BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

LARRY HERRERA, Claimant, v. STATE OF IDAHO, INDUSTRIAL SPECIAL INDEMNITY FUND, Defendant.	**IC 2016-004230** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **FILED August 12, 2022**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Industrial Commission assigned this matter to Referee Douglas A. Donohue who conducted a hearing in Idaho Falls on May 20, 2021. Andrew Adams represented Claimant. Paul Augustine represented ISIF. The parties presented oral and documentary evidence. Post-hearing depositions were taken. Claimant and ISIF submitted briefs. The case came under advisement on March 10, 2022. This matter is now ready for decision.

ISSUES

The issues to be decided according to the Notice of Hearing are:

1. Whether Claimant is totally and permanently disabled or qualifies as such under the odd-lot doctrine;

2. Whether ISIF is liable under Idaho Code § 72-332; and

3. Apportionment to establish ISIF's share of liability under *Carey v. Clearwater County Road Dept.*, 107 Idaho 109, 686 P.2d 54 (1984).

CONTENTIONS OF THE PARTIES

Claimant contends he is totally and permanently disabled both 100% and as an odd-lot worker. Claimant suffered a compensable ankle injury in 2015 which required an Achilles tendon repair in 2016. This combined with lumbar injuries in 2002 and 2008 as well as longstanding

diabetes to cause total permanent disability. Diabetes resulted in amputation of his right great toe. Claimant's diabetes was a subjective hindrance before the industrial accident. He told a doctor that he forgot to take insulin because he worked long hours. On two occasions he suffered incidences of low blood sugar at work and needed something to bring it back up. Claimant meets the requirements for ISIF liability. A subsequent stroke in August 2017 has further harmed him, but Claimant was totally and permanently disabled before the stroke occurred.

ISIF admits Claimant is an odd-lot worker but that neither the hindrance nor combining elements required for ISIF liability have been established. Claimant's disability from his feet is entirely related to his preexisting diabetes. No physician has imposed restrictions as a result of Claimant's industrial accident; his nonindustrial foot condition arose before he reached MMI from the ankle repair surgery. Diabetes, substance abuse, and a post-accident stroke cause his total and permanent disability. The accident and his pre-existing condition do not combine to cause it. Claimant's current condition in his feet arose as a progression of his diabetes. It began five months after surgery to repair the Achilles tendon had corrected any injury from the industrial accident. The accident did not exacerbate, aggravate, or accelerate the diabetes which caused the foot issues. Before the industrial accident Claimant's diabetes did not hinder his employment. It cannot qualify as a pre-existing condition for purposes of ISIF liability.

EVIDENCE CONSIDERED

The record in the instant case included the following:

1. Oral testimony at hearing of Claimant;

2. Joint exhibits ("JE") 1 through 58 admitted at hearing;

3. Joint exhibits ("JE") 59 and 60, as well as additional documents to be included in exhibits 6 and 54; and

4. Post-hearing depositions of Rodde Cox, M.D. and of vocational expert Kent Granat.

The record was held open for purposes of receiving the additions to exhibits 6 and 54 and new exhibits 59 and 60. These additional documents are ADMITTED into the record.

The Referee submitted a proposed findings of fact and conclusions of law for the approval of the Commission. The undersigned Commissioners have reviewed the proposed and, although we agree with the Referee's ultimate conclusion, conclude that additional analysis of the elements of ISIF liability are warranted. Accordingly, the Commission declines to adopt the proposed decision and issues these findings of fact, conclusions of law, and order.

FINDINGS OF FACT

Introduction and Accident

1. On or about Friday, October 2, 2015 Claimant suffered a partial tear of his right Achilles tendon with an ankle sprain. JE 30:12; JE 42:18. He worked for Walters Ready Mix (aka "Valley Ready-Mix").

2. The accident was unwitnessed. Claimant Depo. 50:21-52:4.[1] Claimant testified that he rolled his ankle stepping off of a curb. Tr. 24:11-21. Claimant's wife found him on the ground when she arrived at the end of his shift. Claimant Depo. 51:17-20. He had also struck his head and was disoriented. Tr. 24:14-19.

3. Claimant reported the accident and sought medical treatment on Monday morning. JE 42:18; Claimant Depo. 51:23-25. He tried to provide notice of his injury on Friday evening but could not make contact with any agent of his employer. Claimant Depo. 51:23-52:11.

4. Claimant continued working for Valley Ready-Mix on light duty until that could

[1] Claimant's Deposition, conducted on Feb. 19, 2020, is included in the record as JE 56.

not be accommodated. JE 42:22; Claimant Depo. 52:17-53:7. He returned to work again about December 15, 2015. JE 42:26. He worked until December 18 when he rear-ended another vehicle and was fired. Claimant Depo. 53:14-54:22.

5. He worked for Knife River for a number of months beginning January 2016. Claimant Depo. 55:1-20; Tr. 59:10-17. He stopped working there shortly before his August 2016 Achilles tendon repair surgery.

General Background Facts

6. Claimant has worked as a truck driver for most of his adult life. Claimant Depo. 9:9-10:12, 15:13-20:14.

7. Claimant has sought medical treatment for complaints of low back pain and radiculopathy at least since 1989. JE 5:2.

8. Since about 2002 he has been aware that he has diabetes. JE 9:62-63. It has not been well controlled and at times has included diabetic ketoacidosis. *See* JE 24; Tr. 33:1-7. As of the date of hearing, he takes insulin once daily but has a history of inconsistent compliance. Tr. 47:4-8; JE 24.

9. Claimant injured his left hip and back about March 27, 2002 moving furniture. Tr. 16:3-17:7; JE 9:2-21; JE 18.

10. In 2008 Claimant injured his back in a truck accident. The rig went over a cliff. Tr. 20:10-21:19; JE 25.

11. Claimant has sought medical treatment for chronic low back pain and radiculopathy since that accident. JE 39.

12. The October 2015 work accident required surgery, an Achilles tendon repair, which

was performed on August 10, 2016. JE 49:2.

13. Claimant suffered a stroke about August 8, 2017. JE 6:159-161. He has suffered seizures since. JE 6:420-428. Dementia has been diagnosed as well. JE 59. It affects Claimant's mood, behavior, and memory. JE 59; JE 38:3-7.

14. Claimant's feet developed both claw toe and hammertoe. JE 52. Surgery to correct the hammertoe made things worse. JE 51. Claimant's right big toe was amputated in June 2019. JE 51:21-22.

