BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

JORGE AVALOS, Claimant, v. LAVAL WHITEHEAD, Employer, and STATE INSURANCE FUND, Surety, Defendants.	**IC 2010-021068** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** May 6, 2014

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee LaDawn Marsters, who conducted a hearing in Idaho Falls on June 14, 2013. Claimant was present at the hearing and represented by Jonathan W. Harris of Blackfoot. Scott R. Hall of Idaho Falls represented the Employer (Whitehead Farms) and Surety (collectively, Defendants). The parties presented oral and documentary evidence and post-hearing depositions were taken. Post-hearing briefs were filed, and the matter came under advisement on February 28, 2014.

ISSUES

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

1. Determination of Claimant's average weekly wage (AWW);

2. Whether Claimant is medically stable and, if so, the date thereof;

3. Whether and to what extent Claimant is entitled to benefits for:

   a. Medical care;

   b. Temporary partial and/or temporary total disability benefits (TPD/TTD);

   c. Permanent partial impairment (PPI);

   d. Retraining; and

   e. Disability in excess of impairment;

4. Whether Claimant is totally and permanently disabled pursuant to the odd-lot doctrine, or otherwise; and

5. Whether Claimant is entitled to attorney fees pursuant to Idaho Code § 72-804.

Claimant did not address the fifth issue in his briefing; therefore, that issue is deemed waived.

CONTENTIONS OF THE PARTIES

Claimant, a farm worker, suffered a crush injury to his right tibia and fibula on August 23, 2010 when the front end loader on which he was working accidentally dumped him ten to fifteen feet to the ground. He then developed a severe case of compartment syndrome, complicating the emergency corrective surgery performed by Dr. Woods on the day of the accident, as well as his recovery process, which involved successive procedures under general anesthesia, including a skin graft to close his open wound, physical therapy, and other treatment. Claimant's bones healed, but he continued to report significant swelling in his right lower extremity as well as debilitating pain. He eventually underwent surgery to remove the

hardware from his right leg, but this did not relieve his persistent pain. Subsequently, he developed painful nodules on his right leg.

Dr. Poulter has diagnosed multifactorial nerve pain with chronic regional pain syndrome (CRPS)-like features and has recommended a spinal cord stimulator trial and, potentially, other treatments to alleviate Claimant's pain. Claimant wishes to undergo a spinal cord stimulator trial; thus, he seeks an order requiring Surety to provide coverage for this procedure. In the alternative, he seeks an order determining him totally and permanently disabled. In that regard, he primarily relies upon the opinions of Kathy Gammon, CRC/MSPT, and Nathan Hunsaker, P.T.

Defendants counter that objective testing has not supported Claimant's pain reports and, furthermore, his failure to behave as if he is in as much pain as he claims, his exam performance (including give-away weakness), and other factors, indicate he is exaggerating his symptoms, motivated by secondary gain, and/or malingering. They deny that further medical care is reasonable and assert that Claimant is able to obtain gainful employment, if he wants to. They primarily rely upon the independent medical evaluation (IME) opinions of Drs. Tallerico, Wilson, and Holt, and the vocational opinions of Delyn Porter, CRC.

OBJECTIONS

All pending objections preserved at the depositions are overruled except the following objections, which are sustained: Claimant's objections at pages 11 and 38 of Dr. Wilson's deposition; and Claimant's objection at page 17 of Dr. Holt's deposition.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The pre-hearing deposition transcript of:
    a. Claimant taken April 16, 2012;
2. The testimony taken at hearing of:
    a. Claimant;
    b. Kathy Gammon, CRC, MSPT; and
    c. Chris Horton, Industrial Commission Rehabilitation Division (ICRD) consultant.
3. Joint Exhibits (JE) 1 through 32 admitted at the hearing; and
4. The post-hearing deposition transcripts of:
    a. Jake Poulter, M.D. taken September 18, 2013;
    b. Timothy Woods, M.D. taken September 20, 2013;
    c. Briggs Horman, P.T. taken October 2, 2013;
    d. Richard W. Wilson, M.D. and Eric F. Holt, M.D., taken October 3, 2013;
    e. Delyn Porter, CRC taken October 8, 2013; and
    f. Brian Tallerico, D.O. taken October 22, 2013.

Claimant advised at the hearing that he intended to take the deposition of Nathan Hunsaker, P.T., but that deposition was neither noticed nor submitted to the Commission.

After having considered all the above evidence and briefs of the parties, the Commission renders the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

BACKGROUND

1. Claimant turned 43 years of age on the hearing date and resided just outside of Blackfoot. He was born in Mexico, and attended secondary school there. He started technical school in Mexico to learn how to make ball bearings and other metal products, but he relocated to the United States before he finished the program.

2. Soon after arriving in the U.S., Claimant worked as a farm laborer. He also tried construction labor and potato production line work, but he always returned to working on a farm.

3. At the time of his industrial accident, Claimant had worked for Whitehead Farms for approximately 20 years, off and on. He has four children and an ex-wife, all of whom reside in Mexico. His parents live sometimes in California, and sometimes in Mexico. He lives alone.

CLAIMANT'S ABILITY TO COMMUNICATE IN ENGLISH

4. Claimant has resided in the United States since approximately the mid-1980s. He testified at his deposition and at the hearing without the assistance of an interpreter. However, Spanish is Claimant's native language, he has no formal training in English and, at times, he has trouble speaking and understanding English. Along those lines, Claimant spoke with a heavy accent at the hearing, and he paused and said "uh" regularly as he tried to find the words to respond. His sentence structure was also consistent with the fact that he is not a native English speaker. His deposition transcript also evidences Claimant's problems speaking and understanding English at times.

5. Chris Horton, ICRD consultant, communicated with Claimant mainly in Spanish.

6. Eric Holt, M.D., a psychiatrist, administered written psychological testing on June 13, 2012. Claimant had trouble reading, though, so Dr. Holt's secretary read the questions aloud. Later, during the interview portion of the evaluation, Claimant elaborated on his reading problems:[1]

> D: (Dr. Holt) And then now uh my secretary was reading to ya. How well do you read?
>
> J: (Claimant) I do have a hard time that how I asked her to help me out.
>
> D: Yeah.
>
> J: You know because I know how important this is when it comes like this I get confused or possibly attention or nervous.
>
> D: Uh huh.
>
> J: I'm never know if when I'm right or maybe when I'm a little wrong or maybe when I'm too wrong.
>
> D: Can you read the newspaper?
>
> J: Uh, a little bit.
>
> D: Oh.
>
> J: A little bit, some.
>
> D: Let's see how you can read, at what grade.
>
> J: I can tell you that I do really bad to read it to ya.
>
> D: Huh. Let's try the easier ones first. Try that for me. Start at number 1.

JE-691. Following this exchange, Dr. Holt showed Claimant words, and Claimant read them.[2] The transcript reveals Claimant likely had trouble with "captain" and "delicious," but did well

[1] Dr. Holt recorded and transcribed his interview with Claimant.

[2] The words were: ball, like, boy, me, so, want, your, no, mother, fun, she, about, animal, baby, brown, cried, dinner, cool, every, feed, friends, give, no, almost, beautiful, captain, drink, engine, fasten, grade, himself, knock,

with the remaining words. Dr. Holt told Claimant, "Yeah, very good. So if you take your time you can do okay…." JE-692. Dr. Holt determined that Claimant reads at a fourth grade or higher level.

7. On November 8, 2012, Kathy Gammon, CRC, vocational consultant, administered the WRAT-4 test, which measures reading, spelling, *and* sentence comprehension abilities. Ms. Gammon determined that Claimant reads words at the 11.2 grade level, spells at the 6.7 grade level, and comprehends sentences at the 3.6 grade level. She interpreted his test results to mean that he reads and phonetically sounds out words approximately on par with average for his age group. However, his scores place him well below the statistical mean. "Although Mr. Avalos is able to sound out words correctly in English and appears to speak the language well, he has very poor comprehension of what English words mean when put in sentence form, particularly as the sentences become longer and more complex. Thus his functional skills in reading English are quite limited." JE-427.

8. Claimant also has trouble, at times, with verbal comprehension. For example, during his interview with Dr. Holt, he was confused when asked whether he had worked for Whitehead Farms longer than any other employer:

D: … Now was Whitehead the longest you had ever worked for one person?

J: Uh, no.

D: Do you see what I mean?

J: Yes.

D: You had worked for another employer longer than that?

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attention, breezy, certainly, church, delicious, dagger, fold, impossible, journey, language, admire, adventure, bounce, courage, darkness, difficult, electric, especially, extra, forty, hospital, machine, opposite, recognize, and some others that were not audible.

J: Uh no.

D: Oh Whitehead was.

J: Well I did work like for, work for uh Jerry Elliott for a few months.

D: Uh huh.

J: I tried to work on, uh [inaudible] transformers. They handled a lot of [inaudible]. But then I got my gallbladder removed. I worked in a department where it was very heavy.

D: Uh uh.

J: So they were pretty slow.

D: Oh.

J: That's when I went back to, I don't know if you ever heard of Polatis'?

D: Uhm, hmm.

J: I helped them for a few months also. Also, Scott Whitehead he helps us over there. And here I went back to Whiteheads.

D: Yeah. But it sounds like, you said over 20 years. So maybe 20 years ago you started out …

J: I, I helped him out like 20 years, maybe 21 years. Then I try something else uh for three, almost four years, then I try to help again.

D: Then you go back. So it's been intermittent?

J: Right.

D: On and off, on and off.

J: I uh, help them like 20 years, 21 years straight.

JE-712.

9. Ms. Gammon administered the Personnel Tests for Industry-Oral Directions Test – Form S to assess Claimant's ability to follow directions presented orally in the English language. In deriving her opinion of his ability, Claimant's percentile scores were compared against results of norm groups in a variety of work settings. "This testing demonstrates that Mr. Avalos is at a distinct disadvantage when compared to similar job applicants in the work place in regards to his ability to follow directions given in the English language. Even when compared to similar vocational rehabilitation clients in the western part of the United States, 50 percent of whom are minorities, he scored lower than 85% of that normative population." JE-428.

INDUSTRIAL INJURY

10. On August 23, 2010, Claimant was working alongside another employee while suspended in the bucket of a front-end loader. A third coworker accidentally released the bucket, dropping Claimant and his colleague suddenly to the ground, approximately ten to fifteen feet below. Claimant landed first, then a board fell on his right leg, then his coworker fell on the board. Claimant sustained a right lower leg injury, and he was taken immediately to the hospital, where he was examined by Timothy Woods, M.D., an orthopedic surgeon.

