BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

MARLENA WOODWARD, Claimant, v. NORTHWEST PARAMEDIC ASSOC., Employer, and IDAHO STATE INSURANCE FUND, Surety, Defendants.	**IC 2007-036361** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** Filed 8/21/15

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Brian Harper, who conducted a hearing in Boise, Idaho, on November 7, 2014. Claimant was represented by Sam Johnson, of Boise. Gardner W. Skinner, Jr., of Boise, represented Employer and Surety. Oral and documentary evidence was admitted. Post-hearing depositions were taken and the parties submitted post-hearing briefs. The matter came under advisement on July 6, 2015.

ISSUES

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

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

a. Medical care; and

b. Attorney fees.

Claimant's (potential) future income, impairment and disability issues are reserved.[1]

CONTENTIONS OF THE PARTIES

Claimant asserts that she is entitled to ketamine infusion therapy followed by intensive physical therapy to treat her accepted Complex Regional Pain Syndrome (CRPS). Depending on how she tolerated physical therapy, Claimant, with input from her treating physicians, would subsequently consider enrolling in the LifeFit functional restoration therapy program. Defendants are liable for attorney fees for their unreasonable file adjusting and refusal to timely allow Claimant's infusion treatments.

Defendants argue that past ketamine infusion has provided Claimant with no gradual improvement. Continuing such a regimen is unreasonable. While Defendants are willing to approve the ketamine infusion therapy if Claimant immediately thereafter enrolls in LifeFit or a comparable functional restoration therapy program, she has refused to participate, in spite of her treating physician recommendations. The treating physician, not the Claimant, should be entitled to direct Claimant's appropriate health care. Defendants are not liable for attorney fees.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. Hearing testimony of Claimant and State Insurance Fund examiner Diane Evans;

2. Claimant's Exhibits (CE) A through O, admitted at hearing;

3. Defendants' Exhibits (DE) 1through 31 – including supplemental subparts for exhibits 6, 12, 19, 20, 24, and 25 – and 33 through 40, admitted at hearing;

[1] The issue of TTD benefits was included in the hearing notice, but the parties agreed the TTD benefits for the contested time frame from October 2012 running into January 2013 was no longer an issue, as they had been paid.

4. The post-hearing deposition transcript of Michael Severson, M.D., taken on February 12, 2015; and

5. The post-hearing deposition transcript of Nancy Greenwald, M.D., taken on March 6, 2015.

All pending objections preserved during post-hearing depositions are overruled.

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

FINDINGS OF FACT

1. On October 17, 2007, Claimant, while acting in the course and scope of her employment, injured her neck and right shoulder while transporting an unresponsive infant by ambulance to a medical helicopter.

2. Claimant has developed Complex Regional Pain Syndrome (CRPS) as the result of the accident. The diagnosis was made in September 2008, although it was suspected as early as late April 2008.

3. Claimant has had an involved and varied course of medical treatment and therapy since 2007. A visit-by-visit narrative is not needed to determine the limited issues involved herein. Instead, a summary of events and medical provider records relevant to understanding Claimant's course of treatment is more appropriate.[2] However, a detailed analysis of portions of Claimant's medical history since 2007 is provided where necessary to address a particular point in question.

[2] Not every physician for whom records were supplied is discussed; only those with relevance to the addressed issues.

Medical Provider Summary

Dr. Hajjar

4. After her initial ER visit on the day following the accident, Claimant came under the care of Michael Hajjar, M.D., with whom she had formerly treated for accident-related back, neck, and left-sided upper extremity symptoms. Dr. Hajjar had performed a C5-6 decompression and fusion surgery in March 2007 to treat Claimant's neck symptoms from her previous accident.

5. From the date of the subject accident until September 2011, Dr. Hajjar's involvement in Claimant's care was primarily focused on ordering and reviewing diagnostic films, ruling out surgical treatment for her ongoing neck, back, and upper extremities complaints, prescribing medications, and authorizing physical therapy.

6. On September 19, 2011, Dr. Hajjar surgically implanted a spinal cord stimulator (discussed in greater detail hereinafter) in Claimant's cervical spine via a C5-6 laminectomy procedure. The stimulator was designed to address Claimant's ongoing CRPS involving her right upper extremity.

7. Of significance to the issue at hand, Dr. Hajjar, on March 3, 2013 agreed in a letter to Surety that Claimant "should attend LifeFit" and further opined that Claimant "has to follow through with the recommendations including things that may not sound very attractive such as functional restoration" if she wants to be successful in overcoming her CRPS. DE 11, p.82.

Dr. Morland

8. James Morland, M.D. provided Claimant pain management care from January 2008 through mid-April 2011. It appears the two parted company when

Dr. Morland refused, based on Claimant's psychological testing, to endorse Claimant's use of a spinal cord stimulator.

9. By March 2008, Dr. Morland determined Claimant's complaints could not be explained with objective testing; he suggested a pain psychologist. Claimant was also taking the opioid pain medication Dilaudid, and participating in physical therapy.

10. On April 11, 2008, Dr. Morland released Claimant to full duty work for four hours per day. He also suggested a work hardening program. Claimant was using a TENS unit, and had prescriptions for Neurontin, Lidoderm patches, and Darvocet-N, in addition to the Dilaudid.

11. At her April 28 2008 office visit, Claimant suggested trigger point injections; Dr. Morland acquiesced to a series of injections over the next several weeks. He also prescribed a Medrol Dosepak to address his CRPS suspicions.

12. Claimant asked Dr. Morland to take her off of Neurontin in early May, due to her belief it was making her gain weight. Dr. Morland moved her to Cymbalta.

13. On her May 20, 2008 office visit, Claimant requested more trigger point injections, which Dr. Morland performed. He also started her on Fosamax for her CRPS.

