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

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| JEROLD MOSS,<br><br>Claimant,<br><br>v.<br><br>CDA SERVICE STATION EQUIPMENT, INC.,<br><br>Employer,<br><br>and<br><br>IDAHO STATE INSURANCE FUND,<br><br>Surety,<br><br>Defendants. | **IC 2013-000548**<br><br>**FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION**<br><br>**Issued 2/25/19** |

## INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Brian Harper, who conducted hearings in Coeur d'Alene, Idaho, on June 27, 2016 and May 1, 2018.[1] Claimant was represented by Charles Bean, of Coeur d'Alene. James Magnuson, of Coeur d'Alene, represented CDA Service Station Equipment, Inc., ("Employer") and Idaho State Insurance Fund ("Surety"), Defendants. Oral and documentary evidence was admitted. Post-hearing depositions were taken and the parties thereafter submitted briefs. The matter came under advisement on October 30, 2018.

[1] At the time of the first hearing Claimant was seeking, but had not received, a spinal cord stimulator implant. A key issue for resolution was whether the proposed implant should be paid for by Defendants. Not long after the hearing, Claimant obtained funding for the proposed implant surgery from a third party entity. He moved to suspend proceedings until after the surgery. The motion was granted. Well after this surgery a second hearing was conducted, with Claimant providing testimony as to his then-current physical status post-implant surgery.

## ISSUES

The issues noticed by the parties to be decided are:

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

2. Whether Claimant's condition is due in whole or in part to a pre-existing and/or subsequent injury or condition;

3. Whether and to what extent Claimant is entitled to the following benefits:
   a. Medical Care;
   b. Temporary Disability Benefits
   c. Permanent Disability in excess of Impairment (PPD), including Total Permanent Impairment under the Odd Lot Doctrine;

4. Whether apportionment for a pre-existing condition pursuant to Idaho Code § 72-406 is appropriate; and

5. Whether Claimant is entitled to attorney fees.[2]

## CONTENTIONS OF THE PARTIES

Claimant argues he was injured as the result of a covered fall at work on January 3, 2013. Claimant had neck and lumbar spine surgeries due to injuries he received in his work accident. Even after these surgeries, Claimant had ongoing pain complaints in his back, as well as his upper and lower extremities. Claimant's unrelenting pain and loss of function proved debilitating. A subsequent spinal cord stimulator improved Claimant's condition to some degree, but he is still incapable of sustained employment, and is thus totally and permanently disabled. Surety refused to pay for the stimulator implant. Claimant is entitled to the unpaid medical treatment costs,

[2] The only issues briefed and argued by Claimant were Claimant's right to medical treatment in the form of a spinal cord stimulator, a right to TTD benefits for an indeterminate time period, permanent disability in excess of impairment, and attorney fees. Defendants only briefed and argued against the spinal cord stimulator and permanent disability. As such, issues 1, 2, and 4 are waived, although the issue of disability does tangentially include pre-existing conditions but not as a separate issue for discussion.

including the spinal cord stimulator, temporary disability benefits until he reaches MMI, and total permanent disability benefits. Surety should pay attorney fees.

Defendants contend that Claimant had medical conditions which pre-existed his work injuries, and from which he never fully recovered. The restrictions in place for these conditions were the same as those given by Defendants' expert after Claimant's work accident. As such, Claimant's disability in excess of impairment is at most negligible. Claimant was not a good candidate for a spinal cord stimulator, and the implantation of such device was not reasonable or necessary. It failed to provide meaningful relief. Claimant is not entitled to temporary disability benefits.

## EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant, Claimant's wife, and Jessica Jameson, M.D., taken at the hearing of June 27, 2016, and Claimant's testimony taken at the hearing of May 1, 2018;

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

3. Defendants' Exhibits (DE) 1 through 36, admitted at hearing;

4. The post-hearing deposition transcripts of Daniel McKinney, Sr., taken on July 6, 2016, and May 10, 2018;

5. The post-hearing deposition transcript of Bret Dirks, M.D., taken on May 8, 2018;

6. The post-hearing deposition transcript of Craig Beaver, Ph.D., taken on June 7, 2018;

7. The post-hearing deposition transcript of Robert Friedman, M.D., taken on

June 27, 2018; and

8. The post-hearing deposition transcript of Douglas Crum, taken on June 28, 2018.

All objections and Motions to Strike preserved during the depositions are overruled.

## FINDINGS OF FACT

1. Claimant was a married 61 year old man living in Dalton Gardens, Idaho at the time of the last hearing. He obtained his GED after dropping out of high school as a sophomore. Thereafter he joined the Navy and was enlisted for just over two years. His post-military jobs included warehouse worker, purchasing agent, and wholesale/retail electrical component salesman. His time-of-injury job included purchasing parts and maintaining Employer's warehouse. Claimant also stocked parts, ran a fork lift, made job-site deliveries, bid contracts, and performed telephone sales tasks.

2. While working for Employer on January 4, 2013 Claimant tripped and fell down a three-foot stairway, striking his head. He injured his neck and low back during this accident. Claimant had a history of neck and back pain with past surgeries but during the two years preceding this accident he had not sought medical treatment for his back or neck.

3. Claimant was seen in the Kootenai Medical Center ER, where diagnostic studies were done of his neck and low back. The cervical CT scan showed Claimant's prior C4-C6 anterior fusion, along with spondylosis and bilateral bony foraminal narrowing. No acute traumatic injury was detected. Low back x-rays were positive for moderately severe L5-S1 disc space narrowing, with mild narrowing at L4-5, and mid-lumbar spondylosis.

4. A follow up lumbar MRI showed evidence at L5-S1 of Claimant's prior left

hemilaminectomy and a small broad-based left posterolateral disc herniation impinging the traversing left S1 nerve root. At L4-5 there was advanced disc degeneration with mild to moderate central canal stenosis and mild compression of the traversing L5 nerve root bilaterally. Claimant also had degenerative facet arthropathy throughout his lumbar spine.

5. Upon referral from his family doctor, Richard Bell, M.D., and John Swanson, M.D., who had been managing Claimant's persistent pain since the accident, Claimant began treating with Bret Dirks, M.D., a Coeur d'Alene neurosurgeon, on January 24, 2013.[3]

6. When he first presented to Dr. Dirks Claimant complained of neck and bilateral shoulder pain, right arm and wrist pain, and tingling fingers bilaterally, together with low back pain and shooting electrical pain down his left leg and numbness in his calf.

7. Dr. Dirks diagnosed left sided lower extremity radiculopathy consistent with Claimant's recurrent left L5-S1 disc herniation and L4-5 disc bulge with impingement on the descending and exiting nerve roots. With regard to Claimant's neck, Dr. Dirks found bilateral dysesthesias which he correlated to pseudoarthrosis at C4-5 and C5-6. Dr. Dirks noted that while the work accident "aggravated his symptomatology, [Claimant] is not fused and that will have to be addressed" surgically. DE 3, p. 254. Dr. Dirks prescribed physical therapy and injections for Claimant's low back.

8. Claimant underwent corrective neck surgery on March 11, 2013. His immediate recovery thereafter was as anticipated. Claimant's low back conservative treatments did not resolve his complaints. Dr. Dirks recommended a fusion surgery at L4-5 and L5-S1.

[3] Dr. Dirks was known to Claimant, as he was the surgeon who performed Claimant's prior cervical fusion surgery in 2010.

9. Claimant's lumbar surgery took place on May 15, 2013. Claimant's initial post-surgical recovery progressed well, although Claimant continued to complain of pain in his back with leg numbness, both far less than before surgery.