TREATING PHYSICIANS

11. **Dr. Woods.** Dr. Woods diagnosed unstable fractures of the right tibia and fibula at the proximal junction of the middle and distal thirds (a crush injury), placed Claimant's leg in a splint, and recommended emergency surgery to set the bones. A few hours later, as Claimant was being prepared for surgery, Dr. Woods noted Claimant's blood pressure was "almost uncontrollable." JE-38. Dr. Woods called Jake Poulter, M.D., anaesthesiologist and pain specialist, to consult and assist. With further testing, they determined Claimant's high blood

pressure was likely the result of acute compartment syndrome, which he had developed since he was first examined. Dr. Woods described Claimant's compartment syndrome:

> In this case we're talking about the lower leg. It's divided into muscular compartments that are somewhat separated from one another by a tissue-like covering. Blood gets pumped in, and in this case by a fairly strong heart by Mr. Avalos, and swelling either because of the injury, the fracture, bleeding from the bone or all of the above gets to a critical level where blood keeps coming in but can't get out. So it perpetuates the problem. And the compartments swell to a point that - - it can, in fact, get to a point where blood can no longer get into that muscular compartment and the muscle can die.

Woods Dep., p. 8.

12. "Ischemia" refers to the lack of oxygen delivery that occurs with the blood engorgement from compartment syndrome. Woods Dep., p. 10. "It's not an all or nothing or an on/off switch, but it's a process. And if the body is not getting enough blood and by definition oxygen delivery, then the muscle and the tissue in the leg will become ischemic." *Id.* Left untreated, such ischemia can result in tissue death. "And I probably should clarify, it's not just the muscle. It's everything in the leg. It's not, you know, just the muscle that needs blood. It's all of the living tissue…[…]…blood vessels and nerves in this case, and even, I guess, to a certain extent, to a lesser extent, the bone." *Id.* at 9.

13. Dr. Woods has only seen six to eight cases of compartment syndrome in 15 years. Claimant's is the worst case he had ever seen.

14. Claimant had also developed "a large, rather extensile medial fracture blister." JE-39. "The blister was intact, but this represented a dramatic change. The underlying skin was showing signs of a degloving-type mechanism from the inside-out, with partial thickness skin damage." *Id.*

15. To relieve Claimant's compartment syndrome, Dr. Woods performed a four-compartment fasciotomy. "A fasciotomy is basically opening up the fascia. The lower leg in this case is typically divided into four compartments, four major compartments, and all four of those were in a sense split open to relieve the pressure." Woods Dep., p. 12. Dr. Woods avoided the fracture blister when performing the fasciotomies.

16. Once the pressure was relieved, Dr. Woods set Claimant's broken bones utilizing an intermedullary rod and other hardware.

17. In the days following surgery, Dr. Woods performed serial dressing changes, where he periodically took Claimant back to the operating room and placed him under general anesthesia to recheck, debride, irrigate, and redress his wound. He also deployed a vacuum-assisted closure device (a "wound vac") "to try and draw down swelling from the leg." Woods Dep., p. 12. On August 25, 2010, Dr. Woods observed, "The medial skin, which was obviously traumatized almost in an inside-out degloving mechanism from his original injury, has fortunately recovered and appeared quite viable." JE-42. On August 27, he noted, "The muscle was viable with contractility, a little bit of edema, and viable skin margins." JE-47. On August 30, 2010, Dr. Woods noted, "Good vascular bed of the muscle seen through the lateral fasciotomy incision through which we decompressed all four compartments." JE-50.

18. On September 1, 2010, Dr. Woods performed a split-thickness skin graft with skin harvested from Claimant's right thigh to close his right lower leg wound. The skin graft measured 20 cm by 5 cm (approximately eight inches by two inches).

> It's not uncommon in compartment syndrome to not be able to obtain complete closure. In Jorge's case, his fasciotomies had to be, in my medical opinion, performed from a single incision from the outer part of his leg. Often times it will be done from two incisions, one on the inner half or the inner side, I should say,

> of his calf and the outer side of his calf. But because of some blistering of the flesh on the inner side, I felt it was medically appropriate to do it all from a single lateral incision, a perfectly accepted way of doing it. But it led to, in a sense, all of the swelling being more pronounced on that side.

Id. at 13.

19. Claimant was in recovery for one week at the hospital. Subsequently, he was transferred to the rehabilitation section, where he received physical therapy to improve his ankle and knee ranges of motion as well as wound care and medical follow-up. Claimant remained there for several weeks, and then he was discharged home. He attended outpatient physical therapy thereafter for several months.

20. While in the rehabilitation section, Claimant developed symptoms associated with reflex sympathetic dystrophy (RSD), also referred to as chronic regional pain syndrome (CRPS). Dr. Woods referred Claimant to Dr. Poulter for follow-up with his on-going pain problems.

21. On May 26, 2011, an MRI demonstrated significant edema in Claimant's right lower leg. A few weeks later, Dr. Woods opined Claimant's swelling issue is likely permanent.

22. On August 23, 2011, Dr. Woods removed the hardware placed during his repair of Claimant's industrial injury. Tissue samples were negative for any infection. In October, he again opined that Claimant's swelling and pain were likely permanent.

23. Dr. Woods continued to treat Claimant, but in regard to his continuing pain, he found the opinions of other physicians, including Dr. Poulter's, useful, since Claimant's recovery course is not what he would expect from a well-healed crush injury. Given Claimant's test results alone, he would have expected a more complete recovery.

24. On January 24, 2012, Dr. Woods executed a check-box letter from Surety, indicating he agreed with Dr. Tallerico's opinions (see below), including that Claimant was

medically stable and was exaggerating his symptoms. However, in his chart notes and at the hearing, he was clear in conveying that he believes Claimant is credible. Also, he opined that although he does not feel particularly qualified to treat Claimant's pain, he believes Claimant has still not fully recovered.

> Q. (By Mr. Harris) …Mr. Hall asked you a question about recovery of the nervous system in the lower leg, and you explained how you had observed some recovery of the nerves and the nervous system. How then do you medically explain the pain that Jorge continues to complain of in the lower leg?
>
> A. (Dr. Woods) Well, the nerves serve many functions. One would be sensation, one would be muscle stimulation, another would be pain, temperature. So to say that part of the nerve function meaning the muscle function and some though not all of the sensation function has recovered but that he may still have ongoing pain to me tells- - tells to me that it's not complete.

Woods Dep., p. 50.

25. Dr. Woods last treated Claimant on December 13, 2012, when he prescribed a new CAM boot. He opined that Claimant's bone was well-healed and adequately positioned, and that his remaining symptoms are likely the result of compartment syndrome.

> …[T[he patient's subjective symptoms of pain and disability and swelling and so forth, which I believe are largely attributable to the compartment syndrome and crush component of his original injury, continue to limit his abilities to function in day to day life. He has worn out half a dozen of CAM walker boot, so it is not as if these are sitting in the garage somewhere, he is truly putting mileage on them. He continues to use crutches.
>
> …I will also try to make myself available as possible to help Jorge in his ongoing struggles to get a remedy and/or what he feels a more equitable settlement.

JE-993.

26. **Dr. Poulter.** As mentioned, above, Dr. Poulter is an anesthesiologist and pain specialist. "I usually get involved in managing patients who have very difficult to manage pain, pain issues that go beyond the typical course of healing." Poulter Dep., p. 7. Dr. Poulter

graduated from a one-year pain management fellowship at the University of Utah in 2009 following an anesthesiology residency at the University of New Mexico, and he is board certified in anesthesiology with a subspecialty in pain management. Formerly the department head of anesthesia at Bingham Memorial Hospital, Dr. Poulter resigned in January 2013 to enter private practice.

27. Dr. Poulter first consulted in Claimant's case at his initial surgery, but he began treating Claimant's on-going pain on September 23, 2010, in referral by Dr. Woods. He continued to treat Claimant at the time of the hearing, though his participation in Claimant's care was by then limited by Surety's denial of benefits for additional pain treatments he had recommended.

28. Throughout Dr. Poulter's treatment of Claimant, he noted CRPS-like symptoms. Dr. Poulter described CRPS in general, as well as his related concerns regarding Claimant:

> CRPS or chronic regional pain syndrome is a - - it's a clinical diagnosis. There's not a lab test or an MRI or a diagnostic testing to perform that tells you that he has this or that he doesn't. It's a diagnosis that's made based on symptoms and knowing the clinical context for what has happened.
>
> It's usually a diagnosis that we make when we know that there's been some type of injury, as you say, some preceding injury, and then there's a cluster of symptoms that come together to form this diagnosis of complex regional pain syndrome. Now, it doesn't explain everything that has happened to Jorge, but it potentially would explain parts of it - - […] - - whether it's CRPS or whether it's a complex regional pain syndrome-like phenomenon that he has. But he had - - at this time he had a lot of features concerning for complex regional pain syndrome in addition to his surgical repair and his ORIF [(open reduction internal fixation)] pain syndrome.

Poulter Dep., pp. 13-14.

29. On September 23, 2010, Dr. Poulter noted the following symptoms suspicious for CRPS: Claimant described his pain as sharp, burning, and stabbing; Claimant reported color

changes and swelling; and Claimant had trouble touching some painful areas on his lower right leg. "[H]e propped his sheets on a pillow to keep them off his leg while he was sleeping… - - that is a phenomenon referred to as allodynia…." Poulter Dep., p. 15. "So he had allodynia. He had a burning pain. He had swelling and color changes. Those things fit nicely within a diagnosis of complex regional pain syndrome." *Id.* Subsequently, Dr. Poulter also documented temperature changes (right warmer or colder than left).

30. Over time, Claimant's allodynia changed somewhat, from sensitivity to light touch, to sensitivity to pressure.

> Allodynia always has to be qualified. You have to have allodynia to what. Is it allodynia to sheets on your leg, allodynia to light touch, allodynia to light pressure, allodynia to wearing a sock, allodynia to wearing shoes? These are things that don't typically hurt. So just saying that someone has allodynia doesn't really tell you much as to allodynia to what.
>
> And so for a time Jorge did have some allodynia to light touch, but I believe as we progressed through his management, that it changed a bit to be more of an allodynia to light pressure as opposed to allodynia to light touch. That light touch character seemed to improve over time, if I recall correctly. I'd have to look at some of my more recent notes.

Id. at 20. Dr. Poulter's chart notes are consistent with this conclusion.

