BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

CLAUDIA ANDERSON, Claimant, v. BOUNDARY COMMUNITY HOSPITAL, Employer, and LIBERTY NORTHWEST INSURANCE CORP., Surety, Defendants.	**IC 2009-020954** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** May 4, 2012

Pursuant to Idaho Code § 72-506, the above entitled matter was assigned to Referee LaDawn Marsters, who conducted a hearing on September 23, 2011 in Coeur d'Alene, Idaho. Claimant was present in person and represented by James F. Combo of Coeur d'Alene. Employer ("Boundary") and Surety were represented by E. Scott Harmon of Boise. Oral and documentary evidence was admitted, and one post-hearing deposition was taken. The matter was briefed and came under advisement on April 9, 2012.

ISSUES

The following issues are to be decided as a result of the hearing:

Whether and to what extent Claimant is entitled to the following benefits:

a. Medical care, including whether Claimant is entitled to surgery to repair her right humerus; and

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

CONTENTIONS OF THE PARTIES

Claimant, a licensed practical nurse (LPN) for 37 years, had no significant problems with her right arm or either of her knees prior to falling in a basement hallway while working at Boundary on August 8, 2009. She landed flat, face-down, with her right arm outstretched at an odd angle. Following the accident, she was diagnosed with a spiral fracture of her right humerus and tricompartmental arthritis with tears of the lateral and medial menisci of her left knee, among other things. Surety accepted her claim and paid medical and temporary total disability benefits until January 13, 2010, when William T. Magee, M.D., Claimant's treating physician, opined she had reached maximum medical improvement (MMI).

Claimant contends that she is entitled to surgery to stabilize her right humerus fracture because it has never healed properly, causing her significant pain and difficulty performing basic activities of daily living, like housework and doing her hair. Claimant also contends that she is entitled to arthroscopic left knee surgery to repair her meniscus tears. In addition, Claimant asserts entitlement to temporary total disability benefits since the date of her industrial accident because she has never reached medical stability or been physically able to return to work. John M. McNulty, M.D. and Andrew Howlett, M.D., both orthopedic surgeons,[1] opine that Claimant's fracture is not healed and that her condition would significantly improve with corrective surgery. Dr. McNulty also opines that Claimant's left knee condition is at least partially related to her industrial accident.

Defendants contend that surgery is not a reasonable treatment for Claimant's residual right arm symptoms because her humerus is adequately healed and she could not reasonably be

[1] Dr. McNulty performed an IME at Claimant's request, then saw Claimant once for treatment purposes. Dr. Howlett examined Claimant once in referral from Dr. McNulty. Claimant did not follow up with Dr. Howlett because she could not afford to pay out-of-pocket for the treatment.

expected to improve, even with the proposed surgery. As to her left knee condition, Defendants argue that the only left knee injury Claimant sustained as a result of her fall, a contusion, healed without residual symptoms. Further, her current left knee symptoms are the sole result of preexisting tricompartmental arthritis unrelated to her industrial accident and, thus, are not Defendants' responsibility. Defendants also assert that Claimant is not a good surgical candidate because she has exaggerated her symptoms to several physicians who have examined her. Defendants rely upon the opinions of Dr. Magee, J. Craig Stevens, M.D. (a physiatrist who provided a second opinion in referral from Dr. Magee), and Brian Tallerico, D.O. (an osteopathic orthopedic surgeon and IME physician) to establish that Claimant reached MMI on January 13, 2010, and that further medical treatment for her industrial injuries is neither reasonable nor necessary.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. Joint Exhibits 1 through 29 admitted at the hearing;
2. The testimony of Claimant, Delphia Anderson and John McNulty, M.D., taken at the hearing; and
3. The post-hearing deposition testimony of William T. Magee, M.D., taken December 6, 2011.

OBJECTIONS

All pending objections are overruled.

FINDINGS OF FACT

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

BACKGROUND

1. Claimant, who is right-hand dominant, was 57 years of age and residing in Troy, Montana, at the time of the hearing. She had worked as an LPN for approximately 37 years.

2. Claimant began working as an LPN at Boundary on November 15, 2002. On November 2, 2009, her employment was terminated because she was unable to return to work before her leave period pursuant to the Family Medical Leave Act expired. Prior to her workplace accident, Claimant had no significant problems with her right upper extremity (RUE) or either of her knees.

3. This is an accepted claim. Surety paid medical and temporary total disability benefits through January 13, 2010.

ACCIDENT AND EMERGENT CARE

4. On August 8, 2009, while working at Boundary, Claimant slipped and fell in a basement hallway as she approached the time clock. She landed on her knees, her chin and her outstretched right arm. An "Employee Injury or Illness Report" prepared that day by or on behalf of Claimant confirms injuries to these areas. "I was walking to the time clock to clock out when I tripped & fell, hurting my right arm, both knees and chin." JE 1-07.

5. The Boundary Hospital Emergency Department chart note from that day also documents these injuries. Claimant's right arm symptoms included distal numbness, shoulder tenderness, weakness and pain on movement of her forearm. She underwent x-rays which identified a "markedly displaced…[s]ignificant acute spiral fracture of the proximal humeral shaft." JE 1-06. "There is approximately 3.5 cm of lateral displacement of the main distal fragment. The overriding measures approximate [*sic*] 2 cm." *Id.* In other words, the humerus bone was broken at the mid-arm area, and the bone fragments (one connected to the elbow and

the other to her shoulder) were completely separated from, and overlapping, each other. In addition, the nurse's note reports "both knees [were] a little banged up, [but] not bad." JE 1-04. There is no specific reference to her chin injury.

6. Claimant's right arm was placed in a coaptation splint. She was given pain medication and told to follow up with an orthopedist.

ORTHOPEDIC AND SECOND OPINION FOLLOW-UP: DRS. MAGEE AND STEVENS

7. William T. Magee, M.D. is an orthopedic surgeon. He graduated from medical school, then served a residency and a fellowship prior to entering private practice in Ponderay, Idaho, in the employment of Michael R. Dibenedetto, M.D., of North Idaho Orthopaedics and Sports Medicine. His initial evaluation of Claimant occurred about one year into his practice. At the time of his deposition in December 2011, Dr. Magee had completed his oral board certification exam and was eligible to sit for the written exam in July 2012.

