mention of an issue of unpaid TTD benefits arose in Claimant's posthearing brief. There Claimant merely alleged that 168 weeks had passed to a proposed MMI date of January 28, 2009 and only 156 weeks of TTDs had been paid. Claimant failed to account for the period in January through May 2006 when Claimant actually worked. Rather, given the actual MMI date of August 9, 2007 is appears Defendants may have overpaid TTD benefits.

119. Defendants paid TTD benefits for certain weeks well after the actual MMI date of August 9, 2007. However, neither Defendants' Answer nor request for calendaring raised an issue of overpayment of TTDs. No such issue was raised at hearing. Defendants argued for overpayment in briefing in response to Claimant's belated assertion of these benefits.

120. The issue not having been timely or properly raised, TTD benefits or overpayment therefor are not under consideration at this time. Factually, it appears from the record available that Claimant has received all TTD benefits to which she would be entitled.

Permanent Impairment

121. 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).

122. Dr. Huntsman rated Claimant's knee at 3% PPI. Other physicians have rated it at 5%. There is not a significant objective basis for distinction between these ratings. Competent physicians evaluated Claimant clinically and applied their findings to *AMA Guides*.

123. A PPI rating of 5% of the whole person, causally related to Claimant's knee condition and 2005 industrial accident, without apportionment to her 1994 preexisting knee condition, is appropriate.

Permanent Disability

124. "Permanent disability" or "under a permanent disability" results when the actual or presumed ability to engage in gainful activity is reduced or absent because of permanent impairment and no fundamental or marked change in the future can be reasonably expected. Idaho Code § 72-423. "Evaluation (rating) of permanent disability" is an appraisal of the injured employee's present and probable future ability to engage in gainful activity as it is affected by the medical factor of permanent impairment and by pertinent nonmedical factors provided in Idaho Code § 72-430.

125. The test for determining whether a claimant has suffered a permanent disability greater than permanent impairment is "whether the physical impairment, taken in conjunction with nonmedical factors, has reduced the claimant's capacity for gainful employment." *Graybill v. Swift & Company*, 115 Idaho 293, 766 P.2d 763 (1988). In sum, the focus of a determination of permanent disability is on a claimant's ability to engage in gainful activity. *Sund v. Gambrel*, 127 Idaho 3, 896 P.2d 329 (1995).

126. Permanent disability is defined and evaluated by statute. Idaho Code §§ 72-423

and 72-425, *et. seq.* Permanent disability is a question of fact, in which the Commission considers all relevant medical and non-medical factors and evaluates the purely advisory opinions of vocational experts. *See*, *Eacret v. Clearwater Forest Indus.*, 136 Idaho 733, 40 P.3d 91 (2002); *Boley v. ISIF*, 130 Idaho 278, 939 P.2d 854 (1997). The burden of establishing permanent disability is upon a claimant. *Seese v. Idaho of Idaho, Inc.*, 110 Idaho 32, 714 P.2d 1 (1986).

127. If a claimant is able to perform only services so limited in quality, quantity, or dependability that no reasonably stable market for those services exists, she is to be considered totally and permanently disabled. *Id.* Such is the definition of an odd-lot worker. *Reifsteck v. Lantern Motel & Cafe*, 101 Idaho 699, 700, 619 P.2d 1152, 1153 (1980). Taken from, *Fowble v. Snowline Express*, 146 Idaho 70, 190 P.3d 889 (2008). Odd-lot presumption arises upon showing that a claimant has attempted other types of employment without success, by showing that she or vocational counselors or employment agencies on her behalf have searched for other work and other work is not available, or by showing that any efforts to find suitable work would be futile. *Boley*, *supra.*; *Dehlbom v. ISIF*, 129 Idaho 579, 582, 930 P.2d 1021, 1024 (1997).

128. Here the extent of Claimant's actual injury at the time of the 2005 industrial accident is insignificant. She suffered, at most, a minor sprain. However, extensive medical treatment, including three arthroscopic surgeries and several injections have produced a harmful result. Medical opinions persuasively suggest some pain may be the result of scarring from the surgeries. Protracted treatment has enabled Claimant's perception of chronic pain.

129. On the other hand, Claimant was capable and did return to work in 2006. The record does not show that her condition has objectively worsened. The record does not show a likely basis to explain why she has not worked since. Physicians relying upon objective findings

have refused to impose any restrictions. Other physicians have suggested only nonspecific, nonquantifiable limitations, dependent upon Claimant's perceptions of her tolerance.

130. The consensus of medical opinion agrees Claimant should be weaned from narcotic medications. Claimant has sabotaged attempts to do so. Moreover, Claimant was taking narcotics for a finger injury before the 2005 industrial accident. Causation for her addiction has not been shown to be a likely iatrogenic, compensable consequence of her knee injury.

