BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

FRANCES DENNIS, Claimant, v. DELL COMPUTER CORPORATION, Employer, and ACE AMERICAN INSURANCE COMPANY, Surety, Defendants.	**IC 2004-012556** **FINDINGS OF FACT, CONCLUSION OF LAW, AND RECOMMENDATION** Filed August 24, 2010

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Michael E. Powers, who conducted a hearing in Twin Falls on December 11, 2009. Claimant was present and represented by Keith E. Hutchinson of Twin Falls. Alan R. Gardner of Boise represented Employer/Surety. Oral and documentary evidence was presented and the record was held open for the taking of five post-hearing depositions. The parties then submitted post-hearing briefs and this matter came under advisement on May 13, 2010.

ISSUES

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

1. Whether Claimant was properly diagnosed with Complex Regional Pain Syndrome (CRPS), and, if so,

2. Whether Claimant's CRPS was caused by one or both of her work-related carpal tunnel release surgeries.

CONTENTIONS OF THE PARTIES

Claimant contends that she developed bilateral work-related carpal tunnel syndrome. She further contends that she developed bilateral upper extremity CRPS following a left carpal tunnel release surgery. Her contentions are supported by experts in the care and treatment of CRPS.

Defendants do not contest that Claimant contracted bilateral carpal tunnel syndrome while working for Employer at its call center. However, they do not concede that Claimant has CRPS in the first place and, if it is found that she does, that condition did not originate in Claimant's carpal tunnel surgery or any other work-related activity. Claimant was diagnosed with chronic pain before the occurrence of her carpal tunnel problems and her substantial pre-existing psychological make-up is more to blame for her condition, whatever that might be. Claimant does not meet the AMA Guides' diagnostic criteria for CRPS and the physicians that have so opined did so without full knowledge of Claimant's pre-existing medical and mental condition.

Claimant responds by pointing out that there is often a psychological component present in chronic pain situations; it is a chicken/egg dilemma. Further, throughout her treatment, Claimant presented with numerous objective signs of CRPS that qualify her for that diagnosis under the AMA Guides. Finally, the only real CRPS expert involved with Claimant's treatment has unequivocally opined that she developed that condition as a result of her carpal tunnel release surgery.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant taken at the hearing.

2. Claimant's Exhibits 1-7 admitted at the hearing.

3. Defendants' Exhibits 1-26 admitted at the hearing.

4. The post-hearing depositions of: Shane Brogan, M.D., taken by Claimant on December 15, 2009; K. Cheri Wiggins, M.D., and Akiko Okifuji, Ph.D., taken by Defendants on December 15, 2009; Gerald R. Moress, M.D., taken by Defendants on February 5, 2010; and Michael F. Enright, Ph.D., taken by Defendants on February 20, 2010.

With the exception of Defendants' objection at page 13 of Dr. Brogan's deposition, all other objections made during the course of the taking of the post-hearing depositions are overruled.

After having considered all the above evidence and briefs of the parties, the Referee submits the following findings of fact and conclusion of law for review by the Commission.

FINDINGS OF FACT

1. Claimant was 51 years of age and resided in Twin Falls at the time of the hearing. She attended school through about the 9th grade and obtained her GED. Claimant received an AA degree in computers from the College of Southern Idaho in 1996. Prior to her employment with Employer, Claimant worked at a computer learning center and as a cook. Claimant began working for Employer in January 2002. Her duties consisted primarily of taking phone calls and walking people through the procedures for fixing their computers.

2. In May or June 2004, during the course of her employment with Employer, Claimant developed bilateral carpal tunnel syndrome. James M. Retmier, M.D., an orthopedic surgeon, performed a left carpal tunnel release on August 12, 2004, and a right carpal tunnel release on September 16, 2004.

3. Claimant's recovery from her surgeries was complicated by the onset of chronic pain. She testified:

> Q. (By Mr. Hutchinson): How did the recovery process [sic] after the surgery?
>
> A. It didn't do - - go very well.
>
> Q. Okay. Well, at first, I mean, did you - - did this come on immediately, or did it - -
>
> A. No, at first it felt okay. They were - - you know, it just didn't feel right. And then when I really noticed it was when he took the bandage off my left hand.
>
> Q. And that - - what happened?
>
> A. I screamed, because it was painful and it was burning.

Hearing Transcript, p. 46.

4. Although she does not remember how or when, Claimant testified that the pain moved into her right hand as well. Dr. Retmier noted on October 13, 2004, that Claimant was hypersensitive on her fingers and "over all of her wounds." He sent her to physical therapy and intended to begin weaning her from her narcotic medications. Dr. Retmier noted on October 29, 2004, that Claimant's physical therapist thought that Claimant was developing RSD (Reflex Sympathetic Dystrophy – now known as CRPS). Dr. Retmier agreed that it was "quite possible" that Claimant was developing CRPS so he referred Claimant to Cheri Wiggins, M.D., a physiatrist.

Dr. Wiggins

5. Claimant first saw Dr. Wiggins on November 1, 2004. Dr. Wiggins noted, "She meets three of the four criteria for stage 1 of complex regional pain syndrome or reflex sympathetic dystrophy. This makes her diagnosis as probable." Claimant's Exhibit 3, p. 1. Dr. Wiggins prescribed Baclofen and occupational therapy.

6. Claimant also saw Dr. Retmier on November 1, 2004. His office note for that date indicates that, "She has all the classic s/s [of CRPS] and has been documented by PT and Dr. Wiggins and myself." Claimant's Exhibit 2, p. 8.

