BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

AARON COOK, Claimant, v. ASHLEY INN, LLC, Employer, and EMPLOYERS COMPENSATION INSURANCE, Surety, Defendants.	**IC 2009-025203** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **Filed January 30, 2013**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Industrial Commission assigned the above-entitled matter to Referee Douglas A. Donohue who conducted a hearing in Boise on May 14, 2012. Claimant was represented by Robert Nauman. Defendants were represented by Alan Gardner. The parties presented oral and documentary evidence. After posthearing depositions, they submitted briefs. Claimant moved for Defendants' posthearing brief to be stricken when Claimant filed his reply brief. Defendants responded by moving that Claimant's "objection" be stricken. Those motions are addressed below. 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 issues to be decided are:

1. Whether the conditions for which Claimant seeks benefits were caused by the alleged industrial accident; and
2. Whether and to what extent Claimant is entitled to the following benefits:
    a. Temporary total and or partial disability (TTD/TPD); and
    b. Medical care.

All other issues are reserved.

Posthearing Motions

After hearing, a briefing schedule was issued. It was extended by stipulation of the parties. Parties' briefs were timely filed with the Commission; Defendants' brief was filed by fax. The requisite copies arrived at the Commission the next day. Claimant did not receive a copy of Defendants' brief on the same day that it was filed with the Commission. Instead, the next day, Defendants sent a copy to Claimant by both fax and mail. Before the fax arrived, Claimant contacted Defendants asking why he had not received a copy.

Rule 4 of the Judicial Rules of Practice and Procedure (JRP) expressly requires a party who files by fax to serve a copy "on all other parties the same day as the transmission." Defendants did not do so. A sanction is appropriate for violation of this rule. Contrary to Defendants' responsive motion, the violation is not "virtually frivolous." Defendants' motion to strike Claimant's objection is DENIED.

Claimant did not inform the Commission of this rule violation until he filed his reply brief. Like a party at trial who fails to make a timely objection, Claimant's objection comes too late for a proper curative ruling or sanction. The sanction should not be increased just because Claimant waited to lodge his objection.

Claimant does not allege prejudice. Rather, he correctly argues that a showing of prejudice is not a prerequisite to enforcement of the rule. Nevertheless, had Claimant filed a timely objection to Defendants' late service, an order extending the time for filing of Claimant's reply brief would have been favorably considered for the purpose of curing potential prejudice. Whether additional sanction should be imposed would depend on specific circumstances.

Here, the Commission is unaware of any instance in which untimely service has been attributed to these Defendants previously. When informed of the error, Defendants promptly ameliorated the damage by fax. Service was late by less than 24 hours. Claimant's well-written reply brief is *prima facie* evidence that no prejudice arose. Sanction in the form of a written warning is deemed sufficient under these circumstances. Such warning is hereby given.

Claimant's motion to strike Defendants' reply brief is DENIED.

CONTENTIONS OF THE PARTIES

Claimant contends that he suffered a compensable industrial lumbar injury on September 18, 2009. He has not worked since. Defendants have denied parts of his medical care and temporary disability benefits. Expert medical opinions are sufficient to establish a causal connection between the accident and Claimant's lumbar condition.

Defendants contend they accepted the claim and properly paid for inguinal symptoms which arose at the time of the accident. Claimant has a longstanding preexisting low back condition with radiating pain which has been well documented. After the accident, Claimant did not complain of lumbar symptoms until March 2010 and physicians agree these are unrelated to the accident. Defendants have paid all benefits due Claimant.

EVIDENCE CONSIDERED

The record in the instant case included the following:

1. Oral testimony of Claimant and his wife;
2. Claimant's exhibits A-S;
3. Defendants' exhibits 1-24; and
4. Posthearing depositions of treating physicians Julie Conyers, M.D., (general surgeon) and Shane Andrew D.O. (orthopedic surgeon).

All objections in the deposition of Dr. Andrew are SUSTAINED except Defendants' objection to deposition exhibit 14 (depo. p. 48) which is OVERRULED. All deposition motions

to strike are DENIED.

All objections in the deposition of Dr. Conyers are SUSTAINED.