10. In August 2013 Claimant underwent transforaminal injections due to continuing left-sided back and hip pain.

11. On October 31, 2013, Claimant returned to Dr. Dirks complaining of increased pain in his back and down his legs. Claimant indicated he was having difficulty walking, and was barely able to do his exercises. His gait was slow and hunched over. Dr. Dirks ordered a repeat MRI and a nerve conduction study.

12. The EMG showed no evidence of active lumbosacral radiculopathy bilaterally, but the conducting physician did note that Claimant exhibited a "significantly low pain threshold" during the exam. DE 3, p. 314.

13. In his December 5, 2013 office notes, Dr. Dirks stated that Claimant's most recent MRI was "fairly unremarkable", as was the EMG study. Dr. Dirks prescribed two additional sets of injections at L4-5 and L5-S1, along with an EMG study for Claimant's upper extremities. Thereafter, Dr. Dirks anticipated declaring Claimant fixed and stable if the EMG came back normal. Dr. Dirks suggested Claimant continue pain management with his primary care physician. Dr. Dirks felt Claimant was not capable of returning to work at that time. He also noted Claimant had filed for Social Security Disability.

14. Claimant's upper extremities EMG of January 8, 2014, showed moderate chronic bilateral C5 radiculopathy, left greater than right.

15. Claimant then began a series of various injections and pain medication

treatments for his poorly controlled neck, shoulder, back and left leg pain. He received cervical and lumbar epidural injections, and was prescribed narcotic pain medication. Claimant complained that he had difficulty walking for any considerable distance (he could walk the 75 yards to his mailbox and back), trouble sleeping, numbness in his extremities, and was limited in what he could do on a daily basis. He took oxycodone or oxycontin every four hours, which made him "foggy." He was also treated for depression.

16. In August 2014, Jessica Jameson, M.D., one of the pain management physicians at Pain Management of North Idaho, PLLC, who had been treating Claimant's chronic pain complaints, suggested Claimant try a spinal cord stimulator. She felt Claimant could reduce his opiod consumption with the device, and sought Surety approval.

17. Surety set up a panel examination for Claimant to be seen by Robert Friedman, M.D., a rehabilitation physician, and Craig Beaver, a psychologist. The examination took place in September 2014. Both examiners felt Claimant was not a good candidate for a spinal cord stimulator from a medical and psychological standpoint, respectively.

18. Specifically, Dr. Friedman found after examining Claimant and reviewing medical records that Claimant's repeat cervical fusion with ongoing cervical radiculopathies, and Claimant's lumbar fusion surgery were causally related to his industrial accident. He also noted Claimant had a tremor and other symptoms indicative of possible degenerative nervous system disease (such as Parkinson's) unrelated to the accident, but worth exploring. Dr. Friedman opined that Claimant should wean from his opiates and anticholinergic medications. Claimant should use home icing and stretching for his lumbar spine.

19. Dr. Friedman thought Claimant should have permanent restrictions of 50 pounds occasional, 25 pounds frequent lifting, with no repetitive lifting above shoulder height greater than 20 pounds. However, he felt these restrictions should have been in place from the date of his earlier surgeries, such that there were no additional restrictions related to the work accident in question. Dr. Friedman also felt Claimant was at MMI, and assigned him a 16% whole person permanent impairment rating after apportionment, attributable to Claimant's industrial injuries.

20. From a psychological standpoint, Dr. Beaver diagnosed a somatic symptom disorder with predominant pain. He believed Claimant suffered from persistent, chronic pain, with secondary anxiousness and mood changes. Psychological factors impacted the severity of Claimant's pain complaints. Claimant also struggled with depression, for which he had received treatment and medication. Dr. Beaver noted Claimant met the criteria for an adjustment disorder with depressed mood diagnosis.

21. According to Dr. Beaver, Claimant's somatic symptom disorder reflected a longstanding coping style for Claimant, and was not associated with his work injuries. Instead, it was a pre-existing condition which interacted with Claimant's injuries.

22. On the other hand, Claimant's adjustment disorder with depressed mood was, according to Dr. Beaver, predominately caused above all other causes by Claimant's work injury. Claimant's depression was improved with medication and counseling at the time of Dr. Beaver's visit with Claimant, to the point where the doctor felt it was not causing Claimant significant difficulties. Dr. Beaver opined that any past or further counseling and/or medication for depression would be causally related to Claimant's work accident.

23. Dr. Beaver did not believe Claimant sustained any permanent impairment

from a neuropsychological standpoint as a result of the accident in question.

24. Based on the panel examination findings, Defendants denied Dr. Jameson's authorization request for a spinal cord stimulator.

25. On November 4, 2014, Defendants stopped Claimant's TTD benefits.

26. On March 18, 2016, Claimant returned to Dr. Dirks with complaints of neck, bilateral arm, low back, and bilateral leg pain in his thighs and calves. Additionally, Claimant exhibited upper extremity tremors and weakness. Dr. Dirks noted Claimant's gait was slow and deliberate, and it appeared Claimant had trouble walking. Dr. Dirks suggested diagnostic studies, as Claimant had, in Dr. Dirks' opinion, "gone downhill quite markedly" since his last visit in 2014. CE B, p. 2. Dr. Dirks opined that Claimant was totally disabled at that time, and might prove to be a candidate for a dorsal column stimulator, depending on the results of the planned studies. The doctor also felt Claimant was a candidate for long term narcotic pain management under physician supervision.

27. Claimant returned to Dr. Jameson on March 21, 2016 for a pain management consultation. At that time Dr. Jameson reaffirmed her belief that Claimant was "a perfect candidate for spinal cord stimulator." She noted the stimulator should allow Claimant to be "much more functional" and ideally reduce his opiate consumption by 50% or greater. CE C, pp. 2, 3.

28. Dr. Dirks conditionally signed off on a letter from Claimant's attorney dated March 22, 2016, agreeing with Dr. Jameson that a spinal cord stimulator was "a medical necessity" but noted that he had recommended an MRI. This endorsement pending the MRI results was consistent with the Doctor's office notes discussed above. Subsequently, in May 2016, Dr. Dirks again endorsed the idea a spinal cord stimulator

was medically necessary, if the stimulator trial run proved effective.

29. Claimant's diagnostic studies ordered by Dr. Dirks (lumbar x- rays, cervical and lumbar MRIs, and lower extremities EMG/nerve conduction tests) showed no significant changes from previous studies. No cervical or lumbar nerve root compression was noted, although there was a small disc bulge one level above the L4-5 fusion level. EMG/nerve conduction studies again showed chronic L5 and S1 radiculopathy from pre-surgical nerve damage. Dr. Dirks again stated his opinion that Claimant would be disabled from doing any kind of work at that time, and would support Claimant should he apply for disability.

30. Claimant received authorization from Pacific Source/Medicare for a spinal cord stimulator, and a trial course of treatment took place in November 2016. On December 22, 2016, Claimant had a permanent stimulator implanted. Dr. Jameson managed Claimant's stimulator adjustments in conjunction with the device's technicians. However, Claimant received his prescription narcotics from his family physician Dr. Bell through this time frame.

31. The only medical reference to Claimant's trial stimulator experience is a statement in Dr. Jameson's operative report for the permanent implantation. Therein she states that the trial implant was a success, with Claimant's pain in his hands and legs reduced by 60%, and his functionality significantly improved.