8. During cross-examination questioning, Dr. Magee was defensive and declined to estimate how many patients with conditions like Claimant's he had treated in the past. Although he stated that he had surgically repaired a fractured humerus like Claimant's since treating her, Dr. Magee's testimony reasonably begs the conclusion that he had not previously performed such a procedure, at least not in private practice.

9. Dr. Magee first examined Claimant, accompanied by her daughter, Delphia Anderson, on August 12, 2009. Claimant recalled reporting to Dr. Magee each of her injuries (to her chin, right arm and knees) from her fall. However, Dr. Magee only noted Claimant's "chief complaint" of a right humerus fracture, and only examined and treated her right arm. He also reviewed Claimant's August 8 x-ray, which demonstrated a mid-humerus fracture with "a hundred percent displacement on the AC view." Magee Dep., p. 8.

10. Claimant confirmed that Dr. Magee showed her the x-ray image at Exhibit 26 on her initial visit. The cringe-inducing image depicts Claimant's broken right humerus, with the two fragment ends widely separated and lying beside one another so as to shorten the distance between her shoulder and elbow. "I was appalled. I couldn't believe it. That - - that it happened, you know, on a Saturday and here I was five days later and nothing had been done."[2] Tr., p. 81.

11. Claimant appeared to be in a great deal of pain, but she denied distal weakness or paresthesias, and her peripheral nerves were intact. Dr. Magee noted that Claimant's affect was appropriate. On examination, he identified "palpable deformity at the right proximal arm." JE 4-01. He diagnosed a displaced oblique fracture of the right humeral diaphysis and provided Claimant with a cuff and collar sling while she waited to be fit for a Sarmiento brace. He also provided a prescription for Percocet for pain relief.

12. Dr. Magee opined that spiral fractures of the humerus typically heal well with closed treatment; however, he noted that he was concerned that the amount of displacement in Claimant's case may be too excessive, so he deferred deciding whether surgical repair would be appropriate for one week, at which time he would obtain new x-rays and reevaluate Claimant's condition. According to Claimant, Dr. Magee did not, at any time, discuss the possibility of surgery with her.

13. Claimant followed up with Dr. Magee on August 24, 2009, after having been provided with a Sarmiento brace on some unnoted prior visit. Claimant was still taking Percocet for pain, and Dr. Magee thought her arm brace appeared to fit well. Claimant reported chin and

[2] Claimant miscounted; there is no dispute that her industrial accident occurred on August 8, 2009, nor that her initial visit with Dr. Magee took place on August 12, 2009.

knee pain to Dr. Magee, which he did not note.

14. Dr. Magee testified initially that he did not take new x-rays on August 24, 2009, as per his original plan on August 12, because the expense was unnecessary. On cross-examination, after reviewing additional documents, Dr. Magee's recollection changed, and he admitted that he actually had ordered x-rays, which were taken at Boundary on August 24. He also acknowledged signing for them on September 11, 2009. However, Dr. Magee was apparently oblivious to these studies until his deposition in December 2011.

15. Dr. Melendez, the radiologist at Boundary who originally interpreted the August 24 x-rays, noted in his report that there was no significant change from the August 8 images. He still measured three-and-a-half centimeters of displacement, though he also noted evidence of a faint calcified callus forming between the still-displaced bone fragments.

16. On September 14, 2009, Dr. Magee again examined Claimant. Dr. Magee took new x-rays, which he interpreted to show that Claimant's fracture was now only fifty percent displaced (he used the interchangeable term "translated") on one view, and zero percent displaced (perfectly aligned) on another view. (*See* Exhibit 11 for the perfectly aligned view).[3] Based upon these images, Dr. Magee was satisfied with Claimant's healing process:

> I was very pleased. I felt like that's excellent alignment for humeral shaft fracture, and the x-rays already showed callus formation, bony healing. In the soft tissues you can see that sort of cloudy stuff, that's the sign that the bone is trying to heal. And so I felt that this was a good prognostic indicator.

Magee Dep., p. 17. Claimant, however, was still in a great deal of pain: "I would have thought the pain should have been lessening, you know, but it wasn't." Tr., p. 84.

[3]Being two-dimensional, several views of a fracture must be observed to achieve an accurate diagnosis. Dr. McNulty explained in his deposition that it is standard practice to treat a patient based upon the view revealing evidence of the most severe pathology.

17. On October 9, 2009, Dr. Magee saw Claimant for the third time. It was the first time, however, that Dr. Magee ever noted Claimant's chin and knee problems, even though he acknowledged that she had reported them before. He explained that he had not previously noted Claimant's chin complaints because he did not treat facial conditions. On this visit, two months into his treatment of Claimant, Dr. Magee finally referred her to a plastic surgeon for evaluation of her chin, but only after she pressed him. He did not specifically explain why he did not make this referral earlier; however, he generally explained that referrals should be made by her primary care physician, not him, because he was a specialist. He also did not explain why he had not previously noted Claimant's knee pain, which was clearly within the orthopedic specialty, except to say that he was focusing on treating her humerus fracture. In any event, Dr. Magee deferred examining Claimant's knees again, until her next visit.

18. On October 21, 2009, two-and-a-half months following Claimant's industrial accident, Dr. Magee performed an initial examination of Claimant's knees. He noted "diffuse tenderness to palpation over the anterior aspect of both knees." Magee Dep., p. 18. X-rays revealed "severe tricompartmental degenerative joint disease. Basically, she had severe arthritis in both of her knees." Magee Dep., p. 21. Dr. Magee opined that the arthritis had developed over many years, and that the x-rays failed to identify any acute condition. He did not order an MRI to investigate conditions not identifiable via x-ray or provide any treatment, electing to wait and see if her pain would resolve on its own:

> Regarding her knees, I see no sign of any acute injury radiographically. The distribution of her pain and the nature of her symptoms would suggest that she might have suffered contusions at the time of the fall. I suspect this should resolve with time. I see no other need for further work-up for her knee pain at this time.

JE 4-08.

19. Dr. Magee also took new x-rays (the fourth set) of Claimant's right humerus. These images demonstrated to Dr. Magee that "her longitudinal alignment was excellent, meaning there was no significant angular deformity, but…she had 100 percent… [displacement]… on one view and 50 percent …[displacement]… on the other view." Magee Dep., p. 19. At his deposition, Dr. Magee interpreted this to mean her fracture condition had worsened since her prior x-rays, taken by him on September 14. Nevertheless, Dr. Magee's chart note states Claimant's fracture was healing well, apparently because she had "excellent intervening callus formation." JE 4-07.