31. Regarding the color changes, Dr. Poulter described his observations of Claimant's leg.

> Jorge's leg will typically fluctuate from a pale color to almost a purple-type color with some colors of redness, and it will be a - - every patient's a little bit different, but the most important thing is that when you compare one leg to the other leg in the area where the color changes, if one leg is a pale color and … - - the other leg is a normal color, you've got a color change. There's some blood flow abnormality issue going on. So it's usually a fluctuating color change that happens throughout the course of the day. Or even some people have a very dynamic color change experience where from hour to hour it changes, but he did endure some color changes.

Poulter Dep., pp. 15-16. Dr. Poulter usually does not document a color change unless it is different from the opposing side. He also does not document a color (or temperature) change if there is another explanation for it. For example, "if you have one foot up and one foot down, you would expect the one down to be a little darker." *Id.* at 16. Similarly, Dr. Poulter looked for color changes outside the skin grafted area, where a color change would be expected. As for temperature changes, it is expected that the affected limb would be warmer after a nerve block because the numbing medication dilates the blood vessels in that extremity, increasing the temperature, or after wearing a sock on one foot but not the other. Therefore, for instance, Dr. Poulter did not rely on Claimant's temperature changes following nerve block procedures in determining that Claimant was experiencing such changes. Also, Dr. Poulter explained that a patient's credible description of symptoms can satisfy some of the requirements for a CRPS diagnosis.

32. Dr. Poulter initially prescribed medications and a right lumbar sympathetic block. He anticipated that a series of these injections may be required to achieve results. Claimant obtained no significant pain relief from injections on September 24, October 5, and October 11, 2010.

33. On October 16, 2010, Margarita Llinas, M.D., an internist, evaluated Claimant's persistent right lower extremity swelling. His right calf and foot were swollen and shiny compared to the left side, but his pain was well-controlled with medications. She suspected RSD (CRPS).

34. Around this time, a number of potential causes of Claimant's persistent swelling were investigated and ruled out, including deep vein thrombosis, arterial and venous problems,

abscess, and other conditions. An EMG/nerve conduction test performed by Elizabeth Gerard, M.D., a neurologist, revealed no acute denervation in any muscle tested in Claimant's right lower extremity.

35. On October 19, 2010, observing at least a working diagnosis of CRPS, Dr. Poulter administered a sciatic nerve block into Claimant's popliteal fossa. Claimant reported partial relief of his symptoms. On October 28, 2010, Kevin Hill, M.D., a physiatrist, evaluated Claimant and recommended, among other things, a TENS unit and cognitive therapy to help Claimant deal with his pain. He noted dysesthesias on exam and listed, but did not directly address, the CRPS diagnosis.

36. Claimant's leg swelling persisted and was documented by his physical therapist. In January 2011, Dr. Woods directed the therapist to take precautions for chronic edema. On January 13, 2011, physical therapy notes state Claimant wanted to "keep pushing even though he gets sore." JE-364. On March 9, 2011, the therapist noted that Claimant's range of motion had improved, but his swelling persisted even though he had employed methods to control it.

37. Claimant returned to Dr. Poulter on March 11, 2011. Claimant was wearing a CAM boot on his right foot because, he said, he was recently diagnosed with a fracture near his ankle and he was uncertain whether he would need another surgery. Claimant was apparently confused; his records do not establish that he had another fracture. He was also using a crutch to ambulate and wearing compression stockings. He estimated that he was bearing about 30% of his weight on his right leg. He continued to have pain, which he rated at 6/10[3], in the anterior distribution of his right leg below his knee, as well as on the medial aspect of his left knee and

[3] Claimant is asked throughout his treatment to rate his pain from 0-10, based upon the Visual Analog Scale, with zero signifying no pain.

the medial aspect of his left ankle. He was not sleeping well. He also had tactile allodynia behind the skin grafting site on the lateral aspect of his right calf.

38. Dr. Poulter noted that Claimant's neuropathic pain presented in a nondermatomal distribution. As well, "He continues to endorse sympathetically mediated changes, such as predominant swelling, which occurs towards the end of the day, temperature changes and color changes in his foot and lower extremity." JE-824. Claimant was taking methadone and Percoset as needed for pain, Amitryptiline, and a number of blood pressure medications. He had been taking gabapentin, but Dr. Woods discontinued this.

39. Dr. Poulter diagnosed right lower extremity pain, likely due to a combination of nociceptive and neuropathic pain sources, with symptoms concerning for CRPS. He elucidated his diagnosis at his deposition:

> [N]ociceptive pain is a normal type of pain that a nerve would send. So if you - - nerves are intended to send nociceptive pain. So if you break your arm, it's a nociceptive pain that is being sent to your brain. Your brain is being told about a painful stimulus. Jorge likely has some ongoing nociceptive pain from the injury that he had in his leg from his surgeries, but there's also a part of his pain that is neuropathic, meaning a diseased state or an abnormal function of his nerves, which are sending abnormal messages to his brain, not from a pain source. So in differentiation, nociceptive pain is a normal message from a - - well, a painful message from a normal-functioning nerve. Neuropathic pain is a painful message from a nerve that is not functioning properly.

Poulter Dep., p. 36. "[T]he most difficult pain [to treat] is the multifactorial pain that's due to nerve issues and ongoing postsurgical issues, swelling." Poulter Dep., p. 37.

40. Dr. Poulter assumed management of Claimant's medications from Dr. Woods, and arranged to obtain records and discuss Claimant's case with him (Dr. Woods). Dr. Poulter recommended continuing Claimant's current medications with some dosage modifications, and

possibly restarting him on gabapentin in the future. At his deposition, he described how different medications treat different pain sources:

> Neuropathic pain is treated with nerve pain medications, neuropathic medications. They're designed to target receptors on nerves and quiet them, to change the way that the nerve functions. These medicines are like Lyrica or gabapentin or Cymbalta, medicines that have been shown to work for nerve pain.
>
> Nociceptive pain is treated with other types of pain medicines like anti-inflammatory medications or pain medications, hydrocodone or morphine.

Poulter Dep., pp. 36-37.

41. Dr. Poulter also noted the possibly of getting Claimant back into physical therapy and/or repeating a series of lumbar sympathetic blocks. "[H]is pain experience could respond to this modality." JE-826. Also, "We did not discuss today, but certainly in the future this may be appropriate to discuss a neuromodulation device for [Claimant] if his pain proves to be persistent." *Id.*

42. On March 29, 2011, Claimant's condition was mostly unchanged, though his blood pressure was higher. Dr. Poulter noted Claimant demonstrated "[e]xcellent compliance with his current regimen of medications" and scheduled a sympathetic lumbar block. Dr. Poulter also discussed the future possibility of a spinal cord stimulator with Claimant and provided him an instructional DVD regarding this treatment option. "We will in the future consider additional neuropathic pain, adjunctive medications and another [*sic*] treatment options." JE-830.

43. On April 27, 2011, Claimant was experiencing more pain, which he attributed to recent hyperbaric therapy treatments. Claimant had doubled up on his medications due to increased pain from compression wrappings and testing overseen by Dr. Garrison, and had run out two days previously. He had withdrawal symptoms. He reported dull aching pain with

persistent color and temperature changes and he continued to struggle with swelling. On exam, Dr. Poulter noted Claimant walked with an antalgic gait, with crutches, that his right leg was darker than his left, and that he had allodynia to light touch. "Exam is unchanged from our last documentation." JE-832.

44. Dr. Poulter increased Claimant's Percoset and methadone and restarted him on gabapentin. Also, "Will see if his insurance will reconsider letting us do another LSB. He has persistent findings concerning for sympathetically mediated symptoms and complex regional pain syndrome. From a diagnostic and therapeutic standpoint, this needs to be done, and he likely needs to have a series of these procedures. I would like to do this before we move on to the more costly and invasive spinal cord stimulator, which is from a pain standpoint the next treatment option." JE-832. Surety approved the procedure, which was performed on May 9, 2011. Claimant reported only 25% improvement, prompting Dr. Poulter to surmise that it may be time for a spinal cord stimulator trial.

45. On November 22, 2011, Claimant's condition was largely unchanged. "His current complaints include persistent pain around his ankle, and in his calf and tibial area. He describes his pain with neuropathic descriptors. He endorses stabbing and burning pain. He also has fluctuating swelling, color changes, and temperature changes." JE-835. Claimant rated his pain at 7/10. On exam, Dr. Poulter noted, "He still has quite a bit of swelling in his right lower leg compared to the contralateral side. He has some redness and color changes. He does not have obvious allodynia to light touch but [sic] gentle pressure he has remarkable allodynia." JE-836. Dr. Poulter's diagnosis did not change. "Right lower extremity neuropathic pain. He also has nociceptive pain in this area as well. Many of his current symptoms support the diagnosis of

complex regional pain syndrome. Unfortunately lumbar sympathetic blockade has not changed his pain much." *Id.* Dr. Poulter continued Claimant's medications, and also recommended a spinal cord stimulator trial. "We also discussed that he would likely benefit from a spinal cord stimulator. We spent some time discussing this…the need for a trial and … the subsequent implant. We discussed that he would need to sit down with the psychologist for evaluation." *Id.*

46. On January 19, 2012, Claimant's condition was unchanged. He had undergone IMEs at Surety's request, in reliance upon which Surety ultimately denied further treatment. Claimant was unsure about the spinal cord stimulator, and wished to try adjusting his medications first, which Dr. Poulter did. However, "I feel that it is unlikely that we will be able to offer him much meaningful pain relief without employing a number of different treatment modalities." E-839. Dr. Poulter noted he thought Claimant was getting close to wanting to try a spinal cord stimulator.

47. On January 25, 2012, Claimant reported problems with his medication regimen changes. He was sleepy and groggy, with no improvement in his pain. Also, he had received a copy of Dr. Tallerico's IME report (see below), which frustrated and depressed him.

> He is very frustrated about some of the comments included in this report. It implies that he should not be using crutches and should not be having any pain. Due to the results of the evaluation the patient has lost more of his Worker's [*sic*] Compensation benefits. He is working with an attorney on this issue.

JE-840. He rated his pain at 8/10. Dr. Poulter revised Claimant's medications and tried to encourage him.

> He was told that it is not uncommon for independent medical examinations to preferentially side with the insurance company rather than the patient. All of the providers here at the hospital we'll advocate for him. I encouraged him to continue working with his attorney regarding these issues. He is obviously still suffering from his injury. We have a number of treatment options still available

> to us. It is unfortunate for him to lose his insurance benefits based on the opinion of a single examiner.

JE-841.

