BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

RACHEL WEBB, Claimant, v. BELL PRINTING & DESIGN, Employer, and CINCINNATI CASUALTY CO., Surety, Defendants.	**IC 2017-027843** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** **Filed November 20, 2020**

INTRODUCTION

Referee Michael Powers conducted a hearing in the above-entitled matter in Idaho Falls on January 9, 2019. Claimant, Rachel Webb, was present in person and represented by James Arnold of Idaho Falls. Defendant Employer, Bell Printing & Design (Bell) and Defendant Surety, Cincinnati Casualty Co., were represented by Susan Veltman of Boise. The parties presented oral and documentary evidence. Post-hearing depositions were taken; however, before the matter was briefed by the parties Referee Powers retired.

On July 12, 2019, the Idaho Supreme Court determined that a claimant is entitled to findings and a recommendation from the referee who presided at hearing. Ayala v. Robert J. Meyers Farms, Inc., 165 Idaho 355, 357–58, 445 P.3d 164, 166–67 (2019).

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Alan Taylor, who conducted a telephonic conference with the parties during which Claimant requested a hearing before the newly assigned referee.

On November 7, 2019, Referee Taylor conducted a hearing in Idaho Falls. Mr. Arnold represented Claimant. Ms. Veltman represented Defendants Employer and Surety. The parties presented additional oral and documentary evidence. Additional post-hearing depositions were taken, and briefs were later submitted. The matter came under advisement on September 1, 2020.

ISSUES

The issues to be decided are:

1. Whether Claimant suffers from complex regional pain syndrome due to her industrial accident, and if so, the extent thereof;

2. Whether Claimant is entitled to additional medical care, and if so, the extent thereof; and

3. Whether Claimant is entitled to additional temporary disability benefits.

CONTENTIONS OF THE PARTIES

All parties acknowledge Claimant suffered an industrial accident on September 7, 2017, when she fell down the stairs at Employer's workplace. Defendants accepted the claim and paid for medical treatment and temporary disability benefits until approximately June 13, 2018. Claimant asserts that due to her industrial accident she suffers from complex regional pain syndrome (CRPS) which commenced with her right knee and subsequently spread to her other extremities, requires further medical treatment, and is entitled to additional temporary disability benefits. Defendants assert that Claimant does not suffer CRPS and requires no further medical treatment. In the alternative, Defendants allege that if Claimant has CRPS, it is not related to her industrial accident, or if related, it has not spread to her other extremities and treatment thereof has not been reasonable and necessary.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The Industrial Commission legal file.
2. The testimony of Claimant, Rachel Webb, and Chris Wagener, taken at the January 9, 2019 hearing.
3. Claimant's Exhibits A-Q admitted at the January 9, 2019 hearing.
4. Defendants' Exhibits 1-5, 7, 10, and 12-13, admitted at the January 9, 2019 hearing.
5. The deposition testimony of Daniel P.W. Smith, D.O, taken by Claimant on November 30, 2018.
6. The post-hearing deposition testimony of Richard A. Wathne, M.D., taken by Claimant on February 14, 2019.
7. The post-hearing deposition testimony of Brian D. Tallerico, D.O., taken by Defendants on February 22, 2019.
8. The testimony of Claimant, Rachel Webb, taken at the November 7, 2019 hearing.
9. Claimant's Exhibits R-U admitted at the November 7, 2019 hearing.
10. Defendants' Exhibits 14-15, admitted at the November 7, 2019 hearing.
11. The post-deposition testimony of Daniel P.W. Smith, D.O, taken by Claimant on February 21, 2020.
12. The post-hearing deposition testimony of Dennis Chong, M.D., taken by Defendants on Aril 16, 2020.

Pursuant to Defendants' request, judicial notice is taken of the AMA, Guides to the Evaluation of Permanent Impairment, Fifth and Sixth Editions.

Defendants objected to portions of Dr. Smith's testimony during his February 21, 2020 post-hearing deposition pursuant to JRP 10(E)(4) as based on evidence developed post-hearing and maintained their objection in their Responsive Brief. Said objections are sustained and Defendants' request to strike Dr. Smith's testimony in response to all such questions is granted.

All other outstanding objections are overruled and motions to strike are denied.

After having considered the above evidence and the arguments of the parties, the Referee submits the following findings of fact and conclusions of law for review by the Commission.

FINDINGS OF FACT

1. **Background**. Claimant was born in 1988. She was approximately 31 years old and resided in Idaho Falls at the time of hearing. She is right handed, five foot two inches tall, and at all relevant times weighed approximately 110 pounds.

2. Claimant was born in Florida and graduated from high school in 2006. She developed a swimming injury at the age of 17 in which her right patella dislocated to the side of her knee. In approximately 2007, she underwent arthroscopic right knee surgery to "tighten up the tendons and ligaments to keep my patella in place." January Transcript, p. 32, ll. 20-21. Approximately yearly thereafter Claimant had recurring right knee pain which prompted her to wear a right knee brace from time to time.

3. Claimant received an associate degree from a community college and worked as an administrative assistant at a law office. She also worked in her parents' sports photography business.

4. In approximately 2014, Claimant moved to the Idaho Falls area and began working for Bell assisting as a photographer with school photo shoots.

5. On January 15, 2017, Claimant injured her right knee while skiing. On January 16, 2017, she presented to Bryant Hansen, PA-C, who recorded: "PT presents c/o right knee swelling pain after falling while skiing yesterday. PT was able to ski after the injury but states she could not walk on it last night due to pain and stiffness. Denies any clicking, catching, weakness or numbness. .... mild effusion present …. Range of motion: limited ROM secondary to pain, flexion." Exhibit A, pp. 25-26. He prescribed a knee brace and several weeks of rest. Claimant continued working. She had intermittent right knee symptoms thereafter. At follow-up on February 13, 2017, she reported "pain is much better than it was, continues to have pain only when she is on her feet for a long period of time. Admits to feeling a small clicking with knee flexion on the medial side. Denies any swelling." Exhibit A, p. 30. Claimant continued to experience intermittent right knee pain with prolonged standing or driving.

6. **Industrial accident.** On September 7, 2017, Claimant tripped and fell forward while descending a flight of stairs as she was leaving work for the day. She struck her right knee on a metal stair and then again on the concrete landing at the base of the stairwell. She noted immediate right knee pain. Her coworkers heard her fall and came to assist her. She worked for several more days after her fall, although with difficulty due to persisting right knee pain.

7. **Medical treatment.** On September 17, 2017, Claimant presented to PA-C Hansen who recorded: "c/o right knee pain and swelling after taking a fall down the stairs yesterday. Very painful over the knee cap and feels some clicking and popping with ambulation. ... Right knee … no swelling or redness. …. [L]imited ROM secondary to pain, flexion. Crepitus: mild. Palpation: tenderness on medial collateral ligament." Exhibit A, pp. 50-51. He directed her to wear her knee brace and ordered a right knee MRI. The MRI performed September 19, 2017, documented: "There is subcortical edema along the anteromedial aspect of the medial femoral condyle. No

discrete cartilage defect is identified. ... no joint effusions. Impression: 1. contusion of the anteromedial aspect of the medial femoral condyle. " Exhibit A, p. 55.

8. On September 27, 2017, Claimant presented to PA-C Hansen who recorded: "Pt states there has been little improvement in her pain, bruising has worsened. No new swelling or other symptoms." Exhibit A, p. 58.

9. On October 12, 2017, Claimant presented to PA-C Hansen who recorded:

> Pt presents c/o persistent and worsening right knee pain with swelling and bruising. Pt [sic] initially started after a fall down a flight of stairs at work. MRI showed deep contusion of the knee but patient states that since then she step [sic] on it "wrong" and heard a loud pop and since there [sic] has been worse pain and swelling. …. Inspection: ecchymosis, effusion, right, moderate. Range of motion: painful movements, limited ROM secondary to pain. Crepitus: mild. Palpation: tenderness in anterior joint line. …. Referral … [to physical therapy]. Reason: right knee contusion, pain has not resolved and seems to be getting worse.

Exhibit A, pp. 61-62. PA-C Hansen worried about a new ACL tear and referred Claimant to orthopedic surgeon Nathan Richardson, M.D.

10. On October 20, 2017, Claimant presented to Dr. Richardson who recorded: "Chief complaint of right knee pain. Patient fell down the stairs at work. She had an MRI done afterwards. 2 weeks later, she was stepping out of the shower and heard a 'snap and pop' her knee gave way." Exhibit A, p. 64. Dr. Richardson provided a right knee intra-articular corticosteroid injection and ordered another right knee MRI which documented medial femoral condyle bone contusion and hematoma in the posterior lateral knee but no ligamentous injury. On October 31, 2017, Dr. Richardson examined Claimant again and assessed right knee contusion of the medial femoral condyle and posterior lateral right knee hematoma. He prescribed physical therapy which Claimant consistently attended.

11. On December 12, 2017, Dr. Richardson recorded: "She reports her foot is always 'freezing' and has an audible popping at times." Exhibit B, p. 6. He noted hypersensitivity in the

saphenous nerve and referred Claimant to Nicholas Pearson, D.O., "for a nerve block of the saphenous nerve for pain relief investigation." Exhibit B, p. 7.

12. On December 18, 2017, Claimant presented to Dr. Pearson who recorded:

> … presents with a chief complaint of right knee pain, which began on 9/7/17 when Pt fell down the stairs at work. Pt reports unable to bear weight. Pt has been going to PT 2-3 times weekly and is just starting her third week of physical therapy. She notes that this is helped [sic] her increase her range of motion but she still is unable to bear weight. She is seeing Dr. Richardson in the past and has had two MRIs of the right knee. The patient complains of swelling in the right knee. She also complains of pain to light touch. She is very emotional and distraught at this time as she has been having ongoing symptoms now for three months. Prior to her injury she was very active and enjoyed yoga and swimming and other outdoor activities. Since then she has been restricted significantly to her activities.
>
> Physical examination:
> ....
>
> Swelling: mild
>
> Patient has exaggerated pain response to light touch involving the anterior medial aspect of the knee as well as the insertion of the quadriceps tendon onto the patella. When lightly touching her she jumps on the table. There is also noted that she has got some duskiness and ecchymosis at the anterior aspect of the knee. Her right knee is also cooler to the touch compared to the contralateral knee. ....
>
> Imaging: All her images were reviewed …. MRI shows medial condyle bony contusion. ….
>
> At this time I feel that she has an exaggerated response to her pain stimulus that occurred back in September. I have spoken with Dr. Dan Smith who actually came in and evaluated the patient during her visit. He has agreed to treat her with the working diagnosis of CRPS.

Exhibit B, pp. 8-10.

13. Regarding his December 18, 2017 examination of Claimant, Daniel Smith, D.O., recorded:

> … 29 year old female who presented today with right knee pain, which began on 9/7/17 when she fell down the stairs at work. Since that time, she has been on crutches and has not been able to bear weight. She has had three weeks of physical therapy and to this point has only noticed minimal improvement, and the therapy has been mostly when [sic] I would consider to be traditional physical therapy. She notes that this has helped her increase her range of motion but she still is unable to bear weight and the pain has not improved. She

> has seen Dr. Richardson and today Dr. Pearson, who referred the patient to me. She states that she has had two MRIs of the right knee. The right knee is painful and she has noticed swelling in the right knee. She also complains of pain to light touch, and has not been able to wear normal pants ever since the accident. Before the injury, she was a very active individual who enjoyed yoga but can no longer perform any of her normal activities. She is currently not taking any pain medications and wants to avoid opioid medications. Her pain is at the right knee joints just above the patella on the medial side interestingly, her knee pain improved for 1-2 weeks immediately after the injury, and all of a sudden it became acutely much worse.
> ….
>
> MUSCULOSKELETAL: For sensory, allodynia and hyperesthesia are present over the right knee. Edema is noted on the medial right knee and a dusky gray change to the skin color. The right knee is cold as compared to the left. These obviously fulfill the Budapest criteria for CRPS. Tenderness is present mostly on the medial aspect of the right knee just above the patella. She is tender [to] palpation over the biceps femoris insertion site and into the mid belly.
>
> NEUROLOGIC: ... Sensation is as above, allodynia is present with hyperesthesia.
> ....
>
> Rachel has suffered for a little over three months in regards to this severe pain which has not relented. She has seen multiple orthopedic surgeons for her condition, and the MRI is inconclusive as to how or what is causing the current problem based upon the ruling out of other identifiable causes for pain, as well as for feeling a bit depressed criteria, I believe that this is a presentation of complex regional pain syndrome. We discussed several modalities in order to treat this condition, and she would like to start conservatively with changing physical therapy to exposure therapy. I will also start gabapentin ... we discussed ketamine infusions versus lumbar sympathetic blocks and finally spinal cord stimulation as a possibility. The patient would like to avoid opiate medications and I agree with this. .... I discussed that it is imperative to begin treatments more aggressively if she is not noticing benefit from the noted conservative measures as early treatment for complex regional pain syndrome leads to better outcomes.