15. At hearing, Claimant testified that he began using methamphetamine and other illegal substances after his 2017 stroke. Tr. 42:11-43:17. Claimant admitted to illegal substance abuse as recently as one or two months prior to the hearing. Tr. 43:24-44:5.

16. Claimant testified that he believes he could have driven concrete truck as recently as one month before his stroke. Tr. 45:18-46:7.

Medical Care

17. Medical benefits are not at issue. All medical records in evidence were reviewed and considered. Not all medical records were deemed helpful in determining permanent impairment and/or restrictions arising from pre-existing conditions, from the subject accident, or from post-accident conditions. Nevertheless, some medical records are included in these findings of fact which provide illustrative indicia of Claimant's perceptions of his ability to function at various points in time.

18. On Claimant's first visit for medical care after the accident an X-ray showed osteophytes at the insertion of the Achilles tendon. JE 41:4-5. Ultrasound showed soft tissue swelling was present. JE 41:5. A right ankle sprain was diagnosed. JE 42:17-18.

19. Most follow-up care was unremarkable for any issue relating to ISIF liability.

20. On March 12, 2016 Claimant complained of a headache. JE 6:125. He reported he fell. *Id.* He reported he had failed to take his insulin and anti-hypertension medication. JE 6:140. CT scans of Claimant's head showed no acute injury after complaints of memory loss, light sensitivity, and headache. JE 6:141. A chest X-ray for shortness of breath showed indicia of mild congestive heart failure. JE 6:133. Blood glucose was 463. JE 6:131. He was admitted and stayed two days for evaluation. Right ankle pain was added to the list of complaints. JE 6:140. Examination revealed some ankle edema. JE 6 at p. 141. Upon discharge, physicians believed the headache was due, in part, to caffeine withdrawal and to noncompliance with his medication regimen. *Id.*

21. On March 24, 2016 Casey Huntsman, M.D. examined Claimant's ankle, diagnosed a partial Achilles tear and sprain, and sent him back to work with an ankle brace. JE 44:2-5. He ordered an MRI which, in a follow-up visit, was reported to show a partial tear, incompletely healed. JE 44:6-9. Dr. Huntsman's diagnosis on follow-up added right foot RSD. JE 44:8.

22. On May 2, 2016 Dr. Huntsman responded to written questions from the Surety for Claimant's Employer. JE 44:10. He opined Claimant's right ankle condition was related to the October 2, 2015 accident and that Claimant was not yet medically stable. *Id.*

23. On May 19, 2016 Jason Poston, M.D. examined Claimant. JE 45:2-6. He emphasized to Claimant the risks of using opioids and benzodiazepines together. JE 45:5. As of May 26, 2016 Claimant began endorsing the complete list of symptoms associated with RSD or CRPS in his lower leg. JE 45:7-10. Dr. Poston observed the objective symptoms of this condition. JE 45:11-30.

24. On August 9, 2016 Dr. Huntsman decided on and scheduled surgery for the

following day. JE 44:11-14. The Achilles tendon repair included removal of scar tissue which had only partially healed the tears. JE 49:2.

25. On October 4, 2016 Claimant reported to Dr. Huntsman that while his ankle pain was significantly reduced, walking without an appliance was painful and that his big toe was swollen and infected. JE 44:15. Upon examination Dr. Huntsman found the surgical site well healed without infection. JE 44 at pp. 15-16. He did not note any observations about Claimant's big toe. *Id.*

26. From November 7, 2016 through April 6, 2017 Claimant underwent significant physical therapy. JE 32:104-188. After imperfect compliance he was discharged when he plateaued. JE 32:182-188.

27. On March 2, 2017 Dr. Huntsman first addressed Claimant's report of intermittent big toe pain and swelling. JE 44:20-21. He noted Claw toe deformities of 1st and 3rd toes with tenderness. JE 44:21. On multiple follow-up visits thereafter, Dr. Huntsman note Claimant's claw toes, but did not opine about causation of the claw toes. *See* JE 44:22-27.

28. A February 20, 2017 right ankle MRI showed the surgical changes but was otherwise negative. JE 44:21. An April 25 repeat MRI confirmed. JE 50:4-5.

29. On April 16, 2017 the physician at Mountain View Redicare released Claimant to return to work without restrictions. JE 42:40.

30. As discussed *infra*, Claimant was first seen by Timothy Black, D.P.M. on April 17, 2017. JE 50:2.

31. On August 7, 2017 Claimant sought medical attention for sudden confusion and unsteady gait. JE 6:159-161. These symptoms cleared in about four hours. *Id.* He reported that his

blood glucose was 541. *Id.* A brain MRI revealed evidence suggestive of an "embolic shower" or stroke. JE 6:171. A CT scan of Claimant's head was unrevealing. JE 6:159. Hospitalization followed. Examination showed "trace" edema in the extremities. JE 6:160. Two days later an ultrasound showed no deep venous thrombosis in his right leg. JE 6:177. With treatment his blood glucose dropped to 206. *Id.*

32. On October 16, 2017 orthopedist Eugene Toomey, M.D. reviewed records and examined Claimant for forensic purposes at the request of Surety for Employer. JE 52. He opined Claimant's torn Achilles and ankle sprain was caused by the work accident. JE 52:11. Diabetes was not affected by the work accident. *Id.* Dr. Toomey equivocally opined that gout was a factor in Claimant's right big toe condition and therefore not work related. *Id.* He noted some, but not all, symptoms of CRPS in Claimant's chronic foot pain and opined that the diagnosis was inappropriate. JE 52:11. No condition was caused or affected by the work accident except for the Achilles tear and ankle sprain. *See* JE 52:11-15. He opined that Claimant's condition was at MMI with 5% lower extremity PPI equating to 2% whole person. JE 52:14-15.

33. On November 10, 2018 jail personnel brought Claimant to EIRMC emergency for a complaint of chest pain. JE 6:358. Examination and electrodiagnostic testing revealed that his blood glucose was low at 54 and that a few new white spots showed up in his brain, but nothing provided significant indicia relating to his complaint of chest pain. JE 6:361-362. He also began to complain of intense headache. JE 6:364. At discharge the episode was termed "hypertensive urgency." JE 6:368.

34. On April 5, 2019 surgery to correct hammertoe left Claimant with an open wound which did not heal normally. JE 51:8-15. Within 30 days oral antibiotics were prescribed to get

ahead of a growing infection. *Id.* By May 20 IV antibiotics became necessary. JE 51:16-17.