48. Defendants argue that this note establishes Dr. Poulter is biased against Surety and, thus, his opinions should be discounted. The Referee disagrees. Dr. Poulter's long history treating Claimant and his deposition testimony establish it is more likely that these comments were borne of frustration from being prevented from rendering treatment that he believed may improve Claimant's symptoms along with a desire to comfort Claimant. "I think that in order to give him as fair a chance as possible at getting back to work and getting off of his pain meds and off of his crutches and out of his boot, we have some more work that we need to do on him." Poulter Dep., p. 39. Dr. Poulter's opinions regarding Claimant's case are well-documented and he sets forth sufficient medical basis to support them. The record does not support an allegation that Dr. Poulter's medical opinions were improperly influenced by his opinions about the insurance industry, in general, or Surety, in particular.

49. On April 10, 2012, Claimant's attorney accompanied him to Dr. Poulter's office and attended his examination. "Jorge's presentation, the way he described his pain, the way he interacted, really didn't change significantly when [his attorney] was there compared to when he wasn't." Poulter Dep., p. 49.

50. Claimant's condition was largely unchanged. "He continues to endorse swelling, color changes, temperature changes, and sweating changes in his right lower leg. He tolerates wearing a sock and his walking boot well. He has increased pain with gentle pressure." JE-843. On exam, Dr. Poulter noted, among other things, obvious swelling in Claimant's right lower leg, color and temperature changes compared to the left leg, and allodynia to gentle pressure over

most of the areas between his knee and ankle. "He does not have a pattern of allodynia to light touch." *Id.*

51. Dr. Poulter opined:

> [Claimant's] persistent right lower extremity pain fits nicely with the diagnosis of CRPS type II. He meets the diagnostic criteria by having had an [*sic*] severe traumatic injury to his right leg, including compartment syndrome, which led to his ongoing nerve injury. He has persistent neuropathic pain and hyperalgesia to light pressure in a nondermatomal distribution. He also has persistent lower extremity swelling, color changes, temperature changes, and an abnormal pattern of sweating in his right lower extremity. This is supported both by the patient's history and by physical exam. Dr. Woods has done an excellent job ruling out any other potential contributing issues, and his workup has been very well documented in the medical record. Curiously, a lumbar sympathetic block done early in the course of his treatment fail [*sic*] to change his pain much at that time. The interpretation of this treatment is difficult to interpret [*sic*] however, do [*sic*] to the multitude of other confounding factors that were going on in his lower extremity at that time.

JE-844. He further noted that Claimant was developing sequelae associated with chronic pain. "He was tearful a few times throughout our encounter today. He seems to be struggling with loss of identity and loss of meaningful purpose in his life. Of course persistent pain is also a remarkable stressor for him." JE-844. Dr. Poulter suggested a number of treatments, including another nerve block, ambulatory popliteal fossa catheter, systemic ketamine and lidocaine infusion, spinal cord stimulator and an intrathecal pain pump, through which a number of different medications that could benefit Claimant could be infused.

52. Among other things, Dr. Poulter referred Claimant to Donald Whitley, Ph.D., a pain management psychologist (see below). "I am hopeful that Dr. Whitley can help the patient with some of the sequela from chronic pain. He seems quite depressed and frustrated today." JE-844.

53. On July 19, 2012, Claimant presented to Dr. Poulter in his walking boot and using a cane. He had "developed some exquisitely tender nodules in the subcutaneous tissues that are troublesome for him." JE-845. These nodules appeared at least as early as May 25, 2012, when Claimant first reported them to Dr. Woods.

54. Claimant wished to pursue a spinal cord stimulator trial, so Dr. Poulter sought approval from Surety. "He would likely respond quite well to this." JE-846. Dr. Poulter provided the following information via a questionnaire regarding Claimant's functional abilities, with Claimant's assistance, on August 29, 2012:

- Claimant can only stand 5-10 minutes before requiring a 30 minute rest before returning to standing.
- In an 8-hour day, Claimant can stand a total of one hour, with frequent breaks.
- Claimant cannot walk, climb stairs or walk on uneven terrain at all without his walking boot and/or crutches; he can walk 5-7 minutes with his boot and/or crutches, and can resume after a 5-7 minute break "when pressured." JE-847.
- In an 8-hour day, Claimant can walk up to one hour, in 5-7 minute stretches, with breaks as indicated above.
- Claimant can lift up to 30 pounds with careful positioning.
- In an 8-hour day, Claimant should lift 20-30 pounds for a total of less than one-half hour.
- Claimant cannot carry one-handed.
- Given his chronic right leg pain and use of narcotic pain medication, Claimant is unable to maintain a full-time, 40 hour per week work schedule.
- Claimant is unable to tolerate sedentary work.
- Claimant is unable to do light work requiring him to stand and walk for up to five-and-a-half hours per day.

- Claimant is unable to do medium work lifting up to 50 pounds for up to two-and-a-half hours a day and standing/walking for up to five-and-a-half hours per day.
- Claimant is unable to do heavy work lifting up to 100 pounds for up to two-and-a-half hours per day and standing/walking up to five-and-a-half hours per day.

Dr. Poulter also noted "[e]xtreme limitations with function due to persistent & severe right leg pain." JE-848. On October 30, 2012, Dr. Poulter signed a statement prepared by Claimant's attorney indicating, among other things, that in the event he receives further treatment, his restrictions are not necessarily permanent.

55. Surety denied Dr. Poulter's recommendations for further treatment in reliance on the opinions of the independent medical evaluators (see below). It had also previously denied Dr. Woods' recommendation for hand controls for Claimant's car.

56. Dr. Poulter continued to follow Claimant, whose condition did not significantly change. He continued to report his pain between 6/10 and 9/10. On October 11, 2012, he reported 9/10 pain that was uncontrollable. "He denies any acute changes and tries to stay active. To help with alleviate [*sic*] the pain, he has been taking his pills (both methadone and Percoset) too frequently. Pain is constant and localized to lower right leg." JE-849. On October 24, 2012, he also reported 9/10 pain, and Dr. Poulter adjusted his medications. On October 30, 2012, Claimant's attorney again accompanied him. Claimant rated his pain at 6/10 and he still had painful nodules. Dr. Poulter reiterated his prior opinions, adding, "I consider psychology services to be within the standard of care for one who struggles with chronic intractable pain. We have not full [*sic*] utilized the service at this point." JE-856.

57. Dr. Poulter referred Claimant to Dr. Woods for evaluation of the nodules. Dr. Woods opined the nodules were likely permanent "thrombosed veins that are tender and

superficial in nature." Woods Dep., p. 18. Dr. Woods opined they are typical of poor drainage or outflow from the leg. Treatments include compression stockings (which Claimant wears), heat, and anti-inflammatories.

58. **Additional evaluation and treatment for swelling.** On March 24, 2011, Claimant was evaluated by David Shelley, M.D., a vascular and interventional radiologist. On exam, among other things, Dr. Shelley observed 1+ nonpitting edema in Claimant's lower right leg, no open ulcerations, and no evidence of hyperpigmentation. He performed arterial and venous duplex studies, both of which returned normal results. He suspected lymphedema and referred Claimant to Dr. Baker or Dr. Garrison at The Wound Center in Pocatello for follow up. Dr. Garrison suspected venous insufficiency and/or lymphedema and scheduled a lymphoscintigraphy. That test was painful, and produced normal results.

59. On April 20, 2011, Dr. Garrison opined, "The underlying injury to the vasculature is most likely that of the microsystem which is not evident on any of these studies." JE-556. Dr. Garrison prescribed compression of at least 30-40 mmHg by compression wraps, as well as pneumatic compression boots for daily home use.

60. **Second opinion evaluations.** On May 25, 2011, Claimant was evaluated for a second opinion by Brigham Redd, M.D., an orthopedic surgeon. On exam, Dr. Redd noted, among other things, significant swelling in Claimant's right leg and discoloration from the middle of the shin downward ("kind of a brawny purplish hue"). The leg was well-vascularized and not particularly warm, but he had decreased sensation to light touch in several areas. He was not tender to palpation around the foot or ankle, but he had mild diffuse tenderness about the leg and significant tenderness around the right knee. Claimant's right thigh was mildly atrophied

compared to his left. He had a limp and was unable to bear full weight on his right side. His bone fractures were fully healed. Dr. Redd saw no need for additional surgery. He recommended aggressive physical therapy and continued pain management by Dr. Poulter. After a few physical therapy sessions, Dr. Woods discontinued them, as they were not helpful.

61. On July 18, 2011, Claimant was evaluated for a second opinion by Hugh S. Selznick, M.D., another orthopedic surgeon. Claimant reported his pain at 6-7/10. Following examination, Dr. Selznick noted, "My clinical impression is pain and swelling now almost one year status post intramedullary narrowing of a complicated fracture complicated by compartment syndrome: [*sic*]" JE-871. He recommended a new ultrasound (prior studies ordered by Dr. Woods were negative) to rule out deep vein thrombosis, x-rays to rule out nonunion and a CT scan of the reconstruction to rule out a vascular outlet problem from the limb. Dr. Selznick believed infection had been ruled out by testing previously performed by Dr. Woods, and Claimant reported he had no metal allergy. Without elaboration, he noted that he did not believe Claimant was suffering from dystrophy or CRPS.

62. On July 27, 2011, after reviewing Claimant's imaging results and again examining Claimant,[4] Dr. Selznick opined that Claimant likely had "a low-grade infection subjacent to the fracture despite negative infection markers in the blood and MRI with contrast not confirming any focal abscess." JE-870. He recommended removing the hardware from Claimant's right leg and debriding an area of cystic change that he observed on Claimant's CT scan. He noted that the only test not ordered was a bone scan. Given Claimant's injury history,

[4] "Mr. Avalos [*sic*] exam is consistent with diffuse swelling referable to the right lower extremity. There is warmth to the entire right lower extremity. There is marked tenderness over the anterior tibial cortex distally in the region of the fracture with a small area of cystic changes seen." JE-870.

Dr. Selznick opined such imaging would not return results that would assist in diagnosing the source of Claimant's ongoing pain and swelling.

63. **Dr. Whitley.** Dr. Whitley interviewed Claimant on July 10, 2012. He provisionally diagnosed adjustment disorder with anxiety and depressed mood, with a Global Assessment of Functioning (GAF) score of 60. Factors impacting Dr. Whitley's diagnosis include Claimant's unresolved pain issues, no finances, inability to work, his benefits ending, and some social isolation.