FINDINGS OF FACT

(NOTE: These findings apply only to the issues addressed and are not to be read hypertechnically to dispose of, to prejudice, or to apply to any reserved issues.)

1. Claimant worked for Ashley Thompson beginning about April 1, 2009. Employer is one of a number of companies owned by Mr. Thompson. Claimant worked "heavy labor" and operated some equipment, including a backhoe.

2. On September 18, 2009, Claimant had been felling trees and moving logs in the morning. Later he was removing a metal roof from an outbuilding which was being dismantled to make room for other construction. He felt a "twinge" which he recognized from prior experience to be a probable hernia or pulled groin muscle. He continued working. After work, the pain increased that day and over his next couple days off.

3. On September 24, 2009, he first sought medical treatment. Mikael Bedell, M.D., at Cascade Family Clinic was the primary treater. Dr. Bedell released Claimant from work and referred him to a surgeon for possible hernia surgery. Later—in 2011—Dr. Bedell responded to Defendants' inquiry and stated Claimant reported no lumbar symptoms during the course of treatment September 2009 to January 2010.

4. Julie Conyers, M.D., first saw Claimant on October 10, 2009. She performed surgery on October 26, 2009. She observed Claimant showed no acute hernia but had scarring around his ilioinguinal nerve. She transected this to alleviate pain.

5. On November 18 and 23, 2009, Claimant sought medical attention. He complained of groin and testicular pain.

6. On a November 30, 2009, ER visit, Claimant reported continuing groin pain.

7. On December 1, 2009, Dr. Conyers discussed with Claimant his narcotic dependency and placed restrictions upon his obtaining prescriptions for them.

8. On a December 12, 2009, ER visit, Claimant received medication for his pain and nausea. He again visited the ER on December 14, 15, and 17. These visits were for narcotic injections in the postsurgical area. An ultrasound on December 17 showed bilateral epididymal cysts and a small right-sided hydrocele. The absence of further comment or treatment recorded in medical records suggests these were not clinically significant.

9. On December 22 and 27, 2009, again Claimant visited an ER. He was treated for a possible infection at his surgical site. The medical records generally demonstrate that since Claimant suffered a MRSA infection in 1986 after a football injury, he has been fearful of any symptom that might indicate the presence of infection. He has frequently sought treatment for possible infections.

10. On February 1, 2010, Dr. Conyers surgically removed and revised the mesh from an earlier hernia surgery. During this second surgery, Dr. Conyers observed Claimant did not have an acute hernia. Instead, she observed entrapment of the ilioinguinal nerve and released it. A possible postsurgical infection was never precisely identified because of the loss of a sample. Later—in 2011—Dr. Conyers responded to Defendants' inquiry and reported that during the course of her treatment from October 2009 to March 2010, Claimant did not report symptoms which could be linked to a low back condition.

11. On March 24, 2010, Claimant was seen at a pain clinic. Drs. Steven Williams, M.D., Howard Shoemaker, M.D., and their PA attempted to diagnose and treat Claimant's continuing pain complaints.

12. On March 29, 2010, Dr. Williams examined Claimant. Dr. Williams was

concerned about possible infection related to the earlier hernia repair. He prescribed antibiotics. At a follow-up visit Dr. Williams recorded that he "frankly explained to him [Claimant] that I do not have a surgical reason to keep him from full duty work." Dr. Williams considered Claimant's pain to be related to nerve entrapment although Dr. Conyers had transected the ilioinguinal nerve during the October 2009 surgery.

13. On April 12, 2010, Dr. Shoemaker noted:

> This injury is medically reasonably work related "by history", with a past history of surgery lumbar, addiction to pain meds. Has not worked since 9/2009. No source of pain has been defined. Will look at spinal nerve roots before proceeding with nerve blocks. We had a lengthy discussion with the Patient regarding His/Her condition which is not "totally disabling" but is causing very restrictive activity. Permanent impairment and/or disability not anticipated as long as he/she continues to make functional gain.

(Quotation marks in original). Dr. Shoemaker maintained temporary work restrictions.