Exhibit B, p. 11-14.

14. Prior to this visit with Dr. Smith, Claimant had never heard of CRPS. Dr. Smith prescribed physical therapy which Claimant consistently attended.

15. On January 2, 2018, Dr. Smith examined Claimant and observed no specific changes from his prior examination. He noted that physical therapy and gabapentin were not

helping significantly and recommended ketamine infusions, "twice a week for the next 3 weeks." Exhibit B, p. 18.

16. On January 12, 2018, Claimant was examined by Brian Tallerico, M.D., at Defendants' request. Dr. Tallerico ordered a triple phase bone scan, the completion of which was delayed. He did not produce a written report until June 2018.

17. On January 18, 2018, Dr. Smith examined Claimant and recorded:

> Rachel returns in follow-up. We are still waiting for Workman's Compensation to consider our plea for her to start the ketamine infusions.
> ….
>
> MUSCULOSKELETAL: for sensory, allodynia and hyperesthesia are present over the right knee. Edema is noted on the medial right knee and a dusky gray change to the skin color. The right knee is cold as compared to the left. These obviously fulfill the Budapest criteria for CRPS. Tenderness is present mostly on the medial aspect of the right knee just above the patella.
> ....
>
> Rachel did not have improvement with the gabapentin and it made her stomach upset. Therefore I will discontinue this today. I will collect a baseline urine drug screen today, and based upon the fact that she does have such severe pain and delayed treatment from Workmen's Compensation, I believe a short course of opioid medications for palliation purposes until we are able to fully obtain treatment is in order. Therefore, I will start hydrocodone 5/325 3 times daily as needed for pain ....
>
> As delineated last visit, I recommend trying the next step in therapy which would be the ketamine 1mg/kg infusion over half an hour in a controlled setting .... Otherwise, she will follow up for the procedure and we may consider doing this twice a week for the next three weeks, depending on response to therapy.

Exhibit B, pp. 20, 22.

18. On March 6, 2018, Dr. Smith recorded:

> Rachel returns in follow-up. We are still waiting for Workmen's Compensation to consider our plea for her to start the ketamine infusions. The opioid medications have assisted with her pain significantly to the point where she is actually sleeping a little bit, but she still does not want to have to take these medications nor [do] I believe that she should have to on a chronic basis. We are still waiting for the an [sic] independent medical examination to be finalized before we can have any procedures or treatments considered.
> ....

> MUSCULOSKELETAL: for sensory, allodynia and hyperesthesia are present over the right knee. Edema is noted on the medial right knee in a dusky gray change to the skin color. The right knee is cold as compared to the left. These obviously fulfill the Budapest criteria for CRPS. Tenderness is present mostly on the medial aspect of the right knee just above the patella. She is tender [to] palpation over the biceps femoris insertion site and into the mid belly. There is less allodynia present, although it is still present over the knee itself medial greater than lateral. Her right lower extremity shows obvious signs of muscle wasting. This has progressed beyond my initial assessment. ....
>
> Rachel continues to fight with her insurance about the diagnosis of complex regional pain syndrome and she had an independent medical examiner review her case, but despite the fact that this was a couple of weeks ago and she had the requisite bone scan performed, we still do not have any report from the independent medical examiner. I still believe that bone scan would not show us anything in regard to complex regional pain syndrome, as with the most recent studies about this disease process do not support the use of bone scans for the diagnosis. At this point, we could basically call this neglect for patient care that should have been fairly rapid based upon the disease process, for what we do know about complex regional pain syndrome is that if it goes untreated for too long, it has a greater chance of becoming chronic and more severe and can lead to spread. She has had improvement with physical therapy, which she now has run out of according to her insurance. However, since they have been denying every other treatments, and physical therapy has shown some improvement, if we did discontinue physical therapy at this point it will highly likely negatively impact her progress that she Artie [sic] has made, as she has less allodynia and better range of motion of the knee. I will prescribe her physical therapy twice a week for the next 12 weeks to continue with the therapy which has been the only treatment thus far that has assisted with her overall painful condition. Despite this, it is still not enough, and I will continue medication therapies as noted below and still recommend moving forward with interventional options as discussed at the last visit.
> ....
>
> As delineated last visit, I recommend trying the next step in therapy which would be the ketamine 1mg/kg infusion ....

Exhibit B, pp. 24-27.

19. On or about March 13, 2018, Claimant created a GoFundMe page to obtain funds, after she had maxed out her credit cards, so she could pursue continued medical treatment including ketamine infusions. January Transcript, pp. 43, 54.

20. At hearing, Claimant testified in response to questions about her GoFundMe page.

> Q. (by Ms. Veltman) I'm going to skip forward a little bit to March of 2018 when you opened the GoFundMe page. Again what prompted you to do that?

A. Well I needed a way to pay for my infusions because I was under the impression then I was not approved for my infusions. So my doctor had told me that—or my physical therapist had told me that I had pretty much hit my plateau, that if I didn't get these infusions, then I wasn't going to go anywhere else. So, that's when I decided to set up the GoFundMe page to pay for my infusions.

Q. However, in the GoFundMe page, it indicated that: when you surpassed your fund raising goal, all of that money is being put away to start a nonprofit organization. Did you put away any to start a nonprofit?

A. I did, but then I got cut off from my workers comp and I had to use the money.

Q. OK. Have you established any type of nonprofit organization?

A. Not yet. I plan to.

Q. Have you donated towards any existing non-profit organization?

A. Yes.

Q. Which ones?

A. CRPS for Warriors.

Q. How much did you donate to them?

A. I'm not quite sure.

January Transcript, p. 54, l. 7 through p. 55, l. 10.

21. Claimant acknowledged at hearing that she raised approximately $10,000 through her GoFundMe page. January Transcript, p. 58.

22. On March 28, 2018, Claimant began receiving ketamine infusions prescribed by Dr. Smith as treatment for her CRPS. She also continued with physical therapy. Exhibit B, p. 30. On March 29, 2018, Dr. Smith recorded:

> Edema is noted on the medial right knee and a dusky gray change to the skin color. The right knee is cold as compared to the left. These obviously fulfill the Budapest criteria for CRPS. Tenderness is present mostly on the medial aspect of the right knee just above the patella. She is tender [to] palpation over the biceps femoris insertion site and into the mid belly. There is less allodynia present, although it is still present over the knee itself medial

> greater than lateral. Mild bruising is noted despite the fact that she has not had any trauma on the lateral knee. This has progressed beyond my initial assessment. After the procedure or directly following the procedure, allodynia had improved significantly, although it has returned to roughly 90% of the previous amount .... Rachel has significant improvement with the ketamine infusion. Based upon previous patients who have underwent [sic] this type of therapy for complex regional pain central, I believe that twice a week infusion for 4 weeks would be the most appropriate course to take.

Exhibit B, P. 37.

23. Claimant received multiple ketamine infusions in April.

24. Pursuant to Dr. Tallerico's direction, on April 26, 2018, Claimant underwent a triple phase bone scan that revealed: "mild increased blood pool activity as well as delayed activity within the right patella. Findings could be related to a possible nondisplaced fracture." Exhibit C, p. 1.

25. On May 1, 2018, Dr. Smith examined Claimant again and noted: "Allodynia and hyperesthesia are present over the right knee. Edema is noted on the medial right knee and a dusky gray change to the skin color. The right knee is cold as compared to the left. .... After the procedures allodynia has improved significantly with only tenderness now to palpation." Exhibit B, p. 75. Dr. Smith reduced the ketamine infusions to one per week.

26. On May 7, 2018, Claimant presented to Dr. Smith who recorded:

> Increased right knee pain and swelling into foot. ....
>
> … allodynia and hyperesthesia are present over the right foot extending up the leg to the knee. Edema is noted on the interior right knee and a dusky gray change to skin color extending into the foot. The right knee as well as ankle is cold as compared to the left and less hair is evident on the right lower extremity than on the left. These obviously fulfill the Budapest criteria for CRPS. Allodynia over the knee has slightly improved, but is now extending into the ankle and calf.

Exhibit B. pp. 81, 83. With Claimant's symptoms extending into her right calf and foot, Dr. Smith recommended returning to biweekly ketamine infusions.

27. On May 29, 2018, Claimant presented to Dr. Smith who recorded:

> For sensory, allodynia and hyperesthesia significantly reduced after the ketamine infusions. Edema is improved significantly on the anterior right knee in a dusky gray change to the skin color extending into the foot has improved. The right knee as well as ankle is similar in temperature now as compared to the left and less hair is evident on the right lower extremity than on the left.
> ....
>
> Rachel continues to have significant improvement with the ketamine infusion, and based upon her significant improvement I recommend continuing biweekly infusions of ketamine/lidocaine for the next 4 weeks. She has had functional improvement in the fact that she can walk using one crutch only now, and I will continue to monitor her function to ensure that improvement is occurring.

Exhibit B, p. 108.

28. Claimant continued to receive ketamine infusions in May and June 2018. Defendants paid for Claimant's ketamine infusions until June 2018.

29. In June 2018, Brian Tallerico, M.D., issued his report concluding that Claimant did not suffer from CRPS. Defendants ceased paying for Claimant's ketamine infusions after receipt of Dr. Tallerico's report.

30. On July 3, 2018, Claimant presented to Dr. Smith who noted: "Rachel continues to have significant improvement with the ketamine infusions, but her insurance is no longer accepting these. She has had functional improvement in the fact that she can walk using one crutch only and even has walked without any crutches, and I will continue to monitor her function to ensure that improvement is occurring." Exhibit B, p. 149. Dr. Smith then prescribed oral ketamine. However, it proved to be ineffective.

31. On July 10, 2018, Claimant presented to Dr. Smith who recorded:

> For sensory, allodynia and hyperesthesia significantly worsened since last visit. Edema is improved significantly on the anterior right knee and a dusky gray change to the skin color extending into the foot has worsened. The right knee as well as ankle is similar in temperature now as compared to the left and less hair is evident on the right lower extremity than on the left.
> ....

> Rachel continues to have significant improvement with the ketamine infusions, but her insurance is no longer accepting these. She has had functional improvement in the fact that she can walk using one crutch only and even has walked without any crutches, but unfortunately she has regressed back to using two crutches. It appears that the ketamine/lidocaine infusions were significantly helpful for her, and I will have her repeat this tomorrow and in one week. I will discontinue the oral ketamine as this has not been effective.

Exhibit B, p. 153.

32. On July 11, 2018, Claimant applied for Social Security Disability. Her application was initially denied.

33. On July 13, 2018, Claimant was examined at her counsel's request by orthopedic surgeon Richard Wathne, M.D., who concluded Claimant had CRPS caused by her fall at work.

34. The ketamine infusions decreased Claimant's pain and physical therapy improved her strength and range of motion and allowing her to walk with one crutch. Dr. Smith advised her that if she could not afford both physical therapy and ketamine infusions, the infusions were more critical to manage her symptoms. She continued receiving ketamine infusions at her own expense as she was able.