20. Dr. Magee did not go over these films with Claimant. Because Dr. Magee told her that her fracture was healing well, she believed him. However, her pain now extended to her right shoulder and she was still having trouble taking care of herself. "I was trying to do my own self-care. I mean, I really couldn't do a whole lot. I couldn't hold a brush with my right hand. I can't write. I'm right-handed, so there wasn't a whole lot I could do with that hand, but I was trying to use it a little more." Tr., p. 87. She discussed her concern with Dr. Magee and he agreed that her pain should have improved, but he did not offer her any options. "And he said - - he felt like I - - you know, I should have been better - - better than I was, you know. He just - - I felt like I was being pushed aside, honestly. I don't know. I think it - - yeah, I think I was just kind of being overlooked." *Id.*

21. Dr. Magee prescribed a course of physical therapy for Claimant's RUE after which, if Claimant did not improve, he would order a shoulder MRI to rule out rotator cuff and other intraarticular pathology.

22. Dr. Magee also set up a Percoset weaning schedule and advised Claimant that he

was not a pain specialist, so any persisting pain issues following completion of this schedule would need to be addressed by someone else:

> This weaning schedule was discussed with Ms. Anderson in detail, and she has agreed to this. She understands that continued use of Percocet beyond this time frame constitutes treatment of chronic pain, which is beyond the scope of my practice. She understands she must seek other sources of treatment for her chronic pain if she feels she still requires treatment for her pain at that point.

JE 4-08.

23. As of the October 21 visit, Claimant had also developed pain in her neck and back. As with Claimant's chin complaint, Dr. Magee explained to Claimant that neck and back conditions are not within his specialty:

> With regard to her back, neck and chin complaints, I have explained to Ms. Anderson that these areas of the body are beyond the scope of my practice. I would be happy to refer her to a plastic or oral maxillofacial surgeon for evaluation of her chin lesion. Similarly, I would be happy to refer her to a physiatrist or orthopedic/neurosurgeon for evaluation of her spine, if she wishes. I have suggested at this point that she see her primary care physician for coordination of her care, as she seems to have multi-system complaints as a result of her recent injury. For my part, I will plan to see her back in four to six weeks for evaluation of her right humerus.

JE 4-08. In addition, Dr. Magee contacted Surety in Claimant's presence to advise of his position:

> I also contacted the State Insurance Fund to discuss Ms. Anderson's plan of care. I made it clear to the State Insurance Fund that back, neck and facial complaints are beyond the scope of my practice, and I do not consider myself an appropriate referral source for injuries of this kind. I have suggested that she see an occupational medicine physician or primary care physician to coordinate these referrals if appropriate. This conversation was held in the presence of Ms. Anderson.

Id.

24. Between November 4 and December 4, 2009, Claimant participated in seven

physical therapy sessions to rehabilitate her right humerus fracture. A progress report through December 2, 2009 indicates some improvements in range of motion, but Claimant was still in significant pain. The physical therapist recommended extending Claimant's therapy because she still had significant loss of range of motion and considerable pain, she was unable to do any lifting or overhead reaching, and she was at risk for significant strength deficits due to her long period of RUE inactivity. However, Claimant and Dr. Magee, for different reasons, each apparently disagreed that additional physical therapy would be helpful, so she did not return. In any event, Dr. Magee did not authorize additional treatment and Claimant requested to be discharged, so she did not return.

25. On November 18, 2009, Claimant again followed up with Dr. Magee. She was no longer having crepitus at her fracture site, her right arm internally and externally rotated as a unit, she had a palpable fracture callus, and she was distally grossly neurovascularly intact, so Dr. Magee again opined that her humerus fracture was healing well. However, Claimant was "still having quite a bit of pain that she describes as limiting in severity and nature, over the anterolateral aspect of her shoulder…exacerbated with any attempts to forward elevate or abduct her arm." JE 4-09. She also "winces and guards heavily with attempts to passively manipulate her shoulder." *Id.* Dr. Magee ordered a contrast MRI of Claimant's shoulder.

26. On December 17, 2009, Claimant underwent a second opinion examination by J. Craig Stevens, M.D., a physiatrist board certified in physical medicine and rehabilitation, electrodiagnostic medicine and independent medical evaluation. Surety provided Dr. Stevens with Claimant's prior medical records related to her industrial accident, which he recounted in his report.

27. Claimant reported pain in her right arm and shoulder and left knee.[4] In addition, she had numbness and tingling in the third through fifth digits of her right hand. On examination of Claimant's knees, Claimant demonstrated diminished lower extremity reflexes and a waddling (as opposed to antalgic) gait, but otherwise normal responses. Claimant resisted movement of her right shoulder, but she was ultimately able to flex and abduct to 70 degrees each way. In addition, Dr. Stevens "was briefly able to demonstrate far greater range passively." JE 5-02. Claimant also exhibited patchy hypesthesia in her right hand suggestive of ulnar sensory deficit or C8 deficit, as well as pain without electric sensation on ulnar Tinel's at the elbow, and diminished but symmetrical biceps, triceps and brachioradialis reflexes.

28. Dr. Stevens ordered an MRI of Claimant's left knee and an x-ray of her chin. In addition, he planned to conduct an EMG of her right upper extremity on a follow-up visit to rule out ulnar neuropathy at the elbow, radial nerve injury at the mid humerus, cervical radiculopathy and carpal tunnel syndrome. Dr. Stevens deferred to Dr. Magee regarding Claimant's right arm and shoulder treatment.

29. Dr. Stevens posited that Claimant's multiple-source pain complaints may be related to her withdrawal from Percocet or her termination from Boundary. These opinions are colored by the fact that Claimant's current pain reports were not all previously documented in her accident-related medical records. "After 10 ½ weeks of treatment, Ms. Anderson is now presenting with a plethora of other complaints that were not described anywhere within her records up until that point, other than some brief mention in the initial ER note; and that consists only of a nurse's note reporting some slight bruising of the chin and slight discomfort of the knees." JE 5-03. Indeed, in rendering his opinions, Dr. Stevens opined that the bar should be

[4] Claimant's right knee pain had by then receded to its pre-injury status.

raised in Claimant's case when determining work-relatedness of both her knee and right arm injuries for exactly this reason.[5]

30. As described above, the assumption that Claimant did not report significant knee (and chin) pain early on is misguided, since Dr. Magee admitted that he did not document these complaints even though Claimant reported them. This is relevantly reflected in Dr. Magee's chart note of October 9, 2009:

> Ms. Anderson has also mentioned to me that she fell on both of her knees at the time of her fall, and has bilateral knee pain. We have not addressed this at her previous clinic visits, but we intend to do so at the time of her next clinic visit. The reason for this is that we have been concentrating on her humerus fracture until now.