35. Beginning May 22, 2019 Claimant received outpatient wound care of chronic ulcerations of his right foot. JE 49:30. Dr. Black tentatively opined that the ulcerations were "thought to be related to Diabetes." *Id.* Other physicians—D.O. and M.D.—accepted this language in subsequent notes during wound care. *See* JE 49:39-75. Dr. Black contemplated prolonged medical care and possible amputation for this chronic ulceration condition. JE 49:32-33. Necrosis of the big toe bone was found to be present. *Id.*

36. On May 29, 2019 an MRI of Claimant's right foot showed extensive osteomyelitis and septic arthritis, a draining sinus tract in the big toe with diffuse cellulitis, and a partial tendon tear of the third toe. JE 49:60-61.

37. On June 18, 2019 Claimant's big toe was amputated. JE 49:124-125. Complications followed requiring additional procedures to the stump. JE 49:128-143. These were termed "Amputation of limb(s) as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure." JE 49:129.

38. Claimant visited Eastern Idaho Regional Medical Center (EIRMC) emergency on July 24, 2019 by ambulance after passing out in his vehicle. JE 6:420. He reported the occurrence of seizures of increasing frequency. *Id.* One physician termed them "cryptogenic." JE 6:258. EEG was negative. JE 6:247. His blood sugars were very high, but his A1c was moderately high at 7.8. JE 6:435. With treatment including insulin, his blood glucose was brought down to the 125 range, but a hypoglycemic episode of 62 occurred. JE 6:262. Narcotic dependence (Norco) relating to chronic right foot pain was identified among the discharge diagnoses. JE 6:427.

39. On July 25, 2019 another brain MRI without contrast was negative after Claimant's

complaint of a seizure. JE 5:20. With contrast material added, however, Claimant's brain looked similar to one with multiple sclerosis. JE 5:21. Other diagnostic imaging was negative. JE 5:20-25.

40. On October 28, 2019 Reed Ward, D.O. noted dementia and memory problems, and in follow-up he attributed Claimant's anger and behavior issues to these problems. JE 59.

41. On November 7, 2019 an MRI of Claimant's left shoulder showed a partial rotator cuff tear with bursitis and degenerative disease at the AC joint. JE 59:15. Dr. Ward diagnosed arthritis. JE 59:16.

42. Claimant returned to EIRMC emergency on January 15, 2020 with another episode of left-sided weakness, slurred speech, and a headache which physicians noted may have been related to another seizure, albeit an unwitnessed one. JE 6:320-331. Diagnostic imaging was negative for another stroke-like episode. *Id.* His blood glucose was in the normal range at 86. *Id.* He tested positive for "amphetamines, meth, benzo and cannabis." JE 6:304-305. His wife reported his personality had changed, and he had exhibited more angry behavior. JE 6:305. Physicians suggested a causal connection between his seizure episodes and his illicit drug use. JE 6:330. Claimant reported that until recently, he had not used in 25 years. JE 6:347. CT head and neck scans for possible stroke were negative but did show progression of the chronic infarction noted before. JE 6:285-286. On January 16, 2020 another brain MRI suggested an old ischemic injury. JE 6:329. Claimant complained about what the radiologist termed "stroke like symptoms." JE 5:26.

43. On March 4, 2020 Claimant underwent left shoulder arthroscopic rotator cuff repair. JE 16:22; JE 49:191-217.

44. From November 17-20, 2020 Claimant was hospitalized for mental evaluation relating to his seizures. JE 6:436-963. An MRI showed that he had another stroke. JE 6:504.

45. A November 18, 2020 EEG showed diffuse slowing, but a November 20, 2020 EEG showed normal function. JE 6:504.

46. Another hospitalization at EIRMC February 24-28, 2021 also addressed his brain function. JE 6:965-1299.

47. Claimant has an underdeveloped sense of when an emergency room visit is appropriate. He has shown a propensity to first choose an emergency room even for a known condition for which he has a primary treating physician. For example, on one occasion, he visited for a painful tooth. JE 6:38-42. He told emergency personnel that his dentist would not see him because he owed money. JE 6:41.

48. Claimant mistakenly has reported that he suffered a cerebral aneurism. JE 6:426. In fact, no physician has made such a diagnosis.

49. On March 9, 2021 Rodde Cox, M.D. reviewed records for forensic purposes. JE 16:7-24. He opined Claimant's diabetes, not his industrial injury to his Achilles tendon and ankle sprain, was the cause of his claw toe deformities and amputation of his right great toe. JE 16:22-24.

Prior Medical Records

50. In September 1989 Claimant underwent a lumbar CT and bone scan upon his report of low back pain to both legs. JE 5:2. The CT showed mild degenerative lumbar disc bulges without herniation. *Id.* The bone scan was negative. *Id.*

51. In October 1995 Claimant was evaluated at EIRMC emergency for mental health assessment following an overdose of prescription medication. JE 6:2. The report notes he took

prescribed amounts of Lortab and Tylenol #3, but too much Flexeril with alcohol. *Id.*

52. In October 2001 Claimant visited Jordan Valley Hospital emergency for a headache. JE 7.

53. On March 29, 2002 Claimant visited St. Alphonsus Regional Medical Center (SARMC) emergency for back pain lasting two days after a work-related furniture moving accident. JE 9:2-8. He reported tingling in his left leg. *Id.* An examination was negative. *Id.* X-ray was negative for acute injury, positive for partial lumbarization of S1 and mild degeneration in the lumbar spine. *Id.* Diagnosis was muscle strain. *Id.* This partial lumbarization of S1 makes equivocal all physician reports pertaining to specific lumbar levels depending upon whether the physician is counting from top down or bottom up.

54. On an April 19, 2002 follow-up visit to SARMC emergency for continuing back pain the examination was positive for palpable right SI joint tenderness and right straight leg raising at 30 degrees reproducing radiculopathy symptoms. JE 9:9-25. The record does not address why the original radiculopathy was in his left leg but now in his right. A nurse's note within this visit records Claimant complained of radiating pain in both legs. JE 9:13. Physicians noted that an MRI showed mild degeneration, but that it was negative for nerve involvement or acute disc bulge. JE 9:9-25. None thought it showed a source of Claimant's reported pain.