131. Physicians have suggested potential secondary gain without opining to the standard of medical probability. This issue presents myriad conflicting underlying facts. Claimant's teenage psychological/behavioral history; her use and abuse of medications; Social Security data showing less than full-time, minimum-wage work on an annual basis throughout her work life; prolonged palliative care, including a spinal stimulator, paid by Medicaid; the fact of the duration of active, palliative treatment; her living conditions since October 2011 enabling her perception and lifestyle of disability; these factors all appear to have contributed to the complexity of this issue. The record is insufficient to establish a finding for or against Claimant with regard to secondary gain as a motivation.

132. One or more pain physicians and physicians whose opinions Claimant has sought outside the chain of referral have suggested possible limitations of activity without specifically imposing restrictions. These opinions are unpersuasive. They have done so based upon Claimant's subjective reporting which is inconsistent with all objective measures. Although it would be logical and statutorily consistent to deny disability in excess of PPI based upon the absence of medically-imposed, objectively-based restrictions, one is left with a pervasive disquiet. After nearly 10 years of minimal function, the likelihood of ever returning to gainful

employment appears extremely remote.

133. Clearly, Claimant is not totally and permanently disabled. She is not 100% disabled. She does not qualify as an odd-lot worker. Claimant withdrew these issues at hearing.

134. Equally clearly, the accident and injury described in early medical records is not of the sort that anyone could reasonably expect to have caused more than a brief absence from work with a full and timely recovery with minimal, if any, permanent residual.

135. Claimant has refused some conservative treatment measures and has been uncooperative with others. She has changed physicians when a discontinuation of narcotic prescriptions was announced or seemed imminent.

136. Claimant failed to show why she has not attempted to work since May 2006. Claimant failed to establish by a preponderance of evidence that she is entitled to disability in excess of PPI as a result of her 2005 industrial injury.

Attorney Fees

137. Applying Idaho Code § 72-804, Defendants have acted reasonably at all times. In hindsight, by complying with the ultimately rejected opinions of Drs. Gussner and Friedman about MMI in 2008, they have paid more than legally required. Defendants are to be commended for paying for palliative care well beyond the date of MMI.

CONCLUSIONS

1. Claimant injured her knee in a compensable accident on October 30, 2005;

2. Claimant is entitled to medical care benefits related to the injury to the date of medical stability, August 9, 2007. She failed to show she is entitled to palliative treatment thereafter. Defendants did not unreasonably discontinue payment of palliative treatment in April 2009;

3. TTD benefits or overpayment therefor were issues not timely or properly raised.

Nevertheless, the record shows TTD benefits were appropriately paid to the date of medical stability;

4. Claimant is entitled to PPI rated at 5% of the whole person, without apportionment;

5. Claimant failed to show it likely she suffered permanent disability in excess of PPI as a result of the 2005 accident; and

6. Defendants are not liable for payment of Claimant's attorney fees.

RECOMMENDATION

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

DATED this 24th day of August, 2015.

INDUSTRIAL COMMISSION

_/s/_____
Douglas A. Donohue, Referee

ATTEST:
_/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 23rd day of September, 2015, a true and correct copy of **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** were served by regular United States Mail upon each of the following:

PAUL T. CURTIS
598 NORTH CAPITAL AVENUE
IDAHO FALLS, ID 83402

W. SCOTT WIGLE
P.O. BOX 1007
BOISE, ID 83701

dkb

_/s/_____

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

CHANNEL (BLACKER) RISH, Claimant, v. THE HOME DEPOT, INC., Employer, and INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA, Surety, Defendants.	**IC 2005-011806** **ORDER** Filed September 23, 2015

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

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

1. Claimant injured her knee in a compensable accident on October 30, 2005.

2. Claimant is entitled to medical care benefits related to the injury to the date of medical stability, August 9, 2007. She failed to show she is entitled to palliative treatment thereafter. Defendants did not unreasonably discontinue payment of palliative treatment in April 2009.

3. TTD benefits or overpayment therefor were issues not timely or properly raised. Nevertheless, the record shows TTD benefits were appropriately paid to the date of medical stability.

4. Claimant is entitled to PPI rated at 5% of the whole person, without apportionment.

5. Claimant failed to show it likely she suffered permanent disability in excess of PPI as a result of the 2005 accident.

6. Defendants are not liable for payment of Claimant's attorney fees.

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

DATED this 23rd day of September, 2015.

INDUSTRIAL COMMISSION

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

_/s/_____
Thomas E. Limbaugh, Commissioner

"RECUSED"
_____
Thomas P. Baskin, Commissioner

ATTEST:
_/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 23rd day of September, 2015, a true and correct copy of the **ORDER** was served by regular United States Mail upon each of the following:

PAUL T. CURTIS
598 NORTH CAPITAL AVENUE
IDAHO FALLS, ID 83402

W. SCOTT WIGLE
P.O. BOX 1007
BOISE, ID 83701

dkb

_/s/_____