14. On April 26, 2010, another lumbar MRI was reported as showing the same conditions as the July 2000 MRI.

15. On April 27, 2010, Dr. Shoemaker again examined Claimant. He reported no objective findings to support Claimant's pain complaints. He referred Claimant to Shane Andrew, D.O., for consultation about a surgical option.

16. Dr. Andrew opined it unlikely that Claimant's groin pain could be related to his lower lumbar condition. The area Claimant identified as painful is served by nerves from L1-2, not L4-5 or L5-S1. After examination on May 13, 2010, Dr. Andrew recommended epidural steroid injections to alleviate pain and to assist in arriving at a differential diagnosis. He noted that he observed mild lumbosacral spondylosis with degenerative disc disease at L4-5 on X-ray.

17. On July 29, 2010, Roman Schwartsman, M.D., examined Claimant at Defendants' request. He recommended an MRI to evaluate a possible right hip injury

involving the labrum. He considered Claimant's low back and groin complaints to be subordinate to the dominant complaint involving Claimant's right hip. A MRI confirmed a chronic right hip labral tear. Upon review, Dr. Schwartsman recommended nonoperative management but allowed surgical intervention at Claimant's option after a trial of steroid injections.

18. Claimant attended additional follow-up visits with Dr. Shoemaker, Dr. Williams, or their PA.

19. Diagnostic imaging in 1986 identified a defect of Claimant's L5-S1 pars interarticularis bilaterally. A July 22, 2010 CT of Claimant's pelvis confirmed the presence of the chronic pars defects.

20. The CT scan was negative for ongoing infection or inflammation or recurrent hernia. On July 29, 2010, Dr. Williams stated Claimant had no activity restrictions. An August 5, 2010 right hip MRI showed a "tiny nondisplaced tear in the right anterosuperior labrum." This was considered to be a chronic condition without a clear relationship to Claimant's complaints. On August 17, 2010, Dr. Shoemaker noted Claimant was not yet medically stationary. On August 24, 2010, Dr. Shoemaker was still considering a tripartite differential diagnosis: an entrapped femoral nerve versus an extruded L4-5 disk versus a right hip labrum tear. On October 5, 2010, Dr. Shoemaker recorded that Claimant reported bending over five days earlier and experiencing excruciating right low back pain radiation into his right leg and an episode of incontinence.

21. On October 12, 2010, Dr. Schwartsman opined Claimant's groin pain to a "medical certainty" was not the result of a recurrent hernia. He opined it likely that Claimant's labral tear was not a cause of Claimant's symptoms. He opined that based upon

Claimant's reported history, Claimant suffered a lumbar strain in the work accident which had resolved to baseline.

22. During an examination on October 12, 2010, Dr. Andrew noted objective decrease in Claimant's bilateral lower extremity reflexes. He performed a transforaminal epidural steroid injection on October 22, 2010; another on March 11, 2011. Neither injection provided sufficient relief to allow Dr. Andrew to link Claimant's groin pain with a lower lumbar condition. Dr. Andrew considered Claimant's lower extremity radiculopathy to be consistent with Claimant's lower lumbar condition. A lumbar MRI taken April 22, 2011 was consistent with earlier MRIs. Dr. Andrew recommended laminectomy and foraminotomy bilaterally at L4-5 to alleviate the radiculopathy.

23. Claimant experienced some wound drainage and possible infection complications in January 2011.

24. On April 28, 2011, Dr. Andrew opined in writing that Claimant's groin pain was unrelated to the L4-5 pathology. He performed surgery on May 9, 2011. During the surgery, Dr. Andrew observed the pars defects which had been documented in 1986. Up through that time, Dr. Andrew had not been given the opportunity to review the 1986 records or other records which had identified the pars defects. Dr. Andrew expanded the surgery to include a fusion of L4-5-S1 to resolve the spinal instability arising from the pars defects.

25. Claimant's postoperative course was complicated by renal failure attributable to antihypertensive medication and diuretic use following surgery. This resolved with hydration.