35. On September 26, 2018, Claimant presented to Dr. Smith who recorded:

> Rachel returns and follow up. She is doing relatively well but a fan fell on her foot the day after her last infusion. She had some bruising after her infusion on Thursday, noted on her left upper extremity and it appears to be improving. However, she has pain and twitching in the left hand that was not present before this bruising was noted.
> ...
>
> For sensory, allodynia and hyperesthesia significantly improved. Edema improved significantly on the interior right knee and a dusky gray change to the skin color extending into the foot has improved. Right ankle is cooler to the touch and less hair is evident on the right lower extremity than on the left. Bruising noted over the left medial aspect of the elbow and over the hyper thenar eminence on the left. Allodynia is also present over left forearm, which is not present with distraction.
>
> Regarding the bruising on her left upper extremity, we will avoid placement of the IV in the left arm for now and she will continue to watch the left upper extremity for signs of worsening of the bruising, although they appear to be healing at this point .... Consider the

> EMG/nerve conduction study of the left upper extremity and neurology consult if the twitching in the left hand and allodynia continues.

Exhibit B, pp. 155, 157-158.

36. On October 29, 2018, Claimant presented to Dr. Smith who recorded: "allodynia and hyperesthesia significantly improved after the infusion. Right ankle is cooler to the touch and less hair is evident on the right lower extremity than on the left. Skin mottling and 1+ edema is also noted on the right foot." Exhibit B, p. 178. On November 29, 2018, Dr. Smith examined Claimant and noted no significant changes since her prior visit.

37. On December 10, 2018, Claimant presented to Dr. Smith who recorded:

> … allodynia and hyperesthesia are present. Right ankle is cooler to the touch and less hair is evident on the right lower extremity than on the left. Right foot is also edematous and she is unable to put on a shoe on secondary to pain.
> ,...
>
> Rachel continues to have significant improvement with the ketamine infusions despite the fact that they only last for a short period of time, and she is waiting for workmen's compensation to allow her to continue her treatments. She is currently paying out of pocket, and it is becoming prohibitively expensive. ... As ketamine/lidocaine has proven to be beneficial in the short term but not a good option for long-term overall treatment, I recommend spinal cord stimulation as this has been the proven benefit and of the most long-term benefit for patients who have complex regional pain syndrome. .... We will hold off on moving forward with this therapy however until she is finally able to have coverage through Workmen's Compensation, with a court date set for early January.

Exhibit B, pp. 211-212.

38. Claimant's first hearing occurred January 9, 2019.

39. On January 9, 2019, Claimant presented to Dr. Smith who noted she was able to obtain Social Security Disability and recorded "allodynia and hyperesthesia are present. Right ankle is cooler to the touch and less hair is evident on the right lower extremity then on the left. Right foot is less edematous today but dusky in color." Exhibit S, p. 3. She continued to receive benefit from ketamine infusions.

40. On January 23, 2019, Claimant presented to Joseph Weatherly, D.O., reporting significant hair loss and a low grade fever for the previous month.

41. In approximately February 2019, Claimant qualified for Medicaid and began receiving ketamine infusions in combination with physical therapy again. Dr. Smith continued to diagnose CRPS of the right leg and prescribed two ketamine infusions per week together with physical therapy sessions. He continued to recommend a spinal cord stimulator.

42. On April 10, 2019, Claimant presented to Dr. Smith who recorded: "Allodynia and hyperesthesia are present. Right ankle is cooler to the touch and less hair is evident on the right lower extremity then on the left. Right foot is less edematous today but dusky in color." Exhibit S, p. 28. He recommended one ketamine infusion per week.

43. On April 17, 2019, Claimant presented to Dr. Smith who recorded: "Unfortunately, the weekly infusions of ketamine has [sic] not resulted in sufficient pain relief to allow her to do her physical therapy. She would like to return back to the twice weekly ketamine until we can move forward with spinal cord stimulation." Exhibit S, p. 30.

44. On June 12, 2019, Claimant presented to Dr. Smith who recorded

> The pain has now spread into her left foot, and she has skin changes that are similar to the changes that were initially noted with her right foot. …. Her left foot also has now developed some symptoms similar to the right foot, this is common for complex regional pain syndrome, and hopefully will be treated with the plan as delineated below with spinal cord stimulation.

Exhibit S, pp. 42, 45.

45. Claimant continued to receive ketamine infusions through June 2019. She received a total of approximately 100 infusions.

46. On July 17, 2019, Claimant presented to Dr. Smith who noted that spinal cord stimulator trial was authorized and recorded: "Her left foot has continued with symptoms similar

to her right foot. This is common for complex regional pain syndrome, and hopefully will be treated with the plan as delineated below with spinal cord stimulation." Exhibit S, p. 53.

47. On August 12, 2019, Dr. Smith noted that Claimant experienced 90% pain relief with spinal cord stimulator trial and was "able to walk without crutches Which I have never seen before on examination until now." Exhibit S, pp. 54-55.

48. On September 16, 2019, Dr. Smith implanted a spinal cord stimulator. In follow-up on September 24, 2019, Dr. Smith recorded: "Rachel did very well after the spinal cord stimulator implantation. She will continue with standard precautions avoiding bending lifting and twisting for another three weeks, but she is already walking, an activity that she was unable to do prior to the implantation. She is extremely happy ...." Exhibit S, p. 62.

49. On September 30, 2019, Claimant presented to Dr. Smith who recorded:

> She has developed pain in the right upper extremity. It is in the right radial/C7 or C6 distribution. Numbness and pain has been occurring since Saturday night. She does not recall any injury. She has some subjective weakness although she is able to move her fingers, the movement causes significant pain. There is no muscle wasting and no discoloration and once again no injury that she has seen.
> ….
>
> I'm concerned that this may possibly be turning into a right upper extremity complex regional pain syndrome, as the presentation fits, but will wait to see what the EMG/nerve conduction study shows. I will also need to consider stellate ganglion block if her pain continues.

Exhibit S, pp. 64, 67.

50. On October 2, 2019, Claimant presented to Dr. Smith who noted she had no allodynia in her lower extremities, but allodynia was present in her right hand. He recorded:

> Rachel has developed pain in what appears to be the C6 or C7 or radial nerve distribution on the right hand. It does include some aspects of the median nerve as well. …. However, she now has a dusky discoloration of the hand/fingers and what appears to be a bruise over her thumb and dorsal aspect of her hand on the right side in a similar distribution as described above. At this point, there is no question whether this is complex regional pain syndrome, and early treatment is better. .... I will have her come in as soon as possible for

right stellate ganglion block. If this is effective, we can repeat this if needed, but we may need to consider spinal cord stimulation once again.

Exhibit S, p. 72.

51. On October 9, 2019, Claimant presented to Dr. Smith who recorded:

She had significant benefit from the stellate ganglion block on the right, although there was no relief on the left side. Her skin changes have improved as well. She is able to grasp and pick up items with her right, whereas she was not able to do this prior to the block.
....

Allodynia is present especially on the left hand in a similar distribution as it was on the right. Skin mottling is present on the hand, improved on the right after the stellate ganglion block.
....

Rachel has developed pain in the right hand which has now spread to the left hand due to complex regional pain syndrome, and early treatment is better. Therefore, we will continue with the current therapy as she had such significant relief with the right stellate ganglion block, therefore we will move forward with a left-sided stellate ganglion block. The plan will be to alternate right and left stellate ganglion blocks for a total of eight weeks. If the block is only effective for a number of days as the injections continue, the plan would be to move forward with cervical spinal cord stimulation.

Exhibit S, pp. 73, 75, 76.

52. **Credibility.** Defendants assert that Claimant's hearing testimony impugns her credibility. At hearing she testified:

Q. (by Ms. Veltman) Did you injure your right knee skiing in January of 2017?

A. Yes.

Q. Okay. Why, when you were under oath during your deposition, did you tell me you had not inured your knee skiing?

A. I don't know. I was just very flustered and... I don't know.
….

A. I—it was my first time doing a deposition. I was nervous and I just was very anxious about things, so I am not just—I'm not very aware of why I said what I said at that point.

January Transcript, p. 58 , l. 22 through p. 59, l. 10.

53. At hearing, Claimant was also questioned about her deposition testimony regarding her prior knee injuries:

> Q. (by Ms. Veltman) ... "After the knee surgery that was at some point after high school, between that time and when you fell on the stairs on September 7 of 2017, did you have any other injuries to your right knee?" How did you respond?
>
> A. "No."
>
> Q. Okay. And then a page later when I said "Okay. How certain are you that you didn't have a knee injury in between the date of the 10 year ago surgery and the September 7, 2017 injury?" …. And I said: "Yeah. Are you certain you hadn't had an injury?" And you responded...
>
> A. "Yes."
>
> Q. Okay. So then I waited and went through the records and said: "I guess, did you injure your knee skiing in January of 2017?" And what did you say?
>
> A. I said "no."
>
> Q. I said: "Any idea how Dr. Hanson got that in his note?"
>
> A. "No."
>
> Q. Okay. And when you described the injury to your supervisor the following day, do you recall what you told him?
>
> A. That I hurt my knee. I'm not—like, I don't really recall. That was a long time ago.
>
> Q. If the text indicates that you said: "My doctor said I should be off my knee for two to three weeks but I told him that's wasn't possible. Going to try to tough it out. Can I have someone cover tomorrow?"
>
> A. Yes.
>
> Q. Is that accurate?
>
> A. Yes.
>
> Q. And then a few months later in April of 2017, did you express some concerns about being able to drive for extended periods of time because of your knee?
>
> A. Yes.

Q. Okay. What issues were you having around that time?

A. It wasn't really knee pain, per say. I could drive, like—I told them that I could drive up to an hour, but anything over that, it was just the constant pressure on my knee and stuff like that, that it—since—since I had that knee brace on, it was cumbersome, first of all, to drive. And my doctor told me that it wouldn't be a good idea for me to drive. And it just didn't feel the greatest. So, I figured that if we had other drivers, that it would be possible for them to drive.

Q. So in April of 2017, you were still wearing a knee brace?

A. Yeah. I wore it off and on because I did have my surgery, so...

Q. And do you recall asking for time off from work on August 31st of 2017 due to knee issues?

A. I don't recall.
….

Q. August 31st, it says: "Just wondering if there is any possible way to have tomorrow off. I tweaked my knee. I need a cortisone injection. I promise this won't become a regular thing again. My doctor's going on vacation and I need it done. Let me know. If there's not a way for me to have it off, I will still work. Just have to let my doctor know."

A. Okay. Yeah. I might have, like, tweaked my knee or something like that. Just...

Q. Did you have a doctor's appointment for your knee?

A. I don't—I went to the doctor, but I don't think that I got a cortisone injection then.

January Transcript, p. 59, l. 22 through p. 62, l. 25.

54. Claimant's GoFundMe site contains the following:

I am raising money but I also want to raise awareness of CRPS (complex regional pain syndrome). It almost always involves an injury (which is how mine started), then continues pain that spreads and does not go away. It is a lifelong condition that I'm going to have to deal with my whole life. It goes from that injury to affecting the entire sympathetic nervous system. This started with the fall down metal stairs at work and had a major bone bruise with some fractures. To make a long story short, my company did nothing to help me and lied about things the whole way, forcing me to get a worker's compensation attorney. We are still in the process of waiting. If I would have been treated in the beginning, the CRPS would have never developed. It took three months just to be able to see doctors to see what I had.

Exhibit 3, p. 2. In reality no medical imaging disclosed "fractures" and Defendants paid approximately $24,000 in medical benefits and approximately $6,000 in temporary disability benefits during this time. Exhibit 7.

55. Having observed Claimant at hearing and compared the testimony of Claimant and Chris Wagener with other evidence in the record, the Referee finds that Wagener is a credible witness. The Referee finds that Claimant's recall is unreliable and her declarations imprecise and at times unreliable. Claimant's assertions will be accepted only to the extent they are corroborated by objective evidence in the record.

DISCUSSION AND FURTHER FINDINGS

56. 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).