JE 4-06.

31. On December 23, 2009, Dr. Magee met with Claimant, but he did not examine her. Claimant had elected not to undergo a contrast MRI of her right shoulder because she has a family history of renal failure. Dr. Magee consequently ordered an MRI without contrast. He also noted that Claimant's chin and left knee pain were being treated by Craig Stevens, M.D. Along those lines, Claimant underwent skull x-rays and a left knee MRI earlier that day.

32. Claimant's skull x-rays identified no fractures. Her left knee MRI demonstrated retropatellar chondromalacia and significant tricompartmental arthritic change, meniscal degenerative change and tears in both her medial and lateral menisci. As for her right shoulder

[5] "I am going to raise the threshold of work relatedness such that if a degenerative meniscal tear is identified it will very likely be attributed to preexisting. I state this because again there was no mention of knee complaints for several months after the injury and I feel that that sufficiently reduces the likelihood of injury relatedness of her current knee condition as almost certainly not being caused by the injury but rather a continuation of preexisting degenerative change perhaps accelerated by her obesity." JE 5-03. "Specifically I need to rule out ulnar neuropathy at the level of the elbow, a radial nerve injury at the level of the mid humerus as well as carpal tunnel syndrome or cervical radiculopathy. Again I would raise the threshold for work injury relatedness pertinent to any condition found based on the lack of complaints of dysesthetic symptoms through any of the earlier treatment records up until long after the injury." JE 5-04.

MRI, it revealed acromioclavicular joint spurring with lateral downsloping of the acromion and supraspinatius tendinopathy, but no rotator cuff tear.

33. On January 11, 2010, Dr. Stevens again examined Claimant prior to performing EMG testing. He noted hypesthesia in Claimant's right hand, some thenar atrophy with mild sensory loss, and tenderness over her humerus fracture. Claimant was negative for Tinel's sign over her radial nerve and she did not demonstrate sensory changes generally related to her radial nerve distribution.

34. The EMG revealed findings consistent with significant right carpal tunnel syndrome "more chronic than acute with accumulated denervation over a great period of time." JE 5-05. Dr. Stevens found no evidence of active or ongoing denervation related to her carpal tunnel syndrome and no evidence of either radial or ulnar neuropathy.

35. Dr. Stevens ultimately found that Claimant's chin and right shoulder pain, as well as her right hand paresthesias, were unrelated to her workplace accident. He reluctantly conceded, however, that the evidence may establish that her left knee pain is from a work-related condition:

> Left-sided knee degenerative arthritic change with medial and lateral meniscus tears. This is a very significant judgment call as to whether the tears represent the evolution of a spontaneous degenerative condition or were caused by her specific injury. Review of prior medical records may be necessary in order to determine the extent to which she was having symptoms prior to the injury. If she truly was completely asymptomatic in regard to her knees prior to the injury, and given the fact that the nurse's notes on the date of her initial evaluation do make mention of knee symptoms with her initial presentation, then a work injury-caused meniscal tear may need to be accepted.

JE 5-08. He again deferred to Dr. Magee concerning Claimant's right humerus fracture.

36. On January 13, 2010, Dr. Magee again examined Claimant, who was reporting

pain in her RUE, knees, neck and back. Regarding her RUE, Claimant had full range of motion in both shoulders; however, she also had a positive Neer impingement sign and mild half-grade weakness with resisted abduction and external rotation, presumably on her right, which Dr. Magee suggested may be related to poor effort. She was tender to palpation over her fracture anteromedially but she demonstrated no palpable crepitus. She was distally neurovascularly intact.

37. Dr. Magee also reviewed Claimant's RUE MRI, which he opined demonstrated no acute injury. He did not take new x-rays, apparently electing to rely upon her most recent RUE x-rays, taken on October 21, 2009.

38. Concerning Claimant's right humerus fracture, Dr. Magee opined that it had fully healed and no further treatment was required. With respect to whether Claimant could return to work, Dr. Magee opined that her right shoulder, right humerus and bilateral knee conditions should not prevent her from working:

> With regard to her humerus fracture, I believe that this is fully healed at this point and she does not require any further follow up [*sic*] with me for this condition. With regard to Ms. Anderson's injury of 08/08/09 I am unable to comment regarding her ability to return to her preinjury position/occupation as an LPN. From my perspective I see no objective evidence that she should be limited due to any orthopedic injuries in her knees or right shoulder or humerus.

JE 4-12. For her part, Claimant did not feel that her humerus fracture had healed. She still had significant pain and weakness. Most notably, she could not fully raise her right arm. When she discussed her continuing problems with Dr. Magee, he advised that her condition was as improved as it would get.

39. Dr. Magee also discussed with Claimant the results of her left knee MRI, which identified medial and lateral meniscus tears. He did not believe that these tears correlated with

her industrial accident symptoms, which primarily consisted of anterior tenderness to palpation, and which did not include locking, catching or instability. (But, see findings on exam of Drs. Tallerico and McNulty, below). He further reasoned that, since her right knee symptoms were the same as her left, they too are likely unrelated to her fall at work and, thus, no further follow-up was indicated with respect to Claimant's bilateral knee pain.

40. Concerning Claimant's back and neck pain, Dr. Magee noted that Dr. Stevens was apparently not treating these conditions, either. He recommended that they be evaluated and, after they were medically addressed, that Claimant should then undergo an independent medical evaluation (IME) to determine her permanent disability, if any. Nevertheless, there is no evidence in the record that Claimant ever received any additional follow-up care related to her neck or low back pain.