32. Claimant testified at his 2018 hearing that once his permanent stimulator was implanted, the results were mixed. First he had pain from the implantation surgery, then the machine needed adjustments regularly in an effort to maximize its benefits. Often he would have little pain relief. Other times he experienced temporary

pain reduction.

33. Approximately eight months post implantation, Claimant was taking narcotics (Percocet) at his pre-stimulator rate of four pills per day, was depressed and anxious, and saw no long term benefits. Then, on November 21, 2017, a further adjustment was made to the devicse by upping the amps and changing the unit from intermittent to constant firing. Claimant described the effect as miraculous.

34. Claimant testified that immediately after the adjustment he was able to reduce his opiod intake by half, to two pills per day. Claimant still experienced pain on a daily basis, but with less severity.

35. At the time of hearing Claimant noted that in the hour or two before he takes his next pain pill his pain will increase dramatically. He testified that his memory has improved since he reduced his pain medications, the distance he can walk has increased, and he can shop with his wife for a half hour or so (leaning on a cart) before his back pain becomes severe.

36. Claimant's sleep has reportedly improved as per his hearing testimony. He still only sleeps about six hours, but he claims his sleep is deeper. He is up by 3 a.m. due to increasing pain, and spends much of his day on the couch, but overall he asserted he was more functional on most days, and able to do light chores for half an hour at a stretch.

**DISCUSSION AND FURTHER FINDINGS**

37. Claimant has the burden of proving, by a preponderance of the evidence, all facts essential to recovery to his claims. *Duncan v. Navajo Trucking,* 134 Idaho 202, 203, 998 P.2d 1115, 1116 (2000).

***SPINAL CORD STIMULATOR***

38. The parties' main thrust of argument centers on the question of whether Claimant is entitled to be reimbursed the costs of his spinal cord stimulator from Defendants. In so doing, they necessarily invoke the provisions of Idaho Code § 72-432(1), which mandates that an employer shall provide for an injured employee such reasonable medical, surgical or other attendance or treatment as may be reasonably required by the employee's physician or needed immediately after an injury, and for a reasonable time thereafter. If the employer fails to provide the care, the injured employee may obtain that care at the expense of the employer.

39. The Idaho Supreme Court has determined that it was for the physician, not the Commission, to decide whether the treatment at issue was required. The only review the Commission is entitled to make of the physician's decision is whether the treatment was reasonable. *Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989) (overruled to the extent *Sprague* may have suggested its articulated factors were exclusive by *Chavez v. Stokes*, 158 Idaho 793, 353 P.3d 414 (2015)).

40. An employer is only obligated to provide necessary and reasonable medical treatment necessitated by the industrial accident, and is not responsible for treatment not related to the industrial accident. *Williamson v. Whitman Corp./Pet, Inc.*, 130 Idaho 602, 944 P.2d 1365 (1997).

41. Under the Supreme Court's *Neel* Doctrine, reimbursement of medical charges is made at the full invoiced amounts of a claimant's medical bills when (1) the employer denies a claim and (2) that claim is subsequently deemed compensable by the Commission. *Neel v. Western Construction, Inc.*, 147 Idaho 146, 206 P.3d 852 (2009).

***Claimant's Position***

42. Dr. Jameson testified it was a "medical necessity" that Claimant receive a spinal cord stimulator. TR, p. 38. Her belief was in part based on the fact Claimant had previously tried to control his pain with injections, physical therapy, pain medications, and counseling from a pain psychologist, all to no lasting avail. Further, both in her experience and according to published studies, an SCS could reduce Claimant's opiod use by half, and make Claimant more functional.

43. Dr. Jameson sent Claimant for counseling and psychological testing to Patty Bullick, MSW, LCSW. Ms. Bullick has a Master's degree in social work and is licensed in Clinical Social Work. She counselled Claimant over nine sessions for pain management. Thereafter Dr. Jameson asked her to test Claimant for suitability for a spinal cord stimulator. Ms. Bullick administered a Pain Patient Profile Assessment (P-3), a standardized test designed to measure depression, anxiety, and somatization. Claimant had average depression and somatization scores.

44. This psychological testing coupled with her observations of Claimant in a physician-patient setting and Claimant's pain pattern and etiology convinced Dr. Jameson that Claimant was the "perfect" candidate for success using a spinal stimulator. Without the device, Dr. Jameson felt Claimant's pain symptoms would continue to worsen, with a resulting diminution in his ability to care for himself and perform activities of daily living.

45. Dr. Jameson felt Claimant was not at maximum medical improvement at the time of her testimony in June, 2016.

46. Claimant's trial implantation of a dorsal spinal cord stimulator resulted in significant pain reduction and increased Claimant's ability to function. Given these results,

Claimant obtained authorization from Medicare for a permanent SCS implant, which took place on December 22, 2016.

47. Claimant testified the permanent SCS worked for a couple of months; thereafter numerous adjustments were needed to finally find that "sweet spot" where Claimant reportedly received optimum benefit from the device. The final adjustment was made on November 21, 2017. After this adjustment Claimant testified he reduced his opiod intake by half (from four pills daily to two), which in turn increased his clarity of thought. He testified that while he still copes with daily pain, his ability to do minor tasks like shopping, mowing the lawn, and socializing have increased. Subjectively, Claimant expressed feelings of gratitude, hope, joy, and better outlook from November 2017 up through the time of the May 1, 2018 hearing.

48. In April 2018, Dr. Jameson authored a letter wherein she reiterated Claimant's reported improvements since the stimulator implant. She also reported an improvement in Claimant's mood. Dr. Jameson opined that continued use of the SCS was imperative to assist in Claimant's pain control.

49. Claimant argues that when all the above evidence is considered the use of the SCS was reasonable and medically necessary, and he is entitled to reimbursement for the costs of the stimulator and all medical expenses related thereto.

***Defendants' Position***

50. Defendants contend Claimant was not a good candidate for a spinal cord stimulator, both by prediction and after-the-fact evidence review. Medical experts for Defendants testified that the SCS was not reasonable treatment for Claimant's work injuries.

*Predictive Analysis*

51. Before Claimant received his SCS, Dr. Beaver evaluated Claimant by interview and administration of various standardized psychological tests including the Personality Assessment Inventory, SIMS, Personality Assessment Inventory test, and the MMPI. Review of the testing led the doctor to the belief that Claimant would more likely than not fail to achieve long term benefits from the stimulator. The MMPI results showed a highly pronounced "conversion V profile" which in early studies was indicative of individuals "who tended to have less favorable outcomes" with spinal cord stimulators. Beaver Depo. pp. 16-17. Individuals with a highly pronounced conversion V profile, according to Dr. Beaver, are much more likely to have their emotions and situational stress significantly impact their perception of how bad their pain is on any given day; a condition Dr. Beaver labeled as somatization. (He noted his use of somatization was different than a conversion disorder – where the patient has no medical condition but has convinced himself he does.) Other testing confirmed the validity of Claimant's MMPI findings.

52. Dr. Beaver testified that while Claimant may have significant pain, there were other things besides the pain sensation itself which would influence his perception of his pain level and its effects. These types of individuals tend not to have a positive long-term outcome with spinal cord stimulators.

53. Dr. Beaver's formal diagnosis for Claimant was Somatic Symptom Disorder (SSD), Predominantly Pain – Moderate, and Adjustment Disorder with Depression. Dr. Beaver described the diagnosis of SSD as a person with real pain symptoms who is more highly focused and more highly sensitive to such pain than others. Such individuals will have more distress than other persons with similar problems. The Adjustment Disorder with Depression diagnosis

is related to Claimant's depression stemming from his condition and corresponding lifestyle changes.