14. At her next appointment, Claimant reported that she had seen the psychologist, Robert Calhoun, Ph.D., and he had suggested a repeat MRI prior to Claimant's inclusion in a work hardening program. That suggestion did not make its way into Dr. Calhoun's written records, but nevertheless Dr. Morland ordered one, even though his review of her prior MRI, taken three months earlier, showed no abnormality whatsoever. Dr. Morland felt a repeat MRI could make it "100% sure" there were no

issues with Claimant's cervical spine when she proceeded to a work hardening program. The MRI was negative for any new developments.

15. On June 18, 2008, Claimant told Dr. Morland the Darvocet was no longer working and she wanted Ultram. Dr. Morland complied. She also indicated Dr. Calhoun wanted her off work until he could "reevaluate" her. There is no evidence in Dr. Calhoun's provided records to support this statement.

16. By September 3, 2008 Claimant had stopped counseling with Dr. Calhoun, was still complaining of neck and right upper extremity pain, numbness and weakness, and had gained significant weight, presumably due to certain medications. Dr. Morland diagnosed CRPS, which he had suspected for some time. During this visit, Claimant informed Dr. Morland that she had been researching spinal cord stimulation. Dr. Morland wanted Claimant to resume seeing Dr. Calhoun, and return to work in a light duty capacity.

17. On September 10, 2008 Claimant reported she saw Dr. Calhoun, who was in favor of her enrolling in a multidisciplinary work hardening program. Claimant brought up the idea of a spinal cord stimulator again, and Dr. Morland was not in favor of the treatment at that point. He felt work hardening was a better treatment option.

18. Claimant enrolled in the work hardening program at St. Alphonsus. Nine days into the treatment (October 20, 2008) she reported increased pain in her neck and right arm, but her ROM of her right arm was improving.

19. At her December 3, 2008 visit to Dr. Morland, Claimant reiterated her interest in a spinal cord stimulator. Again Dr. Morland expressed his reluctance.

20. On December 15, 2008, Claimant and her mother presented to Dr. Morland. Claimant had been dismissed from the work hardening program, due to her lack of progress

and issues with her weaning from narcotic medications. Claimant wanted medication for her pain. Dr. Morland was not willing to reinstate Claimant's narcotics at that time. Claimant was taking Elavil for sleep issues; Dr. Morland prescribed her Ambien to assist her in sleeping. Claimant again discussed the possibility of a spinal cord stimulator. Dr. Morland pointed out Claimant needed an appropriate psychological consultation before it would be considered.

21. When Claimant returned to Dr. Morland on January 12, 2009, she indicated Dr. Calhoun suggested a second psychological opinion on whether Claimant was a candidate for a spinal stimulator.[3] Dr. Mike McClay, Ph.D., a clinical psychologist, was suggested.

22. Claimant saw Dr. McClay, who considered Claimant a "guarded" candidate for a stimulator. He felt she would be better served by a functional restoration program, "if she could take it seriously." DE 19, p. 3. With that opinion, Dr. Morland asked for a conference between Dr. Calhoun, Dr. McClay, and himself. On September 2, 2009, they discussed the issue. Both psychologists felt a spinal cord stimulator would "be a mistake." They believed that given her psychological make up, she would likely have a brief period of improvement in her pain, but no long term lasting benefit. The consensus was to not move forward with the stimulator trial. DE 13, p. 63.

23. On October 12, 2009, Dr. Morland indicated in response to a request from Surety that Claimant was fixed and stable.

[3] As will be discussed *infra* Dr. Calhoun did not believe Claimant was a good candidate for a spinal cord stimulator at that time.

24. On December 2, 2009, Dr. Morland told Claimant there was no reason she could not return to full activity, and encouraged her to return to her time-of-injury employer if there was a position for her there. Claimant was not on narcotic medication.

25. On January 11, 2010, Claimant reported her employer would not re-hire her at that time, and she was more functional than she had been in the last couple of years.

26. Claimant had resumed working as an EMT/ambulance driver by the time she saw Dr. Morland in early April, 2010. She was taking Cymbalta, Savella, Elavil, Soma, and Ambien, but no narcotics.

27. Claimant continued to work, but at her September 14, 2010 visit with Dr. Morland, she complained of significantly increased pain, without a precipitating event. Dr. Morland prescribed the narcotic drug Dilaudid for her pain, to be taken at night. He told Claimant she could not work or drive when taking this medication. He also performed trigger point injections.

28. Nine days later Claimant returned to Dr. Morland requesting additional trigger point injections. Dr. Morland asked Michael Severson, M.D. of Advanced Pain Management to see Claimant. Dr. Morland eventually asked Dr. Severson to administer Claimant a series of stellate ganglion blocks.

29. On November 24, 2010, due to Claimant's increased complaints, Dr. Morland refilled Claimant's Dilaudid prescription and recommended a spinal cord stimulator trial. Dr. Morland noted all other conservative measures, including the stellate ganglion blocks, had failed to help Claimant.

30. Surety requested additional information, including a psychological evaluation, in response to the stimulator recommendation. Dr. Morland wanted repeat

cervical MRI films. On January 13, 2011, Claimant presented with increasing symptoms including intermittent numbness in the first and second digits of her left hand. Dr. Morland noted Claimant seemed to be getting worse by the month. She was continuing to work part time.

31. After reading a psychological evaluation of Claimant authored by Craig Beaver, Ph.D. on February 17, 2011, Dr. Morland reversed his course and refused to offer Claimant a spinal cord stimulator.

32. At Claimant's last visit with Dr. Morland, he reiterated he could not recommend a spinal cord stimulator. Claimant wanted to see Dr. Calhoun again. She was still working, but was having difficulty functioning.

