BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

CINDY BROOKS, Claimant, v. GOODING COUNTY EMS, Employer, and STATE INSURANCE FUND, Surety, Defendants.	**IC 2009-025823** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **Filed September 12, 2013**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the above-entitled matter was assigned to Referee LaDawn Marsters, who conducted a hearing on October 11, 2012 in Twin Falls, Idaho. Claimant was present in person and represented by Patrick D. Brown of Twin Falls. Employer ("Gooding County" or "Employer") and Surety (collectively referred to as "Defendants") were represented by Neil D. McFeeley of Boise.

Oral and documentary evidence was admitted, and post-hearing depositions were taken. The matter was briefed, and the case came under advisement on May 13, 2013. It is now ready for decision. The undersigned Commissioners have chosen not to adopt the Referee's recommendation and hereby issue their own findings of fact, conclusions of law and order.

ISSUES

The parties seek adjudication of the following issues:

1. Whether Claimant's condition is due in whole or in part to a preexisting injury/condition;

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

   a. Medical care;

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

   c. Permanent partial impairment (PPI); and

   d. Disability in excess of impairment;

3. Whether apportionment for a preexisting condition pursuant to Idaho Code § 72-406 is appropriate;

4. Whether Claimant sought medical care outside the provisions of Idaho Code § 72-432 and, therefore, is not entitled to reimbursement for the costs of such care.

In her briefing, Claimant raised, for the first time, the issue of attorney fees pursuant to Idaho Code § 72-804. Defendants objected on the grounds that this issue was not timely raised. The Commission agrees with Defendants. Because the issue of attorney fees was not timely raised, it will not be decided herein.

In addition, Claimant did not address the issue of TPD/TTD benefits in her briefing. Therefore, no determinations with respect to these benefits will be made herein.

CONTENTIONS OF THE PARTIES

Claimant, an emergency medical technician (EMT), injured her back on October 3, 2009 when her partner dropped the other end of a gurney they were lifting. Through May 27, 2010, Surety paid for the treatment she received from physicians, a chiropractor and a physical

therapist. Surety ceased paying benefits on the primary authority of Dr. Friedman, who opined Claimant had fully healed from her industrial injury.

At the time of the hearing, Claimant suffered from left-sided low back pain due to muscle spasms and other symptoms she contends are due to her industrial accident. Claimant relies upon the opinions of Drs. Steffens and Wiggins to establish that her low back condition is entirely due to her October 3, 2009 industrial accident. She argues that she is entitled to reimbursement for her medical costs incurred after Surety ceased paying her benefits, including, but not limited to, those charged by Drs. Pryor, Dille, Steffens and Wiggins, as well as future medical care related to her ongoing pain and spasms. Claimant seeks 8% PPI related to her left lumbar paraspinal pain and continued spasm, which causes her difficulty in sitting for long periods, as well as other problems. She also seeks an award of 41% disability in excess of PPI, with no apportionment, based upon Mr. Porter's vocational disability analysis.

Defendants counter that Claimant's time-of-hearing condition is not related to her industrial accident, but to a preexisting condition that originated with a lifting accident in 2007. Relying upon Dr. Friedman's opinion, in which Drs. Jensen and Verst both concurred, Defendants posit that Claimant's industrial accident temporarily exacerbated her preexisting low back condition but, by May 27, 2010, her 2009 industrial injury had fully healed. Therefore, Claimant is not entitled to additional benefits for medical care, PPI or PPD. If, however, the Commission determines that Claimant has suffered PPI, then Defendants argue that 2% of the whole person, assessed by Dr. Friedman in May 2010, is an accurate reflection of the PPI due to Claimant's industrially-related condition. Likewise, if the Commission determines Claimant has suffered PPD, then Defendants assert that Mr. Jordan's vocational disability analysis, which

supports a finding of 19-20% disability with apportionment for Claimant's preexisting back and right knee injuries, is better-founded than Mr. Porter's assessment.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The prehearing depositions of:
    a. Claimant taken April 7, 2011;
    b. Kim Cheri Wiggins, M.D., taken August 20, 2012; and
    c. John Steffens, M.D., taken October 17, 2012;
2. The testimony of Claimant, Tracy Ervin, P.T. and Delyn Porter, CDMS, taken at the hearing;
3. Claimant's Exhibits (CE) lettered A through Y; and
4. Defendants' Exhibits (DE) numbered 1 through 14; and
5. The post-hearing depositions of:
    a. David Jensen, D.O., taken November 29, 2012; and
    b. William Jordan, CDMS taken January 23, 2013.

OBJECTIONS

All pending objections are overruled.

FINDINGS OF FACT

1. **Vocational background.** Claimant was 43 years of age and residing north of Gooding, Idaho at the time of the hearing. She and her husband live on an acreage where they raise beef cattle. At the time of her industrial injury, Claimant was an accomplished emergency medical technician (EMT), employed by Gooding County, from 2005 until January 2010, earning $12.85 per hour at the time of injury.

2. Claimant is a high school graduate with some additional legal assistant training, and college coursework toward registered nursing and EMS/paramedic certifications. She holds certifications in EMT basic, advanced and paramedic studies, and was on the Dean's List while enrolled in the paramedic program. During her lifetime, she has accumulated job experience working in jobs including, but not limited to, customer service representative, EMT, billing clerk, infection control officer, veterinary technician/assistant, assistant innkeeper, chiropractor office receptionist/clerk, hotel maid, convenience store clerk, fast food worker, and insurance office clerk.

3. Following her industrial accident, from August 2010 through June 2012, Claimant worked for C3 at an inbound call center. She was a customer service representative servicing customers with inquiries regarding Medicare, Humana, prescription drug sales, billing, and insurance enrollment, claims, and benefits. She was making $11.79 per hour when she voluntarily left that employment for reasons unrelated to her industrial injury.

4. **Previous substance abuse history.** At the time of the hearing, Claimant asserted she had been clean for approximately nine years from former problems with methamphetamine and marijuana use.

5. **Previous low back treatment.** On September 25, 2007, Claimant sought medical treatment from Thomas Pryor, M.D., her general physician, for a back injury with radicular symptoms down her left leg and, apparently, muscle spasms in her low back, that she incurred while helping three others lift a 400-pound patient. Dr. Pryor's note indicates she was 5-foot-6 and weighed 120 pounds at the time. Flexeril and Norco, a narcotic pain medication, were prescribed, and Claimant attended physical therapy for several weeks with David Hutchinson,

MPT. Mr. Hutchinson recorded Dr. Pryor's diagnosis as "lumbar intervertebral disc injury without myelopathy." CE-310.

6. Claimant's chief complaint to Mr. Hutchinson on September 26, 2007 was lumbar spinal pain, radiating into the left leg, ranging from 3/10 to 10/10, and reported at 6/10 that day. Claimant's pain was exacerbated by remaining for very long in any one position, especially sitting. Her symptoms were relieved by changing position and with pain pills. Claimant described the quality of her pain as "stabbing, sharp [*sic*] prickling, dull and achy and tingling…feels like her leg is not attached to herself…[t]he symptoms last constantly…tingling in the left foot." CE-310. On observation, Mr. Hutchinson noted "good spine curvatures…no obvious wasting of muscles or swelling…no scars or deviations…tight hamstring musculature bilaterally." *Id.* To palpation, Claimant had pain in her piriformis region on the right at the greater trochanter and sacrum, increased pain in the left paraspinal muscle in the lumbar region and point tenderness over the left ilio-lumbar ligament. In addition, Claimant demonstrated pain and/or weakness on other portions of the objective examination. Mr. Hutchinson assessed significant strength deficits and coordination deficits of core musculature and significant pain from disc lesion with force closure deficits in the sacroiliac (SI) joint on the left.

7. On October 8, 2007, Dr. Pryor noted that Claimant's symptoms had resolved. She had no more spasm (just a residual "catch" above her left hip with certain movement) and no radiculopathy in either leg. Claimant was released to full-duty work without any restrictions. Contrarily, on that same day, Mr. Hutchinson opined that Claimant still had not reached pre-injury status, even though her condition had improved. Claimant continued to attend physical therapy until October 25, 2007. In his discharge report, Mr. Hutchinson wrote that Claimant had reached pre-injury status. He also noted that "[l]imitations persist secondary to strength deficits,

poor posture and core strength deficits," and that "[i]mprovements in each goal suggest that continued progression can be expected." CE-322. For these reasons, Mr. Hutchinson discharged Claimant with instructions to continue her rehabilitation at home.

8. **Preexisting right lower extremity (RLE) injuries.** Claimant has been treated repeatedly for RLE injuries. For example, when she was a teenager, Claimant underwent right knee arthroscopy, she thinks, to repair a meniscal injury. In August 1995 she slipped on a gas pump hose at work and twisted her right knee; in September 2002 she was treated for a right foot/ankle injury; in April 2003 she sprained her right ankle while walking in heels, then she resprained it in November 2004 while walking in the store; and, in October 2006 she was treated for right knee pain, swelling and catching after a heavy day of work, but with no known acute etiology.