54. Dr. Friedman also opined on Claimant's suitability for an SCS prior to its implantation. Dr. Friedman specifically felt that Claimant's depression, somatoform and somatic dysfunction were significant contraindications to SCS implantation.

55. Dr. Friedman was critical of the fact Claimant had not exhausted all possible other pain treatment modalities, such as acupuncture, TENS units, and "aggressive" physical therapy prior to seeking a spinal cord stimulator. He was also critical of the fact that Claimant did not, in his opinion, exhibit a true radiculopathy or radiculitis in his cervical and lumbar spine. Dr. Friedman testified that patients with radiculopathy are better candidates for an SCS. He also noted that Claimant exhibited a "number of nonphysiologic findings" such as positive Waddell's signs during examination. Friedman Depo. p. 34. He concluded it was not in Claimant's best interest to have an SCS implanted.

*Post-Implant Analysis*

56. Both Drs. Beaver and Friedman were asked to prepare supplemental reports on whether Claimant's SCS treatment was successful after its implantation. Dr. Beaver prepared a supplemental report dated January 20, 2018, and was deposed on his opinions contained therein. Unfortunately, it appears Dr. Friedman's opinions were sought prior to November 2017 when Claimant asserts the SCS finally began providing consistent and significant pain improvement which allowed for decreased narcotic use and greater functionality. However, Dr. Friedman was deposed on this subject post hearing.

57. Dr. Beaver's supplemental report was made on review of documents and not on any personal contact with Claimant. Dr. Beaver felt after reviewing additional medical records

that his original opinions were accurate; Claimant was not substantially benefited by the SCS. He based this opinion on the fact that, to Dr. Beaver's reading of the record, Claimant was "still on a fair amount of opiate medications, still had significant sleep difficulties, [and] functionally was viewed as limited in what he could do because of his pain." Beaver Depo. p. 24. Dr. Beaver also noted Claimant had not been able to return to work, which would be an ideal outcome. The doctor did acknowledge however, that SCS treatment can still be considered successful when it allows users to reduce pain medications, increase activity, but still not be able to return to work.

58. Dr. Beaver felt the evidence in the instant case was conflicting. On one hand, Claimant's May 1, 2018 hearing testimony spoke of increased functionality, better sleep patterns, and a 50% pain medication reduction. On the other hand, Dr. Beaver pointed to Dr. Dirks' April 12, 2018 office notes which indicated Claimant's condition was actually worsening. At that visit Claimant was having severe difficulty ambulating, with increasing pain and trouble with activity. Dr. Beaver felt Claimant's reported improvements in symptoms were encouraging, but he had reservations concerning Claimant's long-term prognosis. In Dr. Beaver's experience often patients tend to report favorable response to a change in SCS settings, but those positive effects will fade with time. It was his belief Claimant would follow this pattern.

59. Dr. Friedman argued Claimant's SCS was unsuccessful because it did not increase his function until May 2017, and yet by August Claimant was reporting only a 20% pain reduction. Dr. Friedman questioned whether the 20% pain reduction was due to the spinal stimulator or other "nonprescribed drugs" Claimant was using at that time. Friedman Depo. p. 43. (Claimant had tested positive for THC on a previous drug test and admitted to using cannibis to help him sleep on at least one occasion.) Dr. Friedman felt

Claimant should have noticed improvement in less than a week after the SCS was implanted, which he claims did not happen. Dr. Friedman opined that if the stimulator use had been successful Claimant should have been able to completely wean off his opiates.

60. After reading Claimant's May 1, 2018 hearing testimony the doctor believed Claimant equivocated, reporting no increase in function and "a little" decrease in his opiate use. Friedman Depo. p. 45. Dr. Friedman also was skeptical that the improvement noted by Claimant at that hearing came from the SCS; instead Claimant may "just be better." *Id.* at 46.

***Spinal Cord Stimulator Analysis***

61. Whether the Claimant has shown an entitlement to medical benefits in the form of a spinal cord stimulator depends on whether such treatment is necessary and reasonable. The determination of reasonableness of Claimant's request for this medical treatment is a question of fact. This question is resolved by employing a totality of the evidence approach. *Chavez, supra* at 158 Idaho 797-798.

62. Evidence weighing against Claimant's testimony on the efficacy of the SCS includes the notation from Dr. Dirks dated April 12, 2018. Dr. Dirks noted Claimant complained of significant neck and low back pain, to the point that Claimant reportedly fell down in the elevator that very day due to his legs giving out on him due to pain. Dr. Dirks also noted Claimant had trouble "doing anything", with pain down both of his arms and both of his legs. Claimant's gait was "extremely poor" with small shuffling steps "because of pain in his lower back." Claimant was unable to walk heel to toe or tandem gait at the time of examination. Dr. Dirks concluded Claimant, as he presented that day was "clearly [un]able to work"…. Dr. Dirks had no further treatment suggestions for Claimant. CE B, p. 15. Such testimony does not easily square with the upbeat testimony Claimant gave less than one month later at hearing.

63. Defendants are also skeptical of Claimant's purported 50% reduction in narcotic pain medication. They point out that Dr. Bell, who prescribed Claimant's pain medication, never reduced the prescription to the rate of 60 pills per 30 days.

64. While Dr. Dirks' April 12, 2018 observations, confirmed in his deposition, cut against the purported success of the SCS, there is nothing in the record to suggest that Dr. Dirks saw Claimant other than one time between November 2017, when Claimant testified the SCS finally began providing him the sought-after relief he was hoping for, and the May 1, 2018 hearing. Claimant never testified that the SCS allowed him to be pain free, narcotics free, or free of his physical limitations. He still slept only about six hours per night, had trouble walking distances, and could participate in daily activities only for brief periods of time without the need to lie down. However, Claimant testified his sleep was deeper and more rejuvenating, his walking was improved to a degree, and even simple activities such as shopping with his wife or limited yard work, which had been very difficult prior to November 2017, were now possible, albeit with significant limitations. And some days were better than others.

65. This Referee observed significant differences in Claimant's attitude and demeanor at the two hearings (2016 and 2018). Although at both hearings Claimant walked slowly, shuffling along with some bend in his back, in 2016 Claimant's effect was flat, his voice was subdued and monotone, his face was expressionless. In 2018 his effect was lively, his face was animated, and his voice was clear and strong. Admittedly one can manipulate these external effects, dialing up or down emotions to coincide with one's testimony, but feigned or real, there was a marked difference in Claimant's demeanor and attitude between the two hearings. The Referee found the Claimant to be believable at both hearings, and has no reason to doubt his credibility.

66. Records from Dr. Bell are consistent to a degree with Claimant's testimony. On December 27, 2017, Claimant called the doctor's office asking that his Percocet prescription be reduced to 90/30 days, or to three a day from four per day. One month later, on January 29, 2018, Claimant again called the office asking for a further Percocet reduction to 75/30 days, or 2.5 pills per day. About 30 days later Claimant again asked for a further opiod reduction to 65/30 days, or just over 2 pills per day. While Claimant testified that within a few days of the November 21, 2017 SCS adjustment he was taking just two pain pills per day, his requests for a graduated reduction of the narcotics, while not precisely consistent with his testimony, does show he initiated a reduction in narcotic medication such that he was essentially down to two pills per day by March 2018.