Dr. Calhoun

33. Robert Calhoun, PhD., a pain psychologist, began seeing Claimant at Dr. Morland's request on May 21, 2008.

34. Psychological testing characterized Claimant as a person

- likely to somatize stress;
- with a high need for affection and attention;
- who could manipulate others with emotional expression;
- who could be very dramatic in her expressions of emotion;
- who does not take criticism well, even if meant constructively;
- who can be rigid and controlling;
- with histrionic personality trends.

35. At her August 18, 2008 consultation, Claimant related that she had undergone an IME, at which she felt she was degraded and disrespected. Thereafter her

pain intensified. Dr. Calhoun discussed with Claimant how her anger over the IME could intensify her pain and suffering, and encouraged her to process the anger and move on emotionally.

36. Dr. Calhoun was in favor of Claimant's participation in the WorkStar work hardening program, while simultaneously receiving further psychological counseling to address her somatoform tendencies, fear of pain, fear of movement, and pain-contingent activity level.

37. Claimant expressed reservations about St. Luke's work hardening program because her father went through it in the past and had "very negative" experiences. As previously noted, she did enroll in the St. Alphonsus WorkSTAR program.

38. During the early stages of the work hardening process, Claimant complained of increased pain, swelling, and discoloration of her right arm. She raised the idea of a spinal cord stimulator with Dr. Calhoun. He observed that while Claimant was improving functionally with the program, she continued to be highly focused on her pain.

39. Through the fall of 2008, Claimant continually brought up the notion of a spinal cord stimulator, and Dr. Calhoun consistently rejected the notion. During his November 19, 2008 session, Dr. Calhoun suggested Claimant needed to focus on her treatment gains in the WorkSTAR program, and not on her diagnosis, her prognosis, or the use of the spinal stimulator. This admonishment angered Claimant's mother, who was attending the session, to the point she left the room.

40. At her December 1, 2008 session, Claimant reported she had been "kicked out" of the WorkSTAR program. Claimant told Dr. Calhoun she was dismissed because she missed a previous session due to illness. Claimant "was laughing and giggling in

reaction to being kicked out" of the program. The doctor noted Claimant did not appear to be at all upset. DE 14, p. 26.

41. In mid-December, 2008, Claimant again asked Dr. Calhoun to reconsider his position on the spinal cord stimulator. Dr. Calhoun pointed out that relying on medications or a spinal stimulator as opposed to learning cognitive and behavioral strategies for pain management was likely to not provide the relief Claimant sought. Dr. Calhoun suggested a second psychological opinion on Claimant's request for a stimulator.

42. By late January 2009, Claimant was more upbeat and appeared motivated to move into a new line of work. She continued to be off opioids, and was more physically active, which was benefiting her. Dr. Calhoun recommended Claimant avoid opioids moving forward.

43. Dr. Calhoun last consulted with Claimant on February 19, 2009. At that time Claimant stated she was more hopeful for her future, and was coping better emotionally with her pain. Dr. Calhoun pointed out that the sooner Claimant moved forward vocationally, the better off she would be. As he noted, boredom, fear, and insecurity enhanced her pain perception while reducing her level of pain tolerance. Dr. Calhoun felt Claimant was coping sufficiently to cease his psychological treatments.

Dr. Krafft/WorkSTAR

44. Kevin Krafft, M.D. was the medical doctor associated with Claimant's work hardening program, and kept track of her progress as part of a multi-disciplinary team. His file contains records from the program, and will be discussed as appropriate, even if certain notes were generated by a different author.

45. Claimant began the WorkSTAR treatments for two hours per day the first week, but soon progressed to three hours daily. Thereafter, she progressed very slowly. Her right shoulder flexion and abduction increased significantly, but her reported pain increased with therapy. She was using a TENS unit on a constant basis.

46. On her October 17, 2008 visit with Dr. Krafft, Claimant suggested using an "IceMan" cold water device, as she apparently had one prior, and felt it worked to lessen her right extremity pain. Claimant offered to find out the details of how to order the device. On October 28 Dr. Krafft wrote Surety requesting the unit. At the same time, Dr. Krafft began gradually reducing Claimant's Dilaudid use. Subsequently, Claimant was given a pain contract to sign, but she did not execute it.

47. Dr. Krafft monitored Claimant through the work hardening program. He continued to wean her from her opioid use; she continued to complain of varying upper right extremity and neck pains. Her ROM continued to improve.

48. On November 17, 2008, Dr. Krafft provided Claimant trigger point injections at her request.

49. On December 22, 2008, Dr. Krafft prepared an impairment rating report after Claimant had been dismissed from the WorkSTAR program. Therein he made the following observations;

- Claimant's participation in the program from October 7, 2008 until the date of his report had been inconsistent; she missed 14% of her sessions;
- Claimant could lift 35 pounds to shoulder level as of that date;
- Claimant could lift 30 pounds overhead;
- With moderate difficulty she could perform simulated work tasks of carrying a 27 pound standby kit up five flights of

stairs, transfer a 125 pound individual from all levels, including from the floor with assist of one other person, transport 50 pounds on a gurney backboard up two flights of stairs with assistance of another person, and perform CPR for over one minute;

- By the time she was dismissed, she was in therapy for four hours per day without significant signs of CRPS. She improved her body mechanics, and made slow but steady progress throughout the time spent in the program;

- She was no longer taking Dilaudid or other opioid medication;

- She continued to complain of numbness in the fourth and fifth digits of her right hand, with some discomfort on forward flexion of her right arm. Her shoulder ROM, right and left, in degrees, was – forward flexion 145 and 180, extension 45 and 55, internal rotation 65 and 90, external rotation 90 bilaterally, and adduction 30 and 46. She had normal upper reflexes bilaterally.

50. Utilizing the *AMA Guides to the Evaluation of Permanent Impairment,* Sixth Ed.*,* Dr. Krafft computed a whole person impairment of 8% for her current impairment. He noted she previously was given a 10% whole person impairment for her neck injury and surgery, which resulted in a -2% whole person impairment.