55. In April 2002 several follow-up visits, physical therapy sessions, and chiropractic treatments were of limited help. *See* JE 9:9-110. Michael Gibson, M.D. diagnosed a lumbosacral strain. JE 11. Diabetes was diagnosed. JE 9:63.

56. In June 2002 Nancy Greenwald, M.D. was requested to examine Claimant for forensic purposes. JE 18:10-55. Instead she provided a consultation. *Id.* She examined Claimant

and noted some consistent and some inconsistent pain behavior and reports of abnormal sensation in his legs and feet. *Id.* An EMG equivocally suggested L5 radiculopathy. JE 18:22. She recommended diabetes testing as well as a lumbar MRI. In follow-up she noted MRI and CT scans showed a T7-8 disc bulge with lumbar epidural fat present, but she found nothing suggestive of neurological compromise. JE 18:45. A1c was normal. Dr. Greenwald noted that she expected him to recover without permanent restriction. JE 18:29. She noted poor compliance with a work-hardening program.

57. In August 2002 Dr. Greenwald rated PPI at 8%, 5% related to the furniture moving accident, 3% to preexisting congenital narrowing. JE 18:46. Permanent restrictions included lifting 50 pounds occasionally, 40 frequently, 30 continuously, with ad lib position changes and limited motion. JE 18:46-48. She recommended four-hour workdays increasing to full time over the next two months. JE 18:48.

58. In October 2002 Dr. Montalbano provided a consultation. JE 22. After examination, he noted Claimant's symptoms were nonanatomical and recommended against surgery. *Id.* He deferred to Dr. Greenwald's work restrictions. *Id.*

59. In October 2002 Claimant visited SARMC emergency asking for back X-rays. JE 9:33-110. He was instead diagnosed with diabetic ketoacidosis. *See id.* Other lab data from a chemistry panel showed significant metabolic instability. *Id.* A four-day hospitalization followed. *Id.* A lumbar X-ray was negative for acute injury. *Id.* After a complaint of significant headache with visual disturbance a neurologist attributed the cause to diabetic complications. *Id.*

60. By December 2003 Claimant was taking insulin for uncontrolled diabetes. JE 24.

61. In November 2008 Claimant was seen at Community Medical Center emergency

in Missoula, Montana after an accident where Claimant's truck went over a cliff. JE 25. A CT scan suggested probable transverse process fractures at L2 and L3. JE 25, 26. These were at the tips, of indeterminate age, deemed "small," and not requiring surgery. *Id.* A mild contusion about the psoas muscle was seen. *Id.* He was seen days later at EIRMC emergency and elsewhere for back pain following the truck accident. JE 6:3-10. Blood glucose immediately after the accident was 421. JE 25. Claimant reported brakes failed and he may have passed out. *Id.* The history was ambiguous about whether loss of consciousness occurred before or as a result of the truck accident. *Id.*

62. In December 2008 Claimant reported to physicians that he had suffered "2 ruptured disc(s)" in the truck accident. JE 31:2. His report is inaccurate and not supported by any medical record before that date. *See* JE 25, 26, and 39:3.

63. In December 2008 Sara Vlach, M.D. reported Claimant was "not likely" to be able to return to truck driving. JE 29:11. Back and left leg pain was treated on several visits. JE 29. Substantial physical therapy began. JE 28, 29.

64. From January 2009 through April 2010 Claimant underwent significant physical therapy. JE 32:2-103. Progress was "limited." JE 32:103.

65. In February 2009 EIRMC emergency noted Claimant reported that his blood sugar was over 400. JE 6:15. Testing confirmed his level was at 589. JE 6:16. After insulin, blood glucose was measured "in the 300's." *Id.*

66. In April 2009 Brent Greenwald, M.D. began providing treatment. JE 35. He recommended surgery but delayed it because of Claimant's uncontrolled diabetes. *Id.*

67. In May 2009 EIRMC emergency measured blood glucose at 669. JE 6:24. Three

weeks later at 212. JE 6:27.

68. On June 2, 2009 Dr. Greenwald performed a L5 hemilaminotomy. JE 36:2-4. The operative report does not note disc involvement. *Id.* In July Claimant reported that his pain was worse and that his left leg was dragging. JE 35:6.

69. In August and September 2009 Claimant received SI joint injections. JE 35:8-9.

70. In October 2009 EIRMC emergency measured blood glucose at 102. JE 6:33.

71. On October 6, 2009 Dr. Greenwald repeated the June 2 surgery and found extruded disc fragments compressing the left S1 nerve. JE 35:9, 36:5-8. He opined Claimant to be at MMI in January 2010. JE 35:12.

72. In February 2010 Richard Knoebel, M.D. reviewed records and examined Claimant for forensic purposes. JE 39:2-13. He found Claimant "not credible" with nonanatomic complaints and four out of five Waddell signs positive. JE 39:7. Dr. Knoebel opined Claimant has not yet reached MMI. JE 39:9. He noted Claimant had a 2% preexisting PPI for an industrial low back injury "about 20 years ago." *Id.*

73. In May 2010 Dr. Vlach noted on successive visits into 2012 that Claimant could "return to work without restrictions." JE 29:52-85.

74. In June 2010 Dr. Knoebel examined Claimant. JE 39:14-22. He found Claimant "partially credible" with objective left calf atrophy. *Id.* He opined Claimant had reached MMI as of May 3, 2010 with a 12% whole person impairment inclusive of the preexisting 2%. *Id.* He precluded Claimant from medium work—35 pounds occasionally, 20 pounds frequently—and repeated particular motions. *Id.* He opined Claimant could return to truck driving. *Id.*

75. On July 27, 2010 Michael O'Brien, M.D. reviewed records and examined Claimant

for forensic purposes. JE 40:2-4. Dr. O'Brien noted that he changed emphasis during the examination to that of treating physician. *Id.* He opined Claimant had been misdiagnosed, should have included a piriformis syndrome diagnosis. *Id.* He opined that Claimant was not at MMI. *Id.*

76. Repeat forensic examination and review of additional records on April 14, 2011 did not change Dr. Knoebel's opinions. JE 39:23-30.