67. On his April 3, 2018 office visit with Dr. Bell, Claimant noted pain not exceeding 5 on a 10 scale. Dr. Bell noted Claimant appeared well and in no distress. While less than two weeks later Dr. Dirks had a contrary opinion of Claimant's condition, that one observation does not outweigh the consistent records of Dr. Bell showing Claimant's narcotic use declining by nearly 50% in the months preceding the May 1, 2018 hearing.

68. Dr. Jameson's records are likewise consistent with Claimant's 2018 hearing testimony. While many of Dr. Jameson's notations are simply a memorialization of Claimant's reported history and not independent observations, nevertheless Claimant was reporting improvement with the final SCS adjustment in November 2017 in line with Claimant's subsequent testimony. Dr. Jameson felt the Claimant's history supported her goal of increased function and decreased narcotic use by half. Using those criteria Dr. Jameson opined that the SCS implantation was successful.

69. When the totality of the circumstances is considered, the weight of the evidence supports the finding that, at least to some incremental degree, Claimant's spinal cord stimulator was efficacious. However, that finding does not necessary translate to a conclusion that the treatment was reasonable in light of all the circumstances.

*Reasonableness of Treatment*

70. Analysis of reasonableness begins with our Supreme Court's instructions in *Rish v. The Home Depot*, 161 Idaho 702, 390 P.3d 428 (2017). In *Rish*, the Court cautioned that it is error to find palliative care is compensable only if it improves a claimant's medical condition. Instead, the Commission needs to also consider the "important role of pain management." 176 Idaho at 432, 390 P.3d at 706. Also, where the care is palliative, such care may be reasonable even if in hindsight it proves to be ineffectual, if at the time the treatment was prescribed such prescription was reasonable. The Court warned against "armchair doctoring" by simply using hindsight to determine reasonableness.

71. Of course, the analysis should not ignore the reality of the treatment's efficacy, or lack thereof, since reasonableness is to be determined by a *totality* of the circumstances, and *totality* means *all* of the evidence must be considered. To stop the analysis at the time the treatment was prescribed, and ignore the reality of the treatment's effect, would violate the rule in *Chavez, supra.* Instead, all of the evidence must be considered, including whether the treatment seemed reasonable at the time it was prescribed, whether it proved efficacious or ineffective, and a host of other factors as discussed below.

72. As is often the case in disputes going to hearing, strong arguments can be made supporting and refuting the reasonableness of Claimant's SCS treatment. Various factors must be analyzed when making such determination.[4]

73. A list of factors weighing in favor of the treatment includes;

- Claimant's prior industrially-related lumbar and cervical treatments aimed at reducing the consistent pain in his upper and lower extremities, back, shoulders, and neck, including physical therapy, lumbar and cervical injections, counseling, and various narcotic and non-narcotic pain medications, all provided at best short-lived relief. The narcotics also affected Claimant's mental clarity, concentration, and focus.

- Claimant's credible testimony at the first hearing described sharp shooting pains from his neck down through his fingers, with associated numbness, low back and bilateral hip and buttocks pain, and shooting pains into his lower extremities and feet. The pain was temporarily moderated with narcotics, but Claimant still had trouble sitting or laying for more than about a half hour without changing positions. Claimant's pain led to depression. While those shooting pains still occurred after the SCS implantation, their frequency has declined.

- Dr. Jameson testified that a spinal cord stimulator was a medical necessity, and could lessen Claimant's need for narcotic pain medications, as well as make him considerably more functional. She had Claimant undergo psychological testing, and felt the results of the test showed Claimant was a perfect candidate for the treatment. She also testified that without an SCS Claimant would continue to worsen with more intense pain symptoms.

- Claimant's SCS implantation was ultimately successful in reducing his opiate consumption, although it took about a year to find the right settings to provide Claimant the desired relief. Since the last adjustment, Claimant was able to reduce his narcotic use by approximately 50%. Claimant's mental clarity reportedly improved since he began taking fewer opiates. His reported activity level increased somewhat as well. He testified he was able to socialize with people to a greater extent and that over all, his quality of life has improved.

- Dr. Jameson opined that the SCS was an imperative component in her plan for continuing control of Claimant's pain. Further it has allowed Claimant to stop medicating with THC to go to sleep, and should allow him to continue with his reduced opiate use into the future.

[4] In the fact lists which follows, "facts" argued by the parties which are not accurate, or are irrelevant to a determination of reasonableness, or are used out of context in briefing by a party are not included in the discussion.

- Dr. Beaver acknowledged Claimant's results were encouraging, even though there was no long-term data to review to see if Claimant's results would be long lasting.

- Dr. Friedman acknowledged that if Claimant truly reduced his opiate use by half, and increased his daily functionality, one could consider those improvements a successful application of an SCS.

74. A list of factors weighing against the treatment includes;

- Dr. Beaver opined Claimant was not a good candidate for a spinal cord stimulator after testing and interviewing him. Dr. Beaver felt Claimant's psychological profile made it unlikely Claimant would benefit long term from the device. Even if Claimant experienced short-term benefits after adjustments were made, those benefits could tend to fade with time, as evidenced by Dr. Beaver's own experience with SCS patients, and literature. Dr. Beaver opined on a more-likely-than-not basis that it was his opinion that Claimant's limited benefits, if any, would not last more than two years.

- Claimant did not exhaust all other possible treatment modalities before proceeding with a spinal cord stimulator.

- Dr. Friedman testified Claimant would improve by weaning off opiates and implementing a home icing and stretching program. Claimant would most likely "get worse before he gets better" but if he persevered with this program Dr. Friedman felt Claimant should see positive results without the need for drugs and/or an SCS. Furthermore, Dr. Friedman opined that since Claimant had no radiculopathy he would not benefit from an SCS. Claimant's cervical symptoms would not warrant SCS treatment.

- Dr. Friedman asserted that Claimant's gait was due to medical conditions not associated with his industrial accident.

- There is little objective evidence that the SCS has been efficacious. Most of the "evidence" of its benefit centers on Claimant's subjective testimony. Close scrutiny of the records suggests Claimant could go to the store and do limited yard work before the stimulator, could walk as far, and was active at the same level before and after the stimulator, even allowing for the stimulator adjustment period. Claimant may "feel" more hopeful (or testify that he does) with the stimulator, but as far as measurable benefits are concerned the SCS has made only a slight difference. As Dr. Beaver noted, there was not "a substantial functional change in Claimant after the stimulator." Beaver Depo. p. 24. Dr. Dirks felt Claimant's condition was worse than ever less than one month before Claimant's May 1, 2018 hearing.

- Claimant was not working or looking for work after the SCS implantation, despite his testimony at the first hearing that if he could reduce his opiate intake by half he should be able to work part time.

- While not argued by the parties, there is a cost-benefit factor to consider. Here, Claimant seeks over $106,000.00 (at the *Neel* rate) for a treatment which provided him with at best minimal physical benefit for what may be a limited period of time. The SCS did not allow Claimant to re-enter the job market or even seek employment to date, did not allow him to wean off narcotics, or undertake new activities to any significant extent.

***Benefit Determination***

75. Defendants note, and Claimant does not dispute, the fact that the spinal cord stimulator in this case constitutes palliative care. While it does seem clear that such is the case, palliative care may be reasonable treatment, and pain management is an important consideration. *Rish, supra.*

76. At the time the SCS was prescribed, the weight of the evidence argued against its use. Dr. Beaver testified convincingly that the battery of tests he administered would place Claimant in the group of individuals likely to not receive benefits from the device. The P-3 testing conducted at the request of Dr. Jameson was far more limited in scope, and was administered not by a licensed psychologist, but by Ms. Bullick, a licensed Clinical Social Worker. There were no validating cross-check tests, unlike the battery of assessments administered by Dr. Beaver which were designed to validate findings of the other tests.