9. Claimant again twisted her right knee when, on January 21, 2008, she slipped on ice at work carrying a gurney upstairs. Claimant received benefits for significant medical treatment related to this industrial injury. Her recovery was slow and, at one point, she was evaluated by David Jensen, D.O., physiatrist (see below), for reflex sympathetic dystrophy (RSD) as a possible explanation for her ongoing symptoms. Dr. Jensen ruled out RSD and concurred with James Retmier, M.D., Claimant's treating orthopedic surgeon, that arthroscopic chondroplasty was indicated. Following arthroscopic debridement and lateral release in June 2008, Dr. Retmeir opined that Claimant's knee condition was the result of pseudogout plus trauma from the industrial accident. During her recovery, Claimant underwent physical therapy, again with Mr. Hutchinson, and worked a modified-duty job. At her last physical therapy session, on July 30, 2008, Claimant still had not reached pre-injury status according to

Mr. Hutchinson, and she was still working to improve her right knee pain, strength deficits and gait disturbances. By September 9, 2008, Dr. Retmier released Claimant to full-duty work.

10. Eight months later (May 13, 2009), Claimant's right knee pain was significantly worse. She reported more pain than before (75% of the time, daily, mostly after activity), difficulty with stairs and hills, and difficulty with squatting. Nevertheless, she was taking no medications related to her right knee condition, and she felt it was "100% improved over her preop situation." CE-31. On evaluation, Dr. Retmier noted that Claimant had to use both hands to try to do a deep knee bend and that her flexion range of motion was limited to 125 degrees. Otherwise, her findings were normal. Dr. Retmier released Claimant to work without restrictions and opined that she was medically stable. He assessed 10% PPI of the RLE[1], "secondary to a combination of a significant level of pain and functional disability, slightly decreased range of motion and crepitus in the knee." *Id.* Robert F. Lindberg, M.D., performed an independent medical evaluation. On August 26, 2009, he opined that Claimant's PPI should be apportioned 50-50 between her preexisting right knee condition and her industrial injury.

11. Concerning functional use of the right knee, Dr. Lindberg stated:

> At this point there are physical examination findings consistent with good function for activities of daily living. Presumably, during an athletic activity the underlying chondromalacia may cause some underlying symptoms. On the basis of quad atrophy and loss of quadriceps tone it would suggest a continued effort to maintain strengthening exercises on a prolonged basis.

(*See* CE-H, p. 13). Claimant was seen on one final occasion by Dr. Retmier on May 17, 2010. At that time, he recorded the following history from Claimant concerning her right knee status:

> Cynthia is two years status post arthroscopic debridement of her right knee. She is doing very well. She apparently lost her job with the county EMS, but not because of her knee, apparently due to a back problem. Her knee is doing basically well. She says that she is 100% better than preop.

[1] Dr. Retmier attributed the full 10% PPI, calculated according to the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition (Sixth Edition)*, to the industrial injury.

Claimant's knee was normal on exam. Dr. Retmier gave Claimant a work release with no restrictions in regard to her right knee. (*See* CE-G, pp. 25-28).

12. **Industrial accident.** On October 3, 2009, Claimant again injured her low back. This time, her coworker dropped the other end of a gurney they were carrying.

13. **Terminology.** Expert opinions in the record establish the following relevant medical terminology:

a. *MRI.* Magnetic resonance imaging. Relevantly, MRI films would show a muscle tear. *See*, for example, Jensen Dep., p. 24.

b. *Muscle strain.* Injury that can involve micro tears in muscle fibers. A strain involving micro tears would be observable on timely MRI films. *See* Jensen Dep., pp. 62-63; Wiggins Dep., p. 10.

c. *Permanent muscle spasm.* Involuntary shortening of muscle fibers most likely detectable by visualization and/or palpation. Results from significant tearing of muscle tissue followed by improper healing and scar build-up within the tissue. *See* Steffens Dep., pp. 5-6; pp. 10-16.

d. *Quadratus laborum muscle (QLM).* The QLM runs from the midback down to the hip. It is a core postural muscle that allows a person to stand upright. It stabilizes the back and body, and controls twisting and bending. *See* Wiggins Dep., pp. 7-8; Steffens Dep., pp. 4-5.

14. **Initial treatment and diagnosis.** On the day of her accident, Claimant finished the hour or so left on her shift, took a Flexeril, then went home. After a few hours, however, she returned to Gooding County Memorial Hospital for emergent care, reporting low back spasm with pain and soreness. She was having difficulty sitting and standing, and she walked slowly

and with great pain. X-rays showed no deformity, dislocation or fracture. Exam revealed tenderness to palpation in the lumbosacral region[2] and difficulty rotating, bending, straightening, and flexing and extending from the waist. "Back sprain versus strain"[3] was diagnosed, and intravenous pain medication was administered. CE-116. Claimant was instructed to apply alternating hot and cold to her low back, refrain from heavy lifting, and to limit her motion and activity. She was taken off work for two days and advised to follow-up with Dr. Pryor in three-to-five days. Vicodin 5/500 and Norco 5/325 were prescribed.

15. Dr. Pryor examined Claimant on October 7, 2009. Claimant was 5-foot-6 and weighed 126 pounds. Dr. Pryor legibly noted[4] Claimant's previous episode of low back pain in October 2007 and that she was now having pain at the top of her left hip, but not down her leg, among other findings. He prescribed Naprosyn as needed, Norco and Miralax, and took Claimant off work for one week. He also recommended physical therapy[5], home exercises and, apparently, that she reduce the amount of time she spends sitting. By October 14, Claimant developed aching pain down her left leg and she still could not return to work. Dr. Pryor prescribed Oxycontin 10 milligrams (mg), Percocet, Soma and Miralax. On October 21, Claimant still had left leg pain, so Dr. Pryor ordered a lumbar spine MRI (the chart note does not mention back pain, but the MRI report does), which was read as follows:

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[2]There is no indication anywhere in the chart note that either the left or the right side was more affected.

[3] Dr. Wiggins explained that a sprain involves a ligamentous injury, while a strain affects muscle tissue. Wiggins Dep., p. 10.

[4]Dr. Pryor's chart notes are handwritten and, in some areas, they are illegible. He did not testify in these proceedings.

[5] Claimant underwent physical therapy with Mr. Hutchinson from October 7, 2009 through December 7, 2009. On her initial visit, she reported lumbar spine pain (dull, achy, throbbing, stabbing, constant) without radiculopathy. For the next week or so, she had left-sided pain and walked with an antalgic/Trendelenberg gait on the right. Thereafter, Mr. Hutchinson generally just recorded low back pain. On November 23 and 25, Claimant reported her pain was easing. However, it was worse again by December 1, after she had returned to work for four hours per day. After sitting for a long time, she had back pain upon standing. On December 7, she reported that injections into her back had worsened her pain. Mr. Hutchinson's notes during this period do not mention spasms, and he did not testify in these proceedings.

> FINDINGS: On sagittal images, the alignment of the lumbar spine appears normal with the vertebral body heights and intervertebral disk spaces maintained. The signal within the lumbar vertebral bodies is normal. Conus medullaris terminates at the T12 level and appears normal.
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> At the L1-2 through L5-S1 levels, the intervertebral disks are normal without disk herniation. AP diameter of the spinal canal is normal throughout the lumbar spine. Facet joints appear normal and the neural foramina are patent. There is a 6 mm cystic appearing structure lying just superior to the exiting nerve root within the right neural foramen at the L3-4 level. This does not appear to be clinically significant since the patient's symptoms are on the left.
>
> IMPRESSION:
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> 6 MM CYSTIC APPEARING STRUCTURE ADJACENT TO THE EXITING NERVE ROOT IN THE RIGHT NEURAL FORAMEN AT THE L3-4 LEVEL. THE PATIENT'S SYMPTOMS ARE ON THE LEFT.
>
> OTHERWISE NEGATIVE MRI OF THE LUMBAR SPINE.

CE-D, p. 57.

On October 27, Dr. Pryor referred Claimant to Dr. Verst, prescribed Neurontin 300 mg and Soma, and kept Claimant off work. Dr. Pryor did not treat Claimant again until May 11, 2010.

16. David Verst, M.D., an orthopedic surgeon, evaluated Claimant on November 5, 2009. Claimant's chief complaint was left lower extremity pain, with recent onset of some right leg pain, as well. Claimant reported pain that was "deep, aching, and persistent-moderate in severity and frequently present that appears to be worsening." CE-132. Long periods of sitting, standing and walking increased her pain. On exam, Dr. Verst palpated moderate paraspinal muscle spasm with tenderness, and testing revealed Claimant's spinal range of motion was limited in all planes. Dr. Verst also administered credibility tests, which Claimant passed, and reviewed Claimant's MRI, which he opined demonstrated no evidence of acute injury or herniation. Dr. Verst diagnosed "radiculitis absent mechanical findings" and recommended a therapeutic/diagnostic injection. CE-134.

17. On November 11, 2009, Dr. Jensen, who had previously consulted on Claimant's industrial right knee injury, administered a left S1 transforaminal epidural steroid injection and assumed Claimant's industrial injury-related care. On that day Claimant reported "back pain, and a lot of muscle spasms, and she reports the pain radiates primarily into the left leg…a deep ache down into her calf, and then she gets some pain into the right posterior thigh." CE-636. Claimant also reported that anything more than light stretching brought on spasm and that her pain sometimes rose to 10/10.[6] On exam, Claimant had diffuse pain with palpation, flexed-forward posture, significantly reduced lumbar range of motion, and no increase in symptoms with straight leg raise. Acknowledging Claimant's normal results reported from her previous x-rays and MRI, Dr. Jensen diagnosed lumbar radiculitis and an acute lumbar strain. He took Claimant off work for one week.

18. On November 18, 2009, Dr. Jensen prescribed Percocet, a narcotic pain reliever, and diazepam (Valium), for spasm. He continued to prescribe a narcotic pain reliever and an anti-spasmodic until he released her from care, at which time he opined that Claimant should cease taking narcotics for pain relief.