57. **CRPS: diagnosis, causation, spread.** The first issue presented requires three related inquiries including whether Claimant suffers from CRPS; whether her industrial accident caused her CRPS; and finally, the extent to which her CRPS, if any, has progressed. A claim for compensation must be supported by medical testimony to a reasonable degree of medical probability. Langley v. State, Industrial Special Indemnity Fund, 126 Idaho 781, 785, 890 P.2d 732, 736 (1995). "Probable" is defined as "having more evidence for than against." Fisher v. Bunker Hill Company, 96 Idaho 341, 344, 528 P.2d 903, 906 (1974). Claimant herein asserts her industrial injury caused CRPS in her right knee, which has now spread progressively to her right

foot, left foot, and both upper extremities. Defendants deny Claimant suffers CRPS, but assert that if Claimant suffers CRPS, it is unrelated to her industrial accident and cannot spread to other limbs.

58. **Diagnosis.** Several medical practitioners have opined regarding Claimant's asserted CRPS or have reported their observations of Claimant's condition which are relevant to her assertion of CRPS.

59. Physical therapists. Therapists Greg Bailey, PT, DPT, and Kendall Adams, PTA, assisted Claimant in physical therapy for approximately seven months and repeatedly noted her right knee condition. The physical therapy records from approximately November 2017, through June 2018, uniformly list as Claimant's formal diagnosis "Pain in right knee" and "Stiffness of right knee." Exhibit P, p. 1. However, throughout the body of each note reference is made to both right and left knee symptoms. It appears that references to left knee symptoms constituted clerical error and that such observations were intended to pertain to Claimant's right knee.

60. The notes of more than 40 physical sessions between November 29, 2017, and May 29, 2018, record hyperesthesia and light bruising on Claimant's knee. Among those notes, many offer a short description of the bruising. Physical therapy notes record light bruising, increased sensitivity to pain, and ecchymosis around her patella on January 2, 2018. The January 5, 2018, physical therapy notes record: "Continues to have bruising superior and around to her patella that is tender to massage and touch." Exhibit P, p. 38. The January 17, 2018, physical therapy notes record: "She continues to have hypersensitivity superior to patella and medial knee with massage with bruising around patella. The bruising was lighter or seemed to fade after the massage." Exhibit P, p. 53. The February 7, 2018, physical therapy notes record: "knee area continues to have bruising around her patella that fades with massage." Exhibit P, p. 78. The March 19, 2018,

physical therapy notes record: "Pt continues to have bruising and staining around patella that decreases with manual desensitization massaging." Exhibit P, p. 110. The March 23, 2018, physical therapy notes record: "Pt had increased amount of bruising this day around her knee and patella. The biggest bruise was over the area of gurdys [sic] tubercle." Exhibit P, p. 113. The March 26, 2018, physical therapy notes record: "Pt bruising continues to spread around her R knee with observations of effusion. Pt was only able to perform the seated mat exercises this date due to increased pain. Pt bruising and symptoms will continue to be monitored in future visits ...." Exhibit P, p. 115.

61. The physical therapy notes document early progression of symptoms from Claimant's knee to her ankle and foot. The May 4, 2018 physical therapy notes record: "She is also demonstrating increased sensitivity over her ant tib, ant ankle, and dorsum of the foot." Exhibit P, p. 144. The May 8, 2018, physical therapy notes indicate light bruising on her knee and that her CRPS had spread into her foot and ankle such that she was unable to put on a shoe due to the swelling and pain. The May 14, 2018 physical therapy notes record: "Pt presents today with bruising and minimal edema at R knee, along lateral leg and at R ankle/dorsal foot surface." Exhibit P, p. 154.

62. The physical therapy notes document intermittent improved function corresponding to consistent twice-weekly ketamine infusions. On April 20, 2018, Claimant reported her pain was the lowest it has been in a while and she was able to walk with one crutch for approximately 100 feet. Exhibit P, pp. 131-132. The April 30, 2018, physical therapy notes record: "She is demonstrating increased function with single crutch with ambulation. She continues to have bruising above and below her knee but is having decreased sensitivity with deep pressure massage." Exhibit P, p. 141. On May 21, 2018, Claimant attended therapy right after her ketamine

infusion and tolerated therapy well. On May 25, 2018, the therapist noted that Claimant was "happy with her progress the last 2 weeks and she is really wanting to walk." Exhibit P, p. 159. Physical therapy notes also recorded light bruising on Claimant's knee on May 29, 2018, and noted Claimant was able to walk with one crutch for short distances but needed two crutches for community ambulation. On June 6, 2018, Claimant reported she was walking everyday with one crutch at home and feeling a little better all the time. Defendants then ceased authorizing therapy.

63. Throughout the seven months of therapy, the physical therapists repeatedly observed and recorded the bruising, intermittent edema, and hypersensitivity of Claimant's right knee. The later notes also document the progression of symptoms of pain and swelling in her right foot.

64. Dr. Wathne. Richard Wathne, M.D., is an orthopedic surgeon with expertise in CRPS diagnosis. He has been a practicing orthopedic surgeon since 1995. He generally refers his patients with CRPS to pain specialists for treatment. Dr. Wathne examined Claimant at her counsel's request on July 13, 2018 and concluded that she had CRPS due to her industrial accident. Exhibit D.

65. Dr. Wathne recorded his physical examination findings as follows:

> Examination of her right knee and leg does reveal a mottled appearance to the skin. There is coolness to her right knee as compared to her left knee. She has no apparent swelling. No specific joint line tenderness. She has significant pain and discomfort to just light touch that starts along the anterolateral knee and progresses down her leg to the dorsum of her foot. She actually started to cry when I touched the dorsum of her foot. There is discoloration and a mottled skin appearance to the dorsum of her foot with swelling. She does not tolerate me moving her ankle into dorsiflexion or plantar flexion. There is less tenderness on the plantar aspect of her foot. The foot is certainly cool to touch, especially compared to her opposite left foot.
> ...
>
> Review of the report of 3-phase bone scan dated 4/26/2018 is essentially unremarkable other than mild increased blood flow activity in the right patella in the delayed phase.

> Impression: complex regional pain syndrome, right lower extremity, following an on the job injury.
>
> Recommendations: at this point, Ms. Webb does meet diagnostic criteria for complex regional pain syndrome. She continues to have pain which is disproportionate to any inciting event. She continues to have hyperesthesia in the right leg that extends from her knee down into the dorsum of her foot. There is temperature asymmetry from the right leg and foot compared to the left. She has evidence of hyperalgesia to both pinprick and light touch that is especially prominent in the dorsum of her right foot. There is discoloration and a mottled appearance to her skin in the dorsum of her foot as well as the medial and lateral aspects of her knee and leg.
>
> In my opinion Ms. Webb has not reached maximum medical improvement or stability following this on the job injury subsequent diagnosis as discussed above.
> ...
>
> I am not overly familiar with ketamine infusions, but I am aware that they are being used in the treatment of complex regional pain syndrome. As an adjunct, given the chronicity of her symptoms, I believe it would be worthwhile to try 1-2 lumbar sympathetic nerve blocks to try and facilitate alleviation of some of her symptoms, as she is quite incapacitated.

Exhibit D, pp. 3-4. Dr. Wathne provided work restrictions.

66. In his deposition, Dr. Wathne testified of his actual observations:

> [A]t that time frame, that her contusion bone bruise would have resolved itself, but she was left with these ongoing symptoms and her clinical findings were quite pronounced. She had significant hypersensitivity to touch around the knee extending all the way down to the dorsum of her foot on that same side. She had a mottled appearance to the skin. Her left leg, right leg, was much cooler than her left. A lot more of her symptoms even seemed to be referred down to her ankle and foot where she had more swelling there, and she wouldn't even allow me to even range of motion of her ankle and foot, and she certainly had some limitations of motion in her knee as well. So, she really had met all the criteria for, in the old days, that I would term a reflex sympathetic dystrophy or in today's terms a CRPS Type 1.

Wathne Deposition, p. 11, l. 21 through p. 12, l. 14.

67. Dr. Wathne also testified regarding the limitations of bone scans in diagnosing CRPS:

> Q. (by Mr. Arnold) And did you review the findings relative to that bone scan?
>
> A. Yeah. I reviewed the bone scan report, which was basically equivocal, showed some slight increased uptake in the patella in that knee, but bone scans now have been shown to

> be notoriously unreliable in the diagnosis of this condition, and their sensitivity and specificity vary from fifteen percent to eighty percent, so it's not a very reliable test to make the diagnosis.
>
> Q. Would you … order a bone scan to--to help you evaluate to determine--this particular diagnosis?
>
> A. … I'm not opposed to ordering a bone scan because if the bone scan is … markedly positive, then … that potentially supports it even more. But just having a negative result doesn't exclude that diagnosis.

Wathne Deposition, p. 18, ll. 3-20.

68. Dr. Smith. Dr. Smith has been Claimant's treating physician since December 18, 2017. He completed a fellowship at the Center of Excellence of Pain, U.C., Davis Medical Center. He practiced chronic pain treatment in the Kennewick, Washington area in 2016 and 2017 where he treated 50 to 60 CRPS patients and lectured on CRPS at the Tri-Cities Pain Conference attended by over 500 medical professionals. Dr. Smith relies upon the 2007 Budapest criteria which is essentially incorporated into the AMA, Guides to the Evaluation of Permanent Impairment, Sixth Edition and is considered "the gold standard as far as diagnosing complex regional pain syndrome." Smith 2018 Deposition, p. 12, ll. 9-10. Dr. Smith noted that CRPS is relatively uncommon such that many physicians may not recognize its presentation. He testified that the pain itself is typically the first symptom, and the skin, vasomotor, and other changes often develop in four to six weeks. Smith 2020 Deposition, p. 44. Dr. Smith testified that physical examination has always been the main way to diagnose CRPS according to the Budapest criteria which is the gold standard for diagnosing this syndrome. He affirmed that without physically examining his patients he would not be able to make such diagnosis.

69. Dr. Smith confirmed that on December 18, 2017 when he first examined Claimant he noted persisting skin discoloration which looked like a bruise: "So usually a bruise is going to heal after about a week, you know, but if it's that far out, discoloration there, she couldn't tolerate

even very light touching over the top of the skin. Very, very much a nerve related type of pain."

Smith 2018 Deposition, p. 14, ll. 8-12.

70. Dr. Smith testified that when examining Claimant on January 18, 2018, he recorded allodynia and explained:

> Allodynia is an unnatural—an unnaturally painful response to non-noxious stimuli. For example, blowing across the skin or touching the skin lightly normally does not cause pain in her case it causes severe pain which is one of the telltale signs, in particular, of complex regional pain syndrome. .... Hyperesthesia. So an intense increase in sensation.
>
> Q. (by Mr. Arnold) And then you indicated edema is noted on the medial right knee and a dusky, gray change to the skin color.
>
> A. Correct.
>
> Q. And you observed that?
>
> A. I did.
>
> Q. And then you indicated that the right knee is cold as compared to the left?
>
> A. Correct.
>
> Q. And then you stated; These obviously fulfill the Budapest criteria for CRPS.
>
> A. Correct.

Smith 2018 Deposition, p. 21, l. 23 through p. 22, l. 19.

71. Dr. Smith further explained how Claimant's findings satisfied the Budapest criteria:

> Sensory vasomotor, sudomotor and motor/trophic type changes. So under sensory allodynia and hyperesthesia, they both fit. And then with the temperature asymmetry and changes in the skin color that fits with vasomotor and edema fits with the sudomotor changes. Those are three of the four criteria and under the Budapest criteria, the symptoms, they must report at least one symptom in three of the four categories as shown to the right which that fits.
> ....
>
> The symptoms fit, the science fits, and the last thing that needs to fit for complex regional pain syndrome is there is no other diagnosis that can better explain the patient signs and symptoms which there are not ....

Smith 2018 Deposition, p. 22, l. 22 through p. 23, l. 6.

72. Dr. Smith testified regarding the use of bone scans in diagnosing CRPS:

> From my understanding, Dr. Tallerico wanted to get a bone scan in order to rule out the condition known as complex regional pain syndrome. As you can see, according to the most recent data quoted here in this paper from 2018, bone scans have nothing to do with diagnosing complex regional pain syndrome. Initially when causalgia and reflex sympathetic dystrophy were being diagnosed, they would use bone scans to see if there was some bone degradation or changes from one side to the other that could--that can occur. I mean, it is something that can happen with complex regional pain syndrome, but it's not included in any of the up-to-date diagnosis and treatment of complex regional pain syndrome.