51. Dr. Krafft rated Claimant's work capacity as light to medium, with limits of 35 pounds lifting on an occasional basis, as well as crawling and right hand grasping on an occasional basis.

Dr. McClay

52. Michael McClay, Ph.D., a clinical psychologist in Boise, was requested by Dr. Morland in February 2009 to give a second opinion on Claimant's suitability for a spinal stimulator. After testing, Dr. McClay concluded Claimant had a conversion type behavior pattern in which she converts psychological tension to physical tension and pain.

He felt Claimant was likely to over-report and over-react to pain, preferring a medical explanation for psychological issues. Individuals with this behavior pattern may tend to manipulate others through symptom complaints, and are at risk to become dependent on pain killers or other psychoactive medication. As noted previously, he felt she was a "guarded" candidate due Claimant's probable Symptom Magnification Syndrome.

Dr. Beaver

53. In January 2011, Surety requested Craig Beaver, Ph.D., a Boise psychologist, provide a comprehensive psychological evaluation for reconsideration of its previous decision to not fund Claimant's requested spinal cord stimulator. At the outset, Dr. Beaver noted both Drs. Calhoun and McClay had by this time indicated Claimant would be at high risk for having a poor response to a stimulator because of a conversion V type MMPI profile.

54. Dr. Beaver administered Claimant a battery of fourteen psychometric tests and reviewed and summarized her medical treatment history.

55. Dr. Beaver thought a LifeFit or work hardening program would not be very beneficial, since at the time of the examination, Claimant was working full time. He found no chemical dependency, despite Claimant having been on substantial amounts of opiate medications at various times. He noted she was generally compliant when those medications were reduced or stopped. He found no drug-seeking component to her pain complaints. Dr. Beaver found no evidence of substantial mental illness or overt secondary gain.

56. Dr. Beaver was concerned with Claimant's MMPI conversion V profile, which is a negative indicator for a spinal cord stimulator. He felt Claimant minimized her depression and anxiety and its role in her continuing pain.

57. After weighing the psychological pros and cons, Dr. Beaver proposed a stimulator trial for a lengthy time frame to minimize placebo effect, reduced narcotic medications prior to the trial, with no narcotics once the trial has started. If Claimant showed a positive response to the stimulator she should undergo physical therapy, perhaps even a short-course work hardening program with an emphasis on functional restorative measures. She should also maintain employment during the trial period.

58. Dr. Beaver also noted that even if Claimant did not have a stimulator trial she should undergo a course of occupational therapy focused on desensitization of her right arm.

Dr.Severson

59. After Dr. Morland terminated his treating physician relationship with Claimant, she came under the care of Michael Severson, M.D., who had previously provided her with minimally-beneficial stellate ganglion blocks beginning in 2010.

60. From his first visit with Claimant, Dr. Severson was in favor of a spinal cord stimulator. Eventually, in August 2011, Claimant, with the help of Dr. Severson, was surgically fitted with a trial stimulator. Prior to the surgery, Claimant was required to wean off of her opiod medication, which she was able to do.

61. Claimant reported 80% relief from the trial stimulator two weeks post-surgery; she desired a permanent implantation. Her mother noted Claimant was sleeping well, and using her arm.

62. Due to Claimant's reported success with the stimulator trial, the decision was made to implant it permanently, which surgery was performed on or about September 19, 2011.

63. By December 2011, Claimant was reporting worsening pain (from an average 2/10 two weeks after the trial stimulator was implanted, to an average pain of 5/10 with spikes up to 10/10). She was again taking opioids on a daily basis, to Dr. Severson's surprise and disappointment.

64. Claimant's stimulator implant caused her pain and problems to the point a second surgery to revise its location and function was required in March 2012. Thereafter, the stimulator helped reduce her right arm sensitivity and pain. However, her left arm began to hurt severely, which Claimant attributed to the fact she had difficulty with her IV placement pre-surgery. Apparently, the nurse had trouble placing the IV and ended up sticking Claimant multiple times. Eventually the IV was placed in Claimant's foot.

65. At Claimant's June 4, 2012 examination, Dr. Severson found both of Claimant's arms and hands were swollen, purple, and disproportionately sensitive to touch. Her pain level was 7/10. Dr. Severson concluded that while he believed the stimulator was providing some pain benefit, her CRPS was not improving. He felt Claimant would need to continue with her pain medication for the indefinite future. Dr. Severson agreed with Dr. Hajjar's assessment that Claimant was at MMI.

66. Dr. Severson's July 10, 2012 office notes include a reference to ketamine infusion therapy. Apparently he asked Claimant to research this option, as he was out of other ideas for treatment and Claimant's condition was worsening. Claimant's research led

her to Standiford Helm II, M.D., MBA, who provided ketamine infusion therapy through his Helm Center for Pain Management clinic in Laguna Hills, California.

67. Dr. Severson knew Dr. Helm from his days at UCLA. Claimant and Dr. Severson settled on Dr. Helm for the infusion therapy.

68. In his report to Surety (undated but with a fax date stamp of September 18, 2012) Dr. Severson noted that while he disagreed with Dr. Nancy Greenwald's diagnosis (she did not feel Claimant met the criteria for CRPS, as will be discussed below in greater detail), he felt her suggestions for Claimant's treatment were "excellent." After reiterating that Claimant "may benefit" from ketamine injection therapy in spite of its risks, Dr. Severson concluded his observations by recommending Claimant be referred to the LifeFit program, discontinue her "talk therapy", and taper her off opioids and sedatives, as they "are not likely to benefit her over time". DE 20, pp. 47, 48.

69. By late September 2012, Claimant had reached the conclusion that she wanted ketamine infusion treatment, did not want to participate in LifeFit, as she felt the previous work hardening program did not help and was traumatic for her, did not want to wean from Dilaudid, and did not want Dr. Greenwald "taking over" her care.