26. Postoperatively, Dr. Andrew noted a new complaint of intermittent left leg pain. Claimant reported a resolution of his groin pain. Dr. Andrew could find no anatomical basis to explain a link between the surgery and the report of resolved groin pain. One of the fusion

screws appeared to Dr. Andrew to be "low" but a September 6, 2011 CT scan showed no hardware failure. Claimant recovered slowly and on September 20, 2011, he reported some SI joint inflammation. Dr. Andrew considered an SI joint injection. The injection was performed September 23.

27. On September 12, 2011, R. Tyler Frizzell, M.D., examined Claimant at Defendants' request. Claimant reported continuing intermittent groin pain, right sciatic pain and hypoesthesia with radiation, and low back pain. In part because of preexisting conditions, and in part because Claimant's back complaints did not arise at the time of the September 18, 2009 work accident, Dr. Frizzell opined the September 18, 2009 work accident did not cause Claimant's low back condition; also, the reported right groin pain was unrelated to a lumbar condition; the September 18, 2009 work accident probably temporarily aggravated Claimant's preexisting groin issues without causing a new hernia; Claimant had recovered from the groin issues and no additional treatment was to be expected.

28. The loose or broken screw which Dr. Andrew had been watching in follow-up visits could not be confirmed by diagnostic imaging until about February 2012. Dr. Andrew considered revising the rod and screw fusion to add a cage fusion. This was performed on March 14, 2012. An April 22, 2012 MRI showed a successful surgery.

29. On consultation for a postoperative bout of chest pain, Steven C. VonFlue, M.D., found no objective basis for it. He diagnosed "chest pain" and significantly noted "anxiety disorder" among the items in his assessment. After an EKG another consultant, Randolph C. Byrd, M.D., identified a "non-Q wave infarct" considered secondary to hypotension following surgery, and noted, "It is unlikely that the patient has any fixed coronary disease."

Additional facts and prior medical care

30. Born November 1, 1970, Claimant was 41 years old at hearing.

31. As early as 1986, Claimant's medical records showed lumbar pars interarticularis defects. At that time, he also suffered from vertebral osteomyelitis and a staph infection later identified as MRSA. A chest catheter was implanted to assist in treating the infection. Claimant was hospitalized for more than 10 days. Although Claimant sought treatment for pain following a football collision, the pars defects were determined not to be acute in origin. Claimant then complained of low back pain with radiation into his right leg. Spondylolysis was also identified as a chronic lumbar condition.

32. In 1990, Claimant injured his right knee. A single ER visit and X-ray revealed a knee strain. The physician and nurse recorded inconsistent histories—although both were work related—of Claimant's description of the onset of pain.

33. Claimant injured his back in a car accident in March 1992. Litigation ensued. Claimant experienced a course of lingering neck and low back pain with radiculopathy. Medical records of multiple physicians indicated only strained or torn muscles. Diagnostic imaging showed no new injuries. In February 1993, treating physician Gary Botimer, M.D., rated him at zero impairment despite Claimant's report of occasional "twinges."

34. A September 1997 CT and MRI reported the chronic pars defects at L5-S1 with other lumbar areas showing no abnormalities.

35. Claimant again injured his back in a car accident in May 1998. He also complained of radicular pain down his legs. Jeffrey Hansen, M.D., diagnosed a lumbar strain. After about a month, Claimant returned to work part time. At two months, he had returned to full-time work despite continuing complaints. Dr. Hansen formally released him to full duty at three months after the accident.

36. December 1999 notes the onset of treatment for a right inguinal hernia.

Surgeon Christian Vetsch, M.D., performed the hernia repair in early January 2000. Shortly afterward, Claimant visited an ER for a swollen uvula which Claimant, but apparently not the ER physician, attributed to postoperative medication. He visited a pain clinic for continuing postoperative pain. Claimant underwent an ilioinguinal nerve block and trigger point injection.