41. On July 12, 2010, after undergoing IMEs with Dr. Tallerico and Dr. McNulty (see below), Claimant again followed up with Dr. Magee regarding right shoulder and arm pain. "She has had multiple independent medical examinations, the most recent of which suggested that she may have a persistent nonunion or delayed union of her humerus fracture. To further evaluate this, a CT scan was recommended."[6] JE 4-16. On exam, Claimant was "exquisitely tender to palpation about the middle aspect of her right arm. She winces with very slight soft tissue palpation. She also winces and withdraws with gentle passive range of motion. There is no palpable crepitance. Her arm is not grossly deformed. She is distally neurovascularly intact." *Id.* Dr. Magee noted that it is possible that Claimant had a fibrous nonunion, but he was concerned that she was demonstrating a degree of pain in excess of what should be expected. He

[6] Dr. McNulty recommended a CT scan; Dr. Magee admitted at his deposition that he should have obtained a CT scan earlier. "Q. If you could go back and re-manage this care again, is there anything that you would do differently? A. I think I would have probably gotten a CT scan earlier." Magee Dep., p. 69.

ordered a CT scan to "definitively answer this question." *Id.*

42. The CT scan was performed July 27, 2010 at Boundary, and was initially interpreted by Dr. Melendez. According to Dr. Melendez's report, the image confirmed Claimant had a near-complete non-union:

> There is near complete non-union of the proximal humeral shaft fracture. A small portion of the proximal posterior aspect of the fracture was a partial union. However, the vast majority of the fracture is nonunited. There is approximately 2.0 cm of posterior lateral displacement of the main distal fragment. There is approximately 3.5 cm of overriding. There is exuberant calcified callus at the fracture site. There is no significant soft tissue swelling.

JE 4-17.

43. Claimant returned to Dr. Magee, for the last time, on August 5, 2010. She was still experiencing RUE pain both at rest and with activity. On exam, Dr. Magee noted both significant pain and "mild atrophy of the muscles of her shoulder girdle on the right." JE 4-18. Dr. Magee interpreted Claimant's CT scan without reference to the near complete nonunion: "Review of her CT scan from Boundary Community Hospital reveals that her fracture is translated 100% with abundant callus formation. There is sign of bridging bone formation. This is roughly equivalent to one-third to one-half the diameter of the humerus in width." *Id.*

44. Dr. Magee ordered the CT scan to definitively determine whether Claimant's humerus treatment had resulted in a nonunion. Dr. Melendez's opinion confirmed that, indeed, Claimant's CT scan demonstrated a nonunion. Nevertheless, Dr. Magee did not concur that Claimant's pain was the result of a nonunion, so he did not change his treatment recommendations:

> I do not believe Ms. Anderson's symptoms are coming from a bony non-union. She may be experiencing some soft tissue irritation from bony prominence from her mal-union. I am concerned that her symptoms are

> out of proportion to her clinical findings and therefore I do not feel confident that any surgical intervention will address her pain adequately. Accordingly, I do not feel that she is a good surgical candidate. I have recommended that she seek evaluation by another orthopedic surgeon for another opinion if she wishes to investigate surgical treatment options further. She expressed understanding and agreement with this plan.

JE 4-18.

INDEPENDENT MEDICAL EVALUATIONS

45. Brian Tallerico, D.O. Dr. Tallerico performed an IME at Defendants' request on March 9, 2010. Details concerning his experience treating spiral fractures of the humerus or meniscus tears are not evident from the record. His report is in evidence, but he did not provide live testimony in these proceedings.

46. Dr. Tallerico reviewed Claimant's medical records compiled both before and after her industrial accident, as well as a summary of relevant events provided by Surety, which he quoted at length in his report. He confirmed that Claimant's prior medical history was negative for any related medical issues. He also took an oral history from Claimant and performed an examination.

47. Claimant described the symptoms she was currently experiencing. She had very limited use of her right upper extremity and was unable to shake hands upon introduction except with her left hand. Areas around her neck and lumbar spine into her legs were numb. She had burning pain, grinding, popping and swelling in her knees, as well as difficulty sitting for long periods and going up or down stairs. She was also unable to kneel or squat.

48. Prior to examination, Dr. Tallerico advised Claimant not to participate in any painful activities. Claimant was pleasant and cooperative, but appeared depressed. Dr. Tallerico noted no upper or lower extremity atrophy, asymmetry or deformity and concluded that Claimant

asserted less than maximal effort with Jamar hand dynamometer testing on the right. She was guarded with right shoulder testing and had global tenderness over her right upper extremity and into her clavicle. She was negative for both Phalen's maneuver and elbow flexion maneuver at her elbows, and for Tinel's sign at her elbows and wrists. She had mild symmetric atrophy in her thenar eminences which Dr. Tallerico attributed to nonuse rather than denervation.

49. Dr. Tallerico also noted abnormal pain behavior. Claimant's antalgia increased on examination as compared with Dr. Tallerico's observations of her in the waiting room, and he noted five positive Waddell's signs out of five. "I believe Ms. Anderson is capable of embellishing her pain complaints in order to prolong her disability benefits. I cannot identify any objective findings to support her pain complaints today." JE 7-13.

50. The only conditions that Dr. Tallerico attributed to Claimant's industrial accident were her right humerus fracture and her chin and bilateral knee contusions. Specifically, he did not relate her medial and lateral meniscus tears in her left knee to her fall at work, and he opined that her knee and chin contusions had fully healed. Regarding Claimant's RUE symptoms, Dr. Tallerico deferred to Dr. Magee: "She is seven months out from the right humerus fracture, and this is apparently is [*sic*] well healed [*sic*] per Dr. Magee's notes." JE 7-13. Dr. Tallerico recommended no further treatment and he opined that Claimant was capable of returning to work without restrictions.

51. On March 23, 2010, Dr. Stevens indicated to Surety that he "completely" agreed with the findings and conclusions set forth in Dr. Tallerico's IME, even though Dr. Tallerico did not agree with Dr. Stevens' opinion that Claimant's left knee condition would likely need to be deemed related to her workplace fall.

52. On March 24, 2010, Dr. Magee also indicated to Surety that he agreed with

Dr. Tallerico's findings and conclusions set out in his IME report.

53. On November 1, 2010, Dr. Tallerico prepared an updated report after reviewing Dr. McNulty's IME report and subsequent addendum (see below), Claimant's results from her right arm CT scan, and Dr. Magee's chart note following his review of the CT scan. He did not have the CT films for review, so he relied upon the interpretations of Dr. Melendez (radiologist) and Dr. Magee. Dr. Tallerico continued to agree with Dr. Magee, that Claimant would not be a good surgical candidate for repair of any malunion of her humerus.

54. John M. McNulty, M.D. Dr. McNulty performed an IME on June 7, 2010 at Claimant's request. He is a board-certified orthopedic surgeon who has maintained a private practice since 1990. Approximately 15-20 percent of his practice involves knee injuries, and he performs 80-100 knee arthroscopies each year. He treats approximately 20 humerus fractures each year, performing corrective surgery on 4-5 fractures like Claimant's annually. Dr. McNulty's IME report and chart note are in evidence. In addition, he testified at the hearing.