7. Claimant returned to Dr. Wiggins on December 1, 2004, after she had undergone three stellate ganglion blocks administered by Clinton Dille, M.D., with excellent results on her right hand, but not as much on the left. Dr. Wiggins reported that Claimant was doing quite well overall, but she continued to have bilateral upper extremity pain. Dr. Wiggins continued her diagnosis of bilateral CRPS. A three-phase bone scan ordered by Dr. Wiggins was performed on November 11, 2004, and revealed "Increased activity symmetrically in the periarticular aspects of both hands suggesting arthritis. Symmetrical involvement of both hands by RSD seems unlikely." Claimant's Exhibit 3, p. 7.

8. Claimant returned to Dr. Retmier on December 3, 2004 ". . . doing terribly." Claimant's Exhibit 2, p. 9. Dr. Retmier did not understand why Surety denied coverage and noted, "The RSD is secondary to an adverse reaction to both her disease process and the surgical intervention. Therefore, this whole scenario should be being covered by WC, without a doubt." *Id*.

9. Claimant continued treating with Dr. Wiggins, who over the next few months recorded objective signs and symptoms of CRPD such as mottling, long, hard and cracking fingernails, swelling in the hands bilaterally, red spots over palms, flexion contractures of the 4th and 5th digits bilaterally, unusual sweating, and hypersensitivity to touch. On February 8, 2005, Dr. Wiggins noted that Claimant had undergone nine stellate ganglion blocks with little to no pain relief. Dr. Wiggins' impression was "Severe complex regional pain syndrome, which has proved resistant to multiple treatments including nine stellate ganglion blocks." Claimant's

Exhibit 3, p. 16. Dr. Wiggins was concerned that Claimant's depression was worsening and attributed that depression to her pain.

10. Dr. Wiggins noted on February 21, 2005, that Claimant did not want to consider a spinal cord stimulator as was being recommended by Dr. Dille. Dr. Wiggins was frustrated by the lack of success of her treatment and was looking for a referral for Claimant to a complex regional pain center.

11. Drs. Dille and Wiggins referred Claimant to the University of Washington Pain Center in Seattle, where she was evaluated on April 1, 2005. The Center's assessment was: 1) Deactivation. 2) Depression and 3) Complex Regional Pain Syndrome. Staff at The Center concluded that Claimant was not a suitable candidate for their program because she does not move enough to make any progress in their three-week program; Claimant would have difficulty staying in a hotel for the outpatient program; and, she needs more extensive physical therapy. The staff recommended a spinal cord stimulator to help Claimant with her more aggressive physical therapy.

Dr. Friedman

12. Claimant saw Robert Friedman, M.D., a physiatrist, at Surety's request on June 2, 2005. Claimant had previously attended a one-hour presentation given by Dr. Friedman regarding the Life-Fit program at the Elks, but no physician-patient relationship was established. After taking Claimant's history, examining her, and reviewing medical records, Dr. Friedman diagnosed bilateral wrist and forearm pain, possible depression, and an abnormal psychological examination. Dr. Friedman conceded that Claimant had carpal tunnel syndrome but based on inconsistencies in Claimant's history and the medical records, he did not believe she has RSD or CRPS. Interestingly, Dr. Friedman opined that, ". . . [Claimant] may very well have a chronic

regional pain syndrome. From a clinical standpoint the treatment is identical." Defendants' Exhibit 15, p. 636. Dr. Friedman apportioned her chronic pain problem at 50% pre-existing. He recommended against the use of a spinal cord stimulator. Dr. Friedman agreed with the staff of the U of W Pain Center regarding a multidisciplinary approach and recommended the Elk's Life-Fit program, where he is the medical director.

Dr. McClay

13. Claimant also saw Michael H. McClay, Ph.D., a clinical psychologist, on June 2, 2005, in connection with the above IME. Dr. McClay noted:

> On the clinical scales the patient has extreme elevations on scales 1 and 3 in a conversion-type pattern. These individuals convert psychological tension into physical tension and pain. They over-report and over-react to the pain they do experience, preferring medical explanations for symptoms that have a strong psychological component or cause.

Defendants' Exhibit 16, p. 652.

14. Dr. McClay indicated that a spinal cord stimulator ". . . would be a very high-risk procedure . . ." for an individual with Claimant's psychological profile. Dr. McClay concurred with Dr. Friedman that Claimant has elements of chronic pain syndrome, including heightened sensitivity to pain. She needed to get off painkillers. She needed to be out of the workers' compensation system or dealt with in a "behavioral manner." *Id*., p. 653. Dr. McClay opined that overt malingering needed to be ruled out.

15. On October 6, 2005, Dr. Wiggins, without explanation, changed her diagnosis from severe CRPS to "atypical" CRPS.

Life-Fit

16. Claimant entered the Elks Life-Fit program on October 19, 2005. Her admitting diagnosis was bilateral CTS status post-carpal tunnel releases and, despite being ruled out earlier

by Dr. Friedman, the program's medical director, bilateral RSD. Claimant was generally compliant with the program but was self-limiting in many activities due to pain. A functional capacities evaluation was deemed invalid as the result of "manipulated effort." On November 9, 2005, at week four of the program, Dr. Friedman indicated, "The patient has made great gains. He adds the patient might even believe it herself a little." Defendants' Exhibit 17, p. 688. Claimant testified that she did not believe the Life-Fit program helped her. Claimant was discharged from Life-Fit on November 11, 2005 with no upper extremity restrictions. The diagnosis of RSD did not change during the course of the program.

17. Claimant saw Dr. Wiggins intermittently who was attempting to wean her from narcotic medications through March 21, 2006. She continued to complain of severe pain in her hands. She wanted a referral to a physician that would help her, as Dr. Wiggins had nothing left to offer Claimant in terms of treatment or further treatment recommendations. Dr. Wiggins again changed her diagnosis; this time from atypical CRPS to bilateral hand pain.