77. The undersigned must weigh all the evidence, including that which came to pass after Claimant was prescribed the SCS, notwithstanding Justice Bistline's admonition against "armchair doctoring" (quoted in *Hipwell v. Challenger Pallet & Supply*, 124 Idaho 294, 300, 859 P. 2D 330, 336 (1993) and quoted again with approval in *Rish, supra*).

78. Because pain management is an important consideration, and treatment designed to reduce pain even without improving Claimant's physical condition may be

compensable depending upon the weight of all evidence for and against compensability, it is important to consider all the circumstances when determining compensability in this matter.

79. Although Claimant was not a "good" candidate for an SCS according to predictive analysis, he nevertheless obtained some incremental benefit from the device. He was able to reduce his narcotic use by approximately one half, at least after November 2017 through the time of hearing on May 1, 2018. Had Claimant not obtained such benefit from the SCS, it would have been difficult to find the SCS treatment compensable, since at the time it was prescribed such prescription ran contrary to the weight of the predictive analysis. This fact places the instant matter more in line with *Sprague* than *Hipwell.*

80. Simply because Claimant received what by objective standards could be called a minimal benefit from the SCS does not mandate compensability. Such a finding would violate *Rish* in that the determination would rest solely on the retrospective analysis of the efficacy of the treatment. Instead, all of the other factors listed above must also be considered.

81. When all of the evidence is carefully considered the primary benefit provided by the SCS is not so much physical, or even substantial pain reduction, but rather falls into the category of "quality of life." Claimant expressed optimism, hope, and happiness with the stimulator. His demeanor change between the two hearings was very apparent to this Referee. Claimant's outlook was positive in spite of his pain and limitations. He was more willing to put up with his pain instead of letting it drag him into depression.

82. *Rish* does not specifically address the compensability of a treatment which does not significantly reduce a claimant's pain, improve the claimant's physical condition, or return the claimant to the work force, but simply improves the claimant's outlook toward such

chronic pain at least for a period of time, which according to Dr. Beaver may last less than two years, and comes at a cost of over $100,000.

83. Put another way, is palliative care reasonable which is of limited physical benefit, predominantly in the area of an incremental reduction of Claimant's perceived disability for an unspecified time period, and which costs are quite substantial when compared to both the benefit itself and alternative palliative treatments, such as continued narcotic pain pills at the rate of up to four per day, or other alternative modalities.

84. In *Millard v. ABCO Construction, Inc.*, IC 2007-008413 (Aug. 21, 2015) (*appealed and aff'd on other grounds at 161 Idaho 194 (2016)*), the Commission considered, among other things, a cost/benefit ratio analysis when determining if a specific palliative treatment was reasonable. The Commission noted that while cost alone cannot dictate reasonableness it is a factor to consider. The cost must be juxtaposed against the benefit provided. In *Millard* it was determined that requiring Surety to pay for a very expensive treatment with questionable benefit could in certain circumstances be considered a form of economic waste, which by definition is not reasonable. On the other hand, an expensive treatment which was either curative, effective in pain management, or increased a claimant's function may well be reasonable.

85. Also considered was whether there was some objective measure of effectiveness with the treatment. The Commission pointed out that purely subjective responses to treatment are less reliable, and more subject to a wide variety of outside factors, thus making it difficult to determine if the treatment was actually responsible for the response. However, purely subjective responses are not to be ignored.

86. The Commission in *Millard* looked at the availability of alternative treatments and the effectiveness of such alternatives. In that vein, experimental or medically controversial treatments not generally accepted in the medical community might be more difficult to justify as being reasonable.

87. Applying these factors to the present case, the cost of an SCS is clearly far more expensive than any other alternative treatment suggested, including the continuation of narcotic pain relievers at an increased frequency. However, it is unknown if any of the alternative treatments (other than pain medication) suggested by Defendants would be of any benefit. While Defendants were critical of the fact an SCS was implanted prior to trying the alternative treatments, it does not appear Defendants offered Claimant these treatments. Defendants' own experts indicated alternative treatments such as acupuncture, hypnosis, or a TENS unit would be reasonable and necessary prior to trying an SCS, but Defendants failed to provide such treatments to Claimant in spite of that information. As such they cannot now use Claimant's failure to try such alternatives as a defense.

88. While the SCS was quite expensive, its benefits were not objectively substantial. Other than the fact Claimant requested fewer Percocets from December 2017 through at least April of the following year, there is no objective evidence the SCS produced any other benefits. Dr. Beaver's testimony that very few individuals obtain relief for more than about two years is concerning. Dr. Friedman noted that Washington's worker's compensation program excluded spinal cord stimulators as a compensable palliative treatment. Medical literature on the effectiveness of spinal cord stimulators is all over the board. Some studies show a very high success rate, while other studies show a high failure rate. It would be fair to say the treatment is controversial.

89. From a subjective standpoint, Claimant testified his SCS treatment has been very successful, although it did take some time to find the correct settings. The SCS took the edge off of Claimant's constant pain, allowing him to cope much better in his day-to-day life. Reducing his opioids purportedly improved Claimant's mental clarity to a degree.

90. From a strictly objective point of view the spinal cord stimulator treatment as applied to the facts herein seems to be at worst a case of economic waste, and at best a controversial form of treatment with minimal gain and an uncertain lifespan of whatever slight benefits it is providing. However, from the Claimant's subjective point of view it has been something he "wouldn't trade for anything." As he put it, "I would do it over again, easy… I can probably start to deal with things a little better… enjoying some daily activities." Comparing himself pre and post SCS implant, he said "[t]here for awhile… it was very bleak, and I just felt like I was in the wrong tunnel. And this helped me out a lot." Tr. (V. II) p. 148. He concluded by testifying "I'm so grateful now." Tr. (VII) p. 149.

91. While it was not unreasonable for Defendants to deny the spinal cord stimulator treatment when first proposed due to the greater weight of evidence available at the time, when considering all of the evidence available as of the May 1, 2018 hearing, such treatment proved to be reasonable. Claimant's subjective benefits, including his opiate reduction, and our Supreme Court's admonition that palliative care may be reasonable even when it is of limited effectiveness, lead to the conclusion that in this case the factors in favor of the SCS palliative treatment outweigh those factors against its use. This is true even considering the substantial cost of the treatment. It is undeniable Claimant required less narcotic pain medicine with the SCS, which is an objective measure of the device's efficacy.

Furthermore, Claimant experienced significant quality of life improvement with the SCS. In this particular case those two factors outweigh cost considerations.

92. Claimant has proven his right to medical care benefits for his spinal cord stimulator.

***TEMPORARY DISABILITY BENEFITS***

93. Idaho Code § 72-408 provides that income benefits for total and partial disability shall be paid to Claimant "during the period of recovery." The period of recovery ends when Claimant has reached maximum medical improvement (MMI). *Hernandez v. Phillips,* 141 Idaho 779, 118 P.3d 111 (2005). The burden is on Claimant to present medical evidence of the extent and duration of the disability in order to recover income benefits for such disability. *Sykes v. C.P. Clare and Company*, 100 Idaho 761, 605 P.2d 939 (1980).