Smith 2018 Deposition, p. 25, l. 19 through p. 26, l. 8. In response to Defendants counsel's questions, he further explained the utility of bone scans in diagnosing CRPS:

> So before because they had seen that in a few patients, they said: hey, you know, this is specific or this is a sensitive thing that we can use. What they have found after the review happened with all of the people who were the major thought leaders of complex regional pain syndrome back in 2007, when the paper came out for the Budapest criteria, that's why it was discluded in diagnosis because it's not something that is either sensitive or specific enough to CRPS. It's an interesting finding that sometimes we see but it's never--it's not something that we're always going to see with CRPS.

Smith 2018 Deposition, p. 44, ll. 5-17.

73. Dr. Smith testified his fellowship at the Center of Excellence of Pain, U.C., Davis Medical Center did not rely upon bone scans to diagnose CRPS, and "having spoken with many of my other pain physicians that I work with, they don't order bone scans to diagnose CRPS." Smith 2020 Deposition, p. 19, ll. 6-8.

74. Dr. Smith testified regarding the assertion that Claimant's CRPS was actually a manifestation of a somatic symptom disorder and symptom magnification, that: "I disagree with it. You know, physical examination findings you can't fake. So really you can't really have a somatoform faking of CRPS. It's, in fact, quite impossible." Smith 2020 Deposition, p. 13, ll. 13-16.

75. Dr. Smith testified that he physically examines patients in every regard using both history and physical examination findings to correlate the patient's condition. He further described the process that he utilized with Claimant to evaluate the veracity of her subjective complaints:

> In many cases, the first time I see a patient who has complex regional pain syndrome, one of the things that I often do to try and, you know, rule out malingering or faking symptoms is that I will often pull out my stethoscope and start listening to their chest and then lightly rest my hand on the part where they say they are hurting, and often, the distraction itself will let me know that they are not paying attention to that; they're paying attention to breathing; so therefore, you know, if they don't react to my light touch, you know, that could be malingering.
>
> That was not the case with Rachel. You know, as soon as I barely touched her leg, even with other distracting factors, she had pain.

Smith 2020 Deposition, p. 39, l. 11- 25.

76. Dr. Smith opined that Claimant had CRPS Type 1, causally related to her fall at work concluding: "You cannot confabulate physical science and symptoms like this--these." Smith 2018 Deposition, p. 24, ll. 20-21.

77. Dr. Tallerico. Dr. Tallerico is an orthopedic surgeon. He examined Claimant on only one occasion, January 12, 2018, and ordered a triple phase bone scan the completion of which was delayed due to technician error. At the time of his examination, Dr. Tallerico only had Claimant's medical records through October 31, 2017 for review. He subsequently received Dr. Smith's December 18, 2017, January 2, and March 6, 2018 notes. Dr. Tallerico noted that Claimant continued to be on crutches four months after a knee injury that did not cause any internal derangement.

78. Dr. Tallerico recorded his examination findings as follows:

> She ambulates today with crutches and non-weight bearing.
> ....

> She has some thickening anteriorly and some mild soft tissue swelling but no knee effusion on the right. She also has some discoloration interestingly just in the anterior aspect of the knee which appears to be a bruise but no discoloration below the level of the knee.
>
> By using Table 16-16 in the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, for objective criteria for complex regional pain syndrome, this individual demonstrates no local clinical signs in the lower right extremity that would qualify for probable complex regional pain syndrome. In other words, although she has some bruising discoloration in the anterior right knee, this does not qualify as modeled [sic] or cyanotic. Her skin temperature is normal and symmetric and although she complains of her right foot being cold all the time with today's examination, both feet feel exactly the same in regards to hydrosis and cool temperature. ….
>
> Additionally, there [sic] no nail changes or hair growth pattern changes noted in the right lower extremity. Her ankle range of motion is full and symmetric and her knee range of motion is nearly symmetric and only lacking a few degrees on the right compared to the left.
>
> The lower extremity circumference is measured 10 centimeters above and below the poles of the Patella . She had 27.5 centimeters right calf , 28 left calf, 37 centimeters right thigh, and 38.5 centimeters left thigh. A focused right knee examination is very difficult [sic] to her hypersensitivity to light skin palpation and pressure expression especially in the medial side of the knee.
> ....
>
> ADDENDUM-06/04/18
>
> On April 26, 2018, a triple phase bone scan was performed ….
> ....
>
> As suspected, this study does not show any evidence whatsoever of complex regional pain syndrome.

Exhibit 10, pp. 9-10.

79. Dr. Tallerico concluded that Claimant sustained a right knee contusion due to her industrial accident, reached maximum medical improvement by the date of the triple phase bone scan, did not have CRPS, needed no further medical treatment for her industrial accident, and had no restrictions related to her industrial accident. He wrote: "Finally, it is my opinion that the examinee is willfully misrepresenting her current condition as it relates to any industrial injury." Exhibit 10, p. 13.

80. In his deposition, Dr. Tallerico affirmed that he evaluated Claimant based upon the Budapest criteria. Concerning the value of a triple phase bone scan, Dr. Tallerico testified:

> A triple phase bone scan can be useful for ruling in or ruling out chronic regional pain syndrome--I said it--complex regional pain syndrome. But we have to understand that this is a very nebulous diagnosis in condition. So there is not one single criteria, diagnostic criteria, paper or table or anything, or a diagnostic test that can effectively rule out a ruling, meaning completely.

Tallerico Deposition, p. 8, l. 19 through p. 9, l. 1.

81. Dr. Tallerico testified that if Claimant had CRPS, he would have expected the triple phase bone scan to show "Increased uptake and flow activity throughout the lower extremity, rather than just isolated to the patella, which obviously is quite small compared to the whole lower limb." Tallerico Deposition, p. 13, ll. 12-15.

82. When questioned about Dr. Smith's opinion that a triple phase bone scan was not worthwhile in diagnosing CRPS, Dr. Tallerico testified:

> A. I disagree. I think it's still commonly used. And as I said earlier, it's not a failsafe study, hardly any studies are when it comes to a lot of orthopedic diagnosis. ….
>
> Q. (by Ms. Veltman) Is a triple phase bone scan referenced in the Budapest study?
>
> A. I don't believe so.
>
> Q. Is it referenced as a criteria in the AMA Guides?
>
> A. I would have to look at that table in the 5th and 6th edition. But I think the 6th edition is basically a copy of the Budapest criteria, and the 5th edition may be a little different.

Tallerico Deposition, p. 14, ll. 5-24.

83. Dr. Tallerico testified that bone bruising may be evident on MRI for up to six months, "but clinically, people have recovered from them within a couple months." Tallerico Deposition, p. 11, ll. 8-9.

84. Dr. Tallerico explained regarding his physical examination of Claimant:

> So she did have some bruising in the front of the knee, which is consistent with her striking her knee. But that doesn't count as one of the clinical signs and the criteria for CRPS, which is discoloration of the limb. An isolated area of bruising isn't the same thing as the vasomotor changes, which would be either discoloration of the limb or temperature changes. So she had neither of those.
>
> She also had no change in temperature of the skin. She had no abnormal hair distribution. She had no hyperhidrosis, which would be increased clamminess or sweating compared to the other limb.

Tallerico Deposition, p. 11, ll. 13-24.

85. Dr. Beaver. On October 24, 2018, Claimant was examined by clinical neuropsychologist Craig Beaver, Ph.D., at Defendants' request. Doctor Beaver issued his report on November 6, 2018, stating:

> Ms. Webb was administered the SIMS, which is designed to help assess issues of symptom magnification. She had a very elevated score on the SIMS, indicating concern about symptom magnification and her reporting of difficulties.
> ....
>
> Ms. Webb completed the MMPI-II. In reviewing the validity scales of the MMPI, there was no evidence of her exaggerating or overstating psychological difficulties. However, she had marked elevations on the FBS scale, which reflects overreporting of neurological symptomology. This would be very consistent with the elevated score on the SIMS and raises continuing concern that she is likely to grossly overstate her physical problems and issues.
>
> In examining the clinical scales of her MMPI, she had significant clinical scale elevations with a 2-3-1 profile. Persons with similar profiles are often viewed as having a significant somatization disorder, as well as underlying depression and anxiety. This is consistent with her history. These persons are very prone to somaticizing in response to psychological and emotional distress. There is often a clear secondary gain associated with their symptom reporting. These individuals often feel life is a strain. They struggle with a conflict about being dependent on family or others yet being self-assertive.
> ....
>
> Finally, Ms. Webb also completed the SOPA, which looks at adaptive and maladaptive beliefs about their pain issues. In regard to the adaptive beliefs, she was in the average range for a sense of control over her pain. She did have markedly elevated scores in the emotion scale indicating that she currently views herself as experiencing a great deal of emotional distress. This certainly is consistent with her over reporting, as well as her elevated scores on the MMPI.

> In review of maladaptive beliefs, she views herself as potentially harming herself if she engages in increased activities with her leg and does not necessarily feel that she is getting enough support from the people around her because of her pain difficulties. .... Also some of her overstating of her symptomatology may be related, at least in part, to a need for other people to be more supportive to take care of her in a more aggressive manner.

Exhibit 12, p. 14-15.

86. Dr. Beaver diagnosed somatic symptom disorder, with predominant pain, persistent, moderately severe; major depressive disorder, recurrent, moderate, with anxious distress; and panic disorder. He opined that Claimant's somatic symptom disorder reflected her coping mechanisms and longstanding personality style and was not predominantly caused by her knee injury but perhaps exacerbated by it. Similarly, Dr. Beaver opined Claimant's major depressive disorder pre-existed her work injury which may have temporarily exacerbated her depression but was not the predominant cause thereof. Lastly, he opined Claimant's panic attacks pre-existed her work injury and were not caused or significantly exacerbated by it.

87. Dr. Beaver concluded:

> In my opinion, her depression and somatization significantly impact her symptom presentation. She is very prone to magnify her symptom complaints. This concern has in fact been raised by others who have examined her. Her psychological profile also indicates that she is prone to greatly exaggerate or overstate her current problems and difficulties.
>
> This results in her symptom reporting being relatively unreliable with regard to evaluating her current status as it relates to pain. For example, on the one hand, she reports that the ketamine infusions have made a remarkable difference in her pain. She has been receiving ketamine treatments since June. Yet, on the other hand, she describes that she has regressed. She now requires two crutches instead of one. She reports she cannot put any weight on her foot, even though she has been encouraged to do so.
> ....
>
> Additionally, despite medical records in which it is very clear that she has a significant history of anxiety, depression, and panic attacks before her work injury, she essentially minimizes any depression and reports only occasional anxiety or panic attacks before the knee injury, and attributes all of those difficulties essentially to her current knee problems and restrictions. .... All of which indicate that she is unreliable in her symptom reporting, as well as history reporting.

Exhibit 12, p. 16. Dr. Beaver did not opine regarding whether Claimant had CRPS, considering this issue outside his area of expertise, however, he did note that "there is a strong psychological component to all symptoms that she presents with." Exhibit 12, p. 17.

88. Dr. Chong. Physiatrist Dennis Chong, M.D., completed his training in 1993 in Canada. Two-thirds of his patients have chronic pain, and approximately 20% of those have CRPS. On cross-examination he acknowledged that this amounted to a total of four patients with CRPS prior to the onset of the COVID-19 pandemic. Dr. Chong testified there is no gold standard in diagnosing CRPS but affirmed that he utilized the Budapest criteria in arriving at his diagnosis of Claimant's condition. Dr. Chong confirmed the criteria of the AMA Guides, Sixth Edition, significantly mirrors the Budapest criteria.