77. On July 18, 2011 Dr. O'Brien again examined Claimant. JE 40:5-6. He opined restrictions of 20 pounds occasionally with limited standing and frequent position changes. *Id.* He rated PPI for the low back at 20% without apportionment and added another 5% for a related piriformis syndrome. *Id.* He anticipated future medical treatment for the piriformis syndrome for an indefinite time. *Id.*

78. In September 2011 EIRMC emergency evaluated low back pain three days after a fall at home. JE 6:43-47. X-ray was negative. *Id.*

79. In October 2011 EIRMC emergency evaluated chronic low back pain which had increased in the last week with reported chronic paraesthesias in the left leg. JE 6:48-52. He reported leg weakness and trouble walking. *Id.*

80. In October 2011 a functional capacity evaluation (FCE) was performed. JE 43. Claimant described significant left leg pain, with numbness and paresthesias in his whole leg. *Id.* Testing was deemed valid for consistent effort. *Id.* His uninvolved right leg showed only 35% of normal strength, worse on left. *Id.* He could lift and carry in the light-medium range of work at 41 pounds. *Id.* His blood oxygen levels showed he was quite out of shape. *Id.*

81. In November 2011 EIRMC emergency evaluated chronic low back pain with more pain at left second and third toes. JE 6:53-57. Claimant also reported numbness in his right foot, a

new symptom. *Id.*

82. In January 2012 Dr. Vlach examined Claimant for trochanteric bursitis. JE 29:84-85. She deemed it unrelated to his 2008 truck accident, but opined it needed treatment. *Id.*

83. In May 2013 a right lower leg X-ray was negative after he struck his shin against a pipe at work a week before. JE 6:58-64; JE 41:3; JE 42:10-14. The physician's assistant observed mild swelling but no bruise. *Id.*

84. In June 2013 Claimant underwent an MRI of his brain to diagnose left facial numbness. JE 6:66-73. Claimant also reported sudden speech impairment, but this was not found upon examination. *Id.* Muscle droop was noted. *Id.* The MRI was negative. *Id.* Diagnosis was Bell's Palsy with Diabetes. *Id.* Blood glucose measured 382. *Id.*

85. In March 2014 a CT scan of Claimant's neck showed an enlarged left tonsil, plaque along the posterior left margin of his pharynx, and small, scattered, nonspecific lymph nodes. JE 6:78-110. Diagnosis was peritonsillar abscess with pharyngitis. *Id.* He also reported that his chronic back and leg pain was worse. *Id.* Blood glucose at admission was 284. *Id.* Blood glucose measured 368, then 310, then 417 during the course of this overnight stay. *Id.*

86. In June 2014 a CT angiogram showed mild subsegmental atelectasis in the right middle lobe and lingula with trace pericardial effusion. JE 6:111-124.

87. A note in Mr. Granat's summary of record reviewed includes a date of August 5, 2015. JE 55. This is deemed erroneous. No Achilles tendon issue is found in the record before October 2015.

88. In deposition on November 1, 2021 Dr. Cox testified that Claimant's comorbidities of diabetes and stroke account for chronic pain and other abnormalities in Claimant's foot after

the Achilles tendon repair had healed. He described how stroke likely caused the varus deformity, hammertoe, and claw toes. He explained that the length of time after Achilles tendon surgery and the first doctor's mention of varus deformity and abnormalities in Claimant's toes makes it more likely that diabetic peripheral neuropathy and a central nervous system problem which preceded the major stroke caused these conditions. Cox Depo. 23:15-34:18. Dr. Cox opined that the 2015 accident and surgery did not likely cause the need for amputation of Claimant's big toe; diabetes alone likely caused it. *See id.* Methamphetamine use may well have been the primary cause of Claimant's stroke. Cox Depo. 39:3-21. Dr. Cox opined that the 2015 accident caused a partial tear of the Achilles tendon and an ankle sprain, but it did not cause RSD also known as CRPS nor any of the pain nor muscle nor nerve problems arising in that foot after recovery from surgery. Cox Depo. 13:14-15:3.

Vocational Factors

Generally

89. Born September 23, 1966, Claimant was 54 years old at the time of hearing.

90. He began work as a busboy and cook. Claimant Depo. 8:4-11. He worked at various restaurants for about 15 years. *Id.* at 9:2-4. He worked as a furniture mover for about 10 years. *Id.* at 9:9-10. This work also involved driving truck. *Id*. at 9:23-10:2. In the last 20 years or so he mostly drove a concrete truck. *Id.* at 19:22-24.

91. Claimant receives $1,464 per month in SSD benefits. *Id.* at 14:7-8.

Vocational Experts

92. Claimant received services from ICRD in 2008-2010. JE 58:2-13. That file was closed when Claimant was released at MMI without restrictions. *Id.* He had begun working for

Employer. *Id.*

93. Claimant received services from ICRD in 2017. JE 58 at pp. 14-18. The file was closed because Claimant believed he was totally and permanently disabled. *Id.*

94. On August 5, 2020 Kent Granat evaluated Claimant's employability via a telephone interview and records review. JE 55. He opined Claimant has lost 100% of his labor market, meaning he could not do any of the five occupations he has performed as an adult. *Id.* Similarly he has no transferrable skills and thus another measure which results in a 100% loss of labor market access. *Id.* Finally, A SkilTran assessment results in a 93% loss of labor market access. *Id*. Mr. Granat went on to assess factors required to establish odd-lot classification. *Id.*

95. In deposition on October 8, 2021 Mr. Granat testified that Claimant's total and permanent disability arises as "really a combination of his two industrial injuries plus the stroke." Granat Depo. 9:15-17. He deemed restrictions to "seated work only, avoid standing and walking, and avoid driving" as uniquely added by the 2015 accident. *Id.* at 25:12-18. He opined that while 137 unskilled sedentary jobs existed, it would be futile for Claimant to apply. *Id.* at 30:1-33:2.

DISCUSSION AND FURTHER FINDINGS OF FACT

96. The provisions of the Idaho Workers' Compensation Law are to be liberally construed in favor of the employee. *Haldiman v. American Fine Foods*, 117 Idaho 955, 956, 793 P.2d 187, 188 (1990). The humane purposes which it serves leave no room for narrow, technical construction. *Ogden v. Thompson*, 128 Idaho 87, 88, 910 P.2d 759, 760 (1996).

97. Facts, however, need not be construed liberally in favor of the worker when evidence is conflicting. *Aldrich v. Lamb-Weston, Inc.*, 122 Idaho 361, 363, 834 P.2d 878, 880 (1992). A claimant must prove all essential facts by a preponderance of the evidence. *Evans v. Hara's, Inc.*, 123 Idaho 472, 89 P.2d 934 (1993).

