BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

AMY WORKMAN, Claimant, v. WELLSPRING MEADOWS, INC., Employer, and IDAHO STATE INSURANCE FUND, Surety, Defendants.	**IC 2013-002663** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** **Issued 1/7/19**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Brian Harper, who conducted a hearing in Boise, Idaho, on January 20, 2016. Claimant was represented at hearing by Nathan Gamel. James Ford represented Wellspring Meadows ("Employer"), and Idaho State Insurance Fund ("Surety"), Defendants. Oral and documentary evidence was admitted. Post-hearing depositions were taken and the parties submitted post-hearing briefs. The matter originally came under advisement on September 13, 2016.[1]

[1] While the matter was under advisement but before a decision was rendered, the parties requested the matter be held in abeyance while they explored settlement and related issues. The case was suspended until the Commission received further instructions from the parties. During this suspension period, Bruce Skaug substituted in as counsel for Claimant in place of Mr. Gamel. On or about November 2, 2018, Mr. Skaug informed the Commission the parties were unable to reach a settlement agreement. The matter was reactivated and resumed its status as "under advisement" on that date.

ISSUES

The issues to be decided are:

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

2. Whether and to what extent Claimant is entitled to the following benefits:
   a. Medical care; and
   b. Temporary disability benefits.

CONTENTIONS OF THE PARTIES

On January 14, 2013, Claimant sustained injury while acting within the course and scope of her duties for Employer in Coeur d'Alene. Defendants accepted Claimant's lumbar spine claim, and surgery was performed on her low back. Claimant was declared to be at MMI in August 2013. Her low back continued to be symptomatic thereafter, and she sought additional medical care.

In addition to the lumbar spine injury, Claimant asserts she also injured her neck, which led to a cervical fusion surgery. Defendants refused to pay for the cervical surgery, or any care after Claimant was declared at MMI. Claimant continues to suffer pain and limitations post surgeries. She denies she has reached MMI. Claimant is entitled to all unpaid past and future medical costs associated with her lumbar and cervical injuries. She is also entitled to temporary disability benefits.

Defendants argue Claimant suffered a work-related injury to her low back, but not her neck. She received all the reasonable and necessary medical treatment to which she is entitled. Claimant needs no further medical treatment related to her industrial accident. Her cervical surgery was not causally connected to the industrial accident at issue.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. Claimant's testimony, taken telephonically at hearing[2];

2. Claimant's Exhibits (CE) 1 through 13, admitted at hearing;

3. Defendants' Exhibits (DE) 1 through 38, admitted at hearing;

4. Claimant's deposition transcript, taken on December 15, 2015, submitted as a free-standing document and also as Defendants' Exhibit 31;

5. The post-hearing deposition transcript of Gary Cook, M.D., taken on January 29, 2016;

6. The post-hearing deposition transcript of Dennis Chong, M.D., taken on March 9, 2016; and

7. The post-hearing deposition transcript of Jeffrey McDonald, M.D., taken on April 28, 2016.

The objections made during the deposition of Gary Cook, M.D., at page 51, line 23, page 52, at lines 6 and 17, and page 53, line 3 are all sustained. All other objections preserved during the depositions are overruled.

FINDINGS OF FACT

1. As part of her duties for Employer, Claimant provided in-home care to a twelve-year old boy with cerebral palsy in Coeur d'Alene. On January 14, 2013, Claimant was assisting this patient into the bathtub when he went rigid as the result of his condition. As Claimant was attempting to hold on to the patient, she injured her back, (without dispute) and additionally claims she injured her neck in this same

[2] At the time of hearing, Claimant was living in Kansas, and provided testimony at the hearing by telephone. Although the accident took place in Coeur d'Alene, the hearing was held in Boise at the parties' request.

accident (disputed).

2. Claimant immediately informed her supervisor by telephone, and was eventually instructed to seek medical care at Premier Urgent Care, which was near the accident site.[3] Claimant does not recall if she told her supervisor about her neck injury at that time, but admittedly her low back pain was much more severe than any neck pain she was experiencing at the time.

Premier Urgent Care

3. Claimant presented to Henry Downs, M.D., at Premier Urgent Care (Premier) on January 14, 2013, complaining of right-sided lumbar back pain. The physician's office notes of that visit state that while lifting an 80 pound child Claimant felt right lower back pain which extended into her buttocks. Claimant complained of increased pain with walking, and described pain over her SI joint. Claimant denied previous back injury, or other complaints.

4. Dr. Downs diagnosed acute sacroiliitis (right SI joint strain). He ordered x-rays which were negative for fracture, but revealed moderate disc space narrowing at L5-S1, with mild osteophyte spurring at that level. Claimant was given medications and work restrictions. Dr. Downs scheduled Claimant for a follow up examination in ten days with John Swanson, M.D.

5. At Claimant's initial examination with Dr. Swanson, two sets of records were generated. One set, handwritten, perhaps by a nurse (based on the signature line), indicated Claimant was presenting for lumbar pain and pain at the base of her neck,

[3] Claimant testified that her supervisor repeatedly tried to convince Claimant not to make a workers' compensation claim during their initial conversation, but also instructed Claimant to inform the physician the coverage was through State Insurance Fund.

as well as pain into Claimant's right leg. The other set of notes, typewritten, for Dr. Swanson's signature (although not signed or dated), include a notation of chief complaint of low back pain radiating into Claimant's right leg. Under the heading "History of Present Illness" the doctor stated, "[Claimant] denies the presence of any previous history of injury in that [low back] region of the body and there were no other injuries associated with this particular event." DE 7 p. 284. Under the "Physical Examination" heading, Dr. Swanson's notes indicated that Claimant's neck "is nontender, no pain with full range of motion." *Id.* p. 285. Dr. Swanson ordered an MRI for Claimant's lumbar spine to include SI joints. Dr. Swanson scheduled a follow up examination two weeks hence, and started Claimant on physical therapy.