89. Dr. Chong never examined Claimant but reviewed her medical records at Defendants' request and prepared a report dated November 15, 2019, concluding:

> Careful review of the clinical records, particularly the physical examination findings do not meet the Budapest diagnostic criteria 3, signs. What all examiners do describe is allodynia. This is the subjective report of pain with a normal stimulus. In particular, this allodynia appears to influence the objectivity of physicians who are sympathetic to Ms. Webb's cause, such as Richard Wathne, MD, and Daniel Smith, DO. The neuropsychological evaluation already strongly urges caution in interpreting subjective complaints. An unbiased evaluation, which includes Brian Tallerico, DO, who does not find necessary and sufficient signs, then proceeds with an adjunctive test procedure of triple phase bone scan, confirming his opinion that this diagnosis of complex regional pain syndrome diagnosis is not supportable. Another unbiased evaluation is from neuropsychologist Craig Beaver, PhD, who finds that the claimant has a personality trait of great exaggeration and overstatement, which then spillover to behavior such as using crutches, report of response to ketamine treatments without corresponding functional improvement. This then provides an answer to Budapest diagnostic criteria 4, in that there is an alternative explanation that better explains the claimant's symptoms. The bone scan is exceptionally relevant to assist in the diagnosis. In Dr. Smith's rebuttal letter, he states that he has never been taught to use this technology to diagnose this disorder during his fellowship. This would appear to be a deficiency.

Exhibit 15, p. 12.

90. Dr. Chong testified Claimant's triple phase bone scan was absolutely inconsistent with the diagnosis of CRPS.

91. Dr. Chong thoroughly explained his conclusion that Claimant failed to meet the four Budapest criteria required for a diagnosis of CRPS:

> The first criteria is continuing pain; So, yes, Ms. Webb meets that.
>
> Number two, it is one of requiring symptoms and complaining of a variety of different symptoms. The main symptomatic complaint that Ms. Webb has, or had in her records that I reviewed, was pain sensitivity to touch of the limb. So that meets the one area of sensory. In carefully reviewing her records, I find difficulty in no pain; that she met all of the other requirements within the symptom category, which can include what is called vasomotor, sudomotor/edema, and motor/trophic.
>
> Now the third criteria is whereby then an examiner or a physician examines the patient and physically documents those areas that are complained by the patient. Meaning the physician actually observes the hypersensitivity in his presence; that's the sensory. The physician actually documents vasomotor changes, sudomotor changes, and then motor changes.
>
> So in those objective findings, once again the main area of documentation that I observe is primarily in the complaint of hypersensitivity, but I see infrequent or inconsistent documentation of meeting the signs.
>
> So in diagnostic criteria two, which is the symptoms, and diagnostic criteria three, which is the signs, it is inconsistent and debatable whether Ms. Webb continued to meet those criteria.
>
> Now, having said that, if one were to forgive the physicians and state that perhaps there was inadequate documentation, and these were based upon either clinicians, inadvertent, in one word to report and say, to give Ms. Webb the benefit of the doubt, that they were met, meaning diagnostic criteria two and three, there is very clearly diagnostic criteria four which Ms. Webb clearly does not meet.
>
> And that is, there is no other diagnosis that better explains the science and symptoms, especially where the signs and symptoms are equivocal in primarily only meeting the symptom and signs of hypersensitivity.
>
> And where Ms. Webb does not meet, and there is an alternative diagnosis, is that in patients with chronic pain syndrome, maybe meaning the bigger constellation and not the subset of CRPS, such patients have clearly a psychological history, which includes anxiety and depression and denying oftentimes that psychological history.

> They also have a personality trait for which when a psychologist administers objective psychological testing, the testing reveals that the personality traits is such that such individuals exaggerate, overstate, or perceive themselves to be in much greater pain, and also verbalizes that in the manner to convince or attempt to convince a treating physician or provider of their symptoms.
>
> We do have, actually, such documentation, and that is the neuropsychological testing conducted by Craig Beaver, a neuropsychologist, back in November 6, 2018. Assessed then with his administration of neuro psychological testing, his findings was that Ms. Webb's symptom reporting was unreliable and much prone to exaggeration and overstatement.
>
> That is then a huge red flag to caution any physician in making the diagnosis of CRPS, because then diagnostic criteria four is that their patient does have another condition that can explain her disproportionate complaints of pain.
>
> And the reason diagnostic criteria four is placed over there is that this is to caution the physicians, particularly the treating physicians, those who do injections, such as Dr. Smith, that if such a diagnosis is made, then you will find that the patient requires almost astronomical dosages of medications or injections and will require much invasive treatment, and yet there is inconsistent response to the treatment.

Chong Deposition, p. 20, l. 3 through p. 23, l. 3.

92. Dr. Chong expressly opined that Claimant failed to meet the fourth requirement of the Budapest criteria and that Dr. Smith inadequately evaluated whether there were other diagnoses that better explained her signs and symptoms.

93. Weighing the medical opinions. Controversy surrounds the value of the triple phase bone scan ordered by Dr. Tallerico. Drs. Wathne and Smith both testified it was not conclusive or reliable and not included in the Budapest criteria nor the AMA Guides, Fifth or Sixth Editions, which the parties agree are the appropriate and controlling criteria for CRPS diagnosis.

94. Dr. Smith affirmed that triple phase bone scan was not part of the Budapest criteria for diagnosing CRPS. During his deposition, Dr. Smith was questioned extensively about the AMA Guides regarding diagnosing CRPS:

Q. (by Ms. Veltman) Dr. Smith, I know we talked about the value, or lack of value, of the bone scan in detail at your prior deposition, but is it your testimony that a triple phase bone scan has no value in diagnosing CRPS?

A. According to some studies, the bone scan can be somewhat helpful but not in diagnosing. If you look at the Budapest criteria once again, which we use for diagnosing complex regional pain syndrome, it's not part of the algorithm that they use in order to diagnose.

Q. And as part of your practice-- scope of your practice, do you have opportunity to utilize the AMA Guides to the Evaluation of Permanent Impairment?

A. Typically not.
….

Q. OK. I want to point out this is -- we're looking at the 6th Edition of the AMA Guides.
….

Q. And it is on-- there's a table, 16-14, that's page 540 ….
....

[T]the table is titled "Objective Diagnostic Criteria Points for Complex Regional Pain Syndrome."
....

Q. And it lists things that we've talked about throughout your testimony for both, and one indication under "Radiographic Signs" is "bone scan findings consistent with CRPS ." So do you disagree with the standards set out in the AMA Guides?

A. I would disagree with the AMA creating a separate diagnostic criteria that is not recognized by national organizations that are in charge of diagnosing and treating complex regional pain syndrome. So this is the AMA; this is not the American Association of Pain; this is not the American Pain Society; this is not the American Society for Interventional Pain Physicians; this is not the American Society of Anesthesiologists nor ASRA. So once again, I disagree with someone formulating a separate way to look at complex regional pain syndrome other than that which was in the international consensus, which is the Budapest criteria which was-- the entire point of the conference was to diagnose and create a diagnostic criteria for complex regional pain syndrome, which is, once again, the Budapest criteria.

Smith 2020 Deposition, p. 28, l. 10 through p. 30, l. 12.

95. Dr. Smith reiterated that the Budapest criteria is the gold standard:

The standard by which we diagnose complex regional pain syndrome. The idea was to try and avoid medical cost, medical waste, you know, utilization of resources that aren't

necessary in order to diagnose something more simply. …. [T]o my knowledge right now, there is no reason to use those bone scans for the diagnostic criteria.

Smith 2020 Deposition, p. 31, ll. 3-7, 18-20.

96. The AMA, Guides, Sixth Edition, indicate that radiographic signs, including "Bone scan: findings consistent with CRPS" appears, as noted by Defendants' counsel, in Table 16-14 as one of 11 criteria utilized to rate the degree of permanent impairment attributable to CRPS; however, it is not one of the criteria appearing in the diagnosis of CRPS. The Guides explain: "Signs are objective evidence of disease perceptible to the examiner, as opposed to symptoms, which are subjective sensations of the individual." The diagnostic criteria espoused by the Guides, appear in Table 16-13, which provides in full:

Diagnostic Criteria for Complex Regional Pain Syndrome

1) Continuing pain, which is disproportionate to any inciting event.

2) Must report at least one symptom in **three of the four** following categories:

__ Sensory: Reports of hyperesthesia and/or allodynia.

__ Vasomotor: Reports of temperature asymmetry and/or skin color changes and/or skin color asymmetry.

__ Sudomotor/Edema: Reports of edema and/or sweating changes and/or sweating asymmetry.

__ Motor/trophic: Reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin).

3) Must display at least one sign* at time of evaluation in **two or more** of the following categories:

__ Sensory: Evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch and/or deep somatic pressure and/or joint movement).

__ Vasomotor: Evidence of temperature asymmetry and or skin color changes and or asymmetry.

__ Sudomotor/Edema: Evidence of edema and/or sweating changes and/or sweating asymmetry.

__ Motor/Trophic: Evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin).

4) There is no other diagnosis that better explains the signs and symptoms.

* a sign is counted only if it is observed and documented at time of the impairment evaluation.

AMA, Guides, Sixth Edition, p. 539 (emphasis in original).

97. Dr. Smith's strict adherence to the Budapest criteria to diagnose CRPS is in fact entirely consistent with the CRPS diagnostic criteria set forth in the AMA Guides.

98. Dr. Chong never examined Claimant. Dr. Tallerico examined Claimant only once. Dr. Pearson and Dr. Wathne examined Claimant only once. Dr. Smith examined Claimant at least 20 times. The physical therapists observed Claimant more than 40 times.

99. Strictly applying the Budapest criteria memorialized in Table 16-13 of the AMA Guides, Claimant has repeatedly satisfied Criteria 1 with her reports of continuing pain disproportionate to any inciting event. Claimant has repeatedly satisfied Criteria 2 with her reports of hyperesthesia, allodynia, temperature asymmetry, skin color changes and/or asymmetry, edema, and decreased range of motion. Regarding Criteria 3, Dr. Pearson observed and recorded signs including evidence of exaggerated pain response, swelling, "duskiness and ecchymosis at the anterior aspect of the knee," and her "right knee is cooler to the touch compared to the contralateral knee" on December 18, 2017. Exhibit B, p. 10. Also regarding Criteria 3, Dr. Wathne observed and recorded signs of hyperesthesia, evidence of significant pain to just light touch, swelling, decreased range of motion, discoloration and mottled skin appearance of the knee and foot, "coolness to her right knee as compared to her left knee" and "foot is certainly cool to touch, especially compared to her opposite left foot" on July 13, 2018. Exhibit D, pp. 3-4. Finally,

regarding Criteria 3, Dr. Smith observed and recorded signs of allodynia, hyperesthesia, edema, "a dusky gray change to the skin color. The right knee is cold as compared to the left" on December 18, 2017. Exhibit B, p. 14. Dr. Smith further documented observing all of these signs on January 18, March 6, 29, and May 1, 2018. In addition to these signs, Dr. Smith documented observing less hair on the lower right extremity on May 7, 29, July 10, September 26, October 29, December 10, 2019 and continuing thereafter.

100. Clearly, multiple physicians on numerous occasions have observed and documented signs convincingly satisfying Criteria 3. Dr. Chong's criticism that Claimant's exaggerated pain complaints have persuaded Dr. Smith and Dr. Wathne to simply accept her reported symptoms is unwarranted and entirely inconsistent with numerous medical records clearly documenting the physical findings and objective signs observed by these physicians.

101. Defendants' position rests in significant part on Dr. Tallerico's findings from a single examination.[1] Dr. Tallerico's observations in his physical examination report stand alone in stark contrast to the observations of Dr. Pearson, Dr. Wathne, Dr. Smith, and numerous observations by the physical therapists. Dr. Wathne commented on Dr. Tallerico's findings:

> Q. (by Mr. Arnold) Have you also had the opportunity to review Dr. Tallerico's report?
>
> A. Yes, I have.
>
> Q. Are there any specific disagreements that you have with his findings and conclusions and how he arrived at them?
>
> A. Yeah. I mean, my physical findings are completely different than his physical findings and the description; and, I mean, literally, I--you know, you don't have to examine her for

[1] Dr. Tallerico opined that the skin discoloration he observed on Claimant's knee, which he characterized as bruising, did not satisfy Criteria 3 because it constituted isolated bruising rather than limb discoloration. Dr. Tallerico did not explain why the alleged bruising on Claimant's knee from her fall in September 2017, would not have resolved four months later when he examined her in January 2018. However, Table 16-13 requires skin—not limb—discoloration. Even entirely ignoring repeated observations of skin discoloration by three other physicians, the vasomotor subsection of Criteria 3 is also satisfied by signs of temperature asymmetry, which Dr. Pearson, Dr. Wathne, and Dr. Smith repeatedly identified and documented.