70. When Claimant next saw Dr. Severson in October 2012, she had recently been to California for infusion treatment at her own expense. She reported her pain in the right arm to be 80% decreased, and she was able to wear sleeves, something which was normally too painful to attempt. Her left arm was not as improved as her right. In spite of this, Claimant continued taking her same medications, apparently at the request of Dr. Helm. Claimant was still debating whether to participate in LifeFit.

71. In a report to Surety dated March 5, 2013, Dr. Severson commented on a recent IME report from Dr. Greenwald. He agreed that Claimant should be weaned from opioids, but felt it could be difficult to do so. He felt Claimant was likely dependent on them physically, and perhaps psychologically. She might need dependence rehabilitation to get off of them. Dr. Severson also agreed that Claimant may benefit from physical therapy and counseling, but noted Claimant was not receptive to those treatments.

72. However, by September 2013, Claimant and Surety had reached an agreement whereby Surety would pay for an additional ketamine infusion session and associated costs, and Claimant would then immediately thereafter enroll in LifeFit. Unfortunately, just before Claimant was set to travel to California, LifeFit changed its starting date for its next session. In order to have Claimant receive the ketamine immediately prior to starting LifeFit, Surety asked Claimant to reschedule her trip to California from September to October, to coincide more closely with the start of LifeFit. Claimant refused to do so, and proceeded with the treatment as then-scheduled. She did not enroll in LifeFit thereafter.

73. At hearing, Claimant testified she did not reschedule her trip because her boyfriend, who went with her on this trip, had taken days off work, and could not reschedule his vacation time, her hotels in Las Vegas (where they stayed on the first day of the trip) and California were "pre-purchased" and not refundable, and her mother had to re-arrange her schedule to care for her dogs while she was gone. Claimant did acknowledge the Surety had agreed to reimburse her any non-refundable expenses she had incurred by having to reschedule the trip. Claimant also claimed she did not reschedule the infusion treatments from September to October because "delaying treatment for this disorder is the

worst thing you can do. Not having the proper treatment for it and not having the recommended treatment causes the prognosis to worsen." Hearing Transcript, pp. 81, 82.

74. While she claimed three months relief with the first ketamine session, the second infusion treatment's benefits lasted considerably less time. Claimant felt the treatment was less beneficial due to her being hospitalized with pneumonia. IV sticks in the hospital reportedly flared her CRPS.

75. Dr. Severson and Surety continued to exchange information and reports through 2013 and into 2014 regarding Claimant's status and treatment options. In his March 3, 2014 office notes, the doctor noted Claimant had been a no-show (due to illness) for an IME with Dr. Greenwald in January. Dr. Greenwald was still pushing to have Claimant enroll in LifeFit. Claimant had conflicts with Dr. Greenwald and Dr. Friedman, and as such did not want to participate in LifeFit. Claimant showed Dr. Severson online print outs of the LifeFit program and the work hardening program she had undergone previously and they sounded similar "on paper". Claimant called the work hardening program "torture" and wanted nothing to do with a similar program. Also Claimant did not want to be in a program with water therapy as she felt water aggravated her CRPS. Claimant still desired more ketamine treatments, but not followed by LifeFit, as required by Surety. Claimant was willing to do physical therapy instead, although she pointed out she had done P/T previously without lasting benefit.

76. Dr. Severson sympathized with Claimant's hesitation to enroll in a program like LifeFit when it would be painful, but felt she needed to put some effort into improving her condition. He felt that since she refused to participate in LifeFit, then at a minimum

she should do physical therapy after her ketamine infusion treatment. Dr. Severson recommended this compromise to Surety.

77. Over the course of 2014, Claimant began to worry that her CRPS was spreading to her lower extremities. She began having left knee hyperalgesia and could not bear to wear clothing over it. She was having similar problems with her right foot. She still refused to participate in a program like LifeFit, which Surety continued to demand as a condition of further ketamine infusion treatments. She and Dr. Severson continued to debate and discuss what therapies Claimant would and would not be willing to do. By mid June, Dr. Severson and Claimant agreed she would be willing to do "intensive physical therapy" not associated with LifeFit after her ketamine infusion treatment. If Claimant handled the P/T well, she would consider transitioning into a LifeFit type program. This is the regimen Dr. Severson is currently recommending.

78. Surety has consistently demanded Claimant enroll in a LifeFit program immediately after ketamine infusion, for reasons discussed hereinafter. In response to Dr. Severson's proposal, and based on Dr. Greenwald's opinions, Surety wrote to Dr. Severson with its own treatment proposal. Surety suggested a Monday through Friday daily physical therapy program with weekly medication adjustments through Dr. Severson (decreasing dosages), and psychologist counseling on a weekly basis. After two weeks of this program, Claimant would transfer to the LifeFit program for the remainder of her post-ketamine therapy. Claimant balked at psychological counseling; instead she simply wanted the infusion followed by physical therapy. She rejected LifeFit. Dr. Severson went along with her suggestions.

Dr. Greenwald

79. Nancy Greenwald, M.D., first saw Claimant on August 15, 2012 for an independent medical examination on behalf of Defendants. At the time of examination, Claimant had symmetrical arm temperature, symmetrical arm hair growth, no fingernail deformities, symmetrical muscle stretch reflexes at biceps, brachioradialis, and triceps, no arm discoloration or mottling, and right arm trigger points on her upper trapezius. No left arm trigger points noted, although Claimant had tender spots. Claimant was hypersensitive to any touch on her upper extremities. Claimant indicated she could not move her arms.