19. By late December, Dr. Jensen returned Claimant to a four-hour work day in a modified-duty position. Claimant was unable to return to full-duty by January 22, 2010, however, so her employment was terminated.

20. Dr. Jensen referred Claimant for chiropractic treatment with Marjorie Brockman, D.C., a chiropractor and previous employer of Claimant's, who noted significant back spasm on exam at Claimant's initial visit on December 21, 2009.[7] Claimant reported improvement in her

[6] Claimant is frequently asked by medical care providers to rate her pain on a scale of one-to-ten.

[7] Dr. Brockman, treated Claimant on several occasions between December 21, 2009 and February 9, 2010, with spinal adjustments, flexion/distraction, ultrasound therapy and acupuncture. On her first examination, Dr. Brockman noted "considerable muscle spasms" left greater than right from T6 to the iliac crest. CE-730; *see also*

spasm over the next few weeks. On one occasion, she reported that she could feel a spasm coming on and prevent it by stopping what she was doing. On another, she reported that she felt like a spasm was coming on, but it never did. On January 22, 2010, Dr. Brockman reported to Surety improvement in Claimant's symptoms, including her spasms. She also advised that Claimant had a relapse in her symptoms after Dr. Jensen took her off Valium and her pain medications, that Claimant was angry at her condition four months post-injury and the resultant loss of her job. Dr. Brockman was ultimately unable to provide Claimant with lasting relief from her symptoms.

21. While under Dr. Jensen's care, Claimant also underwent an independent medical evaluation (IME) at Surety's request with Robert Friedman, M.D., a physiatrist. Dr. Friedman reviewed Claimant's medical records (including relevant pre-injury records), interviewed Claimant and performed an exam prior to preparing his report.

22. On February 2, 2010, following examination, Dr. Friedman diagnosed, in relevant part, right QLM spasm with documented history of preexisting low back injury. "It is my medical opinion, on a more probable than not basis, that Ms. Brooks did sustain a recurrence of her preexisting low back pain as a result of the twisting injury of 10/03/09. She currently has evidence of quadratus lumborum spasm." DE-102. In his report, Dr. Friedman acknowledged that Claimant denied any prior back symptoms; nevertheless, based upon her prior medical records to the contrary, he maintained that her condition was the result of an exacerbation of her former injury by her industrial accident.

CE-735. Although Dr. Brockman's chart notes are difficult to read, it is evident that Claimant consistently complained of pain and spasm, or anticipated spasm. Claimant also indicated that her back pain was both right and left-sided until January 29, 2010, after which she consistently reported left-sided back pain, without right-sided symptoms. On one occasion, Claimant complained of leg pain, on her right side. Medical records indicate Claimant believed the injections she received from Dr. Jensen were responsible for easing her prior left leg pain.

23. Dr. Friedman recommended "aggressive physical therapy," limited to icing and stretching to relieve pelvic obliquity due to Claimant's QLM spasm, and tapering off all opiates.[8] DE-102. He cautioned that Claimant would get worse before she gets better, but after two-to-three weeks she would slowly improve. He anticipated Claimant would have no permanent restrictions or limitations as a result of this injury.

24. Claimant returned to physical therapy with Mr. Hutchinson from February 21, 2008 through March 19, 2010. However, records reveal that the therapy was not limited to icing and stretching, as recommended by Dr. Friedman. Instead, Mr. Hutchinson administered a course of work hardening treatment including therapeutic activity and exercises, myofascial release, electric muscle stimulation, ultrasound, hot packs and icing. These sessions started at two hours, but increased to four.

25. Mr. Hutchinson's records during this period do not mention spasm until March 3, 2010, when Claimant reported that "her back feels like it wants to spasm." CE-460. In response, Mr. Hutchinson "[h]ad to modify treatment so that the patient's back would not spasm. Patient was able to better perform activities and c/o much less difficulty without causing muscles to spasm." CE-462. Similarly, on March 4, Mr. Hutchinson noted that, going into the fourth hour, Claimant complained of more back spasms, which seemed to improve with use of a TENS unit. On March 5, he noted Claimant was tolerating more intense therapy and more back exercises, though her back "[s]till wants to spasm with closed chain exercises that are more intense on the right posterior paraspinal muscles." CE-471. By March 8, Claimant reported she had been able to sit on her horse for five minutes, but she was still sore. That day, she had increased pain on lower and middle trapezius exercises.

[8] Dr. Friedman noted that the shaking and dry mouth reported by Claimant were due to the discontinuation of her opiates and, also, that the shaking contributed to her muscle pain.

26. On March 9, 2010, Mr. Hutchinson reported to Dr. Jensen that Claimant still had pain, but her functionality had significantly improved. He also noted that she had a high Fear Avoidance Beliefs Questionnaire (FABQ) score of 57 (including a physical activity subscale score of 18), indicating a need to continue skilled physical therapy at a high activity level. In the chart note he authored the same day, he noted Claimant had a repeat FABQ score of 14 (apparently referring only to the physical activity subscale score), a significant improvement over "2 weeks ago," indicating his report to Dr. Jensen was not current with Claimant's condition on March 9. CE-483.

27. On March 11, 2010, Claimant reported pain from injections into her back and dissatisfaction that she was scheduled for discharge from Dr. Jensen's care. "States that she is scared the pain will come back." CE-485. On March 12, she reported her back pain was less "grabby" from the injections and that she had received her TENS unit in the mail. On March 15, she reported she was able to lift a 50-pound sack of chicken feed and work in a bent-over position, but that she was sore afterward. On March 16, Claimant was a little sore from physical therapy, but she reported feeling "a whole lot better than when she first came into therapy." CE-500. On March 17, her therapy included squat-lifting 100 pounds on the Bowflex machine, among other things. She was sore the next day and reported burning in her muscles without grabbing.

28. By March 19, 2010, Mr. Hutchinson wrote to Dr. Jensen, advising that Claimant's functional abilities had significantly improved. Although she still had not reached pre-injury status with respect to being able to lift a minimum of 125 pounds, sit for 30 minutes pain-free or work with her horses and ride them, her PSFS improved from 0 to 4.6 (on a 10 scale), and her physical activity subscale score on her FABQ had significantly improved from 18 to 14. She had

demonstrated ability to lift 125 pounds from knee to waist height using good technique for three consecutive repetitions, though she was more comfortable lifting 80 pounds for three sets of 10 repetitions. Regarding spasms, "Her back spasms have been minimal and we have progressed her to better than 4 hours a day of continuous physical activity. She continues to have soreness in her back as indicated by her moderate decrease in Modified Oswestry Score – she does have less pain with increased activity." CE-515. Although Claimant was still improving and had not yet reached pre-injury status, her approved number of physical therapy sessions was reached, so Mr. Hutchinson released Claimant to a home exercise regimen.

29. Dr. Jensen continued to treat Claimant until April 7, 2010. She remained around 120 pounds throughout the treatment period. To summarize his treatment, he examined Claimant at least once per month, but more than that in November, December, January and February. On most visits, Dr. Jensen's chart notes indicate Claimant complained of spasming and that he palpated her low back. Twice, he specifically noted that he could not feel significant spasm,[9] and he never noted that he detected any spasming. At his deposition, Dr. Jensen confirmed that he never palpated spasm in Claimant's back. Usually, Dr. Jensen's chart notes described diffuse pain in Claimant's lumbar area, most often on the left but, at least once, Claimant had pain mostly on the right. He also noted pain over the iliac crest on the left side and near the top of the QLM in March 2010. *See* CE-709. After several injections by Dr. Jensen, Claimant's leg pain resolved, but her low back pain continued.

30. Upon Claimant's release, Dr. Jensen was still perplexed as to the etiology of her pain. He again reviewed her MRI film, "which looks absolutely normal." CE-720. "There is no

[9] On December 9, 2009, Claimant had no significant spasm on palpation, and her back pain was mostly right-sided. On April 7, 2010, he again noted Claimant did not demonstrate significant spasm.

sign of any focal muscle tear in the paraspinals. I do not see any disk bulges, herniations or ruptures." *Id.* He recommended one more follow-up with Dr. Friedman.

31. Claimant testified that Dr. Jensen released her because she accused him of failing to timely correct for over-prescribing Celebrex. Although she agrees that the over-prescription may be a nurse's or pharmacist's error, she asserts that Dr. Jensen refused to return her calls about it, leading to a breakdown in her trust regarding his care. For his part, Dr. Jensen denied over-prescribing Celebrex.

32. Following Dr. Jensen's release, Claimant sought pain medications from North Canyon Medical Center on April 23, 2010. She was given 30 Norco 5/325s, to be taken one-at-a-time, four times daily. There is no evidence Claimant's back was palpated on this visit. On May 6, 2010, Claimant returned, her Norco and Soma prescriptions were renewed, and her back was palpated. "Patient has tightness of the left lower back in the paraspinal muscles to palpation, these muscles are also tender to touch, patient has pain with movement but does exhibit full active range of motion, patient able to perform straight leg raise." DE-147. Claimant was also advised to apply alternating heat and cold to her back, to decrease her activity with no heavy lifting, and to follow up with her primary care provider or specialist for ongoing treatment. Claimant followed up with Dr. Pryor.