6. Claimant next presented unscheduled to Premier and was seen by Dr. Downs on February 4, 2013, complaining of increased radicular pain to her right foot. Based on her symptoms and MRI findings, Dr. Downs referred Claimant to a neurosurgeon for further evaluation. He suggested Claimant keep her scheduled appointment with Dr. Swanson on February 7, 2013.

7. There was no mention of neck pain in any notes taken in conjunction with Claimant's February 7 office visit to Dr. Swanson, although the hand written notes indicated Claimant was complaining of left arm pain in addition to her lumbar and right leg complaints. However, the examination and treatment for that date focused, as always, on Claimant's low back. Dr. Swanson again noted nontender cervical spine to palpation, and continuing tenderness to palpation of the paraspinous musculature on the right with appreciable muscular spasm. Dr. Swanson noted Claimant had been referred to neurosurgeon Jeffrey McDonald, M.D.

8. On February 17, 2013, Claimant presented at Premier complaining of neck pain with nausea and vomiting. She was seen by Morgan Ford, M.D. Dr. Ford noted Claimant's subjective history as including her assertion that her neck pain began "essentially" from the date of the industrial accident, although initial treatments focused on her low back. Claimant described her neck pain as fairly constant, dull, but sharp pain with movement. Claimant denied any prior neck problems. She claimed her neck pain became much worse without a triggering event two days prior, and the pain radiated bilaterally into her shoulders and arms, with associated tingling and numbness periodically. The pain was so severe it made her nauseous with vomiting. She was unable to keep any food, water, or medications down. She was looking for symptom control. Dr. Ford prescribed Zofran to reduce nausea and vomiting. Claimant was also given a shot of Toradol. On April 14, 2013, Claimant again presented with complaints of neck pain flair ups with associated radiculopathy, and was again provided with a Toradol injection.

Ironwood Drive Physical Therapy

9. As noted previously, Claimant was prescribed physical therapy after her industrial accident. She presented on January 28, 2013 to Ironwood Drive Physical Therapy. Records relevant to assisting in the determination of issues surrounding Claimant's neck complaints are a bit unclear. Initial documents filled out by Claimant do not mention neck injury – on her Medical History Sheets she listed only migraines as an ongoing health issue. The Initial Examination Addendum confined Claimant's pain complaints to her back and right buttock/thigh. Claimant's Patient Information Sheet, filled out by Claimant, explains her mechanism of injury as "[t]aking care of C.P. child in home and injured my back lifting him while working." DE 9 p. 381.

10. An Insurance Verification & Authorization Sheet, filled out by the physical therapy staff does mention neck pain as a secondary diagnosis. However, the record is not clear as to when the notation was made. It appears this record provided ongoing information, and was supplemented as the therapy progressed. There is some indication the neck treatment was authorized by Surety on February 12, 2013, which could imply that prior to that time Claimant was not seeking therapy for her neck. No one from Ironwood Drive Physical Therapy was deposed, and the record remains unclear. The ambiguity in the Authorization sheet does not negate the remaining observations regarding Claimant's lack of initial report of neck complaints in documents she filled out.

Dr. McDonald

11. Claimant presented to neurosurgeon Jeffrey McDonald, M.D., on February 15, 2013 as a referral from Premier. Dr. McDonald noted Claimant was at his office for "neurosurgical evaluation of low back pain and bilateral lower extremity pain, right greater than left." DE 11 p. 529. Dr. McDonald's history lists as a secondary complaint "cervical pain radiating to the right upper extremity that began following this [back] injury as well". *Id.* Claimant denied any pre-existing cervical issues or treatment for neck pain other than chiropractic care associated with her long-standing history of migraine headaches.

12. At the conclusion of his office notes for this visit, Dr. McDonald made a separate entry that Claimant "maintains that consistently and from the beginning following her injury, she has reported to care providers regarding neck pain with right upper extremity radiation in what clearly appears to be a C6 distribution…." DE 11 p. 531.

Dr. McDonald sought authorization for a cervical MRI. At his deposition, Dr. McDonald testified that he included that final notation at Claimant's specific request.

13. Dr. McDonald's initial treatment focused on Claimant's low back problems. Ultimately, on March 13, 2013, Dr. McDonald performed microdiscectomy surgery for her herniated lumbar disc at L5-S1.

14. Claimant underwent a cervical MRI on February 18, 2013. In addition to minor degenerative changes at C4-5 and C6-7, the MRI showed disc protrusion on the right C5-6, which Dr. McDonald felt was a combination of bone spur and soft disc material bulging into the neuroforamen. Dr. McDonald felt the findings provided an anatomic explanation for Claimant's reported symptoms of C6 pain distribution; *i.e.,* pain from her right biceps to her forearm and into her hand, with pain at the base of her thumb.

15. Based upon Claimant's complaints and the MRI findings, on March 7, 2013, Dr. McDonald prescribed physical therapy and cervical traction. Those modalities did not help Claimant's complaints.