94. Claimant argues that Dr. Friedman's September 19, 2014 pronouncement of medical stability was premature. Claimant's argument is based on statements made by Dr. Dirks and Dr. Jameson. Dr. Dirks opined Claimant was at MMI prior to December 12, 2017, when the doctor checked a box in a letter provided by Claimant's attorney asking about this issue. Dr. Dirks did not elaborate on a date of MMI, but rather checked "yes" when asked if Claimant was at MMI as part of the letter referenced above. In his deposition of May 8, 2018, Dr. Dirks confirmed Claimant was at MMI but was not asked to opine when Claimant became medically stable. (Maximum medical improvement, MMI, and medical stability are all synonymous terms.)

95. Dr. Jameson was asked at the June 27, 2016 hearing in this matter if Claimant had by that date reached maximum medical improvement. She said "no." At that time

Claimant had not yet received his spinal cord stimulator. Dr. Jameson went on to discuss at the hearing a number of permanent restrictions she testified applied to Claimant as of that date.

96. Dr. Friedman declared Claimant at MMI after his examination of Claimant on September 19, 2014. At that time, he also imposed permanent restrictions and rated Claimant for permanent impairment.

97. Dr. Friedman's opinion on MMI is persuasive. Claimant was not being treated for industrially-related medical conditions other than pain management by September 19, 2014. Dr. Jameson's goals for a spinal cord stimulator were not curative, but rather focused on reducing Claimant's opiod intake and restoring some of his daily activity function. Claimant was not in a period of recovery by the time of the June 2016 hearing. Although he was symptomatic, the only proposed treatment was the SCS with the goal of pain reduction and increased function of daily living. There was no proposed treatment for any injuries sustained by Claimant in his industrial accident in question. Dr. Jameson would have no reason to impose *permanent* restrictions if she anticipated Claimant's further medical improvement. A claimant may have pain and symptoms from an industrial injury even after MMI, so long as no further material improvement is expected with time or treatment. *Shubert v. Macy's West, Inc*, 158 Idaho 92, 102; 343 P.3d 1099, 1109 (2015), *overruled on other grounds by Chavez v. Stokes*, 158 Idaho 793, 353 P.3d 414 (2015).

98. Defendants paid TTD benefits through the period of Claimant's recovery.

**Permanent Disability**

99. **"**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. That section provides that in "determining percentages of permanent disabilities, account should be taken of the nature of the physical disablement, the disfigurement if of a kind likely to handicap the employee in procuring or holding employment, the cumulative effect of multiple injuries, the occupation of the employee, and his or her age at the time of accident causing the injury, or manifestation of the occupational disease, consideration being given to the diminished ability of the affected employee to compete in an open labor market within a reasonable geographical area considering all the personal and economic circumstances of the employee, and other factors as the Commission may deem relevant." In sum, the focus of a determination of permanent disability is on a claimant's ability to engage in gainful activity. *Sund v. Gambrel*, 127 Idaho 3, 896 P.2d 329 (1995).

100. 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 Claimant. *Seese v. Idaho of Idaho, Inc.*, 110 Idaho 32, 714 P.2d 1 (1986).

101. Defendants argue Claimant's disability should be measured as of the time of the first hearing. The Idaho Supreme Court in *Brown v. The Home Depot*, 152 Idaho 605, 272 P. 3d 577 (2012), held that, as a general rule, Claimant's disability assessment should be performed as of the date of hearing. Under Idaho Code § 72-425, a permanent disability rating is a measure of the injured worker's "present and probable future ability to engage in

gainful activity." Therefore, the Court reasoned, in order to assess the injured worker's "present" ability to engage in gainful activity, it necessarily follows that the labor market, as it exists at the time of hearing, is the labor market which must be considered. Claimant's permanent disability did not change from the time of his first hearing to his second, as he was medically stable throughout this time frame. If anything, Claimant's condition improved slightly. Regardless of which date is used to determine permanent disability, the outcome would be the same. The entirety of the record will be examined.

102. In this case, Claimant's vocational expert opined that Claimant is 100% disabled, and it would be futile for him to seek work. Defendants' vocational expert argued that Claimant has no disability beyond his impairment.

103. Claimant's vocational expert, Mr. Dan McKinney, has not recently testified before the Commission.[5] Mr. McKinney resides in Colbert, Washington, and is a vocational rehabilitation counselor. He holds a Masters' degree in counseling, and has been employed in the field of rehabilitation for many years. He holds several certifications. He is qualified to testify in this case.

104. Mr. McKinney authored a vocational assessment report dated March 7, 2018. Therein he concluded Claimant could not work in any known job. In rendering his opinion of total disability, Mr. McKinney reviewed the medical record, paying special attention to the notes and testimony of Drs. Dirks and Jameson. Without much discussion Mr. McKinney found that Claimant on a more probable than not basis was permanently and totally disabled as a direct result of Claimant's industrial accident.

[5] Records show an individual of the same name, presumably the same Dan McKinney as testifying herein, testified in a case which went to hearing in 1991.

105. Mr. McKinney was deposed twice; first after the hearing in 2016 and again after the 2018 hearing. His conclusions of total permanent disability were presented in both depositions. At his May 10, 2018 deposition Mr. McKinney was walked through the records he reviewed in reaching his disability conclusion. Those included medical records and testimony from the first and second hearings.

106. Mr. McKinney felt it was significant that Claimant spends more than half of his day lying on a couch or on the floor. He reasoned if Claimant was lying on the floor he could not be working during that time. Claimant would have difficulty maintaining employment with that limitation.

107. Dr. Dirks' restrictions of May 12, 2016 for Claimant were also considered impediments to employment. The doctor limited Claimant to never climbing ladders, scaffolds, ramps, and no crouching, crawling, or stooping. Additionally, Claimant was restricted to occasional balancing and kneeling. Dr. Dirks also limited Claimant to frequent lifting of less than ten pounds. Mr. McKinney felt these restrictions would limit Claimant to sedentary work.

108. Claimant's walking and standing were also restricted to less than two hours per workday, and sitting less than six hours per day. Importantly, Dr. Dirks indicated Claimant would need to sit in a recliner up to a third of the work day. Finally Dr. Dirks noted Claimant would need to miss at least one day per week at unpredictable times due to his industrial injuries, and would have trouble focusing or staying on task at least ten minutes per hour at unpredictable intervals.

109. Mr. McKinney opined that these various restrictions and impediments would render Claimant unemployable in a competitive work market. He also noted Dr. Jameson rendered a report which correlated with Dr. Dirks' opinions.[6]

110. With the restrictions and impediments listed above, Mr. McKinney felt it would be a waste of time for Claimant to seek employment, and Claimant was totally and permanently disabled.

111. On cross examination Mr. McKinney acknowledged that if Dr. Friedman's restrictions were used Claimant would have no permanent disability related to the industrial accident.

112. Defendants hired vocational expert Doug Crum, who reviewed medical records and interviewed Claimant. Mr. Crum prepared a report dated May 3, 2016 and was subsequently deposed.

113. In his report and at deposition Mr. Crum relied on Dr. Friedman's September 2014 report wherein the doctor gave Claimant a 15% WP impairment for his cervical spine with 6% pre-existing, and a 15% WP impairment for Claimant's lumbar spine with 7% pre-existing. Dr. Friedman found only myofascial pain still plaguing Claimant at the time of his examination, with no cervical or lumbar radiculopathy. Dr. Friedman placed on Claimant permanent restrictions of lifting 50 pounds occasionally and 25 pounds repetitively with no repetitive over-the-shoulder lifting of greater than 20 pounds. However, Dr. Friedman felt these restrictions were not new, or related to Claimant's industrial accident, but instead

[6] It should be noted the "reports" from Drs. Dirks and Jameson were in fact "check the boxes" forms prepared by Claimant's counsel, where the doctors could agree or disagree with various assertions such as "would Claimant be expected to miss at least one day of work per week… due to his injuries" (paraphrased), and then signed and dated by the physician. The fact the doctors' opinions correlated so well is because they were asked to answer the same questions.

were related to Claimant's previous cervical and lumbar surgeries stemming from pre-existing conditions.