33. Claimant followed up with Dr. Pryor on May 11, 2010. His chart note confirms that Claimant's leg pain had resolved, but she was still having low back pain and spasms. He prescribed Neurontin and recommended three weeks of physical therapy for stretching exercises, so Claimant returned to Mr. Hutchinson from May 24, 2010 through June 9, 2010. On May 24, she reported lumbar spinal pain, significantly worsening if it spasms. She had lumbar pain with both right and left-sided bending, left rotation that was slightly limited, and flexion that was

markedly limited. On palpation Claimant had increased tenderness in the paraspinal region on the left, and she reported more difficulty with the straight leg raise test on the left. Mr. Hutchinson detected no muscle wasting or swelling by observation, but he did note Claimant had an "excessive head forward posture, midthoracic lordosis and thoracic kyphosis." CE-521.

34. On May 13, Claimant's pain was still unresolved, so Dr. Pryor prescribed Norco and Soma.

35. On May 27, 2010, Claimant followed up with Dr. Friedman. Claimant's pain was somewhat improved, but she was still taking narcotic pain medications, prescribed by Dr. Pryor. Dr. Friedman reviewed Claimant's updated medical records conducted an examination, and administered testing. Claimant had retained counsel, and she audiotaped the visit, with Dr. Friedman's consent.

36. Dr. Friedman opined that Claimant's pelvic obliquity and QLM spasm had resolved, that she was medically stable, and that she required no further treatment related to the industrial injury. He also noted that Claimant still had low back pain, and was dependent on narcotics. Based on guidance from the *Sixth Edition*, Dr. Friedman assessed 2% permanent partial impairment to Claimant's low back condition[10], apportioning 100% to her preexisting condition. "The quadratus lumborum, as a cause of this injury, and its spasms have resolved, and there is no medical evidence that she sustained a new injury, or requires an additional impairment rating." DE-111.

37. Dr. Friedman returned Claimant to work without restrictions related to her industrial accident. "As you know, restrictions are provided to limit her risk for future injury.

[10]Dr. Friedman rated Claimant under the Lumbosacral Spine Category, Table 17-4, "for nonspecific chronic, or chronic recurrent low back pain…Class 2." DE-111. "She has had axial pain with non-verifiable radicular complaints previously, now resolved and focused on the low back, there is no evidence for radiculopathy. There is no evidence for a disk herniation, or disk impairment. She will receive no change for her grade modifiers." *Id.*

As there is no permanent anatomic deformity, or change, there is no medical indication for restrictions or limitations in lifting, bending or any other motions." DE-111.

38. Claimant returned to Mr. Hutchinson on May 28, 2010 reporting that "her back wants to grab her." CE-524. By June 4, she was able to ride on a motorcycle for about 30 minutes and ride her horse, but she could not saddle it. On June 7, however, she stated she did not know what she did, but she could not get out of bed on Sunday due to back pain. On June 9, she reported increased pain after shopping for about an hour, without lifting any heavy objects. She reported that her pain level decreased with physical therapy, but she anticipated, based on prior experience, that her pain would return within a couple of hours.

39. On June 8, 2010, Dr. Pryor authored a letter to Surety in which he opined Claimant's need for additional treatment and medications was due to her industrial injury. He acknowledged that Dr. Jensen had not detected spasming, but that Claimant's physical therapist had. Mr. Hutchinson's chart notes through this time do not reflect that he ever palpated or observed Claimant's back spasm. It is unknown how or when Mr. Hutchinson conveyed this information to Dr. Pryor or why Mr. Hutchinson's records do not reflect it. Importantly, Dr. Pryor apparently had not, himself, palpated Claimant's spasm by the time he wrote this letter.

40. On June 23, 2010, Dr. Jensen concurred with Dr. Friedman's May 27, 2010 findings in a check-box letter provided by Surety.

41. On June 29, 2010, Dr. Pryor noted "alt spasm" in Claimant's left paraspinal muscles and that she was tender around at the L5-S1 level of her spine. CE-149.

42. On July 22, 2010, Claimant described to Dr. Pryor an episode where she went into "full spasm," which brought her to her knees in pain. CE-150. Dr. Pryor continued her Norco

and Soma, and added Baclofen. He refilled her prescriptions on August 19, 2010 and referred her to a neurologist.

43. On September 7, 2012, Dr. Verst executed a check-box letter to Surety, indicating he agreed with the findings from the panel/independent medical evaluation for Claimant. (See DE-252.) Apparently, this letter demonstrates that Dr. Verst agreed with Dr. Friedman's May 27, 2010 findings.

44. John Steffens, M.D., a neurologist, evaluated Claimant once, on November 3, 2010, for a second opinion in referral by Dr. Pryor. On that day, Claimant described her back pain as "a muscle achy crampy sensation and that she can feel where it is tight." CE-153. She also reported that the worse her back pain is, the worse her leg pain becomes; but Neurontin does help her leg pain.

45. Dr. Steffens concluded that Claimant had a persistent pain syndrome due to permanent spasm in her QLM. He opined that the spasm, easily palpable,[11] resulted from a muscle tear and scarring which shortened the muscle fibers. "…[T]hat shortened muscle changes the mechanics of back function, hip function, sacroiliac joint function, and all the soft tissues in that area, [*sic*] it can cause secondary pressure on nerves, nerve root endings, those kind of things, so it can look like what would be called pseudoradiculopathy, which is just a fancy term that says nerves are irritated as though they're actually pinched by a disc, but it's not a disc." Steffens Dep., p. 11.

46. Dr. Steffens may have reviewed Claimant's medical records related to her treatment by Dr. Pryor prior to establishing his opinions, but he did not see her records prepared

[11] In his report, he described Claimant's back condition: "On inspection her left mid thoracic and lumbar paraspinous muscles are in palpable spasm being twice the width of the right side and bulging outward compared to the right side. Her left hip is slightly elevated and she has tightness and tenderness of the piriformis region with recreation of the patient's radiating symptoms into her leg. The rest of her general examination is unremarkable." CE-155 and CE-159.

by Dr. Jensen or Dr. Friedman. Dr. Steffens believed Claimant's report that her persistent pain was ignited by her industrial injury, which occurred 13 months before his examination. However, he agreed that if Claimant did not actually have spasm in her back six months before his examination, then the spasm he palpated was most likely episodic, as opposed to permanent. Dr. Steffens also explained that a permanent spasm can vary in intensity from time-to-time, but it is unlikely that a permanent spasm would ever escape detection by palpation or visualization.

47. Based upon his observation of Claimant on November 3, 2010, Dr. Steffens opined, "…I don't think that she could physically, reliably function as an EMT." Steffens Dep., p. 16. He posited that she might improve with aggressive stretching, even to the point of retearing the muscle, and medications to reduce spasm. He did not comment on the appropriateness of continuing narcotic pain medications.

48. Claimant followed up with Dr. Pryor a few more times between November 29, 2010 and August 28, 2012. Although his notes are difficult to decipher, Claimant continued to complain of spasm and left leg pain throughout this time period. He referred Claimant for aggressive physical therapy, and she returned to Mr. Hutchinson on December 2, 2010. Claimant could not sit or stand for very long. Sitting too long increased her pain and changing positions relieved it, and she continued to report spasms. Her FABQ physical activity subscale score was 11, her PSFS was 3.7 and she had a modified Oswestry Score of 50%. Mr. Hutchinson's findings on exam were similar to his previous findings. Following therapy, he noted, "Patient's back musculature appears much less spasmodic today than I have seen before. Muscles seem to grab and spasm at time [*sic*]." CE-542. Mr. Hutchinson provided Claimant with a home exercise regimen to follow in addition to attending therapy sessions. By December 17, Claimant reported she was getting better. However, she reported that Mr.

Hutchinson had backed off on the intensity of her treatments by December 30, 2010. Dr. Pryor continued to prescribe narcotic pain medications, as well as others. On January 7, 2011, Claimant related she had had a bad week. On February 10 she reported her left leg gave out earlier in the day climbing some stairs. On March 2 and 16 she reported having been on her feet walking a lot at work, increasing her pain. Claimant's last session with Mr. Hutchinson took place on March 16, 2011; there is no detailed discharge note from which to ascertain Mr. Hutchinson's opinion of her abilities on that day.

49. On April 5, 2011, Claimant was evaluated by Clinton Dille, M.D., a pain specialist, in referral by Dr. Pryor for a pain injection. She had left-sided back pain radiating into her left leg, down to her foot, worsened with sitting and standing and improved with lying down and resting. She was down to 114 pounds, from approximately 120 at the time of her industrial injury. On exam, Claimant was tender in her thoracic spine along the paraspinous muscles and at the lumbar spine extending to the sciatic notch, and she had decreased flexion and extension.

50. Dr. Dille was uncertain as to the etiology of Claimant's pain. "There is no basis for radicular sx from her xrays or MRI. There is a possibility that she has piriformis syndrome." CE-861.

51. Dr. Friedman wrote to Surety on April 13, 2011 after reviewing Dr. Steffens' report and updated medical records from Dr. Pryor's office. Dr. Friedman agreed that Claimant does have a pseudoradiculopathy. However, he disagreed that any further treatment was likely to improve her symptoms, since Claimant had already tried everything Dr. Steffens was recommending, without success. Dr. Friedman also questioned whether Dr. Steffens had reviewed Claimant's prior medical records, asserting, "Ms. Brooks related to him a history which may or may not have been particularly accurate." DE-113.

52. In late April and early May, after reviewing Claimant's records, Dr. Dille performed two lumbar epidural steroid injections (LESI), one week apart. She received another on June 7, 2011, at which time she reported 60% improvement in her left leg pain and no adverse events. On June 21, 2011, however, she reported to John Urrutia, PA-C (Dr. Dille's physician assistant), no improvement in her left lower back pain and requested hydrocodone/apap. Claimant reported her medications help her perform house work, yard work and full-time employment without side effects. Among other medications, Mr. Urrutia prescribed Norco 7.5/325, Soma and Neurontin (which Claimant had requested tapering off, since the LESI injections had relieved her leg pain), for two months. He also referred Claimant to Dale Smith, M.D., for a consultation regarding Botox injections to relieve her spasm. Claimant lost her secondary insurance and ceased pursuing workers' compensation benefits during this period, so she never received any Botox injections.