16. By Claimant's April 18, 2013 visit with Dr. McDonald, she was "struggling severely" and now complaining of bilateral upper extremity pain with left-sided symptoms beginning within the past two weeks. Dr. McDonald still felt Claimant's symptoms were consistent with the MRI findings. The doctor felt cervical discectomy and fusion surgery at C5-6 was indicated, and sought authorization for it. DE 11 p. 539.

17. On May 2, 3013, Claimant presented to Dr. McDonald for her six-week post lumbar surgery check up. Up to that point Claimant had been recovering as anticipated, with notable improvement in her symptoms and minimal pain. However, she was now complaining of significantly increased lower extremity pain and numbness,

especially severe in Claimant's right posterior and lateral calf, and plantar aspect of her foot. Claimant stated she could not move her right toes two through five. Additionally she had urinary incontinence for the past few days. Claimant also had visited an urgent care facility the previous day due to profound numbness of her entire right lower extremity up to her hip. Dr. McDonald noted that Claimant had nevertheless remained fully ambulatory throughout this time frame.

18. Dr. McDonald reviewed Claimant's most-recent low back MRI and found nothing unusual therein. He explained to her that there was no neurological basis for her incontinence, as she was able to fully drain her bladder, as verified by testing.[4] Claimant's reported numbness also had no anatomical explanation. The doctor testified in deposition that the circumferential numbness reported by Claimant would require simultaneous dysfunction of all eight nerve roots covering Claimant's lower extremity, which he classified as "highly, highly unlikely". McDonald Depo. p. 50. Dr. McDonald further testified that Claimant was either "struggling psychologically with symptoms she perceives to be true and real,…[known as] a conversion disorder,…or she's elaborating on symptoms which simply may not be true." *Id* at 51.

19. On or about June 7, Dr. McDonald received authorization to proceed with cervical surgery on Claimant, if he felt it would be beneficial. By that time, Claimant had been seen by Dennis Chong, M.D., a Seattle-area physical medicine and rehabilitation doctor, for an independent medical examination (IME). That examination took place on May 22, 2013, and will be discussed in greater detail below.

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[4] In deposition, Dr. McDonald explained that if Claimant's incontinence was neurogenic, she would not have been able to void; the incontinence comes from spillage due to the bladder becoming overly full. Ultrasound testing showed that Claimant could fully empty her bladder.

20. On July 1, 2013, Dr. McDonald met with Claimant, who had been out of state for several weeks prior. His notes of that date are illuminating. As stated therein;

> **PROGRESS NOTE:** [Claimant] returns for neurosurgical follow up. She reports severe right-sided posterior neck pain over the past number of weeks, while she has been out of town. She has pain radiating into the bilateral upper extremities, right side worse than left, from the biceps into the forearms and then into the third digits bilaterally. "By the end of the day" both hands and all fingers are numb and painful, per her report. The pain in her neck at times was so severe it caused actual physical nausea and vomiting.
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> Separately, [Claimant] is still struggling with lower back and leg symptoms. She acknowledges that she is "much better" than preoperatively, but describes in vivid detail her persistent lower extremity symptoms of pain radiating bilaterally through the posterior thighs, posterior calves, and then into the feet. She has a painful tingling in the plantar aspect of each foot. She also reports some right SI region discomfort, but is largely negative on provocation testing today in clinic.
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> **DISPOSITION:** I explained to [Claimant] that I do not clearly have a satisfactory explanation for her upper extremity symptoms of bilateral numbness, especially. The radiation of symptoms into the third digit of each hand would suggest a C7 distribution, not C6, in any event. Her scan findings are real, but of moderate severity at worst. She has a moderate right C5-6 disc protrusion.

DE 11 p. 546. Dr. McDonald testified that Claimant's changing symptomatology caused him to consider whether the recommended surgery was the correct way to proceed. Dr. McDonald noted the contemplated surgery was intended to alleviate right-sided C6 symptoms, and now Claimant's complaints were suggesting three nerve root involvement bilaterally. He was growing suspicious that the suggested surgery would not benefit Claimant's complaints. As a result, Dr. McDonald prescribed an EMG of Claimant's right upper extremity prior to further discussion of cervical discectomy and

fusion surgery at C5-6. He wanted to rule out peripheral nerve involvement, such as carpal tunnel or ulnar neuropathy.

21. On July 26, 2013, Claimant underwent the EMG; the results were normal. There was no evidence of cervical, ulnar, or carpal tunnel radiculopathy.

22. When Claimant returned to Dr. McDonald on August 29, 2013, she was still claiming bilateral upper extremity symptoms, right greater than left. Her symptoms included pain and numbness into the fourth and fifth digits, suggesting a C8 distribution.[5] Claimant indicated that from the EMG pain, she suffered nausea and vomiting for six days, and had actually passed out. The EMG had also tremendously aggravated her symptoms. While acknowledging the test is "not pleasant," Dr. McDonald testified that Claimant's reaction to the EMG was "without precedent in any other patient" of his in twenty years of practicing medicine. McDonald Depo. p. 58.

23. At that August visit, Dr. McDonald decided against performing surgery on Claimant. As he described in his deposition, his decision was based upon Claimant's inconsistent radicular upper extremity symptoms, some of which made no anatomical sense, her prior post-lumbar surgery symptoms with non-anatomical origins. These complaints left the doctor with the impression that Claimant projected as a "woman who appear[ed] to be struggling psychologically, perhaps as much or more than physically." *Id; see also* pp. 107, 108. These factors led the doctor to conclude that there was almost no chance that Claimant would benefit from the proposed neck surgery. He felt surgery at that point in time would not be medically reasonable. Dr. McDonald released

[5] During deposition cross examination, Dr. McDonald testified Claimant specifically did not mention symptoms into her thumb and index finger (C6 distribution), but only her ring and little finger (C8 distribution).