55. Dr. McNulty reviewed Claimant's medical records, took a medical history and performed an examination. Claimant was still experiencing 7/10 pain in her right arm, but her right hand numbness had resolved. She could lift her right arm up to about 90 degrees before feeling pain. She felt her right arm symptoms had plateaued. In addition, she was experiencing deep burning knee pain, worse on the left (6/10) than on the right (5/10). Her left knee was catching and popping, while her right knee just popped. Both had given out on her in the past. Claimant was still having intermittent neck pain, usually on the left side, with no radiculopathy symptoms, as well as intermittent stabbing back pain while sitting or lying down that radiated to her thigh and calf. Her chin was no longer a problem.

56. On examination of her RUE, Dr. McNulty observed that Claimant guarded that

area. She had a noticeable deformity on internal and external rotation and she was tender over the fracture site. A fracture callus was present. Claimant was also tender over the right shoulder and her range of motion in that joint was limited. She had reduced grip strength in her right hand versus her left. Dr. McNulty noted giveaway weakness during part of his examination due to pain, and limitations in the right shoulder examination due to guarding.

57. Dr. McNulty obtained new x-rays of Claimant's right upper extremity "which [note] a midshaft spiral humerus fracture which [show] areas of bridging callus, but some areas were of concern for incomplete healing." JE 8-06. Dr. McNulty also noted Claimant's limb was shortened due to the overlap of the fracture fragments. He was not convinced that her fracture was healed and recommended a CT scan for further evaluation.

58. Regarding her knees, Dr. McNulty observed Claimant walked with a slow, methodical gait and that she did not appear uncomfortable while sitting during the interview. He performed a thorough examination which confirmed that Claimant's left knee was more symptomatic than her right. Dr. McNulty concluded that Claimant's left knee meniscus tears were likely related to her industrial accident. "With no prior history of knee complaints, the current knee symptoms on a more probable than not basis in her left knee are related to her work-related injury." JE 8-06. However, his examination of her right knee did not lead him to the same conclusion. "Most likely, the right knee symptoms are attributable to pre-existing osteoarthritis." *Id.*

59. Dr. McNulty also examined Claimant's spine. During this examination, he tested her forward flexion, observing that she could almost reach her ankles. "Of note, she did only extend her left arm and not her right." JE 8-06. He ultimately opined that Claimant's low back and neck complaints were not industrially related, but were instead due to the normal aging

process. His examination of her chin confirmed that it had healed.

60. On July 27, 2011, Claimant followed up with Dr. McNulty. He took new x-rays, opining, "[t]wo views of the right humerus demonstrates [*sic*] an incompletely healed humeral shaft fracture. There is bayonet apposition. There are large areas of incomplete healing." JE 8-10. He notes that he had previously referred Claimant to Dr. Howlett for a second opinion and surgical treatment for her nonunion. She did not undergo surgery, however, because it was not approved by Surety. On exam, she was unimproved from his last evaluation. He diagnosed nonunion of Claimant's humeral shaft fracture with dysfunction of her right upper extremity. "She is still in need of surgery to repair her nonunion. At this point she has a dysfunctional right upper extremity secondary to pain and fracture nonunion. Hopefully her surgery will be approved by the surety." JE 8-09.

61. Dr. McNulty opined that Claimant's right humerus fracture would improve with surgery, that she is a good surgical candidate and that she has been unable to return to work since her industrial accident. He also opined that her left knee pain and instability is at least partially due to meniscal tears caused or aggravated by that fall, and that arthroscopic surgery would improve these symptoms.

ANDREW HOWLETT, M.D.

62. On November 13, 2010, Andrew Howlett, M.D., an orthopedic surgeon, authored a letter to Dr. McNulty following up on his evaluation of Claimant. He unequivocally opined that Claimant's fracture had not properly healed, that she was a surgical candidate and that her unhealed fracture was causing her pain:

> She has no doubt gone on to a hypertrophic nonunion. There is potentially some bridging on the CT scan but the surface area of that is significantly small and in effect has gone on to a nonunion. No doubt based on the

> physical exam performed by myself and Brandi Desaveur, my PAC, that this is causing significant pain and discomfort.
>
> I would recommend surgical stabilization with treatment of the nonunion with local autograft. This will be done through an anterolateral approach…No doubt this is a result of her industrial accident. At this point I would not release her to work with that extremity. For her comfort I would like to proceed with this in the relatively near future.

JE 9-01.

63. On August 29, 2011, Dr. Howlett confirmed his surgical recommendation after reviewing Dr. McNulty's July 27, 2011 chart note and Claimant's x-ray images taken that day. "I would be more than happy to proceed with this surgery at any point with or without approval by her industrial claims. I know that may not be possible for the patient but I do believe this will make a dramatic improvement for her." JE 9-02.

CLAIMANT'S CREDIBILITY

64. At the hearing, Claimant ambulated with difficulty and her right arm hung like a dead appendage. She did not smile or waste words. She addressed most questions put to her with a flat or resigned affect, but a few (regarding her need to rely upon her children for help with activities of daily living like housework and showering) brought quiet tears which she quickly and deliberately brought under control. Claimant's description of her care by Dr. Magee, relevantly corroborated by him and his chart notes, was sadly persuasive. Claimant's symptoms went unaddressed by Dr. Magee for two-and-a-half months, despite her repeated requests for care. Such circumstances could reasonably incent any patient to more deliberately demonstrate pain behaviors on exam in an effort to attract the attention of a caregiver. The evidence in the record establishes that any symptom exaggeration by Claimant was more likely

undertaken for the purpose of obtaining adequate medical care than to prolong any workers' compensation benefits.

65. Still, exaggeration on a patient's part, for whatever reason, can lead to misdiagnoses so, even though Claimant's behavior in this regard is understandable, it could nevertheless affect her credibility. With respect to Claimant's right arm and left knee conditions, however, there is ample objective evidence to support her claims that these injuries became significantly symptomatic only after her industrial accident. Dr. McNulty explained the likely anatomical source of Claimant's RUE symptoms:

> The problem - - some of the - - the pain generated is that when she moves, when she tries to move her arm, bone is going to press on the muscle, there's movement there. The muscle's not used to being pressed on, and that's going to cause some pain.
>
> There's [*sic*] also nerve endings in the fracture site; it's not united, and that's another pain generator.