64. Dr. Whitley administered a number of questionnaires and tests[5] on September 12, 2012. Claimant's Behavioral Pain Assessment indicated he was significantly affected in his life, including his activities of daily living, by his right leg injury. There was no indication for alcohol dependence or abuse on the Alcohol Use Disorder Identification Test, but Claimant's incorrect responses on the Current Opioid Misuse Measure rendered those results inconclusive. Claimant's Pain Patient Profile resulted in a depression score that was above average for pain patients, an anxiety score that was below average for that population, and a somatization score in the average range. As for the somatization score, "The patient feels that physical problems are serious and feels threatened by them, although it is not at the level of obsessive compulsiveness." JE-913. Under the stress moderator's category of the Millon Behavioral Medicine Diagnostic, Claimant's pain sensitivity scale was in the moderate to high range. "This points to the fact that mild or moderate pain might be intensified, but it also indicates more so that pain tends to dominate the overall clinic [*sic*] picture." *Id.* As for the Personality Assessment Inventory, Claimant's response pattern "was somewhat unusual and indicated significant amount of

[5] Dr. Whitley administered the Behavioral Pain Assessment, Alcohol Use Disorder Test, Drug Abuse Screening Test, Current Opioid Misuse Measure, Millon Behavioral Medicine Diagnostic, Personality Assessment Inventory, and the Pain Patient Profile.

defensiveness about any personal shortcomings and given the high level of defensiveness it was likely to possibly invalidate the overall test." JE-914. "Nevertheless, the findings that were on the test indicated concerns of physical functioning. He reports difficulties consistent with relatively mild or transient depression symptomatology as well." *Id.*

65. Dr. Whitley concluded that the testing confirmed his provisional diagnosis. "Diagnostic consideration from … all the testing appeared to be in line with the mental status exam that had been completed in July 2010, that being of an adjustment disorder with anxiety and depressed mood with more focus to the depressed mood." JE-914. "Much of this centers around the fact that he is injured and he cannot do a lot of the activity of daily living things that he did previously." *Id.*

FUNCTIONAL CAPACITY EXAMINATIONS AND AFTERMATH

66. On December 14 and 18, 2012, Claimant underwent a functional capacity evaluation (FCE) by Briggs Horman, P.T. The exam was scheduled for consecutive days, but Claimant was unable to pay for transportation on the second day, so he rescheduled. Mr. Horman opined Claimant did not exert maximal effort on testing, and that he could work in light-medium duty jobs. He measured Claimant's right calf at 6 cm larger than his left.

67. On January 29 and 30, 2013, Claimant underwent an FCE by Nathan Hunsaker, P.T. On the second day of testing, Mr. Hunsaker measured Claimant's right calf at 6 cm larger than his left. Mr. Hunsaker opined that Claimant is limited to sedentary work.

68. On March 13, 2013, Claimant was examined by a nurse practitioner at Bingham Memorial Hospital. He reported 8/10 pain, with reduction in his swelling. He felt like his swelling was exacerbated in the past by strenuous FCEs, but it had since improved somewhat.

Claimant's weight was down to 268 from 305 in October 2012. He was concerned that his pain had not improved, and his medications were continued.

INDEPENDENT MEDICAL EVALUATIONS

69. **Dr. Tallerico.** Brian Tallerico, D.O., an orthopedic surgeon, performed an IME examination on December 16, 2011. Dr. Tallerico is certified by the American Osteopathic Board of Orthopaedic Surgery and has passed parts 1-3 of testing administered by the National Board of Osteopathic Medical Examiners. Dr. Tallerico completed a residency in orthopaedic surgery at Ohio University from 1998 through 2002, and then a fellowship with E. Marlowe Goble, M.D., in knee reconstruction and arthroplasty, from 2007 through 2008.

70. Prior to the exam, Dr. Tallerico provided Claimant with forms to fill out and bring with him. He interviewed Claimant on the day of the exam and, before preparing his report, Dr. Tallerico reviewed Claimant's medical records related to his industrial injury. These are summarized in his report. Laval Whitehead, Claimant's employer, accompanied Claimant at the evaluation.

71. On exam, Dr. Tallerico observed no evidence of CRPS or edema, though Claimant predicted that his lower right leg would be swollen later in the day. As well, Dr. Tallerico described "nonphysiologic give-way weakness of all major motor groups in the entire right lower extremity including his hip flexors, abductors, and adductors, most notably with knee extension, knee flexion, and ankle plantarflexion, inversion, and dorsiflexion." JE-895-96. Later in his report, however, Dr. Tallerico acknowledged that Claimant was able to flex his right hip after receiving further instruction.

72. Dr. Tallerico concluded that Claimant had "right lower extremity dysfunction with subjective complaints that outweigh objective findings" and that Claimant demonstrated "functional overlay". JE-897. He was unable to explain Claimant's severe loss of function for the following reasons:

- Claimant's fracture was completely healed.
- He had no evidence of chronic or latent infection in the right leg.
- His electrodiagnostic studies are completely normal for any permanent nerve injury, though Claimant and his employer still seemed "fixated on that possibility." JE-899.
- He has some functional overlay with give-way weakness of the entire right lower extremity.

73. Dr. Tallerico opined Claimant was medically stable and recommended no further treatment. Along those lines, "Mr. Avalos has had exemplary medical care after this severe injury…[h]e has had some of the best specialists in the region and the most comprehensive work-up and treatment I have ever seen for this type of injury." JE-899. He recommended that Claimant cease taking opioid medications and, without further explanation, opined that a spinal cord stimulator and an intrathecal pain pump are both contraindicated.

74. Dr. Tallerico assessed Claimant's PPI at 11 percent of the right lower extremity based upon guidance from the *AMA Guides, Sixth Edition.*

75. Following review of a job site evaluation prepared by Chris Horton, ICRD consultant, Dr. Tallerico opined that there is no objective reason why Claimant cannot return to his time of injury job. However, he very much doubted that Claimant would. "I doubt he ever will do this job – no objective reason why though." JE-903.

76. Dr. Tallerico concurred in the subsequent opinion of Dr. Wilson, and deferred to Dr. Holt's opinions as to Claimant's neuropsychiatric status. Although Dr. Tallerico largely agreed with Mr. Hunsaker's FCE findings leading to a sedentary work recommendation, he opined that Claimant's functional limitations are purely subjective and, therefore, he would not restrict Claimant even to light duty. Similarly, he agreed that Mr. Homan's FCE and light-medium duty recommendation is "quite reasonable." JE-908. "I believe that no matter what type of Physical Capacities Evaluations/Functional Capacity Evaluations evaluation [*sic*] this individual undergoes the bottom line is that I can see no objective reason why he cannot return to the workforce in some form or fashion." JE-909.

77. **Dr. Holt (panel).** On June 13, 2012, Claimant underwent an IME at Surety's request by Eric F. Holt, M.D., psychiatrist, one member of a two-member panel. Dr. Holt graduated from medical school in 1962, then completed a residency in psychiatry, followed by, among other things, a fellowship in community and forensic psychiatric studies at the University of California in Berkley from 1967 through 1968. He is board certified by the American College of Forensic Examiners and the American College of Medical Examiners.

78. Prior to meeting Claimant, Dr. Holt reviewed and summarized Claimant's medical records. During the evaluation, Dr. Holt administered testing and then interviewed Claimant.[6] Dr. Holt's secretary read many of the test questions aloud to Claimant to facilitate testing. Joint Exhibits 684 through 718 comprise a transcription of a recording of the interview.[7]

[6] Dr. Holt administered the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), the Symptom Checklist 90-R, and the Hendler Screening Test for Chronic Pain Patients.

[7] Claimant's statement was not taken under oath. There are a number of transcription spelling and grammatical errors. The transcriber apparently reproduced the conversation phonetically, providing some insight into both the interview process and Claimant's ability to verbally communicate.

79. In his report, Dr. Holt noted that Claimant demonstrated no pain behaviors during the two hours they spent together. However, he agreed that Claimant had reason for tingly pain in his leg during their discussion:

> D: …Do you have numbness and tingling in your leg?
>
> J: Uh, I got numbness on my 5th and 4th toe.
>
> D: Uh uh.
>
> J: And I got tingling, lately very often on this part where I got my ole' scar and the around right here.
>
> D: Yeah, you would cause they cut, they have to cut through the nerves of the skin.
>
> J: Yeah, it's like … I didn't have that like a year ago. Now I do.

JE-704.

80. Claimant was cooperative, outgoing, expressive, and did not display any passive-aggressive behaviors. He reported constant 7-8/10 pain, worse with increased activity and very cold weather. He reported "tiredness" in his left leg. JE-717. He described his anxiety, depression, sleep and swelling problems. For example:

> D: Okay. You ever feel terrified? Scared?
>
> J: Mmm, I try to keep myself on you know on the line, but I get sick to be so lonely at times.
>
> D: Yeah. Okay. On sleep, how many hours do you get you think?
>
> J: Um, I guess I can say that I can possibly have a sleeping disorder.
>
> D: Why?
>
> J: Because, see I, I have a bunch of troubles staying asleep and uh, I can never go to sleep at one time. Never …

D: Do this, tell me how your day and night goes then. Do you nap, let's take the daytime first. … Uh, do you nap in the daytime?

J: See my daytime life is like I have to get up and try to take my meds.

D: Yeah.

J: First thing in the morning.

D: Yeah.

J: Before 8 o'clock. Between 7 and 8. And, and if I fall asleep I take a little nap between before noon.

D: Uh huh.

J: And after supper I try to nap again. And those naps have like no longer than an hour an hour and a half.

D: Uh uh.

J: At nighttime, like I was saying I haven problems stayin asleep and also fallin asleep.

D: So what time do you go to bed?

J: Well I always try to go to bed like no later than 10.

D: Uh huh.

J: But pretty much what I do is just rest my leg because as the day goes on and my leg gets bigger and bigger.

D: Swells, swells.

J: Yes. And I can only got out asleep in one position like on this position like I'm you know like that.

JE-705. They also discussed how Claimant sleeps with several pillows, one between his legs, on his right side, and how he must get up several times during the night to stretch and walk around because his leg aches from staying in one position. Sleep medication (Desipramine)

prescribed by Dr. Poulter gives him dry mouth so, apparently, he doesn't take it. He sleeps approximately six out of every 24 hours.

81. Claimant also reported headaches about twice per week for three to four hours at a time that he thought may be the result of his sleep problems. Dr. Holt raised the possibility that they are due to stress.