Claimant from his care and returned her to normal activity with no restrictions for both neck and back, declaring her to be at MMI as of August 29, 2013.

Dr. Chong

24. As noted above, Defendants sent Claimant for an independent medical examination with Dr. Chong on May 22, 2013. Dr. Chong prepared an initial report thereafter. Two years later he opined on opinions and conclusions made by Claimant's medical expert; those opinions will be referenced where appropriate separately from his initial evaluation. Dr. Chong was also deposed post hearing.

25. Dr. Chong reviewed medical records, examined Claimant, and responded to specific questions posed by Surety as part of his IME process. At the time of the examination, Claimant's chief complaints included low back pain and constant neck pain along with "bilateral upper limb referral involving bilateral upper limbs globally of the entire arm with the right side worse than the left." Claimant also described numb hands with tingling. DE 14, p. 564.

26. Dr. Chong recorded severely limited range of motion for Claimant's cervical spine, with forward flexion of 10 degrees and extension just to the neutral position. Claimant exhibited lateral flexion of 10 degrees and rotation of 45 degrees to the right, 60 degrees to the left. Dr. Chong noted that "[w]hen not directly observed during the interview and at other parts of the physical examination, [Claimant's] cervical spine range substantially improved. *Id* at 567.

27. Regarding Claimant's cervical spine complaints, Dr. Chong diagnosed "preexisting neck pain" relying in part on cervical spine x-rays taken pre-accident in August 2012, and the fact that Claimant did not report neck pain associated with

the industrial accident at issue until one month after the incident. He also diagnosed "nonspecific widely distributed non-anatomical and non-physiological complaints…not localized to a specific pathology" and unrelated to the industrial accident. *Id* at 569.

28. Dr. Chong was skeptical of Claimant's continuing and expanding symptoms after her otherwise successful neurosurgery to her lumbar spine, including claims of urinary incontinence (not neurological in origin) and right calf pain with no evidence of DVT on ultrasound. Claimant also complained of bilateral foot issues after the surgery. Dr. Chong felt Claimant's non-focal cervical symptoms and history of continuing or new complaints after surgery without a clear explanation for those complaints diminished Claimant's chance for successful cervical surgery.

29. Dr. Chong did not feel Claimant's cervical condition was at all related to her industrial accident. He argued against cervical spine surgery, regardless of causation. He also felt Claimant had a benign musculoskeletal examination in spite of her self-limited range of motion testing. Dr. Chong found no muscle atrophy indicative of an ongoing injury.

30. At deposition Dr. Chong supported his opinion that Claimant would not benefit from, and therefore was not in need of, cervical spine surgery, under the theory that past behavior is a good predictor of future outcome:

> [Claimant] had nonspecific, nonanatomical, nonphysiological presentation to her low back pain and right sciatica, and these persisted after surgery without resolution. So she complained of a similar pattern of nonspecificity to her upper limbs as emanating from the cervical spine, which then prognostically would be a strong indicator that the likelihood of success of surgery to the cervical spine to cure or relieve her symptoms would likely be very low. And so

> my recommendation was that this surgery to be cervical spine not be undertaken.

Chong Depo. p. 48. Dr. Chong subsequently at page 102 of his deposition clarified that he felt Claimant was a poor surgical candidate not only because of the results of her low back surgery, but also because "the clinical findings do not point to a right C6 radiculopathy". He later noted the electrodiagnostic studies (EMG and nerve conduction) were completely normal. Specific tests focused on right C6 and C7 paraspinal muscles confirmed there was no nerve root injury at either of those levels.

31. Dr. Chong also felt Claimant would not benefit from nonsurgical rehabilitative treatment due the doctor's perception that Claimant would not be "sufficiently participatory in a multidisciplinary rehabilitation program" designed to resolve or minimize her cervical complaints. *Id* at 49. Amplifying on this opinion, Dr. Chong testified there are three parts to an evaluation of a potential rehabilitation program candidate. First, symptoms should be concordant with anatomical and physiological findings. Second, the symptoms should present as acute and not chronic. Finally, there is a question of how the candidate has responded to prior treatment. On each of these criteria, Claimant fell short in Dr. Chong's opinion.

32. On cross examination Dr. Chong acknowledged Claimant made a complaint of neck pain to her treating physician ten days after the work incident, but noted the treater did not diagnose, treat, or begin management of her neck pain complaint at that time.

33. While Dr. McDonald's office notes of April 18, 2013 indicated Claimant's symptoms that day correlated "perfectly" with the MRI findings of disc impingement at C5-6, Dr. Chong reiterated that when he examined Claimant on May 22, 2013, the MRI findings "absolutely did not" account perfectly her symptoms. Instead, Claimant's

upper extremity symptoms by the time of the IME with Dr. Chong were more global in nature, and not representative of a "classic right C6 dermatome or myotome pattern to the right upper extremity". Chong Depo. p. 81.

Post MMI Care

34. After Dr. McDonald declared Claimant at MMI, she sought medical care sporadically at various facilities in Idaho, Washington, Oregon, and Kansas, mostly for neck and low back complaints.