98. Uncontradicted testimony of a credible witness must be accepted as true, unless that testimony is inherently improbable, or rendered so by facts and circumstances, or is impeached. *Pierstorff v. Gray's Auto Shop*, 58 Idaho 438, 447−48, 74 P.2d 171, 175 (1937). *See also Dinneen v. Finch*, 100 Idaho 620, 626−27, 603 P.2d 575, 581−82 (1979); *Wood v. Hoglund*, 131 Idaho 700, 703, 963 P.2d 383, 386 (1998).

99. The Referee found that Claimant's demeanor appeared credible. The Commission finds no reason to disturb the Referee's findings and observations on Claimant's presentation or credibility.

Accident Occurrence

100. A compensable accident must be reasonably located as to place and time. Idaho Code § 72-102(17)(b).

Causation

101. A claimant must prove that he was injured as the result of an accident arising out of and in the course of employment. *Seamans v. Maaco Auto Painting*, 128 Idaho 747, 751, 918 P.2d 1192, 1196 (1996). Proof of a possible causal link is not sufficient to satisfy this burden. *Beardsley v. Idaho Forest Industries*, 127 Idaho 404, 406, 901 P.2d 511, 513 (1995). 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). Magic words are not necessary to show a doctor's opinion is held to a reasonable degree of medical probability; only their plain and unequivocal testimony conveying a conviction that events are causally related. *Jensen v. City of Pocatello*, 135 Idaho 406, 412-13, 18 P.3d 211, 217-18 (2001). Aggravation, exacerbation, or acceleration of a preexisting condition caused by a

compensable accident is compensable in Idaho Worker's Compensation Law. *Nelson v. Ponsness-Warren Idgas Enterprises*, 126 Idaho 129, 879 P.2d 592 (1994).

102. Here, the preponderance of medical opinion shows Claimant suffered a partial tear of his Achilles tendon and an ankle sprain in the October 2015 work accident. The August 2016 surgery was reasonable and necessary to repair the partial tear. The medical evidence does not support a conclusion that Claimant suffers from RSD or CRPS. Nor does the medical evidence support a conclusion that Claimant suffered a tear to his peroneus Brevis tendon as a result of the accident.

103. Following the August 2016 surgery, Claimant developed equinus, hammertoe and claw foot deformities (hereinafter "foot deformities") that eventually led to an attempt at surgical correction and a subsequent amputation of his big toe. Claimant argues that the achilles tendon surgery caused his foot deformities because he only developed these problems on the right, and only following the surgical repair. Offered in support of this argument are the records of Dr. Black, who first saw Claimant on April 17, 2017, after the manifestation of his right foot deformities, but before his stroke. Dr. Black's records do not reflect which, if any, of Claimant's prior medical records he reviewed. Following MRI evaluation of the right ankle, Dr. Black proposed that Claimant had "achilles tendinosis likely RSD, tendon problems, equinus all secondary to work accident." JE 50:5. It was only after Dr. Walker performed EMG testing that Dr. Black became aware of Claimant's peripheral neuropathy. In his note of October 23, 2017 he stated:

> "He did get an EMG which did show some abnormalities with his nerves compared to previous EMG. The EMG showed that he has diabetic neuropathy and does not appear to be related to his accident the nerve damage that they found."

JE 50:12.

104. Dr. Black did not offer an opinion on whether, or how, this new information impacted his opinion on the cause of Claimant's foot deformities. Dr. Black did not explain how the accident is responsible for causing Claimant's foot deformities. He does not offer an opinion that the Achilles tendon surgery did something to accelerate or aggravate Claimant's diabetes related peripheral neuropathy to cause the aforementioned foot deformities.

105. ISIF argues that Claimant's foot deformities are entirely unrelated to the subject accident or the August 10, 2016, Achilles tendon repair. Relying on Dr. Cox's testimony, ISIF asserts that were the August 10, 2016 Achilles tendon repair implicated in contributing to Claimant's foot deformities, these deformities would have manifested within a period of a few days to a week following the Achilles tendon repair. Cox Depo. 45:12-46:3. Per Dr. Cox, since right foot deformities were first noted sometime in 2017, it is unlikely that these problems are related to the August 10, 2016 Achilles tendon repair. Cox Depo. 24:11-25:15. More importantly, the Achilles tendon repair was limited to the back of Claimant's heel, and that surgery did not come close to the structures that would have to be damaged in order to cause muscle imbalances that would lead to the type of deformities later seen in Claimant's foot. Cox Depo. 22:1-24:10, 35:22-36:15, 37:18-38:18. Dr. Cox felt that a much more plausible explanation for Claimant's foot deformities is his longstanding diabetes. Diabetes is implicated in causing Claimant's bilateral peripheral neuropathy, which in turn causes muscle imbalance problems which led to varus deformities, claw foot and hammertoe.

106. ISIF also relies on the report of Dr. Toomey in support of its theory that Claimant only suffered injuries to his right ankle and Achilles tendon at the time of the accident, and that the Achilles tendon repair is not implicated in causing his foot deformities. Dr. Toomey examined

Claimant on October 16, 2017. Dr. Toomey's record review suggests that he did not understand Claimant to have symptoms of foot deformities until approximately ten months after the August 10, 2016 Achilles tendon repair. JE 52:7. Dr. Toomey offered the following observations on the nature of Claimant's problems:

> June 6, 2017, the patient was 10 months out from his surgery, according to Dr. Huntsman. He still has some pain in the lateral aspect of his foot and on his heel and his arch. The big toe was swelling. He had mild tenderness over the medial lateral malleoli. He had no effusion of the ankle. He still had tenderness of the Achilles at the insertion. His range of motion was 10 degrees of dorsiflexion, 60 degrees of plantar flexion. He had a first and third claw-toe deformity. He was apparently going to be referred on to Dr. Kaufman for evaluation.

JE 52:7.

107. Although Dr. Toomey did not specifically find that Claimant's diabetic neuropathy is the cause of his foot deformities, he did note that Claimant had absent peroneus brevis function based on exam and the EMG. As Dr. Cox noted, absent peroneus brevis function creates the muscle imbalance that causes the type of muscle imbalance leading to the type of foot deformities seen in Claimant.

108. Therefore, ISIF argues that Claimant's foot deformities are in no wise related to either the accident or the subsequent Achilles tendon repair. The cause of the foot deformities is entirely neurological, either by route of Claimant's well documented diabetes or a hypothetical stroke predating the documented August 2017 stroke, as first proposed by Dr. Toomey. JE 52:11.