Tr., pp. 54-55. He also explained why he believes Claimant's reports of right humerus pain and weakness are accurate even though Dr. Tallerico and Dr. Magee do not:

> She has got a real problem here. This bone is not healed, and she is reluctant to move it because it's not healed. So concerning her arm, I think the degree of symptom magnification is low, based on objective findings of what I see and my experience with this condition.

Tr., p. 55.

> The noticeable absence in Dr. Tallerico's report is his review, actually reviewing and looking at the CAT scan. The CAT scan is clear-cut, objective evidence that yes, it didn't heal.
>
> Dr. Tallerico and to some degree, I think, Dr. Magee discredits Mrs. Anderson, that her pain complaints are disproportionate and that she shouldn't have surgery. In my mind this is pretty clear-cut evidence of a nonunion, confirmed on x-rays as well [*sic*] as CT scan. And the biomechanical limitations of the bone not functioning properly warrants surgery. I mean, she may have complaints in their - - in their eyes about

> other problems, but this is a real problem, and it's demonstrated on the studies.

Tr., pp. 56-57.

66. Similarly, Claimant's left knee x-rays and MRI demonstrate lateral and medial meniscal tears. Further, it is undisputed that she did not experience significant knee pain or instability prior to her industrial accident but, following that event, she consistently reported knee symptoms. Although her right knee symptoms resolved, her left knee remained painful and became unstable. Dr. McNulty agreed that Claimant was possibly exaggerating her back symptoms but, nevertheless, he believed the totality of evidence supports Claimant's left knee symptom reports. The Referee agrees.

67. Claimant is a credible reporter of her right upper extremity and left knee symptoms.

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 (1990). The humane purposes which it serves leave no room for narrow, technical construction. *Ogden v. Thompson*, 128 Idaho 87, 88, 910 P.2d 759, 760 (1996). Facts, however, need not be construed liberally in favor of the worker when evidence is conflicting. *Aldrich v. Lamb-Weston, Inc*., 122 Idaho 361, 363, 834 P.2d 878, 880 (1992).

REASONABLE MEDICAL CARE

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).

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).

The Idaho Supreme Court has held that medical treatment is reasonable when three circumstances exist: 1) the claimant made gradual improvement from the treatment received; 2) the treatment was required by the claimant's physician; and 3) the treatment received was within the physician's standard of practice, and the charges were fair, reasonable and similar to charges in the same profession. *Id.* However, the *Sprague* standard anticipates a situation in which treatment has already been rendered, and the *Sprague* analysis is not readily applicable to care, like that at issue in the instant matter, that is prospective in nature. *See*, *Richan v. Arlo G. Lott Trucking, Inc.,* IC 2007-027185 (Feb. 2011); and *Ferguson v. CDA Computune, Inc.*, *et. al*., consolidated case numbers IC 2001-005778, IC 2001-021764, IC 2004-504577 and IC 2004-000161 (filed Feb. 2011).

68. Drs. McNulty and Howlett have recommended surgery to repair Claimant's right humerus, and Dr. McNulty has recommended surgical repair of Claimant's left knee meniscus tears. To determine whether the care required by these physicians is "reasonable," the Commission must ascertain whether the required care is likely to be efficacious. In other words,

if, from the medical evidence adduced by Claimant, it appears more probable than not that the care required by Drs. McNulty and Howlett will improve Claimant's condition, then the care is "reasonable."

RIGHT HUMERUS FRACTURE

69. There is no dispute that Claimant suffered from a fractured right humerus as a result of her industrial injury or that she continues to suffer pain and reduced strength and range of motion in her right upper extremity. However, Dr. Magee disputes that surgery would improve Claimant's condition. He agrees that Claimant's fracture did not heal ideally, because she continues to have pain and dysfunction, but he has taken the position that Claimant's humerus is adequately healed. "I think she has a bony union. So I think, in my opinion, taking down a bony union to plate and graft her fracture would be unnecessary and would not change her outcome. If someone has a fibrous nonunion or a nonunion, then yes, I would agree, but we are talking about two different diagnoses." Magee Dep., p. 68.

70. Dr. Magee admitted, however, that the proposed surgery, if successful, would accomplish bony union and correct the shortening in Claimant's RUE. More significantly, he inadvertently admitted that Claimant's condition is just like that of a patient with a nonunited humerus that he successfully treated with the proposed surgery:

> Q. Can you estimate for me how many humeral fractures you have now treated in your practice?
> A. I can't.
> Q. More than 20?
> A. I have no idea, [*sic*] I don't keep track of that information.
> Q. How many do you know, if at all, [*sic*] have been surgical?
> A. I can't answer that question. Without reviewing my records, I can't tell you.
> Q. Have you had any that have been surgical?
> A. Yes, absolutely. In fact, I treated a *humeral nonunion almost exactly like this* with open reduction and internal fixation and bone grafting about

a year ago.
Q. You had a good result from that surgery?
A. Yes, I did.

Magee Dep., p. 72. (Emphasis added.)

71. Drs. Stevens and Tallerico both deferred to Dr. Magee with respect to diagnosis and treatment of Claimant's right humerus fracture.[7] However, they each also opined that Claimant is not a good surgical candidate because she exaggerated her symptoms on examination. As determined above, however, Claimant was found to be a credible reporter of her RUE symptoms, which are also adequately supported by objective imaging evidence.

72. Dr. McNulty provided a detailed explanation at the hearing to support his opinions that the proposed surgery would improve Claimant's pain and functioning in her right arm and that her pain complaints were medically justifiable:

> If she was - - let's say day 1 she was in treatment. I saw her day 1; I look at this fracture with the wide separation of the fracture fragments at the time of injury, and I offer - - this is a frequent occurrence. I see these, oh, five, six times a year - - I offer the patient surgery right off the bat.
>
> The benefit of the surgery is, particularly with this wide of a displacement of the fracture fragments, I'm going to get the bone aligned. I'm going to dramatically increase the probability of healing. I'm going to provide some pain relief for her by stabilizing the fracture fragments.
>
> With the fracture separated like this, every time she changes position there's going to be movement in that bone. She's going to have pain. So in her defense, she is being treated with a method that was pretty much doomed to failure and a pain cycle developed. Because just lying down, from lying down to sitting up there's movement between the bones which causes pain, and that could have been alleviated with just a simple putting a rod in to [*sic*] stabilize the fracture site.