35. An MRI performed on May 20, 2014 showed multilevel cervical spondylosis from C3 to C7 with associated neural foraminal narrowing at multiple levels, particularly at C4-C5, where disc protrusion contacted her spinal cord. Claimant also had associated neural foraminal narrowing at that level and early reversal of the normal cervical lordosis, without significant neural foraminal narrowing.

36. Claimant was seen at Coastal Family Health Center in Astoria, Oregon on several occasions over the summer of 2014 for neck and back pain. She complained of tingling in all extremities, and reported she could not move her toes on her right foot. On exam dated June 27, 2014, her physician noted Claimant's demeanor, with "grimacing, grunting and groaning with any type of movement" was "far beyond that which seems to fall in line with her complaint." DE 24, p. 1033. Moreover, the physician found that Claimant seemed to be "fighting to keep her [right] foot from moving" when undergoing strength testing, and had passive full range of motion in her ankles, but less than full range of motion with active testing. *Id.* Claimant was referred to a neurosurgeon for her neck complaints.

37. Claimant came under the care of neurosurgeon Warren Roberts, M.D., of Aspen Spine in Tualatin, Oregon in July 2014.

38. After reading Claimant's MRI from May 2014, Dr. Roberts determined Claimant had cervical spondylosis from C3 through C7, with associated neural foraminal narrowing most notably at C4-C5 where the disc protrusion resulted in spinal cord contact.

39. On September 25, 2014, Dr. Roberts performed a C4-5 foraminotomy, discectomy and fusion surgery on Claimant.

40. After this surgery Claimant, over time, began or continued to complain of various neck and low pain symptoms, pain, weakness, radiculopathy into hands and feet, and sensory changes, *e.g.* swallowing produced an odd feeling at her cervical surgery site. Physical therapy, injections, and narcotic prescription pain medicines failed to resolve Claimant's complaints. Treatment continued through the time of hearing, by which time Claimant had moved to Kansas. Claimant's symptoms were at times exacerbated by falling episodes, but diagnostic films showed no disruption to either of her two surgical fusions.

41. In November 2015, Claimant underwent a Functional Capacity Evaluation. The results were deemed "inconsistent and invalid" due to Claimant's self-limiting performance throughout the testing.

42. Claimant hired Gary Cook, M.D., a licensed anesthesiologist from Chester, Idaho, to perform an IME on her behalf. Dr. Cook prepared a report and a "supplemental" report. He was also deposed post hearing. Dr. Cook opined that Claimant's low back injury and subsequent surgery were causally related to her industrial accident. He also opined that Claimant's "cervical spine injury" was causally

related to the accident. The surgery at C4-5 was reasonable and necessary treatment causally related to Claimant's work accident in Dr. Cook's opinion.

DISCUSSION AND FURTHER FINDINGS

43. Claimant has the burden of proving, by a preponderance of the evidence, all facts essential to recovery on her claims. She carries the burden of proving that the conditions for which compensation are sought are causally related to an industrial accident. *Duncan v. Navajo Trucking,* 134 Idaho 202, 203, 998 P.2d 1115, 1116 (2000). The proof required is "a reasonable degree of medical probability" that Claimant's condition was caused by an industrial accident. *Anderson v. Harper's Inc.,* 143 Idaho 193, 196, 141 P.3d 1062, 1065 (2006). To prove that a causal relationship is medically probable requires Claimant to demonstrate that there is more medical evidence for the proposition than against it. *Jensen v. City of Pocatello*, 135 Idaho 406, 18 P.3d 211 (2000). In determining causation, it is the role of the Commission to determine the weight and credibility, and to resolve conflicting interpretations, of testimony.

44. Defendants do not dispute the fact that Claimant suffered a compensable accident on January 14, 2013. Defendants accepted Claimant's low back claim and resultant surgery, and paid benefits accordingly through MMI. However, they dispute the causal connection between Claimant's claim of neck injury, as well as medical care of any type after Claimant was declared at MMI on August 29, 2013.

<u>Causation</u>

45. Claimant argues she is entitled to recover incurred charges (at the *Neel*[6] rate) for past medical care associated with treatment of her cervical spine and low back,

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[6] *Neel v. Western Construction, Inc.,* 147 Idaho 146, 206 P.3d 852 (2009).

including her cervical surgery, from the time Defendants stopped her medical benefits in August 2013 to the date of hearing. She is also due medical benefits for these conditions into the future as needed, as well as TTD benefits for times when she could not work due to her injuries. Claimant argues her cervical and lumbar conditions are due to her industrial accident in question. In support of this position, Claimant relies on the opinions of Dr. Cook.

Dr. Cook

<u>*Written Report(s)*</u>

46. Dr. Cook prepared a rambling forty-plus page written report, and subsequently prepared an "appendix" to that report, which was really a revised edition of his earlier report, both of which were difficult to follow due to Dr. Cook's writing style and liberal use of out-of-context cites to various medical journal articles and internet sites.

47. Standing alone, Dr. Cook's report carries little weight. The conclusions reached therein are not adequately fleshed out to allow this Referee to determine how Dr. Cook arrived at each of the various diagnoses, and what objective medical evidence supports his position. It appears instead the doctor relied heavily on Claimant's subjective complaints of pain to anchor such diagnoses as "pain syndrome". For example, there is a proposed diagnosis, Post Spinal Surgery Syndrome (PSSS),[7] followed by discussion of the concept, but with no information on how Dr. Cook was able to determine Claimant suffered from such condition as a result of her work accident other than by her history (and a conclusory opinion that Claimant's "mechanism of injury" supports his position). To illustrate, in discussing PSSS, Dr. Cook noted a PSSS diagnosis requires "a thorough and rigorous evaluation of pain complaints, along with the standard medical and psychological workup."