18. In a June 2, 2006 letter to Claimant's attorney, Dr. Wiggins refused to rate Claimant for PPI purposes under the AMA Guides, 5th Edition. She wrote: "I do not believe she has a well established pain syndrome nor does she have a verifiable medical condition. In my opinion she fits more into the ambiguous or controversial pain syndrome category falling under 18.3B. As a result I am afraid that it is not appropriate to use this chapter to rate her based on her pain." Defendants' Exhibit 18, p. 692.

Dr. Enright

19. On September 15, 2006, Claimant saw Michael Enright, Ph.D., a clinical psychologist and Gerald Moress, M.D., a neurologist, at Surety's request. Dr. Enright noted that Claimant first experienced pain in her left hand/wrist when Dr. Retmier removed the bandages

from her wound post-carpal tunnel release. The pain eventually migrated to Claimant's right hand/wrist. Claimant reported that after Life-Fit, the pain has migrated up her arms. Contrary to Life-Fit's records, Claimant referred to that program as "a waste of time." Dr. Enright's considerations and recommendations were as follows:

> At this time there are several psychological and behavioral factors impacting Ms. Dennis' pain presentation. These factors include significant somatization tendencies, depression, fear of pain, anger at her physician [Dr. Retmier], avoidance [sic – of] adult responsibilities, including employment and ongoing reinforcement for pain behaviors. Consequently conservative care is recommended for this claimant.
>
> It is highly unlikely that the events of July 12, 2004 (or the month proceeding) served as the predominate [sic] factor above all other factors combined that account for the combination of psychological and behavioral conditions that contribute to her level of pain and debilitation.

Defendants' Exhibit 19, p. 703.

Dr. Moress

20. Claimant also saw Dr. Moress on September 15. He was only able to complete a limited physical examination because Claimant cradled her upper extremity and kept her hands in a "claw" position. He did notice that her palms were "blotchy." Dr. Moress reached the diagnosis of chronic upper extremity pain syndrome with no evidence of CRPS. He also diagnosed a psychogenetic pain disorder/somatoform disorder. Dr. Moress questioned whether Claimant's carpal tunnel syndrome was work-related. He did not find Claimant's presentation to meet the objective criteria for CRPS as outlined in the AMA Guides, 5th Edition. As he stated, "Subjective complaints, alone, do not establish a diagnosis of CRPS." Defendants' Exhibit 20, p. 724. Dr. Moress recommended no further treatment neurologically. He did not recommend the implantation of a spinal cord stimulator.

University of Utah Pain Center – Dr. Brogan

21. On January 12, 2007, Claimant presented to Shane Brogan, M.D., an anesthesiologist and medical director of the University of Utah (U of U) Pain Management Center. Claimant was referred to the clinic by a hand specialist at the U of U who suspected she may have CRPS. She informed Dr. Brogan that the U of W Pain Center rejected her because her pain was too severe and her pain has been increasing since that time. Dr. Brogan and a clinic intern examined Claimant and found:

> The patient is sitting with her hands elevated on a pillow. Her hands both appear to be quite swollen and edematous. She has mild erythema throughout. Examination of her hands reveals that there is extreme allodynia present over the palmar surfaces of her hands. I am able to touch her dorsal surfaces of her hands without causing pain. The fingernails are severely ridged. There is evidence of increased hair growth over her hands, as well.

Claimant's Exhibit 6, p. 4.

22. Dr. Brogan diagnosed bilateral CRPS - Type 1 caused by Claimant's carpal tunnel surgeries. Due to the history of unsuccessful treatment modalities, Dr. Brogan opined that ". . . it may be a very difficult problem to fix." *Id*. He indicated that a spinal cord stimulator was the only solution at that point. Claimant was to be evaluated by a physical therapist and a behavior medicine specialist at a follow-up visit.

23. Claimant returned to Dr. Brogan in follow-up on February 7, 2007, at which time he noted that:

> Her original work-related injury was a carpal tunnel syndrome, which was treated by bilateral carpal tunnel release procedures. Thereafter, she developed classic symptoms of complex regional pain syndrome, with proximal spread up to the axilla. The patient has what I would consider classic complex regional pain syndrome, with objective evidence of skin color changes, trophic changes of the nails, loss of function, and extreme allodynia.

. . .

> On examination of her upper extremities, she rests her hand on a pillow. She has very obvious mottled skin discoloration in a patchy fashion throughout the hand extending up to the midhumerus level. There are very clear skin color changes consistent with the diagnosis of complex regional pain syndrome. She also has severe allydonia involving the hands and appears to be also developing contractures of the hands.

Claimant's Exhibit 6, pp. 9-10.

Dr. Brogan recommended physical therapy and a spinal cord stimulator; however, due to Claimant's lack of insurance or other funds, Claimant was unable to pursue those options.

24. In a February 7, 2007 letter to Claimant's attorney, Dr. Brogan wrote, "This is the most blatantly obvious case of complex regional pain syndrome I have ever personally seen and I do not for one instant doubt this diagnosis. It is also my opinion that the syndrome as it presents today is as a result of her carpal tunnel releases performed for a work-related injury." *Id*., p. 14.