80. Using the *AMA Guide to Evaluation of Permanent Impairment,* Sixth Ed., Dr. Greenwald concluded Claimant did not meet the criteria for a CRPS diagnosis. Instead, Dr. Greenwald diagnosed hyperesthesia bilateral upper extremities, chronic pain syndrome, and abnormal psychological profile as per Drs. Calhoun, Beaver, and McClay. Dr. Greenwald noted ketamine treatment was "controversial at best" with a 15% failure rate and high risk for serious side effects and complications. Dr. Greenwald felt ketamine infusion was not the right treatment for Claimant at that time. Dr. Greenwald favored LifeFit or similar therapy programs. She felt Claimant could work, although probably not as a paramedic. Dr. Greenwald strongly recommended Claimant be weaned off Dilaudid and Soma.

81. After Dr. Severson wrote Dr. Greenwald and informed the latter that he had photographic evidence of Claimant's edema and vasomotor skin color changes, Dr. Greenwald agreed Claimant "seemed to fulfill the criteria for CRPS", although not under the criteria of the *AMA Guide to Evaluation of Permanent Impairment,* Sixth Ed. As Dr. Greenwald later clarified, a CRPS diagnosis based on a photograph of edema is

more subjective than if the physician actually observed and measured the condition. That said, Dr. Greenwald pointed out she was less concerned with an official diagnosis of CRPS and more concerned about Claimant's treatment, which Dr. Greenwald firmly felt should include the LifeFit program.

82. Shortly after Claimant's first ketamine infusion treatment in October 2012, Dr. Greenwald continued to advise against the treatment, or any further invasive procedures, in spite of Claimant's subjective claim of 80% pain reduction in her right arm with infusion. Dr. Greenwald felt that if Claimant continued to refuse the LifeFit program, then she was at MMI.

83. Claimant was scheduled for a follow up IME on January 15, 2013. By then the effects of the ketamine infusion therapy were wearing off. Claimant began sobbing and complained of extreme pain during manual muscle testing; she refused to allow Dr. Greenwald any further touching. Dr. Greenwald diagnosed CRPS type 1 right upper extremity and CRPS type 2 left upper extremity, together with chronic pain syndrome, chronic opioid use, abnormal psychological profile, low back pain with left leg radiation, migraines, history of falls, and elevated blood pressure and heart rate.

84. Dr. Greenwald opined that Claimant was at MMI as of the examination date.

85. On February 3, 2014, Claimant was scheduled for examination with Dr. Greenwald, but was a "no-show," claiming illness prevented her from attending. The doctor reviewed Claimant's medical records generated since her last examination. Dr. Greenwald opined that ketamine infusion could be a reasonable treatment option, but only if coupled with immediate placement in the LifeFit program. Dr. Greenwald pointed out that LifeFit is a month long functional restoration program, and is not the same as the

work hardening routine Claimant previously attended. Dr. Greenwald noted there was no objective evidence the ketamine alone was effective in providing long term pain reduction. She observed Claimant's narcotic pain medication regimen was unchanged after the infusion treatments. Concerning to the doctor was Claimant's refusal to enroll in LifeFit when no other modality tried by Claimant was helpful long term. Dr. Greenwald noted Claimant had nothing to lose, and potentially much to be gained, and yet Claimant refused to try LifeFit, even in the face of worsening symptoms, and new complains of left leg pain. Dr. Greenwald stressed that "spreading CRPS" is, the majority of times, due to lack of movement and poor function – the very issue a functional restoration therapy program addresses.

86. In July 2014, Dr. Greenwald responded to Dr. Severson's suggestion of ketamine infusion followed by "intensive physical therapy" as an alternative to immediate enrollment in LifeFit post infusion. She noted LifeFit was the only functional restoration program available locally, has set rules and guidelines, and full team support including psychological. Dr. Greenwald opined that if a therapy plan could be developed which included therapy five days a week, visits with Dr. Severson weekly to review and appropriately decrease Claimant's opioid medication, and have a psychologist meet weekly with Claimant for cognitive behavior treatments, that program would be acceptable, provided it was used as a segue into LifeFit. Dr. Greenwald felt two weeks of this intensive physical therapy would be sufficient prior to enrollment in LifeFit.

Dr. Helm

87. Dr. Helm first saw Claimant on October 15, 2012 at his California clinic. Four days later, he conducted infusion therapy via IV solution. Claimant's perceived pain level diminished immediately, but the effects began to wear off by early January, 2013.

88. On April 1, 2013, Dr. Helm authored a pain management progress report. Therein he documented Claimant's concerns about entering LifeFit. Claimant (erroneously) told Dr. Helm she was supposed to be off her medications prior to entering the program, and that she already went through a similar program but had to quit due to her CRPS. Claimant was also still experiencing disproportionate pain, with daily flare ups. Claimant also noted migraine headaches, which she had been experiencing for some time. Claimant rated her pain at 10/10. Dr. Helm felt Claimant should have a repeat ketamine infusion session. He was also critical of LifeFit, questioning why Claimant should repeat a work hardening program when she could not complete the first one. He also noted Claimant did not have a good relationship with Dr. Greenwald, who he (erroneously) was told ran the program. He suggested Claimant have physical therapy with her usual therapist, and simply add aquatherapy, which is provided in LifeFit.[4]

89. Claimant did have a second round of infusion therapy on September 9, 2013. She claimed over 70% initial relief from the treatment. Dr. Helm again expressed his opinions on LifeFit, stating "I support multidisciplinary programs, but a key component to their success is patient desire to participate. Given [Claimant's] prior experience and desire not to participate, I would suggest no money be spent on this program. I do not enable dependency; I just want resources to be wisely spent." DE 25a, p. 5.

[4] Interestingly, one of Claimant's complaints with LifeFit is the pool therapy; she claims she cannot tolerate water on her affected limbs.

DISCUSSION AND FURTHER FINDINGS

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). Facts, however, need not be construed liberally in favor of the worker when evidence is conflicting. *Aldrich v. Lamb-Weston, Inc.*, 122 Idaho 361, 363, 834 P.2d 878, 880 (1992).