> J: Do you think that would make sense doctor, or do you think I go …
>
> D: It's possible, but other things can do it or like stress.
>
> J: I get stress, I have to admit it. I do stress out my limits. My limitation.
>
> D: Like a tension headache. And then you do some worrying, what do you worry about?
>
> J: Well, I'm definitely getting behind my bills and I worry about uh, I'm just hoping I can get back with my life. Worry about how I'm too young to sit.
>
> …
>
> D: … Uh, and then you're slowed down. You would like to do things, but you checked off that your [*sic*] slowed down.
>
> J: Right.
>
> D: Physically. You know [*sic*] have the drive, you want to get back with your life. Okay. …
>
> …
>
> D: Appetites [*sic*] okay. Uh, and then here's one you checked off. Feeling trapped or caught. And that's why?
>
> J: Uh, well there are some days that uh I know it's wrong to think like that but you know there are days that I almost feel like if I paying a sentence you know like a person when, never been in prison,
>
> D: Yeah.
>
> J: but I feel like Jesus man, this is like being in prison almost.

D: So limited.

J: Right.

D: Yeah, yeah. So restrictive. Yeah. And then blocked in getting things done. That makes you feel, you're lonely at times cause your [*sic*] not able to do what you used to be able to get out.

J: Right, and be so dependful on, on other people, you know.

D: Uh huh. And then worrying, and that's about, we talked about that, that's about money and bills and how are things going to be.

J: Exactly.

D: … Then this one was having to avoid some activities. And that would be like you don't want to fall, I'm guessing.

J: Yes, I don't want to fall.

D: So you have to be more careful.

J: Right.

D: And slow down. Okay. You don't have a fear of certain places, like I was telling you about people going to a …

J: No, I don't fear [inaudible] places.

D: Closed space …

J: I just fear like, uh, maybe getting in to anymore trouble.

D: Yeah.

J: By falling down.

JE-710-712.

82. By adjusting the way he does things, Claimant can keep up with the housework in his two-bedroom apartment. He gets help from a friend bringing his groceries in and putting them away, and taking out his trash.

83. Claimant and Dr. Holt discussed Claimant's medications, crutches, boot and the nerve stimulator he uses at least once per day. If his leg was entirely healed, Claimant said he would "absolutely" be more active and "Uh, LaVal he definitely got something for me to do I believe. If it was way better." JE-715. As to whether Claimant would return to work for Whitehead Farms or whether he would look for another type of job, Claimant expressed interest in both. He mentioned returning to farm work or, possibly, retraining for a truck driving job, if he gets better.

84. When Claimant left, Dr. Holt left his office and went to the window in the stairwell on the floor where his office is located to watch Claimant walk back to his hotel (wearing his boot and using crutches). He opined the distance was much greater than what Claimant had reported he could walk. On February 13, 2012, Dr. Holt wrote:

> This therapist states that Mr. Avalos is able to walk five minutes or approximately 115 feet consecutively before requiring rest and then would be able to walk for three minutes or 50 feet consecutively before requiring rest without his boot or crutches.
>
> I dictated my observations of viewing Mr. Avalos walking from my office at the Boise Medical Center over to the Rodeway Inn, which is approximately one block away. He did not rest during that time and ambulated at the same pace stepping over at least three curbs and probably one berm. When he walked he planted one down [*sic*] one foot after the other as he proceeded across the hospital parking lots. He did limp slightly to minimally and he did not appear to be putting his full weight on the crutches.

JE-682. It is unclear what foundational information Dr. Holt believes is inconsistent with his observation. During the interview, Claimant said he could walk down about two store aisles

when he goes shopping. If he has more shopping to do, he will get an electric cart they have available to drive in the store. At the hearing, Claimant testified that he does not know, for example, how long a football field is. Dr. Woods and Dr. Poulter opined that Claimant could probably walk in his boot and crutches for a block or more before having to stop and rest.

85. Claimant reported he was depressed and lonely because he could not work and was stuck indoors. "He misses his work and his abilities to use his leg without pain as he used to." JE-633. Dr. Holt's secretary read most of the MMPI-2 to Claimant after he reported difficulty reading some of the words. "Right after she starts him out - - and she noticed that he was slow. And some people who - - you know, they may not have gone through very much schooling, and in his case, he was slow in trying to figure out the wording in the tests." Holt Dep., p. 10. A word comprehension test, not in evidence, led Dr. Holt to opine that Claimant reads well at the fourth grade level. Dr. Holt did not test Claimant's sentence comprehension. He opined that the tests Claimant took are "built for people who have an education equivalent to probably - - they say, in any event - - about a seventh grade education to eighth grade education." JE-10; Holt Dep., p. 10.

86. Claimant's MMPI-2 results were invalid due to a response pattern suspicious for random answers, leading the computer scoring system to automatically recommend retesting, if possible. None was offered. In review with Claimant, a number of mistaken answers were identified. Acknowledging that the test results were invalid, Dr. Holt, nevertheless, believed he could draw some conclusions therefrom.

87. Dr. Holt concluded that Claimant does not have any psychiatric or personality disorders. He had a GAF score of 75 because he does have psychosocial/environmental

problems, including financial stress and economic-occupational problems. He specifically has no stressors from lack of housing, food, or transportation (even though he relied upon a hearing disabled neighbor to drive him to appointments, for a price), or from educational problems of illiteracy. Dr. Holt also noted Claimant has good social support from friends and family. He assessed a GAF score of 75, noting Claimant's despondency and feelings of being down which occur only occasionally, transiently and situationally. Dr. Holt added, "Also, it is my opinion that he is grossly exaggerating his pain symptoms to the point that it borders on malingering which he is doing purposefully for secondary gain." JE-636.

88. On December 28, 2012, Dr. Holt opined, in a four-plus-page letter to Surety, that Dr. Whitley's request to perform further psychological testing or treatment with Claimant should be denied.

> It would be a waste of time and of no value to obtain further testing on Mr. Avalos in my opinion. It is also my opinion that he would not be a candidate for supportive or insight oriented psychotherapy as this would be an attempt for him to further maximize his limitations and delay any rehabilitative efforts that would return him to the workplace. Unfortunately, he is dependent on opioid medications. He is taking one of the strongest available by prescription – Dilaudid. Those medications in my opinion are not indicated and have a distinct quality of diminishing motivation.

JE-672.

89. On February 13, 2013, after reviewing Dr. Whitley's report and the raw test scores underlying his opinions, Dr. Holt reaffirmed his own opinions regarding Claimant's psychological state. He noted that the Personality Assessment Inventory results were invalid, that the Survey of Pain Attitudes is useless for patients with secondary gain issues, that the Millon Behavioral Medicine Diagnostic and P-3 Pain Patient Profile results are not reliable for Claimant because there is no validity scale on those tests.

90. Also on that day, Dr. Holt reported his opinion of Claimant's case following review of the FCE report prepared by Mr. Hunsaker and the vocational rehabilitation notes of Kathy Gammon, vocational rehabilitation consultant.

91. **Dr. Wilson.** On June 14, 2012, Claimant underwent an IME at Surety's request by Richard W. Wilson, a neurologist, chairman of a two-member panel. Dr. Holt attended. Dr. Wilson graduated from medical school in 1969, then completed a residency in neurology, among other things. He then completed a fellowship in neuromuscular physiology and electromyography at the Mayo Clinic in Rochester, Minnesota, from 1976 through 1977. He is board certified in neurology and electrodiagnostic medicine. Dr. Wilson retired from private practice in September 2013, and now he only performs IMEs.

92. Dr. Wilson reviewed Claimant's medical records and interviewed him prior to his examination. He also reviewed a pain diagram completed by Claimant.

93. Claimant reported current symptoms, including: a burning, stabbing, constant pain, worst in the right lateral calf region underling his skin graft, and in his posterior calf; prominent dysesthesias in the right posterior calf, medial ankle and distal anterior lower leg, largely sparing his foot and toes; right knee pain that began in fall 2011 and occurs only rarely (Dr. Wilson noted this was not mentioned elsewhere in Claimant's medical records); weakness in leg strength below the knee (though proximal leg strength was normal on exam); incapacitating pain while weight-bearing without the boot; need to use crutches or a cane to ambulate; and swelling in his right leg that increases through the day and resolves during sleep. He reported no problems with the left leg, and 60%-70% improvement in his right leg with medications

(Methadone and Percocet). Among other things, Claimant cited an inability to drive a car as a barrier to employment.

94. On exam, Dr. Wilson noted, among other things:

- Claimant was pleasant and jovial.
- Claimant's industrial scarring on his right lateral thigh and right calf.
- Excellent right dorsalis pedis pulse.
- Inability to tolerate medial ankle pressure to assess the posterior tibial pulse.
- Equal skin color, temperature, turgor and hair growth pattern in both feet; however, there were skin color changes over his industrially scarred areas.
- Moderate hypalgesias/hypesthesias involving the fourth and fifth toes of his right foot.
- Ability to feel light touch, but not vibratory sensation.
- Ability to feel pressure without pain or temperature perception over the skin graft site.
- Complaint of "an intense dysesthetic sensation which is not reliably produced on repeat examination over the left distal lateral leg scar and anterior distal leg scar" and Claimant had "an intense adverse reaction with any more than just very light touch pressure somewhat diffusely over the right posterior calf. Squeezing the gastrocnemius soleus group even gently evokes a response indicating intense discomfort." JE-662.
- Reduced right ankle range of motion.
- Significant diffuse give-away weakness in right ankle and knee ranges of motion and, to a lesser degree, in hip/thigh.
- Left and right thighs each measured 52.5 cm in circumference, and calves each measured 39 cm.
- "When asked to ambulate barefooted, he does so using his crutches without weight-bearing. When ambulating with his walking boot, he appears to weight-bear normally on the right, and uses his crutches in a somewhat nonproductive fashion. He does limp favoring his right leg." JE-663.

95. On behalf of the panel, Dr. Wilson opined that Claimant's symptoms do not fit within a defined neurologic pattern or diagnostic condition and that Claimant "is exaggerating his current pain complaints and right leg weakness for secondary gain." JE-663. He elaborated that Claimant's muscle testing results were inconsistent with his demonstrated gait pattern and his use of a walking boot and crutches. Also, his symptoms did not support a CRPS diagnosis. The panel concurred in Dr. Tallerico's assessment of PPI of 11% of the right lower extremity, "realizing that this is awarded primarily for his subjective pain complaints," with no apportionment. *Id.*

96. The panel could not reliably assess Claimant's ability to return to work in "his previous employment as a construction laborer" due to his exaggerated pain complaints and functional findings on exam. "However, motivated, he could return to sedentary and light duty activities. These work restrictions should be reassessed in 12 months, as they may not be permanent." JE-663. The panel also recommended immediate tapering and eventual discontinuation of opioid pain medications. No additional treatment was recommended, and, without elaboration, "a spinal cord stimulator or intrathecal pain pump would be contraindicated." *Id.*

97. Dr. Wilson explained at his deposition that a spinal cord stimulator is contraindicated for patients like Claimant for two reasons:

> Well, first of all, I don't have a defined neurological problem for which you're treating him. Secondly, they have a personality structure which they are amplifying for secondary gain. Meaning, an aggregate that he's either not motivated to get better as a primary issue, or that he has some psychological, educational misconceptions of the disease process, the injury he had, and he feels as though he's still - - the leg is still broke and his leg should still hurt, that you're not going to change that with anything you do.