> very long and observe her limb to see that she has that diagnosis, and this is not abnormal [sic.]
>
> And whether or not you want to try and attribute that to psychological problems, the physical findings don't lie, and--and they had to be staring him in the face. So, either he didn't do a complete exam on her or he missed, just completely missed it, but I disagree with his findings in the report and conclusions.

Wathne Deposition, p. 16, l. 16 through p. 17, l. 10.

102. Defendants' position also rests upon the assertion that Criteria 4 is not satisfied, which requires that there be no other diagnosis that better explains Claimant's signs and symptoms.

103. Dr. Beaver interviewed Claimant only once but administered extensive testing and persuasively diagnosed psychological issues that significantly impact Claimant's perception and emphatic reporting of her symptoms. However, her psychological issues do not erase or explain the objective physical findings observed by several physicians. The record contains no medical evidence establishing that a somatoform disorder would produce not only disproportionate pain complaints, but also skin discoloration, edema, limb temperature asymmetry, and/or hair growth asymmetry.

104. Dr. Smith testified that Dr. Beaver's diagnosis of somatoform disorder did not dissuade him from diagnosing CRPS because "I don't see how--anyway somatoform disorder could fake physical examination findings." Smith 2020 Deposition, p. 35, ll. 15- 17. He explained:

> And I see how that [allodynia] could possibly be faked, but the other portions of the diagnostic criteria, you know, I don't see as possible. So with those—with the allodynia specifically being improved, and on the subsequent examinations were talking the allodynia itself was within seven days of the spinal cord stimulator placement. But with subsequent examinations, the other findings such as the changes with the skin, etc, everything that is in my reports, those were also improved; so therefore you can't really fake improvement in that either.

Smith 2020 Deposition, p. 36, ll. 5-17.

105. While Claimant's somatoform disorder may in part explain her disproportionate pain complaints, the simple response to Dr. Chong's and Dr. Tallerico's criticism is that offered by Dr. Smith, namely the physical examination findings of edema, skin discoloration, temperature and hair growth asymmetry cannot be faked even by someone with a somatoform disorder who is prone to overstating her pain complaints. A diagnosis of somatoform disorder does not explain the skin color changes, edema, and temperature asymmetry repeatedly observed and documented by multiple physicians. There is not a better diagnosis than CRPS which accounts for Claimant's constellation of observed symptoms.

106. Even considering Claimant's somatoform disorder influencing her subjective reports of allodynia and hyperesthesia, the weight of the evidence establishes that Claimant suffers CRPS Type 1. Claimant has proven that she suffers CRPS.

107. **Causation.** Claimant asserts her fall on the stairs at work caused her CRPS. Defendants argue that Claimant's CRPS, if any, was more likely caused by her stepping wrong as she got out of the shower in late September or early October 2017.

108. The parties have focused on three 2017 insults to Claimant's right knee: a January skiing accident, the September 7 fall on the stairs at work, and a late September or early October pop in her knee when she stepped wrong while getting out of the shower. Of these three events, Dr. Tallerico considered the pop the least traumatic but the most proximate in time to Claimant's development of CRPS. He testified that Claimant's pop in her knee when stepping out of the shower was likely a muscle strain which corresponded to her October 2017 MRI showing some fluid in the back of her knee. Tallerico Deposition, p. 22. He testified that assuming Claimant has CRPS, the most likely inciting event was "the slip getting out of the shower." Tallerico Deposition, p. 25, ll. 22-23.

109. Similarly, Dr. Chong concluded that if Claimant does have CRPS it was not due to her January 2017 ski injury, nor the result of the industrial accident as he maintained there were no signs or symptoms of CRPS after those events. Dr. Chong opined that Claimant's severe allodynia presented after the shower incident at the end of September or early October 2017. He therefore opined that assuming Claimant has CRPS, the inciting event would correlate with the shower incident.

110. Dr. Chong recounted Claimant's September 7, 2017 fall on the stairs but then observed:

> Then Ms. Webb has the incident of where she was stepping out of the shower and heard a smack and pop, and this was documented by, again, the different physicians as well as her own recorded statement.
>
> And as a result of a substantially increased pain from that event that led to disability and swelling, a repeat MRI was done. And the repeat MRI, which was done on October 27, 2017, and compared to the original MRI of September 19, 2017, showed a finding of edema within soft tissues of posterolateral knee tracking between biceps femoris and lateral head of gastrocnemius muscle.
>
> This new finding in the knee, the posterolateral, meaning the outside and back side, is completely opposite to the contusion of the anteromedial, meaning the front and inner side of the knee. And not only was there edema, this was also observed than to be a hematoma in that part.
>
> And subsequently that became the main area of Ms. Webb's symptoms, and that is when she began to develop hypersensitivity to light touch. And this is first documented by a different orthopedic surgeon, Nicholas Pearson, D.O., on December 18, 2017.

Chong Deposition, p. 33, l. 18 through p. 34, l. 15 (emphasis supplied).

111. Indeed, Claimant's new knee complaints after the pop were on the posterolateral area of her right knee. However, a significant misstatement in Dr. Chong's analysis is that Claimant's complaints to Dr. Pearson on December 18, 2017, were not posterolateral but rather "exaggerated pain response to light touch involving the anterior medial aspect of the knee …. This is also noted that she has got some duskiness and ecchymosis at the anterior aspect of the knee."

Exhibit B, p. 9 (emphasis supplied). Claimant's persisting right knee complaints have been consistently in the anteromedial knee, corresponding to her bone contusion from her fall on the stairs, not the posterolateral knee, corresponding to the back of her knee from the pop she noted stepping out of the shower.

112. Having reviewed Claimant's medical records, Dr. Wathne concluded: "it is my opinion that all of her current symptoms are directly related to her original on the job injury of 9/7/2017 on a more probable than not basis." Exhibit D, p. 4. He testified that Claimant's fall on the stairs caused her CRPS. Wathne Deposition, p. 30, ll. 13-17.

113. Dr. Smith testified regarding the cause of Claimant's CRPS. Like Dr. Tallerico, Dr. Smith noted that the ski injury was too remote in time to cause Claimant's CRPS. He testified: "The blunt trauma to the right knee, this is more consistent with something that I would see with a complex regional pain syndrome presentation. It's usually trauma. .... I've never seen it in somebody who has a--like a tendon rupture or like a ligament rupture, something like that." Smith 2020 Deposition, p. 10, ll. 15-25.

114. Dr. Smith noted that Claimant was having knee pain that persisted after her fall and continued to persist up to the time of her stepping out of the shower, thus her fall would be more likely the cause of her CRPS. Smith 2020 Deposition, p. 42. He noted that Dr. Richardson expressed concern about Claimant's apparent saphenous nerve pain and that a saphenous nerve involvement with a fall on the anterior medial aspect of the knee would more directly relate to complex regional pain syndrome than feeling a pop in the posterolateral knee. "So the more likely than not case, the industrial accident would be the more likely cause in my opinion." Smith 2020 Deposition, p. 21, ll. 14-16.

115. The opinions of Dr. Wathne and Dr. Smith are persuasive. Claimant has proven she suffers CRPS due to her industrial accident.

116. **Spread.** Claimant asserts that her CRPS that commenced at her right knee, spread to her right foot, then to her left foot, right hand, and left hand. Defendants deny this assertion.

117. Dr. Chong reported that CRPS has not been shown to spread from one extremity to another based on any objective evidence. He opined that "spread" as a medical scientific term is appropriate to describe the growth of cancer or the progression of a bacterial infection, but when asked if there was medical or scientific evidence that CRPS can spread without new trauma from one leg to another or up into the upper extremities, he replied: "No, there is not." Chong Deposition, p. 26, l. 1. However, Dr. Chong later acknowledged "The articles that have been published with regards to such a belief of spread of CRPS has [sic] been by individuals, including the first person who described this, Robert Schwartzman, MD, in a manner of observation of their own patients." Chong Deposition, p. 27, ll. 8-12. Dr. Chong discounted these articles as being non-evidence based.

118. Dr. Smith testified generally regarding the progression or spreading of CRPS:

> Every other physician that I have discussed complex regional pain syndrome with -- and, you know, in the area I am considered to be one of the authorities regarding complex regional pain syndrome. Every other one agrees with me that this is definitely something that can happen-- spread to the other side. That's something we're taught in fellowship. So, once again, if he wants to question my education, that's fine, but he will have to question also the entire board ….
> ....
>
> The American Board of Anesthesiology which has the--the board certification for interventional pain management.

Smith 2020 Deposition, p. 23, ll. 7-22.

119. Dr. Smith testified specifically regarding the spread of CRPS to Claimant's lower right leg:

> So complex regional pain syndrome if inadequately treated will spread. It's documented that it can go to the opposite leg. In her case, the pain started manifesting itself into the foot and the foot now is the most painful area for her. And despite the fact that her knee was the original injury, the foot, it's extremely common, like I say to have the most distal part of the extremity to be the most affected portion of complex regional pain syndrome.

Smith 2018 Deposition, p. 32, ll. 11-20.

120. Dr. Smith's notes from his periodic examinations of Claimant document the progression of her CRPS. On June 12, 2019, Dr. Smith documented Claimant's "pain has now spread into her left foot, and she has skin changes that are similar to the changes that were initially noted with her right foot" noting this was consistent with CRPS. Exhibit S, p. 42. He noted similar persisting left foot symptoms on July 17, 2019, observing "This is common for complex regional pain syndrome, and hopefully will be treated with the plan as delineated below with spinal cord stimulation." Exhibit S, p. 53. Claimant received her spinal cord stimulator in September 2019 and thereafter no significant progression of left lower extremity symptoms was noted.

121. On September 30, 2019, Dr. Smith recorded Claimant's report of numbness and pain in her right upper extremity, including significant pain with moving her fingers. He observed no discoloration and no injury but was concerned about right upper extremity complex regional pain syndrome. On October 2, 2019, Dr. Smith recorded allodynia in Claimant's right hand together with:

> a dusky discoloration of the hand/fingers and what appears to be a bruise over her thumb and dorsal aspect of her hand on the right side in a similar distribution as described above. At this point, there is no question whether this is complex regional pain syndrome, and early treatment is better. .... I will have her come in as soon as possible for right stellate ganglion block. …. [W]e may need to consider spinal cord stimulation once again.

Exhibit S, p. 72.

122. Finally, Dr. Smith recorded on October 9, 2019, that Claimant had improvement on the right hand with the stellate ganglion block; however, "Allodynia is present especially on the

left hand in a similar distribution as it was on the right. Skin mottling is present on the hand, improved on the right after the stellate ganglion block. …. Rachel has developed pain in the right hand which has now spread to the left hand due to complex regional pain syndrome ….” Exhibit S, p. 75-76.

123. Dr. Smith summarized the unpredictable progression of CRPS:

> It's hard to determine what complex regional pain syndrome is going to do. It is unpredictable. You know, it's not common for it to spread to the upper extremity, but if the signs symptoms and diagnosis fits you know, it very much can be spreading to other areas of the body. It's well documented. Despite what is said here in this rebuttal, it's well documented for it to spread. It's what's taught in fellowship; it's taught to the individuals academically that are graduating in pain management, such as myself, that complex regional pain syndrome is known to spread to the opposite extremity if--you know if it becomes more severe.
>
> Now, with her having had complex regional pain syndrome for so long, you know, is it likely for it to move to the hand for most individuals? No. But normally I don't have to wait two years before I actually treat complex regional pain syndrome; therefore--you know, I've never seen a case where it had to go on for this long, and it was the diagnosis that made the most sense regarding her hand.

Smith 2020 Deposition, p. 16, ll. 3-24.

124. Dr. Smith’s opinion and diagnosis are based on repeated observations over time, rather than a single examination. His opinion is well explained, supported by extensive medical records and numerous examinations, and persuasive.