91. Idaho Code § 72-432(1) mandates that an employer shall provide for an injured employee such reasonable medical, surgical or other attendance or treatment, nurse and hospital service, medicines, crutches, and apparatus, as may be reasonably required by the employee's physician or needed immediately after an injury or manifestation of an occupational disease, and for a reasonable time thereafter. If the employer fails to provide the same, the injured employee may do so at the expense of the employer.

92. Claimant has the burden of proving, by a preponderance of the evidence, all facts essential to recovery. *Evans v. Hara's, Inc.,* 123 Idaho 473, 849 P.2d 934, (1993). Claimant must provide medical testimony, by way of physician's testimony or written medical record, which supports a claim for compensation to a reasonable degree of medical probability. *Langley v. State Industrial Special Indemnity Fund*, 126 Idaho 781, 785, 890 P.2d 732, 736 (1995). However, magic words are not necessary to show a doctor's opinion is held to a reasonable degree of medical probability; only their plain and unequivocal testimony conveying a conviction that events are causally related. *Jensen v. City of Pocatello*, 135 Idaho 406, 412-13, 18 P.3d 211, 217-18 (2001).

Ketamine infusion

93. In the present case, Defendants agree it would be reasonable for Claimant to receive ketamine infusion therapy *if* coupled with Claimant participating in a functional restoration program such as LifeFit. Otherwise, the infusion therapy is simply a short-term pain reducing regime, and not reasonable given the fact Defendants already are providing Claimant with a pain relief program through Dr. Severson. The ketamine treatment has not led to improvement in Claimant's condition.

94. Claimant desires additional ketamine therapy, but for all realistic purposes, rejects participation in LifeFit or its equivalent. While she claims she would consider LifeFit under certain conditions, even her treating physician Dr. Severson testified repeatedly that Claimant is likely not going to participate in the program. As an alternative, Dr. Severson suggested an undefined "intensive physical therapy" program as an adjunct to the ketamine infusion.

95. Defendants have not asked for a determination that Claimant is currently at MMI, or if she refuses LifeFit would be at MMI. Therefore, the issue for resolution is limited to whether it is reasonable for Claimant to receive ketamine infusion followed by some form of physical therapy, or must she participate in a recognized functional restoration program post-infusion. Put another way, is the proposed medical treatment (ketamine followed by "intensive physical therapy") reasonable under Idaho Code § 72-432(1) even when 1) that treatment is acknowledged by Claimant's treating physician to be less-than-ideal, 2) the ideal treatment exists and is available to Claimant, 3) Claimant refuses to participate in the ideal treatment, 4) based solely on Claimant's refusal to

participate in the ideal treatment, Claimant's treating doctor recommends the less-than-ideal treatment.[5]

96. The medical records and her own testimony repeatedly show that if Claimant does not want to participate in a particular program, she will refuse to acknowledge its benefits. Conversely, when she participates in treatment of her choosing, or of which she approves, subjectively she touts how successful such treatment was in assisting her. This is true even when the record is directly at odds with her assertions. For example, the work hardening program which Claimant called "torture," and was eventually kicked out of, improved range of motion in her affected limb, weaned her off of narcotic drugs, and actually restored her function to the point she was able to return to employment. Yet she testified to obtaining no benefits from the program and had nothing but negative comments about it to her treating doctors. On the other hand, she persisted for years in demanding a spinal cord stimulator, and when she finally was fitted with one, she claimed it significantly helped her condition. The medical records do not support this contention. She did not stop taking narcotic drugs, did not return to work, did not have increased function, and in fact has seen her CRPS spreading since. Her argument that her pain is reduced is also not borne out by the record. She continues to rate her pain higher than before the stimulator was implanted. The same applies to her ketamine infusion sessions; they have been of limited and short-lived benefit, in spite of her contrary claims. In reality, Claimant has had no reduction in her pain medication, her subjective pain perception on a pain scale is higher now than before the infusion therapy, and with the exception of being

[5] It is worth noting Dr. Severson would not testify under oath that the ketamine treatment was "necessary," only that it could benefit her or was a good idea. Nevertheless, Defendants did not seek to exclude ketamine treatment on that basis, but rather acknowledged the treatment could be used in conjunction with LifeFit to improve Claimant's condition.

able to wear sleeves for some short period of time post-infusion, has shown no real benefits to infusion therapy alone.

97. Defendants point to this lack of "gradual improvement" as evidence continued ketamine treatment is not reasonable. The problem with this argument, ignoring any outdated *Sprague* implications, is that Claimant has not tried Dr. Severson's currently-recommended treatment regimen. It is not possible at this time to know if or to what extent that treatment plan will assist Claimant.

98. Given the fact that Claimant's attitude so greatly affects her perception of benefit, Dr. Severson testified against forcing Claimant into a program she is pre-determined will not help. He has fashioned his recommendation to avoid such a scenario. Instead, he crafted his current treatment suggestions by determining what Claimant would agree to do. In short, Claimant is the navigator of her course of treatment, and Dr. Severson is the driver, to an extent going where he is directed. This is not to disparage the doctor; he feels that in Claimant's case, it is better to provide her a program she will accept, even with a lower chance of success, than to shove her into a program she does not accept, and therefore has almost no chance of success. After all, it is difficult to succeed against one's will to fail.

99. As is replete in her medical records, it appears Claimant may be more interested in getting her way, and proving those who oppose her are wrong, than in doing what it takes to overcome her condition. (*See, e.g.* her testimony as set forth in paragraph 71 of this document.) This personality trait, coupled with Claimant's noted fear of pain (recorded by Dr. Greenwald as well as the psychologists discussed above) make her participation in LifeFit futile in her current state of mind.

100. The options available to Dr. Severson in this case are to try one last time to find a program Claimant will embrace and hopefully succeed in, or (again) declare Claimant at MMI and assess her impairment. He has chosen the former. Defendants balk at his proposal due to its perceived low chance of improving Claimant's condition.