Wilson Dep., p. 38.

98. On November 5, 2012, after reviewing the August 23, 2012 request from Mr. Horton that Surety authorize hand controls for Claimant's car, Dr. Wilson opined that these were not medically necessary. He based his opinion on Claimant's "subjective complaints of leg pain and paresthesias and physical examination which reveals predominantly nonanatomic, nonphysiologic findings." JE-666. Also, he posited that Claimant could drive with his left leg, if he needed to. Claimant explained at the hearing that he does not feel safe to drive with the boot because he cannot feel the pedal. He also believes his medications interfere with his driving ability. As for driving without his boot, Claimant said he would like to think it could work, but – like exercising at home – he doesn't think it will. It is hard to discern from Claimant's response whether he has tried driving without the boot or not.[8] In any event, he had to sell his car.

VOCATIONAL REHABILITATION

99. **Chris Horton.** Mr. Horton, ICRD consultant, testified that Claimant always said he wanted to work, but transportation was a barrier, since he could not drive with his right leg condition, wearing his boot. Mr. Horton's assistance in trying to obtain Surety's approval for hand controls was unsuccessful. Ultimately, Claimant's ICRD file was closed because Mr. Horton had nothing vocationally to offer until Claimant could at least drive.

DISCUSSION AND FURTHER FINDINGS

The provisions of the 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

[8] "I can't. You know, it is something like exercising myself at home - - trying it with something and it something I just really can't - - it would be nice to do it, but - - because I'm sure I would take a smart part of my life back. I might have a life then." Tr., p. 192.

(1990). The humane purposes which it serves leave no room for narrow, technical construction. *Ogden v. Thompson*, 128 Idaho 87, 88, 910 P.2d 759, 760 (1996). However, the Commission is not required to construe facts 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).

CREDIBILITY

100. **Physicians.** All of the opining physicians are qualified to render an expert opinion and, notwithstanding the rather bitter arguments posed by each party regarding the lack of objectivity of the expert witnesses supporting the other party's position, there is insufficient evidence to establish that any of these physicians based any opinion in this case on principles unrelated to Claimant's condition. This is not to say that all of the opinions merit equal weight, however. Dr. Poulter has advantages over the other physicians that render his opinions most persuasive. Unlike the IME physicians and many of Claimant's treating physicians, as well, Dr. Poulter has the distinct advantage of treating Claimant over more than three years. Given Claimant's communication barriers, this is an especially important factor in this case. Dr. Woods also treated Claimant over three years, and his opinion also carries heightened weight. Importantly, Drs. Poulter and Woods have a clear understanding of Claimant's relevant medical course, having directed his care.

101. **Claimant.** Claimant's credibility is hotly contested. His treating physicians since the day of his industrial fall, Drs. Woods and Poulter, find him credible, with no evidence of exaggeration or malingering. However, all three independent medical evaluators concluded that Claimant is exaggerating, malingering, and/or motivated by secondary gain factors. For the reasons discussed, below, the Referee finds the opinions of Drs. Poulter and Woods regarding

Claimant's credibility most assistive in assessing Claimant's credibility. The evidence of record and Claimant's presentation at the hearing establish he is a credible witness, both observationally and substantively.

102. Given Claimant's limited reading and verbal comprehension ability, Drs. Poulter and Woods, who have interacted with Claimant since the date of his industrial accident, are in a better position to gauge the credibility of Claimant's reports. As mentioned and demonstrated, above, Claimant faces communication barriers. He is a non-native English speaker with a limited ability to understand what he reads and hears in English. Because he reads relatively well, his comprehension difficulties are not necessarily obvious.

103. Drs. Poulter and Woods are in a better position than any other physician to assess the meaning to be given to Claimant's reports, which cannot always be taken at a native English speaker's face value. They both find Claimant credible. Also, there is evidence in the record suggesting that Claimant may not have understood directions or questions posed by Drs. Tallerico and Holt during their respective evaluations.

104. Psychological expert opinions do not establish that Claimant is not credible. Drs. Holt and Whitley both administered testing which produced invalid results on the tests featuring validity scales. Nevertheless, they each offered opinions regarding Claimant's psychological status which, confoundingly, contradict each other. The psychological expert opinions fail to establish that Claimant is not a credible witness.

105. Claimant's apparent over-rating of his pain based on the Visual Analog Scale does not establish he is exaggerating, and is less compelling than Dr. Poulter's interpretation over time of his functionality, in determining Claimant's pain level. Defendants argue that

Claimant's behavior is not consistent with the behavior of someone with pain rated at 7/10 or 8/10 on the VAS, or thereabouts, as Claimant consistently reports. Therefore, he is exaggerating his pain. Given Claimant's consistent presentation to his care providers – as well as the IME examiners – it is more likely that as per Dr. Poulter, he simply labels his pain inaccurately in terms of a true VAS scale. This likelihood is best demonstrated by Claimant's report of 10/10 pain after receiving morphine and Dilaudid in the emergency room soon after his industrial fall. Claimant's pain was at least partially subdued, so he was able to conceive of worse pain than he was experiencing when he reported 10/10. Yet, there was no reason for him to intentionally exaggerate his symptoms at that time. So, while Claimant's idea of 10/10 pain maybe more inclusive than envisioned by the VAS, it cannot be concluded that he is trying to manipulate his care with his reports.

106. While physicians are very aware of definitions given to each pain level, laypeople are not. Dr. Poulter elaborated on why he thinks talking with the patient to determine what they can actually do is more assistive than relying upon a VAS number:

> Q. (By Mr. Hall) The VAS scale…talks about pain between seven and nine being individuals who are in such terrific pain that they really can't function in their activities of daily living; is that correct?
>
> A. Yes.
>
> Q. And patients at that level, would you expect that they can live alone, make their own meals, take care of themselves, regimen their medications, those sorts of things?
>
> A. We - - I guess I come - - I look at the visual analog scale - - it's difficult to - -- a little bit differently. It's difficult to compare your seven to my seven to your seven to Jorge's seven. Oftentimes when I'm seeing someone, I really don't even pay attention to that number because it's really meaningless.

> What we try to look at is function, what are they able to accomplish during the day. Because we have - - I have people that are working, carrying full-time jobs, who drive their cars, who come to see me and rate their pain as a 15 out of 10 every time I see them. The number means nothing. What means - - what's important to me is that they're working. They're driving a car. They seem awake and alert when I see them. They don't seem to be in distress. Those are the more indicative things to me.
>
> So just because someone tells me they have a number of seven or a nine out of ten, I guess I would kind of maybe trend that over time as we try things to see if that number changes, but it wouldn't really reflect their functional ability to me.
>
> Q. If it's nonmeaningful, as a physician, why do you record it in your record?
>
> A. It's just traditional, something that everybody does. It's - - you know, we record it, but it's - - I typically don't look at the record and say, oh, Jorge's a nine today. I say, oh, Jorge is here, let me go talk to him. Jorge, how are you. What were you able to do this week. How is your pain doing. Whether it's a nine one week or a seven the next week, it's not a number that I - - I personally don't track it very closely.

Poulter Dep., pp. 50-52.

107. Dr. Poulter opined that Claimant's ability to function is significantly limited by pain even though Claimant may not actually be experiencing pain strictly consistent with his VAS reports. His opinion is persuasive.

108. Claimant is consistent in showing up for his medical appointments and following his physician's orders. Defendants posit that if Claimant were in as much pain as he claims, preventing him from driving, he would not have been able to make it to all of his 100-plus medical appointments. Moreover, if he can go for treatment, he can work in, at least, a sedentary position. However, Claimant persuasively testified that he pays a disabled neighbor gas money to take him to his appointments; otherwise, he has no transportation since he cannot drive because of his right leg condition.

109. Also, Dr. Poulter opined, "Jorge seems to have the type of personality that if I recommended he do something, he would do it. He seemed to be very invested in trying to get better. And I would interpret his compliance with that in an attempt to make sure that he was doing everything that the doctors asked him to do because he wanted to get better." Poulter Dep., p. 50. In addition, the record bears insufficient evidence to evaluate Claimant's effort and attendance at medical appointments against a hypothetical sedentary job.

110. Even Dr. Wilson finds this line of reasoning spurious. "I'm not sure that would prevent him from going to the doctor, the pain level. I mean, you could argue that because he was hurting so much, that he wanted to go in hopes of getting relief. So I don't think that one way or another that says much." Wilson Dep., p. 40. Neither does the Referee.

111. Claimant's use of boot and crutches does not establish he is exaggerating his pain. Early on, Dr. Woods recommended that Claimant cease wearing his boot to promote better ankle function, but Claimant did not do so. He tried; however, his pain increased without the boot, so he kept wearing it. Dr. Woods drew no significant conclusions affecting Claimant's motives or credibility based on his decision to keep wearing the boot. In fact, he continued to write prescriptions for new boots as the old ones wore out.

112. Dr. Poulter explained that it is not uncommon for a chronic pain patient to wear a protective device on an affected limb. Also, Claimant's use of such a device is not necessarily inconsistent with his allodynia.

113. The Referee draws no unfavorable inferences regarding Claimant's credibility from the fact that he continues to wear the boot or, for that matter, that he uses crutches or a cane.

114. Claimant's consistent presentation as cooperative and motivated to improve, his reluctance to put weight on his right foot, and his frustration at the pain and restrictions he faces due to his right leg injury, outweigh his lack of other overt pain behaviors. Sometimes, claimants are accused of exaggerating their pain behaviors by over-acting. Here, Claimant's *non*demonstrative behavior has raised red flags for the independent medical evaluators, especially Dr. Holt. He posits that Claimant would have demonstrated *some* pain behavior during their two-hour discussion if he were in significant constant pain, as he claims; yet, he did not. As well, Claimant's presentation at the hearing revealed a cooperative, seemingly comfortable man, with the exception of the apparent discomfort of ambulating with a boot and crutches. Even as he rested his leg in an elevated position part of the time, Claimant did not appear to the Referee to be in pain.