[7] Dr. Tallerico purports to offer an opinion regarding Claimant's RUE in his November 1, 2010 addendum in which he reviewed documents and then elected to support Dr. Magee's opinion. Since Dr. Tallerico had previously deferred to Dr. Magee and did not explain why he completely discounted Dr. Melendez's and Dr. McNulty's opinions that Claimant's humerus was nonunited, his addendum opinion regarding Claimant's RUE lacks foundation and amounts to another deferral to Dr. Magee.

> The rod goes from the top by the shoulder. The bone is hollow. It dramatically limits the ability of the fracture to move and, as I mentioned, would increase the chance of healing dramatically.

Tr., pp. 58-59.

73. In addition, Dr. Howlett wholeheartedly opined that Claimant's right humerus did not properly heal and that a stabililization, fixation and allograft surgery would improve her RUE symptoms.

74. The Referee finds the opinions of Drs. McNulty and Howlett more persuasive than those of Drs. Magee, Stevens and Tallerico. It is likely that the proposed surgery to repair Claimant's right humerus fracture will reasonably improve her condition. Claimant has proved her entitlement to benefits to additional reasonable medical care, including but not limited to a stabililization, fixation and allograft surgery.

LEFT KNEE MENISCUS TEARS

75. It is undisputed that, following her industrial accident, Claimant had tears in her medial and lateral menisci of her left knee. Drs. Stevens (at first) and McNulty opined that if Claimant was asymptomatic before her industrial accident, then this event likely permanently aggravated her left knee condition, including her meniscus tears, even though she had preexisting tricompartmental arthritis that may also have been a contributing factor to her post-accident symptomatology. Drs. Stevens (later) and Tallerico, however, ultimately concluded that Claimant's reporting accuracy must be discounted, so the medical evidence was inadequate to establish that her meniscal tears and relevant symptomatology did not predate her industrial accident.

76. As determined above, Claimant's symptomology reports regarding her left knee

are credible. Therefore, the evidence in the record establishes that Claimant's significant left knee pain and instability only developed after her industrial accident. Given this finding, Dr. Stevens' earlier opinion supports Dr. McNulty's finding of a causal connection between Claimant's industrial accident and her resultant left knee pain and instability.

77. Claimant has met her burden of proving that her preexisting left knee arthritis was permanently aggravated by her workplace fall in August 2009. She is entitled to reasonable and necessary medical treatment to improve her pain and instability that resulted from that event. Dr. McNulty has opined, without opposition, that arthroscopic surgery to repair her meniscus tears would improve her relevant symptoms. Dr. McNulty's opinion is persuasive. Claimant is entitled to reasonable medical treatment for her left knee condition, including but not limited to arthroscopic surgery to repair her medial and lateral meniscus tears.

Temporary Total Disability (TTD)

78. Idaho Code §§ 72-408 and 409 provide time loss benefits to an injured worker who is temporarily totally disabled. Here, it has been determined that Claimant's right humerus fracture has never properly healed, but that it could, with surgery. In addition, Dr. McNulty opined that, as a result her failure to use her right arm, Claimant has never been able to return to work as an LPN, where she is required to be capable of lifting at least 50 pounds.

79. Dr. Magee's opinion that Claimant reached MMI on January 13, 2010, and the concurrences of Drs. Stevens and Tallerico therein, are unpersuasive. The Referee finds Claimant has never achieved medical stability since her industrial accident on August 8, 2009. Under *Malueg v. Pierson Enterprises*, 111 Idaho 789, 727 P.2d 1217 (1986), once a claimant establishes by medical evidence that she is within a period of recovery from the industrial accident, she is entitled to TTD benefits *unless* and *until* evidence is presented that she has been

medically released for light work and 1) that an employer has made a reasonable and legitimate offer of suitable employment to her or that 2) there is employment available in the general labor market which claimant has a reasonable opportunity of securing, and which is consistent with her physical abilities. Claimant has been in a period of recovery since the date of her accident. Therefore, the burden shifted to Defendants to adduce the proof required to curtail the obligation to pay TTD benefits. Here, no such proof has been presented, and the default case is that Claimant is entitled to time loss benefits effective August 8, 2009, through the date of medical stability, with credit for payments already rendered, unless and until Defendants can meet their burden of proof.

CONCLUSIONS OF LAW

1. Claimant has proven that she is entitled to reasonable and necessary medical care for her right upper extremity and left knee injuries, specifically including a right humerus stabilization and fixation with allograft surgery to improve her RUE symptoms, and arthroscopic surgery to repair her left knee meniscus tears.

2. Claimant has proven that she is entitled to TTD benefits through the date on which she becomes medically stable, with credit for payments already rendered, or until Defendants adduce proof sufficient to meet their burden under *Malueg*.

3. All other issues are reserved.

RECOMMENDATION

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

DATED in Boise, Idaho, on the ___1st____ day of _____May_____, 2012.

INDUSTRIAL COMMISSION

/s/_____
LaDawn Marsters, Referee

ATTEST:

/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the ___4th___day of _____May_____, 2012, 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:

JAMES F COMBO
2005 IRONWOOD PARKWAY STE 201
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E SCOTT HARMON
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sjw

/s/_____

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

CLAUDIA ANDERSON, Claimant, v. BOUNDARY COMMUNITY HOSPITAL, Employer, and LIBERTY NORTHWEST INSURANCE CORP., Surety, Defendants.	**IC 2009-020954** **ORDER** May 4, 2012

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 she is entitled to reasonable and necessary medical care for her right upper extremity and left knee injuries, specifically including a right humerus stabilization and fixation with allograft surgery to improve her RUE symptoms, and arthroscopic surgery to repair her left knee meniscus tears.

2. Claimant has proven that she is entitled to TTD benefits through the date on which she becomes medically stable, with credit for payments already rendered, or until Defendants adduce proof sufficient to meet their burden under *Malueg*.

3. All other issues are reserved.

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

DATED this __4th____ day of _____May_____, 2012.

INDUSTRIAL COMMISSION

/s/_____
Thomas E. Limbaugh, Chairman

/s/_____
Thomas P. Baskin, Commissioner

/s/_____
R.D. Maynard, Commissioner

ATTEST:

/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __4th__ day of _____May_____, 2012, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

JAMES F COMBO
2005 IRONWOOD PARKWAY STE 201
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sjw

/s/_____