101. The weight of the evidence supports Dr. Greenwald's opinion that Claimant is *best served* by enrolling in a LifeFit functional restoration-type program immediately after a ketamine infusion session; an opinion shared by Dr. Severson. However, that does not mean that any other physical therapy regime is necessarily unreasonable.

102. Under the unique facts presented herein, Dr. Severson's recommendation of ketamine infusion followed by a therapy program ultimately designed by the doctor, (undoubtedly with input from Claimant), is reasonable treatment under Idaho Code § 72-432(1). The Referee finds Dr. Severson's reasoning persuasive that enrolling Claimant in a program she will willingly tolerate is better than putting her into one she utterly rejects. However, it is important to realize that whatever course of treatment is chosen post-infusion, it is, by all medical accounts in the record, Claimant's one last treatment opportunity. No doctor has suggested any further treatment beyond the one contemplated, and at least four doctors have opined at one point or another that Claimant has reached her maximum medical improvement. While Dr. Greenwald testified quite convincingly that Claimant's chance of success with this program is scant, given the emotional and psychological components involved, and Claimant's medical history to date, in this particular case with this particular Claimant, a scant chance of success is better than no chance, and is reasonable treatment when the totality of the evidence is examined.

103. Claimant has proven her entitlement to one further ketamine infusion therapy session, followed immediately by an intensive physical therapy program designed by Dr. Severson. If Dr. Severson so recommends, Claimant is also entitled to enroll in LifeFit immediately after the intensive physical therapy.

104. Claimant did not prove her entitlement to reimbursement of past ketamine therapy sessions. The first was undertaken independently and not in conjunction with any physical therapy, which was contrary to Dr. Severson's treatment plan. Claimant pursued her second infusion session unreasonably, after being advised by Surety to change her appointment to the following month, in order to correlate the infusion treatment with the LifeFit scheduling. Claimant stubbornly refused to reschedule, and her excuses for not doing so proffered at hearing were trivial and inadequate to justify her behavior.

Attorney fees

105. Claimant argues she is entitled to attorney fees for Defendants' unreasonable denial of ketamine treatments. The record as a whole does not support Claimant's position.

106. While Claimant argues Dr. Greenwald "misdiagnosed" Claimant initially, (which seems to be a real sticking point for her), such a claim is inaccurate. At the time Claimant presented to Dr. Greenwald initially, she did not exhibit the required symptoms for a CRPS diagnosis. In fact, Dr. Greenwald changed her diagnosis only after she was informed that other doctors had seen photographs of Claimant which showed CRPS symptoms. Without seeing the symptoms, or photographs of them, (if that is even acceptable in reaching the CRPS diagnosis), Dr. Greenwald was technically accurate in not diagnosing CRPS at Claimant's initial visit.

107. Importantly, Dr. Greenwald's opinion that ketamine infusion alone is not a reasonable treatment appears to be sound. Other than the temporary relief provided by the ketamine, "a very strong painkiller," (Greenwald depo. p. 12) Claimant cannot point to any lasting benefits the infusion provided. It did not help her wean from narcotics, become more functional, return to work, resume daily activities (other than wearing sleeves for a period of time), or even prevent the spread of the condition.

108. The reason Defendants agreed to the infusion treatment was to allow Claimant to participate in a functional restoration therapy program, hopefully without a disabling level of pain. The ketamine therapy has been shown not to be a stand-alone cure in this case. Rather, it has functioned as a pain reducer which might allow Claimant to tolerate the functional restoration program, which is Claimant's best chance to improve her condition. It was not unreasonable for Surety to deny such infusion treatment without coupling it with a therapy program designed to actually assist Claimant in her recovery.

109. Claimant failed to prove her claim for attorney fees.

CONCLUSIONS OF LAW

1. Claimant has proven her entitlement to one further ketamine infusion therapy session, followed by an intensive physical therapy program designed by Dr. Severson. If Dr. Severson so recommends, Claimant is also entitled to enroll in LifeFit immediately after the intensive physical therapy.

2. Claimant has failed to prove her entitlement to reimbursement for her past ketamine infusion therapy sessions or costs related thereto.

3. Claimant has failed to prove her claim for attorney fees.

RECOMMENDATION

Based upon 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 30th day of July, 2015.

INDUSTRIAL COMMISSION

/s/
Brian Harper, Referee

CERTIFICATE OF SERVICE

I hereby certify that on the 21st day of August, 2015, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

SAMUEL JOHNSON
405 S 8TH ST STE 250
BOISE ID 83702

GARDNER W SKINNER JR
PO BOX 359
BOISE ID 83701

/s/

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

MARLENA WOODWARD, Claimant, v. NORTHWEST PARAMEDIC ASSOC., Employer, and IDAHO STATE INSURANCE FUND, Surety, Defendants.	**IC 2007-036361** **ORDER** Filed 8/21/15

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

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

1. Claimant has proven her entitlement to one further ketamine infusion therapy session, followed by an intensive physical therapy program designed by Dr. Severson. If Dr. Severson so recommends, Claimant is also entitled to enroll in LifeFit immediately after the intensive physical therapy.

2. Claimant has failed to prove her entitlement to reimbursement for her past ketamine infusion therapy sessions or costs related thereto.

3. Claimant has failed to prove her claim for attorney fees.

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

DATED this 21st day of August 2015.

INDUSTRIAL COMMISSION

/s/
R.D. Maynard, Chairman

Participated but did not sign
Thomas E. Limbaugh, Commissioner

/s/
Thomas P. Baskin, Commissioner

ATTEST:

/s/
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 31st day of August, 2015, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

SAMUEL JOHNSON
405 S 8TH ST STE 250
BOISE ID 83702

GARDNER W SKINNER JR
PO BOX 359
BOISE ID 83701

/s/

jsk