115. Pain, especially chronic pain, is a subjective experience to which individuals react differently. Again, Drs. Poulter and Woods are in the best position to opine on this topic, having seen Claimant's demeanor over time. "Jorge is usually pretty even-keel when we see him. He's fairly relaxed. He doesn't seem distressed when we're talking to him….he doesn't really ever have the appearance of distress…" Poulter Dep., p. 64. Yet, neither Dr. Poulter nor Dr. Woods has significant concerns over Claimant's alleged lack of pain behaviors after interacting with him over several years. Their opinions are persuasive in this regard. Also, no witness disputes that Claimant guards his leg and is reluctant to put weight on his right foot. He has not been seen placing full weight on his right foot, notwithstanding Dr. Holt's and Dr. Wilson's criticisms of his crutch skills, and he has obtained replacements or replacement parts for worn out boots and crutches over the years, indicating that he consistently uses them.

116. The totality of evidence indicates Claimant is more motivated to return to work than to remain disabled. Although the IME physicians have opined Claimant is motivated by secondary gain, they have not persuaded the Referee that Claimant would not return to work immediately if he could. Claimant is not receiving benefits, and he is stressed about his inability to work and earn. Along those lines, he had to sell his car. In addition, Claimant first and foremost seeks further treatment, rather than a disability award, and he looks forward either to returning to Whitehead Farms or retraining as a truck driver, if and when he can. He does not like being restricted or dependent.

117. Dr. Wilson raised the possibility that Claimant may have a misunderstanding about his condition, leading him to unconsciously believe he is more disabled than he is. The record contains evidence consistent with this concern. Drs. Poulter and Hill have each recommended counseling to help Claimant cope with his condition. Dr. Wilson's concerns could be addressed in a counseling situation. They do not establish that Claimant is not credible or that he is intentionally avoiding returning to work.

118. Claimant's persistent swelling and nodules evidence that he is experiencing unforeseen sequelae from his industrial accident. Notwithstanding IME opinions to the contrary, the record establishes that Claimant's swelling, without apparent objectively identified source, and his nodules attributed to poor drainage, are quite real. Drs. Poulter and Woods persuasively attribute them to the compartment syndrome Claimant contracted following his industrial accident. These objective symptoms are consistent with Dr. Poulter's opinion that Claimant suffered tissue injuries that cannot be identified through the testing Claimant has undergone.

119. Along these lines, Dr. Poulter and Dr. Garrison both opined that Claimant has likely suffered damage to microsystems not identifiable through objective testing.

120. Give-away weakness detected by Drs. Wilson and Tallerico does not establish Claimant is not credible. Dr. Wilson and Dr. Tallerico both noted "give-away" weakness, in which Claimant did not exert maximal effort on strength testing while also failing to evidence any sign that he was in pain. "[I]f they just give away and don't give away acknowledging that they're giving away because it's painful but they're giving away because it's "weak," then you know that it's true give-away weakness, not pain determined, and that's what we call overlay." Wilson Dep., p. 27. Neither Dr. Poulter nor Dr. Woods reported concerns about give-away weakness. Claimant's demonstration of give-away weakness at IMEs is insufficient to raise a credibility concern not previously raised by Drs. Woods and Poulter.

121. Defendants raise other specific facts in support of their assertion that Claimant is not a credible witness. These facts are not persuasive when viewed along with the balance of evidence in the record.

122. Claimant is a credible witness, though his communication barriers present challenges to conveying and receiving information to/from him.

MEDICAL CARE/MEDICAL STABILITY

123. Claimant carries the burden of proving, to a reasonable degree of medical probability, that the injury for which benefits are claimed is causally related to an accident arising out of and in the course of employment. *Wichterman v. J.H. Kelly, Inc.,* 144 Idaho 138, 158 P.3d 301 (2007). It is clear that in order to recover medical benefits, the injured worker must prove both that the need for medical care is causally related to the accident and that the medical

care is "reasonable." See *Henderson v. McCain Foods, Inc.,* 142 Idaho 559, 130 P.3d 1097 (2006).

124. Idaho Code § 72-432(1) obligates an employer to provide an injured employee reasonable medical care as may be required by her physician immediately following an injury and for a reasonable time thereafter. It is for the physician, not the Commission, to decide whether the treatment is required. The only review the Commission is entitled to make is whether the treatment is reasonable. *See, Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989).

125. Under the facts presented in *Sprague*, medical treatment already received was deemed reasonable when: 1) the claimant made gradual improvement from the treatment; 2) the treatment was required by the claimant's physician; and 3) the treatment was within the physician's standard of practice, the charges for which were fair, reasonable, and similar to charges in the same profession. *Id.* The Court has announced no similar standard for prospective medical treatment; thus, *Sprague* provides some guidance but the reasonableness of prospective care must be based on consideration of other factors. *Ferguson v. CDA Computune*, 2010 IIC 0015 (February 25, 2011); *Richan v. Arlo G. Lott Trucking, Inc.*, 2001 IIC 0008 (February 7, 2011); *Dalton v. Lincoln County*, 2013 IIC 0069 (October 18, 2013).

126. 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). "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). Magic words are not necessary to show a doctor's opinion was held

to a reasonable degree of medical probability; only their plain and unequivocal testimony conveying a conviction that events are causally related. *See, Jensen v. City of Pocatello*, 135 Idaho 406, 412-13, 18 P.3d 211, 217 (2001). Although these rulings are related to determinations of industrial cause, it is also appropriate to accept a physician's plain and unequivocal testimony that recommended treatment is reasonable.

127. As explained above, the Referee finds the opinions of Claimant's treating physicians most persuasive.

128. Claimant has proven that further treatment for his right lower extremity pain, including but not limited to a spinal cord stimulator trial and counseling to assist with chronic pain management, is reasonable.

129. **Maximum medical improvement (MMI).** Dr. Poulter posits that Claimant's condition may significantly improve with treatment. If so, his disability is likely to decrease. Defendants cite the *AMA Guides, Sixth Edition* to define MMI. That tome states at pages 25 and 26, "[MMI] refers to a status where patients are as good as they are going to be from the medical and surgical treatment available to them…MMI represents a point in time in the recovery process after an injury when further formal medical or surgical intervention cannot be expected to improve the underlying impairment."

130. Claimant cannot be deemed at MMI until he receives the reasonable medical treatment recommended by Dr. Poulter. At present, he is not medically stable.

TEMPORARY TOTAL DISABILITY/AVERAGE WEEKLY WAGE

131. Idaho Code § 72-408 provides that income benefits for total and partial disability are paid to disabled employees "during the period of recovery." The burden is on a claimant to

present expert medical opinion 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, 763, 605 P.2d 939, 941 (1980). Once a claimant establishes by medical evidence that he or she is still within the period of recovery from the original industrial accident, an injured worker is entitled to temporary disability benefits unless and until such evidence is presented that the worker has been released for light duty work *and* that (1) the former employer has made a reasonable and legitimate offer of employment to the worker who is capable of performing such a job under the terms of a light work release and which employment is likely to continue throughout the period of recovery *or* that (2) there is employment available in the general labor market which claimant has a reasonable opportunity of securing and which employment is consistent with the terms of a light duty work release. *Malueg v. Pierson Enterprises*, 111 Idaho 789, 791-92, 727 P.2d 1217, 1219-20 (1986).

132. **TTD.** Claimant was determined, above, to be in a period of recovery and not medically stable. He has not been released to work, and he is awaiting further reasonable medical treatment.

133. Claimant is entitled to TTD benefits from August 23, 2010 until such time as he is released to work and Whitehead Farms offers him a reasonable and legitimate position or, in the alternative, reasonable work is available to him in the general labor market. Defendants are entitled to credit for benefits already paid through early 2012.

134. **Average weekly wage.** Only Defendants addressed the issue of AWW, asserting that they had paid TTD benefits through the time of denial based on a wage of $10 per hour and

a 35-hour workweek. Claimant's testimony affirms the accuracy of these figures. Claimant's average weekly wage is appropriately calculated thereon.

135. All other issues are reserved.

CONCLUSIONS OF LAW

1. Claimant has proven that he is entitled to additional reasonable medical care related to his August 23, 2010 industrial lower right extremity injury, including but not limited to a spinal cord stimulator trial and pain management counseling, as recommended by Dr. Poulter.

2. Claimant is not presently medically stable.

3. Claimant is entitled to TTD payments from August 23, 2010 until such time that he becomes medically stable and Whitehead Farms offers him suitable employment or, in the alternative, employment in the general labor market is available to Claimant, with credit to Defendants for TTD benefits already paid.

4. Claimant's average weekly wage shall be calculated based upon an hourly wage of $10 and a workweek of 35 hours.

5. Claimant waived the issue of attorney fees pursuant to Idaho Code § 72-804.

6. All other issues are reserved.

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RECOMMENDATION

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

DATED this 28th day of March, 2014.

INDUSTRIAL COMMISSION

/s/
LaDawn Marsters, Referee

ATTEST:

/s/
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 6th day of May, 2014, 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:

JONATHAN W HARRIS
BAKER & HARRIS
266 W BRIDGE
BLACKFOOT ID 83221

SCOTT R HALL
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sjw /s/

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

JORGE AVALOS, Claimant, v. LAVAL WHITEHEAD, Employer, and STATE INSURANCE FUND, Surety, Defendants.	**IC 2010-021068** **ORDER** May 6, 2014

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

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

1. Claimant has proven that he is entitled to additional reasonable medical care related to his August 23, 2010 industrial lower right extremity injury, including but not limited to a spinal cord stimulator trial and pain management counseling, as recommended by Dr. Poulter.

2. Claimant is not presently medically stable.

3. Claimant is entitled to TTD payments from August 23, 2010 until such time that he becomes medically stable and Whitehead Farms offers him suitable employment or, in the alternative, employment in the general labor market is available to Claimant, with credit to Defendants for TTD benefits already paid.

4. Claimant's average weekly wage shall be calculated based upon an hourly wage of $10 and a workweek of 35 hours.

5. Claimant waived the issue of attorney fees pursuant to Idaho Code § 72-804.

6. All other issues are reserved.

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

DATED this __6th____ day of ____May_____, 2014.

INDUSTRIAL COMMISSION

__/s/_____
Thomas P. Baskin, Chairman

__/s/_____
R.D. Maynard, Commissioner

__/s/_____
Thomas E. Limbaugh, Commissioner

ATTEST:

__/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 6th day of May, 2014, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

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/s/