25. On June 4, 2007, Claimant underwent a behavioral medicine evaluation conducted by Akiko Okifuji, Ph.D., a psychologist at the U of U Pain Center. Dr. Okifuji interviewed Claimant and reviewed available medical records. The purpose of the evaluation was to determine the extent of the psychosocial factors relevant to her bilateral hand pain and to see if she would benefit from psychological treatment. During the interview, Dr. Okifuji noticed that Claimant, "exhibited significant bracing behavior, tenderly holding up her hands as not to touch anything with the palms of the hands." Claimant's Exhibit 6, p. 20. Dr. Okifuji noted that Claimant had an abusive childhood and became involved with IM drug usage leading to some legal issues. Dr. Okifuji diagnosed: Axis I: Adjustment disorder with depressive mood. Axis II: Deferred. Axis III: Chronic pain. Axis IV: Chronic pain, significant functional limitation, disability/Workers Compensation issues, vocational issues, recreational and social issues. *Id*., p.

22. Dr. Okfuji recommended physical and behavioral medicine therapy as Claimant's finances would allow.

26. Claimant followed-up on June 20, 2007, at which time it was noted that she had diffuse edema in her hands. She also had blue mottling over her knuckles as well as new notable ridging on her fingernails.

27. In her August 15, 2007, follow-up, Claimant informed Dr. Brogan that she had recently been approved for Social Security Disability and Medicare benefits. At that time, it was noted that Claimant had diffuse swelling of her hands with marked palmar erythema and extreme allydonia. She was scheduled for a spinal cord stimulator trial.

28. After a successful trial period, on December 21, 2007, Dr. Brogan surgically implanted a cervical spinal cord stimulator.

29. In a January 2, 2008, follow-up, Dr. Brogan noted, "She reports a dramatic improvement in her pain, rating it as a 1/10 today. She has been able to use her hands fully, without significant impairment. She notes that the swelling in her hands has decreased to the point where she has been able to wear rings that she has previously been unable to get on." *Id*., p. 31. Further, "She is very upbeat and happy with her outcome." *Id*.

Drs. Moress and Enright revisited

30. Surety arranged for a second IME by Drs. Moress and Enright on April 10, 2009. This time, relying on the AMA Guides, 6th Edition, Dr. Moress again discounts the diagnosis of CRPS:

> We would reemphasize that the onset of this problem was abrupt and at that time she was on narcotics for an abdominal problem then developed a new focus on the upper extremities. We began with the comments made by the AMA Guidelines Sixth Edition regarding the rare entity of CRPS and that disuse

> atrophy, unrecognized general medical problems, somatoform disorders, factitious disorders, or malingering should always be considered foremost.

Defendants' Exhibit 20, p. 732.

31. Dr. Enright's April 10, 2009, report indicates that Claimant discontinued the use of her methadone at the time the spinal cord stimulator was implanted. She also reported a decrease in pain bilaterally in her hands and arms. She further reported experiencing severe pain if she is active for 10 – 20 minutes at a time. Claimant has constant "low-grade" pain, but it does not interfere with her sleep. She continues to have bilateral swelling in her hands to the extent that she cannot get her rings off.

32. Dr. Enright's diagnostic impression was:

> The current medical evaluation (following the implantation of a spinal cord stimulator) continues to be less than conclusive for CRPS. Psychological evaluation and testing continue to confirm a significant psychogenetic etiology for the claimant's pain and debilitation. The implantation of the spinal cord stimulator has apparently worked as a "credible ritual" to facilitate partial recovery. However, the claimant continues to rely on others, especially her boyfriend, receives monetary support and healthcare coverage from the Social Security Administration and is free from expectations of gainful employment consequent to her present condition. Secondary diagnosis continues to include dependent personality traits. Symptoms of depression have ameliorated.

Defendants' Exhibit 19, pp. 710-711.

Dr. Enright does not relate Claimant's condition to her CTS or the release surgeries.

DISCUSSION AND FURTHER FINDINGS

A claimant must provide medical testimony that supports a claim for compensation to a reasonable degree of medical probability. *Langley v. State, Industrial Special Indemnity Fund*, 126 Idaho 781, 785, 890 P.2d 732, 736 (1995). "Probable" is defined as "having more evidence for than against." *Fisher v. Bunker Hill Company*, 96 Idaho 341, 344, 528 P.2d 903, 906 (1974). Magic words are not necessary to show a doctor's opinion is held to a reasonable degree of

medical probability; only their plain and unequivocal testimony conveying a conviction that events are causally related. See, *Jensen v. City of Pocatello*, 135 Idaho 406, 412-413, 18 P.3d 211, 217-218 (2001).

The Medical Testimony

Dr. Brogan:

33. Dr. Brogan's deposition was taken on December 15, 2009, by Claimant. Dr. Brogan is a board-certified anesthesiologist who specializes in pain medicine. He is the Medical Director of the University of Utah Pain Center. He described his duties as follows:

> Well, as the medical director of the Pain Management Center, we have the only truly multidisciplinary pain clinic in the Intermountain West. We have a clinic comprised of four physicians, three physical therapists, two psychologists and - - as well as our supporting nursing staff. And we operate a multidisciplinary pain clinic model where each new patient is seen by three providers: a physical therapist, a psychologist and a physician. We all work together and come up with a treatment plan for the patient and execute that plan the best we can.

Dr. Brogan Deposition, p. 5.

34. Dr. Brogan's program treats only patients with chronic v. acute pain. He described chronic pain thusly:

> Q. (By Mr. Hutchinson): Now, just discussing chronic pain. Because the records will show that Mrs. Dennis for years has been described as having chronic pain, can you just tell us what chronic pain is?
>
> A. Well, it's loosely defined as pain that persists for six months or more without any obvious acute pain issues going on. So a patient who has perhaps had an acute pain issue, but six months later they still have pain and typically this pain is starting to have an impact on their functionality and quality of life.
>
> Q. Now, in treating this, have you treated on the chemical basis and also the psychological basis?
>
> A. Both. Every pain patient and every pain problem is very different, so it entirely depends on the patients. The chronic pain very typically results in decreased function; consequently a lot of patients end up depressed or with anxiety. So we try to address all those issues, we don't just treat their pain with medications or injections or physical means. We also consider their

> psychological well-being and help them learn how to cope with pain and get back to a better functionality.