37. In June 2000, Claimant suffered acute low back pain with radiculopathy after bending to pick something off the floor. MRI showed a small L5 disc herniation. Epidural steroid injections helped, but he visited an ER in August for abdominal and flank pain which was diagnosed as kidney stones. About 10 days later, a follow-up visit for his back pain showed he was doing worse. What had previously been a radiculopathy on only the right side was becoming bilateral. After a third injection, L4-5 surgery was scheduled. An August 19, 2000 CT scan for possible kidney stones was positive for a right ureteral calculus; it also suggested the presence of spina bifida occulta of L5. The chronic spina bifida was apparently never clinically significant.

38. A right L4-5 diskectomy was performed by Dr. Botimer on September 26, 2000. In October, Claimant had a brief flare-up of pain and radiculopathy after a friend shoved him. A post-Christmas recheck in December 2000 showed he was improving.

39. In December 2000, Claimant had a recurrence of symptoms due to his kidney stones.

40. On January 28, 2002, Claimant visited an ER complaining of back pain with right radiculopathy after lifting baggage for Horizon Air. Two weeks later, he reported he was not improving. On February 13, an MRI showed mild lumbar degeneration without acute injury.

41. On February 19, 2002, Claimant was struck by a car. X-rays showed no C-spine or T-spine trauma. He complained significantly of pain and radiculopathy or neuropathy.

The ER physician diagnosed a contusion and mild C-spine sprain.

42. Despite the September 2000 surgical changes, a July 2002 MRI of Claimant's low back was reported as showing no significant changes since a July 2000 MRI. The pars defects and other conditions were noted.

43. On February 18 and 24, 2003, Claimant's visits for treatment for low back pain after handling Horizon Air baggage were recorded. His lumbar strain resolved.

44. On September 26, 2003, Claimant sought treatment for low back pain after another episode of handling Horizon Air baggage on September 9. This lumbar strain improved slowly and resolved about October 20.

45. On November 4, 2004, Claimant visited an ER for low back pain after bending to pick up his shoes. He also complained of testicular pain and left lower extremity weakness.

46. On April 12, 2005, Claimant complained of a hernia. It was repaired.

47. On May 21, 2005, Claimant visited an ER complaining about abdominal and flank pain. An examination revealed no injury or serious condition. An ultrasound allowed a diagnosis of a "probable tiny" kidney stone.

48. On June 7, 2005, Claimant visited an ER complaining of right upper quadrant pain. This recurrent complaint resulted in removal of his gallbladder. The pathologist's examination revealed no gallstones and only "focal mild chronic inflammation."

49. Claimant visited an ER on August 26, 2005 for back pain. He described a lifting and twisting event at work. Upon examination and finding only some tenderness, the physician diagnosed an acute back strain without ordering any diagnostic imaging.

50. On January 16, 2006, Claimant was LifeFlighted for a left knee injury after a snowmobile accident. Upon reaching the ER, a physician diagnosed a soft tissue injury,

a contusion. Diagnostic imaging revealed no ligament or bone injury and no dislocation.

51. On December 30, 2007, Claimant visited an ER for an inguinal hernia. He was discharged with some medication, the physician took a wait and see approach.

52. On January 8, 2008, Claimant was treated for left groin pain following some heavy lifting. The physician diagnosed a left inguinal hernia and probable bilateral groin strain. The hernia was surgically repaired on January 15.

53. Claimant dislocated a rib while working for Tamarack Homeowners Association in February 2009. He fell down some stairs. He testified that this had resolved before his September 18, 2009 accident. He received regular treatment through March 2009. In mid-June, he visited a clinic and reported continuing occasional "twinges" of rib pain. At an August 12 visit, he reported no more rib pain.

54. An August 7, 2009, visit occurred for possible cellulitis, a skin infection described as inflamed lesions on his lower abdomen.

55. Claimant's prior medical history also includes a sprained right shoulder, hypertension, and depression. Including the subject claim, Claimant has filed 23 workers' compensation claims.

56. Form 1's from prior claims include 9 hand or finger lacerations, contusions, strains, or infections; 1 upper arm strain; 1 contagious disease; 1 pelvic infection; 4 foreign particles in eyes or facial lacerations; 1 "multiple trunk" strain; 3 low back strains; 2 knee sprains or lacerations; and 1 groin strain.

57. Claimant was assisted by ICRD from February through December 2010. In December 2010, Claimant reported he was not able to work or look for work.