109. The only problem with the opinions of Drs. Cox and Toomey is that both appear to have a flawed understanding of when Claimant first manifested symptoms of foot deformities. This is important because of Dr. Cox's testimony that the closer in time the manifestation of the deformities is to the surgery, the more likely that there is a causal relationship between the surgery

and the foot deformities. Per Dr. Cox, in order to say that something happened at surgery to cause a muscle imbalance which in turn led to the foot deformities, one would need to see the onset of the muscle imbalance within a few days to a week following the August 10, 2016 surgery. Per Dr. Cox, no such symptoms were noted until sometime in 2017 and per Dr. Toomey, not until ten months after the surgery.

110. A review of the medical records shows that Claimant presented with symptoms of foot deformities as early as November 28, 2016, as noted by Physical Therapist Nathan Hunsaker;

> [Claimant] has acquired some significant hypersensitivity in the heel area which is making it difficult to ambulate. I am somewhat puzzled by this reaction as we have slowly increased weight-bearing and AROM activity. He continues to have a hammer toe like presentation in the third toe which, even with repeated stretching, does not seem to be lessening. This interferes with his gait pattern per his report. His achilles tendon appears to be doing well and his AROM is improving.

JE 32:123.

111. Although Mr. Hunsaker's note might be read to suggest that he observed evidence of deformities even earlier than November 28, his earlier notes fail to so reflect. At any rate, there is no evidence that we can find in the voluminous record which demonstrates that Claimant had evidence of foot deformities within a few days to a week after surgery, as prescribed by Dr. Cox. This timeframe is important because, as explained by Dr. Cox, the only path by which the surgery could cause the muscle imbalance is to hypothesize that the surgery caused some damage to nerves or muscles necessary to keeping the foot flat. Obviously, if any of these structures were damaged at surgery, one would expect evidence of such damage almost immediately.

112. From the foregoing, we are unable to conclude that the medical evidence establishes that it is more probable than not that the August 10, 2016 surgery is responsible for the foot deformities which have proven so debilitating to Claimant. Nor does the medical evidence allow

us to say that it is more probable than not that the accident accelerated or aggravated Claimant's diabetic neuropathy such that he developed foot deformities on the right but not on the left. The fact that Claimant developed foot deformities in the same extremity involved in the Achilles tendon repair does not provide an explanation of how the surgery aggravated or accelerated Claimant's diabetic neuropathy. Cox Depo. 37:18-38:5.

113. In coming to this conclusion, we are conscious of the recent case of *Sharp v. Thomas Brothers Plumbing*, 510 P.3d 1136 (2022). In that case the Court adopted a two-part test to determine the compensability of the remote consequences of an otherwise compensable accident. Part one of the test requires proof of a causal connection between the accident and the remote consequence of the accident. "What matters is whether there is a demonstrable causal connection between the compensation sought and the work-connected injury." *Id.* Here, the argument would be that Claimant's debilitating foot deformities are a compensable consequence of the accepted work injury because Claimant's diabetes aggravated/accelerated what would otherwise have been a manageable injury to the right ankle. However, absent medical proof that it is more probable than not that the ankle injury is implicated in causing/contributing to Claimant's foot deformities, the requisite causal connection is not made. We are not persuaded that such proof is made, even though we acknowledge that it may be supposed that the tendon surgery must have contributed to Claimant's eventual foot condition because he did not develop foot deformities on the left. However, our supposition is not a substitute for medical proof.

Permanent Impairment

114. Permanent impairment is defined and evaluated by statute. Idaho Code §§ 72-422 and 72-424. When determining impairment, the opinions of physicians are advisory only.

The Commission is the ultimate evaluator of impairment. *Urry v. Walker & Fox Masonry*, 115 Idaho 750, 769 P.2d 1122 (1989); *Thom v. Callahan*, 97 Idaho 151, 540 P.2d 1330 (1975). Impairment is an inclusive factor of permanent disability. Idaho Code § 72-422.

115. Claimant suffered PPI amounting to 2% of the whole person as a result of the October 2015 accident and subsequent surgery. The preponderance of medical opinion shows Claimant required no additional restrictions beyond those imposed for his prior low back and diabetes related complaints.

Permanent Disability

116. **"**Permanent disability" results when the actual or presumed ability to engage in gainful activity is reduced or absent because of permanent impairment and no fundamental or marked change in the future can be reasonably expected. Idaho Code § 72-423. "Evaluation (rating) of permanent disability" is an appraisal of the injured employee's present and probable future ability to engage in gainful activity as it is affected by the medical factor of permanent impairment and by pertinent nonmedical factors as provided by Idaho Code § 72-430.

117. The test for determining whether a claimant has suffered a permanent disability greater than permanent impairment is "whether the physical impairment, taken in conjunction with nonmedical factors, has reduced the claimant's capacity for gainful employment." *Graybill v. Swift & Company*, 115 Idaho 293, 766 P.2d 763 (1988). In sum, the focus of a determination of permanent disability is on a claimant's ability to engage in gainful activity. *Sund v. Gambrel*, 127 Idaho 3, 896 P.2d 329 (1995).

118. Permanent disability is defined and evaluated by statute. Idaho Code §§ 72-423 and 72-425 *et. seq.* Permanent disability is a question of fact, in which the Commission considers

all relevant medical and non-medical factors and evaluates the purely advisory opinions of vocational experts. *See, Eacret v. Clearwater Forest Indus.*, 136 Idaho 733, 40 P.3d 91 (2002); *Boley v. ISIF*, 130 Idaho 278, 939 P.2d 854 (1997). The burden of establishing permanent disability is upon a claimant. *Seese v. Idaho of Idaho, Inc.*, 110 Idaho 32, 714 P.2d 1 (1986). Where preexisting impairments produce disability, all impairments and disability should be accounted for with a subtraction back for the compensable portions. *Page v. McCain Foods, Inc.*, 145 Idaho 302, 179 P.3d 265 (2008). An employer takes an employee as he finds him. *Wynn v J.R. Simplot Co.*, 105 Idaho 102, 666 P.2d 629 (1983).

119. Clamant is 100% totally and permanently disabled as of the date of hearing. Resort to odd-lot analysis is moot. ISIF concedes total and permanent disability is reasonably present here.