53. On August 17, 2011, Claimant had tapered off Neurontin and Mobic. She still had left low back pain radiating to the left hip. She was down to 106 pounds. On September 14, 2011, Claimant reported midline low back pain that radiated to her left hip and buttock. Claimant was down to 105 pounds. Mr. Urrutia refilled her medications. On November 30, 2011, Claimant had right low back pain that radiated to the right hip. Her weight was 105, clothed with shoes. Mr. Urrutia increased her Norco to 10/325, three times per day and recommended physical therapy, which Claimant declined due to her work schedule. In addition, Dr. Dille administered the first of several apparently random drug screens.

54. Claimant continued to present monthly with medication requests and low back pain, usually on the left but sometimes at the midline, that sometimes radiated leftward and sometimes did not, until August 2012. On exam, Claimant sometimes demonstrated tenderness

in her low back area and, initially, either an antalgic or asymmetric limp. Once during this period, she had decreased flexion. However, these symptoms were either minimally noted or, more often, absent from November 30, 2011, onward. Muscle spasm was never noted. In May 2012, Lidoderm patches were prescribed at Claimant's request. In early August, Claimant reported that her drug screen that day may not be consistent with her prescription medications because she had pulled back on her medications and had done a liver cleanse.

55. On August 17, 2012, Dr. Dille discharged Claimant from care because she had provided three drug screens that were inconsistent with her prescribed medications. Only the third failed test was reported in the records in evidence. That failure was due to test results that were negative for Soma and hydrocodone, which Claimant was supposed to be taking.

56. Kim Cheri Wiggins, M.D., a physiatrist, evaluated Claimant on June 1, 2012 to assess a permanent impairment rating. Her report does not itemize which (if any) medical records she reviewed before assessing an opinion; however, at her deposition, Dr. Wiggins testified that she reviewed Claimant's records compiled by Drs. Dille, Jensen, Steffens, Verst and Pryor. These were apparently all post-industrial injury records, because she had not seen any medical records evidencing prior back problems. When questioned, Dr. Wiggins testified that any prior back condition must have healed by the time of Claimant's industrial injury.

57. Claimant described left lumbar spine and paraspinal pain that most often aches, but is "occasionally grabbing and spasm like." CE-863. Claimant's pain was worse with activity, lifting weights in excess of 20 pounds, and remaining in one position too long; and better with medication, physical therapy exercises, and her E-Stim unit. "If she does too much then she has a bad day and reports that this happens about 2 to 3 times a month." *Id.* Her pain level was generally 4/10, with her best days registering at 2/10 and her worst days at 7 or 8/10.

She was taking Norco, Soma, and tizanidine, and was using Lidoderm patches for breakthrough pain.

58. On examination, Dr. Wiggins visualized differences in Claimant's back indicating left QLM spasm. Claimant reported she had not been particularly active that day. Nevertheless, Dr. Wiggins noted, "She has very clear palpable spasm with fullness and a little bit of warmth over the left quadratus lumborum." CE-865. These symptoms were all absent on the right side. Claimant's related range of motion and strength testing showed slight limitations on her left side, but all of these results were within functional range.

59. Musculoskeletal testing revealed lumbar flexion and extension within functional range (though slightly limited), symmetric shoulder and hip heights while standing, lateral bending and lateral rotation within functional range (though slightly limited on the left on both measures), negative straight leg raise (though Claimant reported some pulling), gait within normal limits and other normal findings. Strength testing demonstrated very subtle left-sided weakness in hip flexion and extensor hallucis longis (4+/5 vs. 5/5 on the right) and symmetric quadriceps and tibialis anterior.

60. Although Dr. Wiggins would normally expect a muscle strain such as Claimant's industrial injury to heal in one to eight weeks – a few months at most – she opined that Claimant was an outlier and just did not heal properly. At one point, Dr. Wiggins said she had no opinion as to why Claimant may have had such a bad outcome. However, she ultimately concurred in Dr. Steffens' opinion that Claimant sustained a torn QLM from which she did not properly recover. Dr. Wiggins relied primarily upon Claimant's recollection of her injury and her pain, noting that she had reviewed Claimant's records "and as best as I can tell there has been no evidence of any type of malingering or other concerning behaviors." CE-865. She also opined

that Claimant "is a very reasonable historian and I believe she that she is having the difficulties that she says she is." CE-865.

61. Given that Dr. Wiggins saw Claimant two-and-a-half years after her industrial accident, she opined that Claimant would likely never properly heal, that no treatment is indicated, and that Claimant's functionality is not likely to significantly improve. Nevertheless, at her deposition, Dr. Wiggins recommended a trial Botox injection into Claimant's QLM. Dr. Wiggins did not know why Claimants QLM was spasming. However, she opined that if Claimant's QLM spasm was the result of nerves involuntarily firing and overactivating the muscle, then Botox injections into the QLM may relieve Claimant's pain. "[I]f we can decrease her pain, then we might be able to improve her quality of life, her ability to function, that sort of thing." Wiggins Dep., p. 16.

62. Dr. Wiggins assessed 8% whole person PPI pursuant to the *Fifth Edition* of the *AMA Guides,* and 3% pursuant to the *Sixth Edition,* related to Claimant's "continued spasm and physical disability resulting in her back, and then the associated pain, and loss of ability to perform things like she normally would." Wiggins Dep., p. 6. In addition, she assessed permanent restrictions consistent with Claimant's activity modifications triggered by her pain:

> With regard to restrictions it appears that Mrs. Brooks has modified her activity to deal with her pain. She is able to perform sedentary and light activities as long as she is able to shift positions frequently. With regard to lifting I do not think that she should be lifting over 20 to 30 pounds more than extremely rarely due to exacerbation of the spasm. It is my medical opinion that she would be able to do sedentary and light duty work with frequent position changes. I do not think that she would be able to do moderate to heavy-duty work, however.

CE-865.

63. On September 4, 2012, after reviewing Dr. Wiggins' report, Dr. Friedman wrote to Surety. He disagreed with both Dr. Wiggins' and Dr. Steffens' findings as of May 2010. He

reasserted that, on May 27, 2010, there was no evidence of muscle spasms on examination, and no evidence of a QLM tear. He acknowledged that such a tear would be consistent with Claimant's right QLM symptoms on February 2, 2010. However, since those symptoms had resolved by his follow-up exam on May 27, 2010, Dr. Friedman opined that Claimant's subsequent symptoms were not related to her industrial injury. Instead, he speculated that they may be related to a new injury. As to Dr. Wiggins' impairment rating, Dr. Friedman opined that the symptoms upon which she relied in assessing an additional 1% over his own impairment rating were not present in May 2010; therefore, the additional impairment would not be related to Claimant's industrial accident.

64. On June 21 and 22, 2012, Tracy Ervin, P.T., conducted a functional capacity evaluation (FCE) utilizing the WorkWell system to determine Claimant's functional abilities and limitations related to her low back condition. Claimant reported left low back pain, constant but variable depending upon her activity level and medication. She also reported radiating pain, at times, into her left lower extremity that was also dependent upon activity level.

65. Claimant also reported difficulty with activities requiring lifting over 50 pounds, such as lifting saddles, hay bales, bags of grain, calves, buckets of milk; sitting/driving for more than a half-hour; static standing more than 5-10 minutes; walking greater than a quarter of a mile; and tolerating extreme cold. Claimant agreed that she could independently perform her activities of daily living, physical therapy home exercise program, light housework, light yard work, errands, arts and crafts, and job searching.

66. Ms. Ervin opined that Claimant's patterns of movement (such as increased accessory muscle recruitment, counterbalancing, and use of momentum) and physiological responses (such as increased heart rate) were consistent with maximal effort. Claimant's

performance on Day 2 of testing yielded lifting results that were decreased by 5% over her performance on Day 1. Ms. Ervin opined that the Day 2 results are more accurate indicators of what Claimant can do on a day-to-day basis. On Day 1, Claimant rated her pain at 3/10 at the beginning of testing, and at 6/10 at the end. On Day 2, she rated her pain at 6-7/10 at the beginning of testing, and at 7-8/10 at the end.

67. On functional testing, Claimant was stronger with floor-to-waist lifts than with overhead lifting. She was strongest with lifting weight close to waist level. Claimant's standing and walking were best when she was allowed to shift positions frequently. Ms. Ervin opined that Claimant demonstrated functional lower extremity weakness and decreased lumbar range of motion. Along with her reported low back pain, these conditions contributed to Claimant's limitations with "all heavier lifting/carry, prolonged walk, stoop/forward bend, and kneel." CE-908.

68. There is no indication that Ms. Ervin's finding that Claimant suffers from a loss of functional lower extremity strength has anything to do with her prior right knee injury and arthroscopic surgery. It was Claimant's low back discomfort that impacted her ability to lift/carry, forward bend, kneel and engage in prolonged sitting, standing and walking activities. With heavier lifting, Claimant reported functional lower extremity weakness and radiculopathy into the left lower extremity. Again, nothing in Ms. Ervin's report reflects that Claimant's limitations are, in some respect, referable to her right knee condition.

69. Comparing Claimant's abilities with a list of her time-of-injury job requirements, Ms. Ervin opined Claimant was unable to return to this employment, and that retraining may be a better option. *See* CE-908-909.