DISCUSSION AND FURTHER FINDINGS OF FACT

58. 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

59. 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). The Commission does not expect a claimant to have medical knowledge without medical training. He or she is not legally bound to his impression of causation. Conversely, a claimant's impression of causation cannot substitute for a physician's medical opinion. Rather, there must be medical testimony or a medical record sufficiently showing a physician's opinion 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).

60. 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).

61. The critical causation question in this case is whether the condition for which Claimant required low back surgery is causally related to the subject accident. Claimant has a well documented history of pre-existing low back problems and surgery. The question is whether the subject accident caused additional injury such as to require surgical intervention at

L4-S1. The matter is complicated by the fact that the record clearly establishes that Claimant presented with neither low back nor lower extremity symptomatology until many months after the subject accident. The lack of a temporal relationship between the subject accident and the development of low back and lower extremity symptomatology makes causation between the subject accident and Claimant's low back condition somewhat tenuous. Claimant counters by arguing that there is in fact a close temporal relationship between Claimant's symptomatology and the subject accident. Claimant argues that his well documented groin pain which developed contemporaneous with the subject accident is actually mediated by a lumbar spine injury. Therefore, a close temporal relationship between the development of symptomatology consistent with a low back injury and the subject accident is demonstrated by the facts of this case.

62. Dr. Shoemaker initially qualified his causation opinion by inserting quotation marks, i.e., "by history." However, by mid-2010 he unambiguously opined it more likely than not that Claimant's low back condition was work related. Later, he particularly disagreed with Dr. Schwartzman's opinion that the low back condition was preexisting. Dr. Shoemaker noted that Claimant's October 2010 symptoms indicated a new extruded disk fragment was generating pain and neurological symptoms. On May 19, 2011, Dr. Shoemaker stated he agreed with Dr. Andrew's opinion that there was no relationship between the work accident and the lumbar complaints.

63. Dr. Shoemaker's opinion is problematic. The record gives no medical basis why his initial skepticism, as indicated by his "by history" quotation marks, was suppressed later, although he continued to use the quotation marks. Moreover, his new less skeptical opinion was pronounced at a time when he was still unsettled about which of his three potential diagnoses was correct. Rather, Dr. Shoemaker's first opinion change occurred contemporaneously with

his perturbation over Surety's delay in paying benefits and in securing an IME. Finally, he reversed course after Dr. Andrew performed surgery when he (Dr. Shoemaker) opined that there was no link between the accident and Claimant's lumbar condition.

64. Dr. Conyers' treatment of Claimant was limited exclusively to possible hernia repair. Claimant's pain description was localized to that condition. It did not include any low back or lower extremity radiculopathy or other generalized complaints. In briefing, Claimant alleges that Dr. Conyers considered "radicular" pain. Claimant's attempt to link this to a lumbar injury is misplaced. Clearly, that note refers to inguinal pain radiating into the testicle along the ilioinguinal nerve, not lower extremity pain radiating from a lower lumbar nerve root.

65. During surgery, Dr. Conyers found scarring and a suture from a prior hernia repair which impinged the ilioinguinal nerve; she considered mesh or screws from the prior hernia repair to be possible pain generators and removed as many as possible. At surgery, she believed that any or all of these had caused Claimant's pain complaints. Afterward, Claimant complained that the transection of the nerve had not helped alleviate his pain. At no time during her treatment of Claimant did he exhibit symptoms which could relate to a low back condition.

66. Dr. Conyers opined that the pain location Claimant described was inconsistent with a low back condition. The ilioinguinal nerve is associated with T12-L1, not L3-4 or lower.

67. Dr. Schwartzman's opinion linking lumbar complaints to the work accident is based entirely upon the history Claimant provided to Dr. Schwartzman. To the extent that history suggested Claimant had lumbar complaints between September 2009 and March 2010 it was misleading. Dr. Schwartzman's opinion was based upon an inaccurate history and

does not outweigh the opinions of treating physicians Bedell, Conyers, Williams, Shoemaker, and Andrew.