ISIF ISSUES

120. In a case where total and permanent disability is proven, Idaho Code § 72-332(1) provides for the apportionment of this liability between Employer and ISIF where certain criteria are satisfied. In pertinent part, the statute specifies;:

> If an employee who has a permanent physical impairment from any cause or origin, incurs a subsequent disability by an injury or occupational disease arising out of and in the course of his employment, and by reason of the combined effects of both the pre-existing impairment and the subsequent injury or occupational disease or by reason of the aggravation and acceleration of the pre-existing impairment suffers total and permanent disability, the employer and surety shall be liable for payment of compensation benefits only for the disability caused by the injury or occupational disease, including scheduled and unscheduled permanent disabilities, and the injured employee shall be compensated for the remainder of his income benefits out of the industrial special indemnity account [fund].

Idaho Code § 72-332(1) (brackets in original). A four-factor test is employed in this analysis. The test requires proof of: (1) a preexisting physical impairment, which was (2) manifest,

(3) subjectively hindered Claimant's employment, and (4) combined with the compensable industrial impairment to render a claimant totally and permanently disabled, or was aggravated/accelerated by the industrial injury to render a claimant totally and permanently disabled. *Dumaw v. J.L. Norton Logging*, 118 Idaho 150, 795 P.2d 312 (1990); *Aguilar v. ISIF*, 164 Idaho 893, 436 P.3d 1242, (2019). A "but for" test is required to establish the "combined with" element. *Bybee v. ISIF*, 129 Idaho 76, 921 P.2d 1200 (1996).

121. A progressive, preexisting physical impairment shall be considered in evaluating ISIF liability and *Carey* apportionment. *Colpaert v. Larson's, Inc.*, 115 Idaho 825, 771 P.2d 46 (1989). However, for purposes of Idaho Code § 72-332, such a progressive condition must be evaluated as of the date of the subject accident, not as of the date of the date of hearing. To do otherwise would implicate ISIF liability for impairments which were not "preexisting." *Ritchie v. Industrial Special Indemnity Fund*, 081516 IDWC, IC 2008-014338 (2016). In this case, the evidence establishes that Claimant's diabetes progressed after the subject accident and is likely responsible for Claimant's right foot deformities. Under *Ritchie*, for purposes of establishing ISIF liability, Claimant's diabetes must be evaluated as it existed immediately before the subject accident

122. It is conceded that Claimant has a preexisting impairment for his low back which was manifest, and which constituted a subjective hindrance to employment. We assume that Claimant's pre-existing diabetes also entitles him to an impairment rating. However, ISIF asserts that Claimant's diabetes did not constitute a hindrance to Claimant in keeping or finding a job prior to the subject accident. ISIF relies on Claimant's testimony that prior to the subject accident his diabetes did not limit him in any employment related activities. However, Claimant's attitude

toward his diabetes is only one factor to be considered in determining whether diabetes constituted a subjective hindrance to Claimant prior to the subject accident. *Archer v. Bonners Ferry Datsun*, 117 Idaho 166, 786 P.2d 557 (1990). Claimant's diabetes did require him to take insulin once a day, and occasionally he became fatigued when his blood sugar got too low. Usually this was remedied by a sugary snack. Historically, Claimant's diabetes has been poorly controlled, although it was under better control as of the date of hearing. We cannot agree that as of the day of the subject accident, Claimant's insulin dependent diabetes did not constitute a hindrance to employment.

123. Even so, the claim against the ISIF must fail because Claimant cannot demonstrate that the subject accident "combined with" or was "accelerated/aggravated by" his pre-existing impairments to cause total and permanent disability. First, the medical evidence we find persuasive establishes that as a consequence of the subject accident Claimant suffered a right ankle sprain and a partial tear to the right Achilles tendon. For these injuries he has been given a 2% PPI rating. No restrictions for the ankle sprain and tendon tear have been substantiated. As developed above, Claimant has failed to adduce medical evidence showing that it is more probable than not that the ankle sprain and Achilles tendon tear are implicated in causing or contributing to, Claimant's debilitating foot deformities. Claimant's foot deformities are shown to be more likely related to a neurological cause, arising independent of the ankle injury. The Achilles tendon injury and the ankle sprain added nothing to Claimant's disability. These injuries neither combined with, nor aggravated/accelerated any of Claimants pre-existing impairments.

124. In evaluating the impact of the subject accident, Mr. Granat assumed that Claimant's debilitating foot deformities are part and parcel of the subject accident and must be

considered in evaluating the contribution of the accident to Claimant's disability. The residual functional capacity (RFC) calculated by Mr. Granat for the work injury includes restrictions based on Claimant's foot deformities. JE 55:9-11. As such, Mr Granat's opinion that the work accident combined with Claimant's prior back injuries to cause odd-lot disability is without foundation.

125. Finally, Mr. Granat's testimony makes it clear that Claimant's total and permanent disability is the result of conditions which progressed, or which arose, subsequent to the work accident. However, the ISIF can only be held responsible for pre-existing impairments as they existed immediately prior to the industrial accident. Claimant's diabetes is a progressive condition. His diabetic neuropathy and related foot deformities are not shown to have existed at the time of the subject accident. *Ritchie,* supra. Claimant's pre-existing diabetes and low back injury, in combination with the subject accident, do not result in total and permanent disability. Moreover, per Mr. Granat's testimony, Claimant did not become and odd-lot worker until he suffered a stroke in 2017. Until that event it was not yet "futile" for Claimant to search for employment. Granat Depo. 34-36. In all, Claimant did not become totally and permanently disabled until he developed physical ailments unrelated to the subject accident and which arose subsequent to the subject accident, i.e, the foot deformities and the stroke.

126. For these reasons Claimant has failed to prove ISIF liability.

127. Without ISIF liability, *Carey*, formula apportionment is moot.

CONCLUSION OF LAW AND ORDER

1. Claimant suffered a compensable accident which resulted in Achilles tendon repair surgery;

2. Claimant did not show it likely that the compensable accident contributes to total and permanent disability; and

3. ISIF is not liable for benefits.

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

DATED this 12th day of August, 2022

INDUSTRIAL COMMISSION

Aaron White, Chairman

Thomas E. Limbaugh, Commissioner

Thomas P. Baskin, Commissioner

ATTEST:

Kamerron Slay
Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 12th day of August, 2022, a true and correct copy of the **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** was served by regular United States Mail and Electronic Mail upon each of the following:

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