125. Claimant has proven that due to her industrial accident she suffers from CRPS which has progressed from her right lower extremity to her other extremities.

126. **Medical treatment.** Idaho Code § 72–432(1) requires an employer to provide 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. Claims for medical treatment must be supported by medical evidence establishing causation. A claimant must provide medical testimony that supports a claim for compensation to a reasonable degree of medical probability. Langley v. State, Industrial Special Indemnity Fund, 126 Idaho 781, 785, 890 P.2d 732, 736 (1995). The reasonableness of medical treatment is determined by the totality of the circumstances. Chavez v. Stokes, 158 Idaho 793, 353 P.3d 414 (2015).

127. Claimant asserts that the medical treatment she received from Dr. Smith is medically appropriate and reasonable and that Defendants are liable for payment thereof. At issue is medical treatment Claimant received after approximately June 13, 2018, including ketamine infusions, spinal cord stimulator, and stellate ganglion blocks. Defendants assert ketamine infusions cost approximately $2,500 each and expressly contest the number of ketamine infusions prescribed by Dr. Smith.

128. Dr. Tallerico reviewed a 2015 article entitled "A Systematic Review of Ketamine for Complex Regional Pain Syndrome" which he represented concluded there was no high quality evidence available evaluating the efficacy of ketamine for CRPS. Tallerico Deposition, p. 31. Dr. Tallerico acknowledged at his deposition that he did not know the pharmacologic properties of ketamine.

129. Dr. Smith affirmed that the most recent data published in March 2019 in an article entitled "NMDA Receptor Antagonists and Pain Relief, a Meta-Analysis of Experimental Trials," concluded that there is "robust evidence for analgesic and anti-hyperalgesic effects of ketamine, supporting its utility for acute and chronic pain management." Exhibit R, p. 7.

130. Dr. Chong testified that ketamine infusions are a temporizing measure used during rehabilitation. He opined that ketamine infusions would be necessary in short term management

of CRPS citing the Consensus Guidelines in the Use of Intravenous Ketamine Infusions for Chronic Pain from the American Society of Regional Anesthesia and Pain Medicine recommending no more than 6 to 12 ketamine infusions in one year. He observed Claimant has received approximately 100.

131. Dr. Smith testified that ketamine "can be called an all-in-one general anesthetic." Smith 2018 Deposition, p. 18, ll. 10-11. He testified that weekly or biweekly infusions are utilized, noting "ketamine can be one of the most potent pain relievers that we have." Smith 2018 Deposition, p. 18, ll. 24-25. He explained:

> But we have found that ketamine has assisted complex regional pain syndrome and has led to regression or complete resolution of symptoms over time. Typically over a period of 6 to 12 months of ketamine infusions, if there hasn't—if it hasn't, quote/unquote, cured the complex regional pain syndrome, then we use it as a temporizing type of medication to help them live their life. But it's not the permanent solution.

Smith 2018 Deposition, p. 19, ll. 14-23.

132. Dr. Smith testified that the 6-12 per year ketamine infusion guidelines were just that, guidelines, and "it's not uncommon for patients to receive ketamine infusions more than 6 to 12 per year, especially in the setting of pain as acute as Rachel's was." Smith 2020 Deposition, p. 13, ll. 5-7. Dr. Smith began treating Claimant with one ketamine infusion per week with physical therapy and then progressed to two infusions per week as single weekly infusions were not benefitting her as long. He testified the reason ketamine infusions were used long term was because better treatment was being denied Claimant. Smith 2020 Deposition, p. 12. He explained another reason for continuing Claimant's ketamine infusions beyond three to six months:

> A few hundred dollars for a ketamine infusion twice a week is--not many people can afford that. But, really, out of pocket paying upwards of 40-, 50,000 dollars or more for spinal cord stimulator implant is beyond the capabilities of Rachel in particular but really most individuals in America. So unfortunately we were using what we could in order to help her maintain a level of pain relief.

Smith 2018 Deposition, p. 31, l. 19 through p. 32, l. 2.

133. Dr. Smith explained that his assessment of 90% symptom improvement due to ketamine therapy was made "within five minutes after the infusion was complete." Smith 2020 Deposition, p. 37, ll. 2-3. When further questioned he explained:

> Q. (by Ms. Veltman) And during that-- well, even up to even up and to the second hearing in this matter, which was November 2019, I believe Ms. Webb was unable to weight-bear, was utilizing crutches, and I want to reconcile-- you know, if I think someone is 90% improved, I would-- to me, I would assume that they could walk without crutches or possibly be gainfully employed. Are you able to reconcile?
>
> A. Yeah, sure. So 90% improvement of pain is what I said, not of overall symptoms; not of overall atrophy; not of overall disuse; not of overall inability to function as she was unable to do for two years before someone finally let me do something.
>
> Q. As far as the denial of treatment, I think that the evidence-- the documentary evidence from the hearing will show that medical treatment in this case had not been-- wasn't denied until June 13th of 2018. Do you have any information contrary to that?
>
> A. All I can say is that, typically when I submit for authorization for spinal cord stimulation, it typically can take six months for me to be able to see the patient initially to do the initial trial; So therefore if we receive the denial, that is consistent with the time frame that I would expect an answer from insurance; so therefore, we were electing to treat the pain using the ketamine infusions to at least give her a semblance of relief until we were able to do a more definitive treatment. The goal was always to do spinal cord stimulation.

Smith 2020 Deposition, p. 37, l. 4 through p. 38, l. 9.

134. Dr. Smith described Claimant's improvement with decreased pain sensitivity in her knee after ketamine infusions. Smith 2018 Deposition, pp. 47-48. He rejected the assertion that she was malingering, described his use of distraction during physical examination to evaluate credibility, and concluded that he had "never seen malingering with Rachel." Smith 2018 Deposition, p. 53, l. 4.

> And I see how that [allodynia] could possibly be faked, but the other portions of the diagnostic criteria, you know, I don't see as possible. So with those—with the allodynia specifically being improved, and on the subsequent examinations we're talking the allodynia itself was within seven days of the spinal cord stimulator placement. But with subsequent examinations, the other findings such as the changes with the skin, etc,

> everything that is in my reports, those were also improved; so therefore you can't really fake improvement in that either.

Smith 2020 Deposition, p. 36, ll. 5-17.

135. Physical therapy notes indicate Claimant progressed to walking with one crutch when receiving twice weekly ketamine infusions. Dr. Smith's notes also document Claimant's improvement in function, including ambulation, resulting from the medical treatment he has prescribed including ketamine infusions. Further, his notes document Claimant's significantly improved function with spinal cord stimulator implant and stellate ganglion blocks.

136. Dr. Chong did not consider Claimant's spinal cord stimulator necessary and reasonable medical treatment because he did not believe CRPS had been established. Exhibit 15. Dr. Tallerico opined similarly. Dr. Wathne opined Claimant's treatment by Dr. Smith was reasonable and necessary. Dr. Smith testified that the spinal cord stimulator was medically necessary treatment for Claimant's CRPS. Smith 2020 Deposition, p. 22. His opinion is supported by the record and persuasive.

137. Claimant was not medically stable when Defendants ceased payment of medical benefits in June 2018 and had limited financial resources for medical treatment. Considering the totality of the circumstances, the Referee finds reasonable and necessary the treatment prescribed by Dr. Smith for Claimant's CRPS, including ketamine infusions, spinal cord stimulator, and stellate ganglion blocks.

138. Claimant has proven she is entitled to additional medical treatment for her industrial accident including that prescribed by Dr. Smith.

139. **Temporary disability benefits.** The final issue is whether Claimant is entitled to additional temporary disability benefits due to the industrial accident. Disability for the purpose of determining temporary disability income benefits, is a decrease in wage-earning capacity due

to injury or occupational disease. Idaho Code § 72-408 provides that "Income benefits for total and partial disability during the period of recovery … shall be paid to the disabled employee …." Claimant bears the initial burden of presenting 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). Entitlement to time loss benefits comes with statutory constraints specified by Idaho Code § 72-403. "[I]njured workers who receive total or partial temporary disability income benefits during a period of recovery have an obligation to seek or accept suitable employment consistent with their restrictions. Employer bears the burden of proving that an injured worker has failed to satisfy this statutory obligation." Soderling v. West Ada School District, 2020 WL 1957678, at 11 (Idaho Ind. Com. Mar. 19, 2020).

140. In the present case, Claimant has proven that she is not medically stable and is entitled to additional medical treatment. It follows that she was still within a period of recovery after June 13, 2018. There is no evidence Claimant unreasonably failed or neglected to work after suitable work was offered to her and no evidence shows she refused, or unreasonably failed to seek, suitable work. Pursuant to Idaho Code § 72-408, Claimant is entitled to temporary disability benefits until she reaches medical stability, unless Defendants prove the statutory constraints specified by Idaho Code § 72-403 apply. Roberts v. Portapros, IC 2019-008048 at 12-13, Malueg v. Pierson Enterprises, 111 Idaho 789, 727 P.2d 1217 (1986).

141. Claimant has proven her entitlement to temporary disability benefits from June 13, 2018, through the date of the November 7, 2019 hearing and continuing until she reaches medical stability or Idaho Code § 72-403 is shown to apply.

CONCLUSIONS OF LAW

1. Claimant has proven that due to her industrial accident she suffers from CRPS

which has progressed from her right lower extremity to her other extremities.

2. Claimant has proven she is entitled to additional medical treatment for her industrial accident including that prescribed and provided by Dr. Smith.

3. Claimant has proven her entitlement to temporary disability benefits from June 13, 2018, through the date of the November 7, 2019 hearing and continuing until she reaches medical stability or Idaho Code § 72-403 is shown to apply.

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 31st day of October, 2020.

INDUSTRIAL COMMISSION

Alan Reed Taylor, Referee

ATTEST:
Assistant Commission Secretary

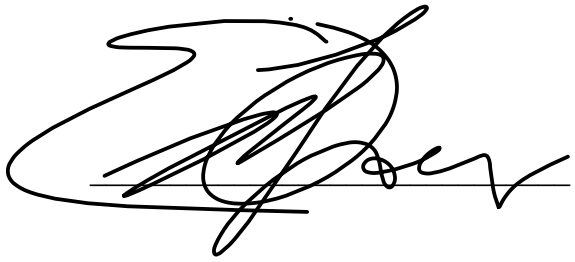
INDUSTRIAL COMMISSION SEAL STATE OF IDAHO

CERTIFICATE OF SERVICE

I hereby certify that on the 20th day of November, 2020, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail and email upon each of the following:

JAMES ARNOLD
PO BOX 1645
IDAHO FALLS ID 83403
jcarnold@ppainjurylaw.com

SUSAN VELTMAN
1703 W HILL RD
BOISE ID 83702
veltman@bvwcomplaw.com



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BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

RACHEL WEBB, Claimant, v. BELL PRINTING & DESIGN, Employer, and CINCINNATI CASUALTY CO., Surety, Defendants.	**IC 2017-027843** **ORDER** **Filed November 20, 2020**

Pursuant to Idaho Code § 72-717, Referee Alan Taylor 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 recommendation 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 that due to her industrial accident she suffers from CRPS which has progressed from her right lower extremity to her other extremities.

2. Claimant has proven she is entitled to additional medical treatment for her industrial accident including that prescribed and provided by Dr. Smith.

3. Claimant has proven her entitlement to temporary disability benefits from June 13, 2018, through the date of the November 7, 2019 hearing and continuing until she reaches medical stability or Idaho Code § 72-403 is shown to apply.

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

DATED this 20th day of November, 2020.

INDUSTRIAL COMMISSION

Thomas P. Baskin, Chairman

Aaron White, Commissioner

Thomas E. Limbaugh, Commissioner

ATTEST:

Kamerron Slay
Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 20th day of November, 2020, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail and email upon each of the following:

JAMES ARNOLD
PO BOX 1645
IDAHO FALLS ID 83403
jcarnold@ppainjurylaw.com

SUSAN VELTMAN
1703 W HILL RD
BOISE ID 83702
veltman@bvwcomplaw.com

ge

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