70. Like Dr. Friedman and Mr. Hutchinson, Ms. Ervin administered the Oswestry Disability Assessment. Ms. Ervin opined that Claimant's results on this administration indicate that she perceives her abilities to be greater than those objectively evaluated by the FCE. Therefore, she may require monitoring to avoid unsafe activities.

71. At the hearing, Ms. Ervin confirmed and explained her methodology and findings.

CLAIMANT'S CREDIBILITY

72. Claimant was articulate and, by all appearances, sincere, in her testimony at the hearing. In addition, her medical records demonstrate no evidence that she malingered or exaggerated her symptoms to her medical care providers. Dr. Dille's records raise the issue of whether Claimant had some secondary motive for seeking medications, but there is insufficient evidence from which to determine this was actually the case. Claimant's work history, both before and after her industrial injury, indicates that she is a diligent and motivated worker.

73. Claimant's testimony regarding her medical condition at the hearing was sometimes inconsistent with her medical records. For example, she testified that she never significantly improved under Dr. Jensen's care; however, contemporaneous records prepared by both Dr. Jensen and Mr. Hutchinson, as well as Dr. Friedman, document improvement. Where Claimant's testimony conflicts with information reported in otherwise credible contemporaneous documentation, Claimant's testimony will carry less weight. The Commission finds no reason to disturb the Referee's findings and observations on Claimant's presentation or credibility

DISCUSSION AND FURTHER FINDINGS

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

construction. *Ogden v. Thompson*, 128 Idaho 87, 88, 910 P.2d 759, 760 (1996). Facts, however, need not be construed liberally in favor of the worker when evidence is conflicting. *Aldrich v. Lamb-Weston, Inc.*, 122 Idaho 361, 363, 834 P.2d 878, 880 (1992).

CAUSATION

75. The Idaho Workers' Compensation Act places an emphasis on the element of causation in determining whether a worker is entitled to compensation. In order to obtain workers' compensation benefits, a claimant's disability must result from an injury, which was caused by an accident arising out of and in the course of employment. *Green v. Columbia Foods, Inc.*, 104 Idaho 204, 657 P.2d 1072 (1983); *Tipton v. Jannson*, 91 Idaho 904, 435 P.2d 244 (1967).

76. The claimant has the burden of proving the condition for which compensation is sought is causally related to an industrial accident. *Callantine v.Blue Ribbon Supply*, 103 Idaho 734, 653 P.2d 455 (1982). Further, there must be medical testimony supporting the claim for compensation to a reasonable degree of medical probability. A claimant is required to establish a probable, not merely a possible, connection between cause and effect to support his or her contention. *Dean v. Dravo Corporation*, 95 Idaho 558, 560-61, 511 P.2d 1334, 1336-37 (1973), *overruled on other grounds by Jones v. Emmett Manor*, 134 Idaho 160, 997 P.2d 621 (2000). *See also Callantine*, Id.

77. The Idaho Supreme Court has held that no special formula is necessary when medical opinion evidence plainly and unequivocally conveys a doctor's conviction that the events of an industrial accident and injury are causally related. *Paulson v. Idaho Forest Industries, Inc.*, 99 Idaho 896, 591 P.2d 143 (1979); *Roberts v. Kit Manufacturing Company, Inc.*, 124 Idaho 946, 866 P.2d 969 (1993).

78. The Industrial Commission, as the fact finder, is free to determine the weight to be given to the testimony of a medical expert. *Rivas v. K.C. Loggin*g, 134 Idaho 603, 7 P.3d 212 (2000). The Commission can accept or reject the opinion of a physician regarding impairment. *Clark v. City of Lewisto*n, 133 Idaho 723, 992 P.2d 172 (1999). The Commission's conclusions as to the weight and credibility of expert testimony will not be disturbed unless such conclusions are clearly erroneous. *Reiher v. American Fine Food*s, 126 Idaho 58, 878 P.2d 757 (1994). "When deciding the weight to be given an expert opinion, the Commission can certainly consider whether the expert's reasoning and methodology has been sufficiently disclosed and whether or not the opinion takes into consideration all relevant facts." *Eacret v. Clearwater Forest Industries,* 136 Idaho 733, 40 P.3d 91 (2002). Unless a decision to render no weight to a medical expert opinion was clearly erroneous, it will be affirmed. *Id.*

79. Defendants do not dispute that Claimant suffered an industrial accident when she injured her back on October 3, 2009. They do argue, however, that Claimant did not suffer permanent left-sided muscle spasm of her QLM, or any other injury as a result of that event that remained symptomatic as of May 27, 2010. In the event the Commission finds otherwise, Defendants argue that Claimant had a preexisting back condition that contributed to her post-industrial injury condition.

80. It is well-settled that the permanent aggravation of a preexisting condition is compensable. See, for example, *Bowman v. Twin Falls Construction Company, Inc.*, 99 Idaho 312, 581 P.2d 770 (1978). "The fact that [claimant's] spine may have been weak and predisposed him to a ruptured disc does not prevent an award since our compensation law does not limit awards to workmen [or women] who, prior to injury, were in sound condition and perfect health. Rather, an employer takes an employee as he [or she] finds him [or her]. *Wynn v.*

J.R. Simplot Company, 105 Idaho 102, 104, 666 P.2d 629, 631 (1983). Regardless of Claimant's preexisting degenerative condition, Defendants will be liable for at least a portion of Claimant's benefits if her industrial injury permanently aggravated a preexisting condition.

81. **Nature of industrial injury and medical stability.** The nature of the injury Claimant suffered on October 3, 2009 is in dispute. There is no dispute that the MRI of October 23, 2009 was read as being negative. However, the real question that is suggested by this study is whether the negative study is proof that Claimant suffered no injury to her QLM as consequence of the subject accident. For example, Dr. Jensen, who has proposed that the negative MRI is evidence of a lack of any significant injury, initially diagnosed Claimant as suffering from a lumbar strain. Per Dr. Jensen, one of the principle components of a strain is a muscle tear. (*See* Jensen Dep., p. 60, ll. 23-25). This is a view also shared by Dr. Wiggins. (*See* Wiggins Dep., p. 10, ll. 4-15). Paradoxically, although acknowledging that Claimant probably suffered a muscle strain as a result of the accident, and that a muscle strain implicates the existence of a tear of the muscle fibers, Dr. Jensen concluded that Claimant did not suffer a muscle tear because the MRI was negative. The closest Dr. Jensen came to reconciling his belief that Claimant suffered from a muscle strain with the negative MRI is found in this excerpt of his post hearing deposition testimony:

> Q. Okay. You testified that you thought she had a muscle strain when you saw her earlier on, Correct?
>
> A. Correct.
>
> Q. How did you determine that it was a muscle strain?
>
> A. History. Mechanism of injury. The fact that she complained of diffuse pain. The fact that I didn't find anything else. No evidence of radiculopathy as far as her reflexes, sensation, motor. The MRI was normal. So common problem.
>
> Jensen Dep., p. 42, ll. 2-11.

Based on Dr. Jensen's testimony, we are unable to conclude that the negative MRI is, standing alone, dispositive of the question of whether or not Claimant suffered an injury to his QLM as a consequence of the subject accident.

82. Another puzzling aspect of Dr. Jensen's testimony is his conclusion that Claimant did not suffer an injury to her QLM, because he was never able to objectively verify that she suffered from QLM spasming on exam. In fact, Dr. Jensen testified that during the period he treated Claimant he was never able to verify by objective means that Claimant suffered from QLM spasming, the presence of which would suggest damage to the QLM. However, Dr. Jensen's insistence that Claimant had no evidence of QLM spasming is belied by his own records, as well as by the records of other physicians who treated Claimant prior to the date on which Dr. Friedman found Claimant medically stable in May of 2010. In his initial evaluation of Claimant dated November 11, 2009, Dr. Jensen noted Claimant's complaints of "a lot of muscle spasms". On November 18, 2009, he noted that Claimant's most significant complaints were of muscle spasm in the spine. He prescribed Diazepam (Valium) as an anti-spasmodic medication.

83. Other of Claimant's initial treating physicians have either observed evidence of QLM spasm, or noted Claimant's complaints of the same. Claimant was evaluated by Dr. Verst on November 5, 2009. On the occasion of that exam, Dr. Verst noted that Claimant suffered from "moderate paraspinal muscle spasm that is tender to palpation". Dr. Brockman, a chiropractor to whom Dr. Jensen referred Claimant for treatment, noted on the occasion of her initial exam of Claimant that "there are considerable muscle spasms on left greater than right T6 to iliac crest". (*See* CE-M, p. 6). Dr. Brockman's notes, generated between December 20, 2009 and February 9, 2010, generally reflect Claimant's consistent complaints of muscle spasm or anticipated spasm.

84. Dr. Friedman, to whom Claimant was referred by Surety for purposes of independent evaluation, too, confirmed the presence of right QLM spasm on palpation. Dr. Friedman recommended aggressive physical therapy which was provided by Mr. Hutchinson. Mr. Hutchinson's notes commencing in March of 2010 reflected that Claimant presented with complaints that her back felt like it wanted to spasm. Mr. Hutchinson revised Claimant's treatment regimen so that her back would not spasm. In May of 2010, when Claimant returned to Dr. Pryor for treatment, his notes reflect that Claimant complained of low back pain and spasms.