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[7] A conceptual proposed diagnosis Dr. Chong noted has not taken root in the mainstream medical community, and which goes by what he called the "unfortunate" acronym of PSSS.

CE 11B, p. 1799. Dr. Cook reviewed some medical records (incomplete set) and saw Claimant for less than two hours on one occasion. No psychological workup was performed. Furthermore, no treating physician suggested such a diagnosis. This is but one example in a report which repeats this or similar flaws throughout.

48. Many of Dr. Cook's other diagnoses rely entirely on Claimant's history, *e.g.* neuropathic pain, sleep disorder, depression, chronic pain syndrome, anxiety attacks, and migraine headaches (which Claimant testified pre-date the work accident).[8] Such conclusory opinions carry little weight.

Cook Deposition

49. It appears Claimant recognized the limited value of Dr. Cook's report(s), as in briefing she does not cite to his written works other than to point out that they are "quite lengthy". Instead, she relies on Dr. Cook's deposition to support her position.

50. In his deposition taken on February 29, 2016, Dr. Cook stated Claimant's "initial" work injury was what he termed "a lifting injury" involving "significant torsional and lifting forces on her entire spinal column." Cook Depo. p. 33. He supported his opinion by noting Claimant's first MRI showed "a posterolateral broad-based disc protrusion which traversed the S1 nerve root sheath" as well as "foraminal narrowing bilateral to the annular bulging, and that impacted the exiting L5 nerve root sheaths". *Id.* Specifically, Dr. Cook opined that Claimant "sustained this broad-based disc protrusion in the foraminal narrowing secondary to the annular bulging as a consequence of her initial lifting injury". *Id.* Dr. Cook acknowledged that Defendants recognized Claimant's low back injury,

[8] Only Dr. Cook's diagnosis of deconditioning could be observed first hand by the doctor during examination.

described above, paid for surgery to Claimant's low back, and that Claimant reached MMI with regard to this injury.

51. Dr. Cook was asked about Claimant's cervical spine. He opined that she suffered a cervical spine injury as a result of her work accident in question. He did not specify a level where Claimant's neck injury occurred, unlike his opinion concerning Claimant's low back.

52. When asked the basis of his opinion, Dr. Cook testified that Claimant's "mechanism of injury" involved "significant torsional forces". Also Claimant felt neck pain immediately after this accident, but "her back pain became so overwhelming that the neck pain was kind of related [relegated?] to the secondary complaint". Dr. Cook acknowledged the initial treating physicians (Drs. Down and Swanson) did not diagnose cervical problems, but pointed out nursing notes mentioned neck pain along with lumbar pain during this timeframe. Cook Depo. pp. 36, 37.

53. Dr. Cook traced some of Dr. McDonald's history with Claimant, concentrating on the time period when Dr. McDonald recommended surgery. Dr. Cook misspoke concerning Dr. McDonald's intended surgery, stating the surgery contemplated was a cervical fusion at C4-5. In reality, Dr. McDonald suggested initially a fusion at C5-6, and never contemplated a surgery at C4-5. In any event, Dr. Cook testified that to his knowledge Dr. McDonald's change of heart regarding the efficacy of the proposed surgery was not due to any anatomical changes in Claimant's cervical spine (no "magical" change of findings, as Dr. Cook put it at page 40 of his deposition), a fact not in dispute.

54. Claimant eventually had surgery at C4-5 at the hands of Dr. Roberts in Oregon. Dr. Cook opined that this surgery was medically necessary and reasonably connected and related to her industrial accident. He supported this opinion by testifying that the "forces" involved in

Claimant's "initial lifting injury" were "transmitted to [Claimant's] spine", and "subsequent imaging … confirmed disc bulges with nerve root compression" such that Claimant "did indeed sustain a cervical injury related to her initial lifting – industrial lifting accident". Cook Depo. p. 41. Surgery was necessary because Claimant's symptoms were "progressive upon review of the history". *Id.*

55. Dr. Cook acknowledged that Claimant continued to complain of ongoing significant pain and weakness after her low back and cervical surgeries. In fact, after a telephone conference with Claimant subsequent to his examination and original report, Dr. Cook felt Claimant's condition was likely deteriorating with time.

Causation Analysis

56. Claimant argues the causation question comes down to one point – whether the anatomical findings causing Claimant's neck and back symptoms were caused or permanently aggravated by her industrial accident in question. She then argues the answer to this question is found in the "mechanics of injury" involved in her accident. Claimant cites to Dr. Cook's testimony in an attempt to prove that the mechanics of her injury account for her ongoing complaints in her low back and cervical spine.

57. Dr. Cook testified that Claimant's accident involved "significant torsional forces". Cook Depo. pp. 36, 37. Dr. Cook did not present credible evidence explaining what forces were at work in Claimant's cervical spine, and how those forces would have caused Claimant's cervical disc bulges discovered on MRI. Contrary to Claimant's argument, Dr. Cook did not "provide his opinion regarding *how* the mechanism of injury would certainly have caused Claimant's injuries to her cervical spine". *Accord.* Claimant's brief, p. 25. (Emphasis added.) Instead, he simply made a conclusory statement that Claimant experienced significant

torsional forces during her accident which impacted her entire spine. His statement lacks the weight needed to establish to a reasonable medical probability the theory that Claimant, while lifting and moving her young client who had gone spastic, permanently injured her cervical spine at multiple levels.