Id., p. 6.

35. Dr. Brogan, anecdotally, believes there is support in the pain community that chronic pain may predispose one to CRPS, but he is not aware of any empirical or clinical studies supporting that belief. The Pain Center sees an average of two to three new CRPS patients a month. Dr. Brogan defined CRPS as follows:

> Well, so, number one, it's a painful condition usually involving an extremity that is not explained by an obvious injury or infection or so forth. So there is a presence of pain, features consistent with neuropathic pain such as allydonia, hyperesthesia, but importantly there's also very noticeable objective findings like color changes, trophic changes which means, you know, wasting. There are pseudomotor changes which means alterations in sweat. And there is often a difference in temperature regulation between an affected extremity and the unaffected extremity. That would be the main criteria.

Id., pp. 9-10.

36. Dr. Brogan testified that his review of the November 11, 2004 bone scan found it to be consistent with a diagnosis of CRPS as he never found any signs of arthritis in Claimant's hands, although he admitted that making such a diagnosis would be difficult due to the deformity in her hands initially and her sensitivity to touch. In any event, he does not believe bone scan findings are necessary in diagnosing CRPS. He further testified that there is a "huge spectrum" of severity in CRPS among patients depending on the stage of the disease. Moreover, regarding the symptoms associated with the diagnosis of CRPS, "Some patients have all of the symptoms and signs, others only have a handful of them." *Id*., p. 12. CRPS patients can have good days and bad days depending on the weather and their activity levels as examples.

37. Dr. Brogan described his physical findings on examination as follows:

> Q. (By Mr. Hutchinson): Did you undertake a physical examination of Mr. Dennis?
>
> A. Yeah. At that first visit. It was notable for her - - her posture. She sat with her hands elevated. I believe she had them resting on a pillow. They were contracted. The color was - - I can't recall the color change, but I do recall she had ridging of the nails.
>
> There was some atrophy in her hands. There were - - there was hair loss in the back of her hands. And when I went to touch her hands, she demonstrated extreme allydonia. She recoiled when I attempted to touch her hands. Those were the most elite findings.

Id., p. 16.

38. Dr. Brogan testified that in his experience, a spinal cord stimulator is approximately 80% effective in helping control pain in CRPS cases in the event that other treatment modalities such as medications, physical therapy, and stellate ganglion blocks are unsuccessful, as here. He indicated that the spinal cord stimulator does not cure the underlying problem, but usually simply masks the pain. Dr. Brogan gave Claimant a good prognosis as of the last time he saw her in March 2009.

Dr. Okifuji:

39. Dr. Okifuji"s deposition was taken also on December 15, 2009, by Claimant. Dr. Okifuji is a clinical psychologist specializing in pain management. She is on the faculty of the University of Utah Pain Center. Dr. Okifuji is not a proponent of a lot of psychological testing for chronic pain patients as most tests are more for research purposes than for dealing with individual assessments. The MMPI is one of the most widely used tests that Dr. Okifuji described as follows:

> The MMPI was originally developed in the 1930s to identify psychopathology in the general public and in the psychiatric population. So what they did is they had a whole bunch of people and people who had depression, who didn't have depression, what kind of items would discriminate between those people. Then it's been readjusted a little bit to make it more - - because it was initially developed in the very white community in Minnesota, in the Midwest.

> So they tried to make it more diverse, population friendly. So that is the purpose of the MMPI.
>
> And the MMPI has been used frequently in the chronic pain population, but I believe that despite lots and lots of research that's been done in this area, I don't think there has been a good data showing that MMPI predicts those things in a chronic pain situation.

Dr. Okifuji Deposition, p. 12.

40. Dr. Okifuji testified that it was the interpretation of the results of the testing due to ". . . so many confounding factors that can come into play" that brings the validity of the testing into question. Dr. Okifuji utilizes more pain-specific questionnaires developed specifically for pain patients rather than the MMPI. However, she does not base her diagnoses on the responses to questionnaires alone, but on her observations and clinical interviews as well.

41. Dr. Okifuji does not concern herself with the etiology of a patient's pain:

> Yeah, the answer would be no. I would not be looking into whether it's a functional non-organic problem versus organic problem. It's relatively, I think, a moot point. And by the time patients come to the clinic, we would be certainly looking into presentation of pain, expression of pain, but not the etiology of pain.

Id., pp. 16-17.

42. After their one and only meeting, Dr. Okifuji diagnosed Claimant as follows:

> My general impression was that she was suffering from bilateral hand pain which was impacting her life tremendously. I do remember she was very careful with her hands, trying not to touch anything because she was experiencing hypersensitivity. That she has been struggling with the treatment and the lack of progress as well as the continuing disability and that was impacting her life tremendously.

Id., p. 17.

43. Dr. Okifuji questioned Dr. McClay's 2005 report regarding the elevated scales 1 and 3 because most, if not all, chronic pain patients would score higher on those scales

(hypochondria and hysteria). Further, it was difficult for Dr. Okifuji to interpret Dr. McClay's report without his raw data. Dr. Okifuji did not know what Dr. Enright meant when he referred to Claimant's spinal cord stimulator as a "credible ritual." She has not seen that term in any psychological literature. Dr. Okifuji disagrees with Dr. Enright that Claimant has psychogenetic pain.