85. Dr. Jensen has testified that based on the negative MRI and his inability to ever objectively validate Claimant's complaints of QLM spasming, he could not disagree with Dr. Friedman's conclusion that Claimant had recovered from the effects of the subject accident. Although Dr. Jensen did not attempt to distance himself from his initial diagnosis that Claimant suffered a lumbar strain as a result of the accident, he appears to be of the view that Claimant's strain, which by Dr. Jensen's own admission incorporates a component of muscle tearing, could not have been severe, and should have resolved long ago. Specifically, Dr. Jensen disagrees with the views expressed by Drs. Steffens and Wiggins that Claimant suffers from a chronic muscle tear with associated adaptive shortening, all related to the subject accident. Although Dr. Jensen does not disagree with the findings of Drs. Steffens and Wiggins on exam, he merely posits that the condition observed by Drs. Steffens and Wiggins could not be associated with the subject accidents since he (Dr. Jensen) never saw any objective evidence of the spasming observed by Dr. Steffens and Dr. Wiggins. In reaching this conclusion, however, Dr. Jensen has not given appropriate deference to the findings of the other physicians, referenced above, who did note objective evidence of muscle spasming, contemporaneous with Dr. Jensen's inability to

independently verify this objective finding. On the occasion of his first examination of Claimant Dr. Friedman did note objective evidence of QLM spasming. However, Dr. Jensen discounted, if not ignored, Dr. Friedman's finding when making his own assessment about whether or not Claimant suffered a significant injury as a consequence of the subject accident:

> Q. Can you explain to me any medical reason why each of the observations about spasms by anybody, other than you or Dr. Friedman, aren't valid?
>
> A. Say that again.
>
> Q. Can you explain to me why observations of spasms by everybody - - the health care providers, other than you and Friedman, are not valid? In other words, it's documented she had them before she saw you and Friedman, and after she saw you and Friedman, and even when she saw Friedman the first time. Aren't those valid findings that you would have to rely on as a medical doctor?
>
> A. Sure. But I personally didn't see them.
>
> Q. Okay. You personally didn't see them, but they're documented medical history, right?
>
> A. Yes.
>
> Jensen Dep., pp. 58, l. 25-59, l. 15.

Finally, Dr. Jensen appeared to acknowledge that muscle spasms can be episodic. In other words, just because Claimant did not present with objective evidence of muscle spasming at the time he examined her does not mean that Claimant did not present with objective evidence of muscle spasming at other times:

> Q. Okay. Well, let me just be straight with you. As I've reviewed the medical records, I've identified 58 records in which it's documented by health care providers that she had a spasmodic quadratus lumborum muscle. I just heard you testify today that you never saw that spasmodic - -
> A. She felt diffuse pain. I didn't feel a spasm.
>
> Q. Okay. You've never felt a spasm in her back?
>
> A. I did not.

Q. How did you rule out the fact that she was having muscle spasms as a cause of her pain?

A. By palpation.

Q. So if you feel it, and you don't feel a spasm, you can rule out spasm as a cause of pain?

A. I think she didn't have a spasm - -

Q. My question was - -

A. - - Muscle. That you can rule out by palpation.

Q. My question was, can you rule out the fact that a spasm is causing pain if she doesn't happen to have a spasm at the time you palpate her?

A. I'm not sure completely. Probably not. At the time she never presented with it to me.

Jensen Dep. p. 39, ll.3-24.

86. Both Dr. Steffens and Dr. Wiggins found objective evidence of muscle spasming, leading them to conclude that Claimant suffers from an unhealed, and chronic, QLM tear. Dr. Steffens cogently described the mechanism by which QLM spasming is caused by a tear and the related process of adaptive shortening:

Q. And you concluded that it tore and scarred. Can you explain to us the process of tearing and scarring of the muscle?

A. Sure. So when a muscle tears - - so take a step back. So muscles work by shortening. There are several kinds of fibers that slide across each other and they form connections and they shorten. That's how you contract, that's how you develop strength. That's how a muscle works. When you tear it, the ability to do that changes. And depending on the severity of the tear, it can be a very mild tear where you don't get any scarring, it can be a significant tear or even a rupture where there's complete separation of fibers, or it can be a partial tear where some of the fibers are torn and disrupted. And then the body starts setting in with an inflammatory response, and you then begin getting scar tissue formation.

Q. Okay.

A. So the first thing that happens with a tear is the separation of those fibers and the spontaneous contraction on either side of the tear so that the muscle fibers on either side are shortened. Okay? And the scar tissue sets up in the middle.

Q. Okay.

A. And once that happens, if the scar tissue is allowed to or is given enough time to develop, then those muscle fibers cannot relax anymore. And they're permanently shortened, so the whole muscle is shortened. So you lose the dynamic ability of that muscle to extend, flex, all that kind of stuff.

Steffens Dep. pp. 5, l. 9-6, l.14.

87. The medical opinions on the etiology of Claimant's current complaints are in significant dispute. Dr. Friedman saw Claimant on two occasions. During his first visit with Claimant he validated her subjective complaints of spasming by noting objective evidence of QLM spasming. On his second visit with Claimant, he found no evidence of spasming and pronounced her stable and recovered from the effects of the subject accident. Dr. Jensen, by his report, was unable to ever verify to his own satisfaction that Claimant had objective evidence of muscle spasming. However, many of the other providers who treated Claimant during the same time frame did note objective evidence of muscle spasming. The existence of these records, including the records from Dr. Friedman's initial visit, denigrate the ultimate conclusion reached by Dr. Jensen that Claimant's QLM injury cannot be related to the work accident since spasming was never detected in Claimant's back until well after she had been pronounced medically stable and ratable by Dr. Friedman. These facts are fatal to Dr. Jensen's opinion on causation. We find that Claimant has consistently complained of lumbar spasming from the outset, which has been objectively verified by numerous other treating physicians. We find the opinions of Dr. Wiggins and Dr. Steffens to be well reasoned and find that Claimant has met her burden of establishing that the conditions diagnosed by Drs. Steffens and Wiggins are causally related to the demands of her employment.

Medical Stability

88. Since we adopt the views expressed by Dr. Steffens and Dr. Wiggins, we believe it appropriate to find Claimant medically stable as of the date of her exam and rating by Dr. Wiggins on June 1, 2012. We note that while Dr. Wiggins speculated that Claimant might experience an improvement in her pain with Botox injections, nothing in these comments is inconsistent with Dr. Wiggins findings that Claimant was medically stable and ratable as of June 1, 2012.

MEDICAL BENEFITS

89. As a result of Dr. Friedman's' May 27, 2010 follow up evaluation of Claimant, Surety had declined to pay further medical benefits on this claim. However, Claimant has incurred significant additional medical expenses in connection with the treatment she continued to pursue for her unremitting complaints. She asks of the Commission that Surety be required to pay these and future medical expenses associated with what we have found to be a compensable condition. I.C. § 72-432(1) defines the Surety's obligation in this regard:

> Subject to the provisions of section 72-706, Idaho Code, the employer shall provide for an injured employee such reasonable medical, surgical or other attendance or treatment, nurse and hospital services, medicines, crutches and apparatus, as may be reasonably required by the employee's physician or needed immediately after an injury or manifestation of an occupational disease, and for a reasonable time thereafter. If the employer fails to provide the same, the injured employee may do so at the expense of the employer.

Once Surety denied responsibility for Claimant's further care, Claimant was free to pursue such care on her own, without further notice to Surety. *Reese v. VI Oil Company*, 141 Idaho 630, 115 P.3d 721 (2005).

90. Generally, it is for the Claimant's physician to decide whether treatment is required. The only review the Commission is entitled to make is whether the required treatment

was reasonable. *Sprague v. Caldwell Transportation, Inc*. 116 Idaho 720, 779 P.2d 395 (1989). In *Sprague*, the following factors were found relevant to the determination of whether the particular care at issue in that case was reasonable; (1) the claimant experienced gradual improvement from the treatment rendered; (2) the treatment was required by claimant's treating physician; (3) the treatment was within the physician's standard of practice and the charges were fair and reasonable. Here, it is argued by Defendants that the care that Claimant received subsequent to Dr. Friedman's closing evaluation has done nothing to improve her condition. Therefore, Defendants argue that Claimant is not entitled to payment for this care. While we acknowledge that this is a correct reading of the criteria considered by the Court under the facts before it in *Sprague*, we decline to rule that simply because Claimant has not enjoyed relief from her symptoms as the result of the treatment she has sought on her own that she should be denied reimbursement for these expenses. The physicians with whom Claimant consulted tried various modalities to deal with her intractable pain. Simply because aggressive physical therapy was not successful in one instance, does not mean that Claimant should forever be barred from physical therapy thereafter. Were we to conclude, in every case, that unless a medical treatment is successful in providing relief an injured worker is not entitled to payment for the same, a significant fraction of our workers' compensation population would be denied care which it was reasonably thought would offer some relief. We are not prepared to read *Sprague* this broadly.

91. Based on the foregoing, Claimant is entitled to recover 100% of the medical bills she incurred in connection of her treatment between Dr. Friedman's May 2010 pronouncement of medical stability, and the date of hearing. *Neel v. Western Construction, Inc*., 147 Idaho 146, 206 P.3d 852 (2009).

PPI

92. "Permanent impairment" is any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved and which abnormality or loss, medically, is considered stable or non-progressive at the time of evaluation. Idaho Code § 72-422. "Evaluation (rating) of permanent impairment" is a medical appraisal of the nature and extent of the injury or disease as it affects an injured employee's personal efficiency in the activities of daily living, such as self-care, communication, normal living postures, ambulation, traveling, and non-specialized activities of bodily members. Idaho Code § 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 Contractors*, 115 Idaho 750, 755, 769 P.2d 1122, 1127 (1989).