58. Dr. Cook's second prong of causation testimony centers on the fact that Claimant began complaining of neck pain soon after the accident; complaints which carried through the time of hearing. She argues the record does not contain evidence that she had suffered from neck pain (other than associated with her migraine headaches) prior to her accident.

59. Defendants contest that notion, pointing to an auto accident involving Claimant in 2007 in which Claimant suffered a "whiplash" type injury. Furthermore, Defendants note that less than five months before the work accident in question Claimant presented for a cervical x-ray at a clinic in Kansas. Her history at that time included a notation of her previous neck injury. In addition to the x-ray Claimant returned to the clinic for her neck pain on September 6 and 14, 2012. Then on October 12, 2012, Claimant went to the Dirne Care Center in Coeur d'Alene complaining of low back and neck pain. She was given exercises for her back and neck pain.

60. While Claimant's history of neck complaints is noted in the record, it is not dispositive to the issue of causation. Claimant argues her prior neck pain was associated with migraine headaches. The record provided, and cited by Defendants, is not clear on this point. Regardless of whether Claimant had non-migraine related neck pain prior to the work accident, the entirety of the evidence does not support her position on causation for her cervical spine complaints, (or continuing lower extremity complaints), as addressed below.

61. Claimant and Dr. Cook are highly critical of Dr. Chong's analysis and opinions. Defendants are highly critical of Dr. Cook's analysis and opinions. Rather than address point by point the numerous criticisms each party made against the opposing IME physician, it is sufficient to note that poking holes in the Defendants' IME physician does not increase the weight of Claimant's expert's opinions, although it may, if the arguments are well founded, reduce the weight of the Defendants' expert's opinions. As such, even if all of Dr. Chong's opinions are dismissed (and that would not be appropriate, as several of his opinions were valid), that does not mean that Claimant has carried her burden of proof on causation. This is especially true in this case where Claimant's treating physician, Dr. McDonald, opined against causation in a convincing fashion.[9]

62. At deposition (and in medical records previously discussed above), Dr. McDonald described how Claimant's MRI was consistent with Claimant's initial report of right upper extremity issues associated with a C5-6 distribution. Over time, Claimant's symptoms expanded to include her left upper extremity, but still in a C5-6 distribution. Dr. McDonald still felt Claimant was an appropriate candidate for a cervical discectomy and fusion at C5-6. He strongly felt there were no surgical conditions at any other cervical level at that time (April 2013). He testified there was no reason to operate at C4-5 during the time he treated Claimant.

63. By May 2013 Claimant's low back was spiraling downhill. Claimant reported several new symptoms, including non-neurogenic urinary incontinence, profound numbness of Claimant's entire right leg circumferentially (for which there was no anatomic

[9] Much of the testimony detailed below was previously set forth in this document, but is reiterated here for emphasis and continuity.

explanation), and excruciating pain. There were no documentable findings on repeat MRI to explain these symptoms. Dr. McDonald testified that while these symptoms "made absolutely no sense" he nevertheless felt they should subside with time. McDonald Depo. p. 48.

64. By May 2013 Claimant was frequently in and out of urgent care clinics with "extremely dramatic symptoms". Dr. McDonald felt Claimant was in psychological crisis. Soon thereafter Claimant was seen by Dr. Chong, with his opinions detailed above.

65. By the time Dr. McDonald saw Claimant in early July he was becoming concerned about her shifting symptoms. No longer were her complaints in a C5-6 distribution. Now they were bilateral and more suggestive of a C7 distribution at best. Some of her symptoms implicated three nerve roots bilaterally. Dr. McDonald felt these symptoms were nonanatomic. He began to doubt the efficacy of cervical surgery. Dr. McDonald testified he does not operate unless he believes the surgery will benefit the patient, and felt he needed more information prior to proceeding with surgery. He ordered an EMG; the results came back normal. There was no electrophysiological explanation for Claimant's reported upper extremity symptoms.

66. Claimant described the EMG as being unbearably painful; she passed out from pain and vomited for six days from the pain. Dr. McDonald grew wary of Claimant's inconsistent and often nonanatomical shifting symptoms and her "grossly exaggerated pain mannerisms." McDonald Depo. p. 114. He felt Claimant was struggling psychologically as much as or more than physically. He was convinced fusion surgery would not benefit Claimant. He decided against surgery, as he felt it would not be reasonable, as he was convinced Claimant would not get better with surgery.

67. Dr. McDonald had no objective findings to limit Claimant in any fashion. He testified that as of August 2013 Claimant needed no additional medical treatment or care for her low back or cervical spine.

68. Dr. McDonald had authority to operate on Claimant's cervical spine at C5-6 if he felt surgery would benefit her. For the reasons explored above, Dr. McDonald elected to not perform the surgery, a decision against his financial interest, but in the best interest of his patient as he saw it. Dr. McDonald's chronology of events as explained in his deposition fits well with the weight of the evidence in this case. His observations of Claimant are consistent with other evidence in this matter, including medical records, physician observations, and Claimant's hearing testimony.

69. Dr. McDonald's opinions are afforded the greater weight when considering causation.

70. Regarding Dr. Roberts' surgery at C4-5, the diagnosis was degenerative disc disease and cervical spondylosis with radiculopathy. While no one disputes the fact that Claimant suffers from degenerative disc disease throughout her cervical spine, a progressive condition tending to worsen over time, Claimant has failed to prove her neck condition, including surgery at C4-5, was causally connected to her industrial accident in question.