Dr. Moress:

44. Dr. Moress was deposed by Defendants on February 5, 2010. Dr. Moress is the neurologist who examined Claimant twice along with Dr. Enright. Dr. Moress at one time was a pediatric neurologist who now does mostly IMEs, the "vast" percentage for the defense, and also has a private practice. He testified that he has been involved with the diagnoses of RSD/CRPS "for decades." He generally described CRPS as follows:

> Yeah. Well, CRPS basically - - we'll call it CRPS - - is a pain syndrome, the cause of which has not been specifically designated or discovered as yet, although there are theories about it. And following either - - and frequent trauma, injury to either soft tissue or to nerve[1] - - there develops a cascade of symptomatology; which includes alterations in blood flow, pain, [sic] symptoms, atrophic symptoms having to do with skin, nails, the integument, changes of hair, joints, and weakness. That would be a general statement regarding it.

Dr. Morres Deposition, p. 8.

45. Dr. Moress questions the original CTS diagnosis rendered by Dr. Retmier in 2004 as, in reviewing his records, he could not find Claimant exhibiting symptoms generally associated with that condition. In any event, when Dr. Moress saw Claimant in 2006, he observed only allodynia, the loss of the ability to fully extend a joint in her finger, and erythematous or blotchiness in her palms as objective signs of CRPS.

[1] Dr. Moress defined injury to soft tissue as CRPS Type 1 and injury to a nerve as CRPS Type 2. Both types are treated the same way.

46. Dr. Moress opined that Claimant had pertinent pre-existing medical issues he considered to be "extremely important" in reaching his opinions, although he conceded that people with chronic pain have lots of emotional problems:

> Q. (By Mr. Gardner): Were there relevant past medical histories to pain that you observed or reviewed at that time?
>
> A. Yes, I did feel there were pertinent pre-existing issues.
>
> Q. Can you tell me what they were?
>
> A. Well, this lady had had years of abdominal pain - - which I found in reading the records to be [sic –of] obscure origin - - and had been treated by a pain doctor, Dr. Dille, in Twin Falls, with opiates, Oxycontin, and other modalities. And as I recall, this injury occurred in June, but she really had been complaining about it throughout the year before. I'm talking about - -
>
> Q. The hands?
>
> A. The hands. But it just come on [sic] three months. Dr. Retmier said it had been there for a year.
>
> So overlapping with her complaints in her hands, she has been treated with heavy doses of narcotics for abdominal pain of what looks like to me to be of obscure origin.

Id., pp. 18-19.

47. When he saw Claimant in 2006, Dr. Moress diagnosed idiopathic bilateral upper extremity chronic pain syndrome. Dr. Moress disagreed with the diagnosis of CRPS:

> Because she had some of the criteria but not all of the criteria. And CRPS and - - You know, so many people, I mean authorities - - let's talk about the AMA Guides - - they call it an extremely rare condition. And you've got to make sure you've got the DMS-IV conditions ruled out. Because it's extremely rare in the population. And you've got to exclude everything else. And it has to meet specific guidelines. Unfortunately, guidelines for CRPS are kind of - - they keep - - they are influx [sic]. And one group may recommend one guideline, diagnose [sic]. Another, another guideline. You really have to stick with one guideline. And in this case, I feel obliged to stick to the A.M.A. Guidelines. And in that sense, she did not meet the criteria.

Id., p. 22.

48. Dr. Moress next saw Claimant on April 10, 2010, post-spinal cord stimulator implant. Even though Claimant, at that time, had no complaints of pain in her upper extremities, Dr. Moress was still unable to examine her due to diffuse, functional give-away strength in that area. Regarding his diagnosis on Claimant's second visit, Dr. Moress testified:

> Well, looking at the guidelines - - and now we're kind of updating to the sixth edition. And they had varied them a little bit, but - - And now with the new - - I don't know if you're familiar with the sixth guidelines. They have classifications and things are quite a bit different than they were in classifying CRPS, not in terms of the criteria so much, but in trying to rate them. They have class 0, 1, 2, 3. In class 0, you've got less than four points assigned. And she had less than four points and, therefore, wouldn't fall into the category of ratable CRPS.

Id., p. 27.

49. Dr. Moress testified that he is not a "nihilist" when it come to spinal cord stimulators and agrees that, in certain circumstances, they may be beneficial. However, in Claimant's case, he testified:

> In her case, I found it to be inappropriate. Because, number one, I didn't feel she met the criteria for the use of it. And I know she had gone off the drugs. That's another big one. I'm not sure if - - I know she was seen by a psychologist, but I'm not sure that psychologist didn't - - in terms of is she an appropriate candidate for it. I don't think she answered it. That's a very important thing to look at before you have it done, is the candidate an appropriate person. Considering history of drug abuse, IV drug abuse, prescription drug use and maybe abuse, psychological profile of that individual, are they appropriate for that procedure? I don't think they did that here.

Id., p. 32.

Dr. Moress attributed the apparent success of the spinal cord stimulator in decreasing Claimant's pain to a "placebo effect."

50. On cross-examination, Dr. Moress conceded that people with chronic pain may be more susceptible to developing CRPS and further conceded that CRPS actually does exist on

occasion, just not in Claimant. Dr. Moress discussed his reasoning for finding Claimant's pre-existing abdominal pain significant this way:

> Q. (By Mr. Hutchinson): Okay. And the fact that you indicate that - - well, at least your reading of Dr. Dille and prior medical records is that as to this chronic abdominal pain, which I think you described as undifferentiated or undiagnosed - - is that significant?
>
> A. I think so.
>
> Q. In what way?
>
> A. Because I think this woman has dealt with maybe emotional problems, with somatic manifestations. I mean, here she went for years. Nobody could diagnose her abdominal pain. Had to go see a pain doctor. And while she's being treated with Oxycontin and being seen by Dr. Dille, she starts developing pain in her upper extremities, overlapping. Suddenly - - I don't know suddenly, but within not too long a period of time, the focus on her abdomen, which has been terrible for her, requiring very potent opiates, refocused on her upper extremities, and the abdominal pain disappears. There's something peculiar there, if you think of this as being an organic problem. I mean, I think logically there is some peculiarity in that logic, thinking what medical condition goes from here to there, unless there's something supertentorial, in the head. That usually means kind of flaky.