68. In support of his theory, Claimant points out that the two surgeries performed by Dr. Conyers in search of a hernia as the explanation for Claimant's discomfort failed to demonstrate any such injury. Therefore, the argument goes, the groin pain was caused by something else, *i.e.* a L4-5 lesion. Moreover, the ilioinguinal nerve dissection performed by Dr. Conyers failed to alleviate Claimant's groin pain. Further, Claimant has testified, and there is no evidence to denigrate his testimony, that his groin pain resolved following the L4-S1 surgery performed by Dr. Andrew. Even Dr. Andrew has recognized that in evaluating the cause of Claimant's groin pain, this is a fact worth considering:

> Q. Okay. We've been talking about how unlikely it is for groin pain to emanate from an L4-5 herniation. But this note says he does get radicular pain, however, his groin pain from prior to the surgery is gone. So does that suggest to you that there is a connection between what Aaron was identifying as groin pain and the L4-5 disk herniation?
> A. It does.
> Q. So is this a case then where – well, I guess, there's – in my mind, there's a couple of possibilities, and I'd like you to address them. One is that actually the groin pain emanated from an L4-5 disk herniation. The other is that Aaron Cook was identifying groin pain based on his prior experience and no medical training –
>
> A. Sure.
> Q. -- and the fact that it seems similar?
> MR. GARDNER: I've got to object to that. One, it's very leading and suggestive, and it also is interjecting – it's speculation of the claimant as to what was going on, and counsel's speculation as well. And I think asking the Doctor to speculate on some things that I'm not sure anybody could know. So I think it's –
> MR. NAUMAN: It was a great question, but I'd still like to hear what you think.
> THE WITNESS: All I can say is that it surprised me that he got some relief in his groin from the surgery. And so as to the exact reason, you know, all I can say is that we did a surgery, and his groin got better, according to him.";
>
> . . .

> "Q. And so my mind says, well, does that matter, because what you have is a surgery where you were going to do an L4-5 laminectomy that relieved the groin pain? So even absent the pars defect, you're still going to have to do the L4-5 laminectomy because of the foraminal stenosis, correct?
> A. Correct.
> Q. Okay. And that is what appears to have relieved the groin pain, correct?
> A. Well, there's a correlation, that we did the surgery, and his groin pain and his leg pain got better.
>
> Andrew Depo. pp. 42/20-43/23; 58/1-11.

69. However, it is notable that the quoted testimony does not stand for the proposition that Dr. Andrew is of the opinion that Claimant's groin pain was caused by injury at L4-S1. All that his testimony establishes is that he is cognizant of a temporal relationship between the L4-5 surgery and the cessation of groin pain. Whereas the existence of a temporal relationship between an accident and the subsequent development of symptomatology is a necessary element of causation, the existence of a temporal relationship, without more, is insufficient to prove causation. Knowlton v. Wood River Medical Center, 151 Idaho 135, 144, 254 P.3d 36, 45 (2011) (While the temporal connection certainly supported the claimant's position, such a connection alone does not establish that her symptoms were *caused* by the chemical exposure.)

70. In fact, Dr. Andrew's testimony makes it clear that he does not believe that Claimant's groin pain is associated with a low back injury. First, and perhaps most important, is the fact that the groin is not innervated by any of the nerve roots exiting at L4 through S1. The only way that Claimant's groin pain could be mediated by a lumbar spine injury, is if the injury existed at L1-2 or L2-3. Neither of these levels was involved in the surgery performed by Dr. Andrew. Although Dr. Andrew would not say that it is impossible for Claimant's groin pain to have been mediated by an injury at L4 or lower, his opinion is clearly to the effect that

Claimant's groin pain is not anatomically consistent with an injury at L4 or below. Dr. Andrew's opinion finds support in the fact that the diagnostic epidural steroid injections he performed at L4-5 did not show that this level was implicated in causing or contributing to Claimant's groin pain.

71. On balance, the Commission finds that the testimony of Dr. Andrew fails to demonstrate that it is more probable than not that Claimant's groin pain is causally related to an injury at L4 or below. As noted, the only other symptoms that have been clearly associated with an L4-5 injury, *i.e.* low back and lower extremities symptomatology, arose many months downstream of the subject accident, and the medical record fails to establish a relationship between the onset of these symptoms, and the subject accident.