71. Reviewing the record as a whole, the totality of the evidence fails to support a finding that Claimant's cervical condition was caused by the industrial accident at issue.

72. Reviewing the record as a whole, the totality of the evidence fails to support a finding that Claimant's current low back complaints were caused by the industrial accident at issue.

73. Claimant has failed to prove her cervical spine and continuing low back complaints after surgery are causally related to her industrial accident in question.

Medical Benefits

74. The next issue is Claimant's entitlement to medical care. Idaho Code § 72-432(1) mandates that an employer shall provide for an injured employee such reasonable medical, surgical or other attendance or treatment, nurse and hospital service, medicines, crutches, and apparatus, as may be reasonably required by the employee's physician or needed immediately after an injury or manifestation of an occupational disease, and for a reasonable time thereafter. If the employer fails to provide the same, the injured employee may do so at the expense of the employer. Of course an employer is only obligated to provide medical treatment necessitated by the industrial accident, and is not responsible for medical treatment not related to the industrial accident. *Williamson v. Whitman Corp./Pet, Inc.*, 130 Idaho 602, 944 P.2d 1365 (1997).

75. After Defendants discontinued coverage for Claimant in late August 2013, Claimant obtained for her low back and/or neck additional treatment, diagnostic studies, sporadic physical therapy, chiropractic care, prescription pain medication, and surgery at C4-5.[10] These medical expenses were not incurred in connection with a covered event, and Defendants are not liable for such medical expenses.

76. Claimant has failed to establish her right to medical care related to her cervical spine.

77. On the evidence produced herein, Claimant has failed to prove her present entitlement to medical care related to her low back beyond that provided by Defendants previously.

[10] Claimant did not argue her continuing treatment was palliative in nature, and thus compensable in spite of her reaching MMI. Rather she argues her continued treatment is designed to be curative, and she is not yet at MMI.

Temporary Disability Benefits

78. Idaho Code § 72-408 provides for income benefits for total and partial disability during Claimant's period of recovery. The burden is on Claimant to establish through expert medical testimony 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). Once Claimant reaches medical stability, he is no longer in a period of recovery, and temporary disability benefits cease. *Jarvis v. Rexburg Nursing Center*, 136 Idaho 579, 38 P.3d 617 (2001).

79. Claimant seeks temporary disability benefits from the date such benefits were discontinued through the present, and until Claimant "undergoes additional reasonable future medical care, as identified by Dr. Cook in his report, and is adequately determined to have reached maximum medical improvement…." Claimant's Brief, p. 28.

80. Because Claimant has failed to prove she is entitled to medical care for industrial injuries past August 29, 2013, the date she reached MMI, she has failed to establish her right to temporary disability benefits beyond such date.

81. Claimant has failed to prove she is entitled to temporary disability benefits beyond August 29, 2013.

CONCLUSIONS OF LAW

1. Claimant has failed to prove her cervical spine condition is causally related to her industrial accident of January 14, 2013.

2. Claimant has failed to prove her current low back condition is causally related to her industrial accident of January 14, 2013.

3. Claimant has failed to establish her right to medical care related to her cervical spine.

4. On the evidence produced herein, Claimant has failed to prove her present entitlement to medical care related to her low back beyond that provided by Defendants previously.

5. Claimant has failed to prove she is entitled to temporary disability benefits beyond August 29, 2013.

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 20th day of December, 2019.

INDUSTRIAL COMMISSION

/s/
Brian Harper, Referee

CERTIFICATE OF SERVICE

I hereby certify that on the 7th day of January, 2019, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

BRUCE SKAUG
1226 E KARCHER RD
NAMPA ID 83687

JAMES FORD
PO BOX 1539
BOISE ID 83701

/s/

jsk

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

<table>
<tr><td>AMY WORKMAN,

Claimant,

v.

WELLSPRING MEADOWS, INC.,

Employer,

and

IDAHO STATE INSURANCE FUND,

Surety,

Defendants.</td><td>IC 2013-002663

ORDER

Issued 1/7/19</td></tr>
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Pursuant to Idaho Code § 72-717, Referee Brian Harper submitted the record in the above-entitled matter, together with his recommended findings of fact and conclusions of law, to the members of the Idaho Industrial Commission for their review. Each of the undersigned Commissioners has reviewed the record and the recommendations of the Referee. The Commission concurs with these recommendations.

Therefore, the Commission approves, confirms, and adopts the Referee's proposed findings of fact and conclusions of law as its own.

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

1. Claimant has failed to prove her cervical spine condition is causally related to her industrial accident of January 14, 2013.

2. Claimant has failed to prove her current low back condition is causally related to her industrial accident of January 14, 2013.

3. Claimant has failed to establish her right to medical care related to her cervical spine.

4. On the evidence produced herein, Claimant has failed to prove her present entitlement to medical care related to her low back beyond that provided by Defendants previously.

5. Claimant has failed to prove she is entitled to temporary disability benefits beyond August 29, 2013.

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

DATED this 7th day of January, 2019.

INDUSTRIAL COMMISSION

/s/
Thomas E. Limbaugh, Chairman

/s/
Thomas P. Baskin, Commissioner

/s/
Aaron White, Commissioner

ATTEST:

/s/
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 7th day of January, 2019, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

BRUCE SKAUG 1226 E KARCHER RD NAMPA ID 83687	JAMES FORD PO BOX 1539 BOISE ID 83701

/s/

jsk