Id., pp. 37-38.

51. Dr. Moress testified that Claimant may have had CRPS when Dr. Wiggins first saw her, but by the time he saw her in 2006, she did not. However, he conceded that Dr. Wiggins recorded that Claimant was showing signs of improvement in July 2005. Dr. Moress never saw any indication of an arthritic disease process in Claimant's hands. He testified that some physicians do not believe at all in the diagnosis of CRPS due to its controversial nature. Finally, Dr. Moress testified that there is a "possible relation" between Claimant's chronic pain and the onset of her carpal tunnel syndrome.

Dr. Wiggins:

52. Dr. Wiggins, a physiatrist, was deposed on February 16, 2010 by Defendants. Dr. Wiggins first saw Claimant on November 1, 2004, at which time she took a history from

Claimant, examined her, and reached the initial diagnosis of probable CRPS. Claimant was referred to Dr. Wiggins by Dr. Retmier, who had performed Claimant's bilateral carpal tunnel releases. Dr. Retmier had also diagnosed CRPS. During the remainder of 2004 and into 2005, Dr. Wiggins began to have second thoughts regarding her CRPS diagnosis:

> Q. (By Mr. Gardner): Okay. During that time frame, what was the progression of your thinking, if you will, pertaining to the RSD diagnosis based upon her presentation and other factors which may have come to your attention?
>
> A. As I recall, initially, I was very concerned about complex regional pain syndrome, and we attempted with multiple medications, continued therapies to improve her pain, her disability, her level of function. She seemed to have somewhat of a waxing and waning course, as I recall, with her exam varying somewhat, but consistently complaining of pain for several months.
>
> She then seemed to improve for a brief period of time after several months, and it appeared that we were making some progress, and then she seemed to have somewhat of a regression with worsening of her symptoms.
>
> Around that time, she also was being seen by some other physicians and some other information came from Elks. I began to have some concerns that there may be some embellishment or some - - focusing more on her symptoms than focusing on getting better, if that makes sense.
>
> Q. Okay.
>
> A. Uhm, things - - it just didn't add up quite as much as I wanted it to. And I'm not a detective. I'm a physician. I want to treat my patients, but I began to be concerned about some possible inconsistencies that I was seeing.
>
> Q. What were some of those inconsistencies?
>
> A. Her examination - - and this normal [sic]. Her examination would vary somewhat from visit to visit, but sometimes her pain would be so severe that I could hardly touch her hands, and that - - and on other visits, I would be able to range her hands without pain. That change back and forth is not something that I typically see in complex regional pain syndrome.
>
> Also, there seems to be a significant emotional component to her pain. On some days she would be so tearful in the office that I could hardly talk to her. I remember specifically one visit where her mother-in-law - - or her fiancé's mother came in with her and helped her take her coat off, and the manner in which that happened was concerning. This was an adult woman who had an elderly woman easing her coat off, and it just - - I sometimes say my antenna go up about certain things, and my antenna started to go up on this. I was - - I became - - I became concerned.

Dr. Wiggins Deposition, pp. 8-10.

53. After having nothing left to offer Claimant by way of treatment in March of 2006, Dr. Wiggins had the opportunity to review the University of Utah's records. She testified that Dr. Brogan did not have a complete history in that he did not believe Claimant had received adequate functional therapies and medications. Dr. Wiggins did not believe a spinal cord stimulator was a good idea and questions whether her 90% improvement in the five days following its implantation was due more to her psychological response to the stimulator, rather than due to the stimulator itself.

54. On cross examination, Dr. Wiggins acknowledged that when she first saw Claimant on December 1, 2004, Claimant had many physical signs and symptoms consistent with a diagnosis of CRPS. Dr. Wiggins never saw any signs of arthritis in Claimant's hands. By February 2005, Dr. Wiggins had no doubt that Claimant had CRPS, but over time her physical symptoms got better but her emotional/psychological problems got worse.

55. Dr. Wiggins admitted she is not an expert in CRPS.

Dr. Enright:

56. Dr. Enright, a psychologist, was deposed on February 20, 2010, by Defendants. He was an IME panel member along with Dr. Moress who examined Claimant in 2006 and 2009 at Defendants' request. Dr. Enright obtained his Ph.D. from the University of Utah and is board certified in clinical and counseling psychology and has had a private practice in Jackson, Wyoming for over 30 years. By the time of his deposition, Dr. Enright had reviewed all the hearing exhibits as well as the hearing transcript and the deposition transcripts of Drs. Brogan and Okifuji.

57. Dr. Enright testified that a pain disorder is a subcategory of a somatoform disorder. He described somatic as a bodily presentation without a physiological cause. Based on the 2006 IME, Dr. Enright reached the diagnosis of psychogenetic pain disorder. In 2006, Claimant presented with a pre-existing "chronic pain situation" that Dr. Enright attributed to her abdominal difficulties. Dr. Enright was unable to say whether Claimant's somatoform disorder pre-dated the onset of her carpal tunnel syndrome.