114. Because the above restrictions were in place (or should have been in place) since before Claimant's industrial accident, and the accident resulted in no greater restrictions, Mr. Crum felt Claimant had no loss of market, no loss of income potential, and therefore no permanent disability from the subject accident.

115. Defendants argue that while Claimant presents himself as a disabled person with a multitude of pain complaints, his somatic symptom disorder, a longstanding coping mechanism, may account for some of his presentation. In any event they argue the weight of the medical evidence supports a finding that Claimant's current condition is not the result of the two industrially-related surgeries necessitated by the work accident.

116. In reality, the so-called "weight of the medical evidence" relied on by Defendants is the report and deposition testimony of a single physician, Dr. Friedman, who was hired by Defendants, saw Claimant on a single occasion as part of a panel examination, and rendered an opinion that in spite of two surgeries Claimant has no additional permanent disability related to the industrial accident, because he had previous surgeries at the same locations. He rendered this opinion in spite of the fact Claimant was able to work full time before this accident with little or no complaints for the two years before the accident. While his employer wanted Claimant to limit his lifting since his previous surgeries, and at times had to call Claimant out for improper lifting, the fact remains Claimant's troubles began when he fell at work. That event was the catalyst for what has transpired since.

117. While Mr. McKinney's report left a lot to be desired in terms of analytical thinking and detail, it nevertheless correlated more closely with Claimant's credible presentation at both hearings than did Dr. Friedman's findings.

118. When all the circumstances and evidence is considered, including Claimant's consistent testimony, the observations of Dr. Dirks, Claimant's treating physician, and the testimony of Dr. Jameson, also a treater, the weight of the evidence supports a finding that Claimant is totally and permanently disabled under the 100% method of analysis.

119. Claimant has proven his entitlement to benefits for total and permanent disability, as of his September 19, 2014 date of medical stability.[7]

120. Apportionment under Idaho Code § 72-406 is inapplicable to the present case, as it only applies to cases of disability less-than-total.

**Attorney Fees**

121. The final issue is Claimant's entitlement to attorney fees pursuant to Idaho Code § 72-804. Claimant has proven his entitlement to medical and permanent total disability benefits related to his industrial accident. However, attorney fees are not granted as a matter of right under the Idaho Workers' Compensation Law, but may be recovered only under the circumstances set forth in Idaho Code § 72-804 which provides:

> If the commission or any court before whom any proceedings are brought under this law determines that the employer or his surety contested a claim for compensation made by an injured employee or dependent of a deceased employee without reasonable ground, or that an employer or his surety neglected or refused within a reasonable time after receipt of a written claim for compensation to pay to the injured employee or his dependents the compensation provided by law,

[7]Claimant has claimed entitlement to ongoing TTD benefits on the theory that he was not medically stable as of September 19, 2014. This Referee has found otherwise. However, because Claimant is totally and permanently disabled, he is entitled to lifetime benefits at the TTD rate per Idaho Code § 72-408 following his September 19, 2014 date of stability. Per *Dickinson v. Adams County*, 2017 IIC 0007 (March 2017), Defendants are allowed to apply any indemnity payments made subsequent to September 19, 2014 to their obligation to pay Idaho Code § 72-408 benefits from September 19, 2014 forward.

> or without reasonable grounds discontinued payment of compensation as provided by law justly due and owing to the employee or his dependents, the employer shall pay reasonable attorney fees in addition to the compensation provided by this law. In all such cases the fees of attorneys employed by injured employees or their dependents shall be fixed by the commission.

The decision that grounds exist for awarding attorney fees is a factual determination which rests with the Commission. *Troutner v. Traffic Control Company*, 97 Idaho 525, 528, 547 P.2d 1130, 1133 (1976).

122. Claimant argues Defendants were unreasonable for refusing to pay for the SCS, and for cutting off Claimant's TTD benefits when they did. These arguments are not valid.

123. Defendants acted reasonably in denying Claimant's request for an SCS. They relied on Dr. Beaver's opinions that based upon several tests Claimant was in the high risk of failure group. Furthermore, Dr. Friedman informed Defendants that spinal cord stimulators did not work well for individuals like Claimant based upon the doctor's findings at the time of his examination, and based on Claimant's own history of symptoms. Also, Defendants were correct to cease TTD payments upon the finding of MMI by Dr. Friedman, which was a sound conclusion. Finally, since Claimant did not prevail on the issue of TTD benefits, attorney fees cannot be awarded for failure to pay such benefits. *Accord, Salinas v. Bridgeview Estates*, 162 Idaho 91, 394 P.3d 793 (2017).

## CONCLUSIONS OF LAW

1. Claimant has proven his entitlement to additional medical benefits in the form of reimbursement for his dorsal spinal cord stimulator at the *Neel* rate.

2. Claimant has proven he is totally and permanently disabled under the 100% method.

3. Apportionment under Idaho Code § 72-406 is inapplicable.

4. Claimant has failed to prove he is entitled to attorney fees for Defendants' failure to authorize the spinal cord stimulator and for terminating Claimant's TTD benefits when he was determined to be at maximum medical improvement.

## RECOMMENDATION

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

DATED this 13th day of February, 2019.

INDUSTRIAL COMMISSION

/s/
Brian Harper, Referee

## CERTIFICATE OF SERVICE

I hereby certify that on the 25th day of February, 2019, 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:

CHARLES BEAN
2005 IRONWOOD PKWY, STE 201
COEUR D ALENE ID 83814

JAMES MAGNUSON
PO BOX 2288
COEUR D ALENE 83814

/s/

jsk

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

| | |
|---|---|
| JEROLD MOSS,<br>Claimant,<br>v.<br>CDA SERVICE STATION EQUIPMENT, INC.,<br>Employer,<br>and<br>IDAHO STATE INSURANCE FUND,<br>Surety,<br>Defendants. | **IC 2013-000548**<br><br>**ORDER**<br><br>**Issued 2/25/19** |

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 his entitlement to additional medical benefits in the form of reimbursement for his dorsal spinal cord stimulator payable per *Neel*. Pursuant to *Williams v. Blue Cross of Idaho*, 151 Idaho 515, 260 P.3d 1186 (2011), such an award by the Commission is subject to the claim of the subrogated health carrier.

2. Claimant has proven he is totally and permanently disabled under the 100% method.

3. Apportionment under Idaho Code § 72-406 is inapplicable.

4. Claimant has failed to prove he is entitled to attorney fees for Defendants' failure to authorize the spinal cord stimulator and for terminating Claimant's TTD benefits when he was determined to be at maximum medical improvement.

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

DATED this 25th day of February, 2019.

INDUSTRIAL COMMISSION

/s/
Thomas P. Baskin, Chairman

/s/
Aaron White, Commissioner

/s/
Thomas E. Limbaugh, Commissioner

ATTEST:

/s/
Assistant Commission Secretary

## CERTIFICATE OF SERVICE

I hereby certify that on the 25th day of February, 2019, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

CHARLES BEAN
2005 IRONWOOD PKWY, STE 201
COEUR D ALENE ID 83814

JAMES MAGNUSON
PO BOX 2288
COEUR D ALENE 83814

/s/

jsk