72. In view of the foregoing, the Commission concludes that Claimant has failed to demonstrate that he suffered an injury to his lumbar spine at L4-5 and/or L5-S1 as a consequence of the subject accident. Having failed to adduce medical evidence sufficient to meet his burden of proof, Claimant is not entitled to medical and other benefits associated with the lumbar spine condition treated by Dr. Andrew.

73. Claimant showed his treatment for complaints of inguinal pain by Dr. Conyers was causally related to the work accident. Consultations and treatment by other physicians around the time of Dr. Conyers' treatment was similarly causally related.

Medical Care Benefits

74. An employer is required to provide reasonable medical care for a reasonable time. Idaho Code § 72-432(1).

75. Dr. Conyers' treatment was reasonably related to the work accident and should be compensable.

76. Claimant showed his treatment by Saltzer physicians Williams, Shoemaker and

their PA was causally related, in part, to the work accident. These physicians were attempting, among other things, to diagnose and treat the inguinal pain Claimant had consistently described since the date of the accident. As such, this treatment is entirely compensable. Confounding issues relating to preexisting conditions which obscured diagnosis and treatment do not render this treatment noncompensable. All treatment by these physicians should be compensable.

77. Dr. Andrew limited his treatment to Claimant's low back condition. Because this condition was unrelated to the work accident, this treatment should not be compensable.

TTDs

78. Idaho Code § 72-408 provides income benefits for total and partial disability during an injured worker's period of recovery. The burden is on the claimant to present expert medical opinion evidence of the extent and duration of the disability in order to recover income benefits for such disability. *Sykes v. C.P. Clare and Company*, 100 Idaho 761, 763, 605 P.2d 939, 941 (1980); *Malueg v. Pierson Enterprises*, 111 Idaho 789, 791, 727 P.2d 1217, 1220 (1986).

79. Though Claimant requests TTD benefits through the date of hearing, he is only entitled to TTD benefits during his period of recovery from the compensable groin injury—not the lumbar spine injury. Claimant's groin condition showed substantial improvement as early as March 5, 2010, when treating physician Dr. Conyers did not anticipate further medical treatment for the groin injury. Claimant's ongoing pain complaints elicited additional referrals and investigatory treatment, culminating in the Claimant's April 12, 2010 lumbar MRI with Dr. Shoemaker. After reviewing the lumbar MRI results on April 26, 2010, Claimant's low back injury was considered the source of his

pain complaints. Any work restrictions after April 26, 2010 cannot be fairly related to the groin condition. Claimant has not shown he remained in a period of recovery beyond April 26, 2010.

CONCLUSIONS

1. Claimant suffered a groin injury, or a compensable temporary aggravation of a previous groin injury, as a result of the September 18, 2009 accident;

2. Claimant failed to show it likely that he injured his low back or aggravated a prior low back condition as a result of that accident;

3. Claimant is entitled to TTD benefits from the date of accident to April 26, 2010;

4. Claimant is entitled to medical benefits for treatment through April 26, 2010, and for palliative and diagnostic treatment provided through the office of Drs. Williams and Shoemaker afterward;

5. Claimant failed to show he is entitled to medical benefits for a lumbar condition unrelated to the accident;

6. All other issues are reserved;

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

DATED this _30th_____ day of ___January_____, 2013.

INDUSTRIAL COMMISSION

/s/_____
Thomas P. Baskin, Chairman

/s/_____
R.D. Maynard, Commissioner

/s/_____
Thomas E. Limbaugh, Commissioner

ATTEST:

/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the _30th_____ day of ___January_____, 2013, a true and correct copy of **FINDINGS, CONCLUSIONS, AND ORDER** were served by regular United States Mail upon each of the following:

ROBERT A. NAUMAN
3501 W. ELDER STREET, STE. 108
BOISE, ID 83705

ALAN R. GARDNER
P.O. BOX 2528
BOISE, ID 83701-2528

/s/_____