93. In May of 2010, Dr. Friedman awarded Claimant a 2% PPI rating under the 6th edition to the AMA Guides to the Evaluation of Permanent Impairment. However, Dr. Friedman concluded that this impairment rating was entirely referable to Claimant's pre-existing condition. Dr. Wiggins awarded a 3% PPI rating under the 6th edition to the Guides, and concluded that this impairment is entirely referable to the work accident. Dr. Wiggins was evidently unaware of Claimant's pre-injury low back condition from 2007. However, she proposed that if Claimant's 2007 problems had resolved prior to the subject accident, then this would cause her to conclude that the 2007 injury is not implicated in Claimant's current low back condition.

94. As noted above, we have found that the opinions of Drs. Steffens and Wiggins are more persuasive than those of Drs. Friedman and Jensen in identifying the cause of Claimant's ongoing complaints. Further, we believe that Dr. Wiggins has sufficiently explained why she would discount the 2007 low back injury as a contributing cause of Claimant's current

impairment. Indeed, the record fails to reflect that Claimant had any ongoing low back symptomatology between approximately October 25, 2007, when she last saw Mr. Hutchinson, and October 3, 2009, the date of the subject accident. We conclude that Claimant has met her burden of showing that she suffered a 3% whole person rating as a consequence of the subject accident.

PERMANENT PARTIAL DISABILITY

95. "Permanent disability" or "under a 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. Permanent disability is a question of fact, in which the Commission considers all relevant medical and nonmedical 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. State, Industrial Special Indem. Fund,* 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).

96. Where apportionment under I.C. § 72-406 is an issue, as it is in this case, a two step approach is envisioned when making an apportionment. First, the claimant's permanent disability from all causes combined must be determined. Second, a determination must be made of the extent to which the injured worker's permanent disability is attributable to the industrial accident. *See Page v. McCain Foods, Inc.*, 145 Idaho 302, 179 P. 3d 265(2008).

97. Here, the only limitations/restrictions that are identified are those referable to the subject accident, given by Dr. Wiggins and Ms. Ervin. Although Claimant also has documented pre-existing injuries to her right knee and low back, the record does not reflect that Claimant has

been assigned any permanent limitations/restrictions for either of those injuries. The only limitations/restrictions revealed by the record are those referable to the subject accident.

98. Dr. Wiggins and Ms. Ervin are in essential agreement concerning the extent and degree of those limitations/restrictions. As a result of the subject accident, Claimant is restricted to performing light and sedentary work.

99. In this case, two vocational experts have rendered opinions concerning the extent and degree of Claimant's disability. The qualifications of both experts are well known to the Commission.

100. Delyn Porter testified that prior to the subject accident, Claimant had access to approximately 41% of the total labor market in her geographic locale. He opined that as a consequence of the accident, Claimant has lost access to approximately 56% of her pre-injury labor market. Mr. Porter also opined that Claimant has suffered wage loss of approximately 26% as a result of the accident. Considering Claimant's loss of access to the labor market and her wage loss, Mr. Porter ultimately concluded that Claimant's disability is in the range of 41% of the whole person, inclusive of impairment. He reached this conclusion based on the limitations/restrictions imposed by Dr. Wiggins and Ms. Ervin, in combination with his synthesis of Claimant's relevant non-medical factors, including her educational background, transferable job skills and work history.

101. At the instance of Defendants, Claimant's disability was also evaluated by William Jordan. Mr. Jordan testified that if the limitations/restrictions imposed by Drs. Friedman and Jensen are taken into consideration, Claimant has no disability, since, per Dr. Friedman and Dr. Jensen, she has neither impairment nor permanent limitations referable to the subject accident. However, Mr. Jordan conceded that if the limitations of Dr. Wiggins and Ms.

Ervin are assumed to accurately reflect Claimant's functional abilities, then she has suffered disability in excess of impairment. However, Mr. Jordan noted that most of Claimant's historic work is consistent with the limitations/restrictions imposed by Dr. Wiggins and Ms. Ervin. In fact, he believed that of the jobs Claimant has historically performed, she could perform approximately 81% of those jobs at the present time. Most of Claimant's historic work has been in the light to sedentary category.

102. Mr. Jordan, too, concluded that on a pre-injury basis Claimant had access to approximately 41% the jobs in her local labor market. His analysis persuaded him that Claimant had lost access to approximately 30% of her pre-injury labor market as a consequence of the limitations/restrictions imposed by Dr. Wiggins. He further concluded that Claimant had suffered wage loss of between 8 to 10% as a result of the accident. Mr. Jordan ultimately concluded that Claimant has disability in the range of 19 to 20% of the whole person, inclusive of permanent physical impairment.

103. On balance, the Commission finds the opinion of Mr. Jordan to be more persuasive than that of Mr. Porter. We reach this conclusion for the following reasons.

104. First, in calculating Claimant's wage loss, Mr. Porter did not think it appropriate to consider Claimant's post-accident employment at C3. Explaining his reasoning in this regard, Mr. Porter testified:

> It appeared to me, based upon my review of Mr. Jordan's report, that he used Cindy's earnings when she was at the call center, C3, as a post-injury wage-earning capacity. And I understand how he did that. I understand why he did that.
>
> But my argument would be that's one employer in an entire labor market area. And she was no longer working for that employer either.
>
> Hr. Tr., p. 197, ll. 11-18.

105. Although it would probably be inappropriate to measure Claimant's disability simply by comparing her time of injury wage to her post-injury wage at C3 (*See Baldner v. Bennetts, Inc*., 103 Idaho 458, 649 P. 2d 1214(1982)), there is no indication that this is what Mr. Jordan did in evaluating Claimant's disability. Moreover, it seems inappropriate to exclude Claimant's earnings in a post-injury job she successfully performed for well over a year in determining the extent to which Claimant has suffered a wage loss as a consequence of the subject accident.

106. Mr. Porter also failed to consider how Claimant might exploit the expertise and skills she acquired while working for C3. At C3 Claimant developed expertise in selling and servicing various insurance products. She obtained state licenses to perform this work. However, because she was about to lose her state certifications, Mr. Porter did not consider the experience she acquired at C3 might be applied to other employment. He evidently did not feel it worth asking of Claimant that she re-certify. He also objected to insurance sales and other similar sales positions because those holding such employment are frequently compensated on a commission basis. Because it is hard to determine what one might earn in a commission sales job, Mr. Porter declined to include such jobs in his analysis. However, it seems clear that there are many such jobs in the labor market, and that people make money and survive while performing such work. There is no good reason to exclude commission sales work in performing a disability evaluation.

107. Finally, the underlying analysis that Mr. Porter applied to this case is called into question by his conclusion that even if the limitations/restrictions defined by Drs. Jensen and Friedman are utilized, Claimant has still suffered a labor market access loss of 46% and wage loss of 18 to 19%. (*See* CE-R). This conclusion is unexplained, and seems clearly at odds with

the findings of Drs. Friedman and Jensen that Claimant has neither impairment nor limitations referable to the subject accident.

108. On balance, we find the conclusions of Mr. Jordan to be more persuasive, and conclude that Claimant has suffered disability of 20% of the whole person inclusive of impairment.

APPORTIONMENT

109. I.C. § 72-406(1) provides, in pertinent part:

> In cases of permanent disability less than total, if the degree or duration of disability resulting from an industrial injury or occupational disease is increased or prolonged because of a preexisting physical impairment, the employer shall be liable only for the additional disability from the industrial injury or occupational disease.

Here, medical evidence establishes that Claimant has a 10% lower extremity impairment referable to her right knee which predated the subject accident. As well, Drs. Friedman and Jensen have proposed that Claimant has a 2% impairment referable to her low back which predates the subject accident. As explained above, we have rejected the opinions of Drs. Friedman and Jensen in this regard, leaving for consideration the question of whether any portion of Claimant's disability should be assigned to her pre-existing right knee impairment. After having reviewed the medical records, we conclude that none of Claimant's disability should be assigned to a pre-existing condition. There is no indication that Claimant has any limitations/restrictions referable to the right knee impairment which would suggest that apportionment is appropriate.

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CONCLUSIONS OF LAW AND ORDER

Based on the foregoing, the Commission hereby ORDERS the following:

1. Claimant has proven that she sustained a low back injury as a result of the industrial accident of October 3, 2009. These injuries include a strain or tear of Claimant's QLM with associated adaptive shortening of the muscle and spasming.

2. Claimant is entitled to reimbursement for medical expenses she incurred subsequent to May 27, 2010 through the date of hearing. Claimant is entitled to payment of these expenses at 100% of the invoiced amount of the bill.

3. Claimant is entitled to such further reasonable medical care as she may require pursuant to I.C. § 72-432.

4. Claimant reached a point of medical stability on June 1, 2012.

5. Claimant is entitled to a 3% PPI rating for the effects of the subject accident.

6. Claimant has suffered disability of 20% of the whole person, inclusive of impairment.

7. Apportionment of Claimant's disability rating under I.C. § 72-406 is not indicated.

8. Pursuant to I.C. § 72-718, this decision is final and conclusive as to all matters adjudicated.

DATED this 12th day of September 2013.

INDUSTRIAL COMMISSION

_/s/_____
Thomas P. Baskin, Chairman

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

Participated but did not sign.

_____
Thomas E. Limbaugh, Commissioner

ATTEST:

_/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 12th day of September 2013, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSION OF LAW, AND ORDER** was served by regular United States Mail upon each of the following:

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