58. Dr. Enright characterized Claimant's presentation at the post-spinal cord stimulator implant 2009 IME as:

> Her overall presentation on the second exam was marked by a sense of kind of euthymia. She was childlike, very dependent on the boyfriend, but overall happy. The symptoms of depression had really diminished and they weren't very strong in the first place. She appeared to be quite content with her life situation. And that is important, if you will, because typically people with the chronic pain suffer a good deal of depression and dysphoria consequent to that. And the claimant's presentation was contrary to that. These were just observations, if you will.

Dr. Enright Deposition, p. 21.

59. After the second IME, Dr. Enright again diagnosed psychogenetic pain disorder. He would not have initially recommended the spinal cord stimulator and testified that Claimant's response thereto (the 90% improvement in pain) is consistent with her somatoform disorder. He discussed his use of the term "credible ritual" regarding the spinal cord stimulator:

> I wish I could say I invented it. It's actually a term of art on psychology. Credible ritual just has to do with the involvement, especially with something like pain because pain has so much to do with anticipation and with expectation. And so, for example, when a physician gives a patient an inert substance and tells them that it will cure whatever their symptom is the fact that a person of authority in a white coat has administered the inert substance is the "credible ritual" the inert substance really brings nothing to the table except that it's accepted within that context, the "credible ritual context." And so in many cases the placebo causes relief of symptoms. That's really what the term means. It's a little bit like when the toddler bumps their knee and they go to their parent and say kiss it and make

> the pain go away, and sure enough when the parent kisses the injured knee then the child stops crying. That's, if you will, a very simple form of credible ritual because the parent is seen as the authority that has the magical ability to provide pain relief.

Id., pp. 26-27.

60. Dr. Enright further opined that Claimant's carpal tunnel onset in 2005 was not the predominant cause of her psychogenic pain or the need for the spinal cord stimulator. However, on cross-examination, he conceded he was not an expert on spinal cord stimulators and the treatment of CRPS.

Final analysis

61. In order to adopt Defendants' position in this matter, the Referee and the Commission would have to totally ignore the reports from the University of Washington Pain Center and the reports and testimony of the University of Utah Pain Center, both of which specialize in the diagnosis and treatment of chronic pain including CRPS. Initially, Drs. Retmier, Dille, and Wiggins came to the conclusion that, based on physical signs and symptoms, Claimant was indeed suffering from CRPS. Dr. Friedman, although ultimately diagnosing chronic pain syndrome, never bothered to alter his original diagnosis of bilateral RSD in his weekly staffing reports, and testified that the treatment for chronic pain was the same as the treatment for CRPS in any event. He failed to delineate the difference between chronic pain syndrome and CRPS.

62. Claimant's course of treatment, prior to the implantation of the spinal cord stimulator, did not provide her much in the way of pain relief. It was not until her treatment with Dr. Brogan and the implantation of the spinal cord stimulator, (Dr. Enright's "credible ritual"

nonsense aside,)[2] that her CRPS symptomatology began to subside. Dr. Brogan unequivocally, in reports, letters, and testimony opines that Claimant suffers from CRPS, and that her CRPS originated from her carpal tunnel surgeries. While there has been much discussion regarding whether Claimant's signs and symptoms strictly comply with the AMA Guides to reach the diagnosis of CRPS, the Referee would note that Defendants' own expert, Dr. Moress, testified that the Guides are "in flux" and are, as the name implies, just that: guides. Also, Dr. Moress' background is in pediatric neurology and his practice is neurology, not the care and treatment of chronic pain and CRPS patients as is Dr. Brogan's. Further, it is undisputed that Claimant, throughout the course of her treatment with Drs. Retmier, Dille, and Wiggins demonstrated objective physical signs and symptoms of CRPS identified in the Guides. It is highly unlikely that Claimant could "make up" those signs and symptoms.

63. Defendants argue that Claimant's response to her alleged CRPS is the same response she had to her abdominal pain prior to the onset of her carpal tunnel syndrome. That is, her pain was psychogenic. However, when a large stone was removed from Claimant's bladder, her abdominal pain went away. Here, when the spinal cord stimulator was implanted, her hand pain went away for the most part. Defendants' analogy is not persuasive.

64. The Referee acknowledges that Claimant has a history of chronic pain complaints, physical, mental, and sexual childhood abuse, and psychological issues. Some of her past medical complaints are without clear etiology. However, the Referee is unwilling to deny her compensation in this case due to her past problems. It is not readily evident, as Claimant points out, which came first; her chronic pain or her psychological issues (or a combination of the two).

[2] If Claimant improved due to the placebo effect of the spinal cord stimulator, why did she not improve with the other treatment modalities prescribed by a "person of authority in a white coat" referenced by Dr. Enright?

In any event, there is substantial and competent evidence in the record that supports Claimant's position that she has suffered debilitating pain in her hands since her carpal tunnel surgeries. An employer takes an employee as found. *Wynn v. J.R. Simplot Co.*, 105 Idaho 102, 666 P.2d 629 (1983).

65. In this Referee's view, once it became apparent that their attempts to alleviate Claimant's pain were failing, Drs. Wiggins and Friedman began doubting their diagnoses. However, when the record is viewed as a whole, it is apparent that Claimant could not contrive the physical signs and symptoms of CRPS as observed by virtually all of the medical care providers as well as the IME physician and psychologist. Nor could she contrive the results of the bone scan after ruling out arthritis.

66. Defendants ask the Commission to disregard the opinions of Dr. Brogan because it is impossible to determine what evidence he relied on in forming those opinions. The Referee is not impressed. As Claimant's counsel points out, "We would certainly not discount the opinion of a doctor who is reviewing an x-ray showing a broken leg because he did not review all of the other records. The diagnosis is clear based upon the physical findings." Claimant's Rebuttal Argument, p. 7.

67. The Referee finds, on conflicting medical evidence, that Claimant developed CRPS as the result of one or both work-related carpal tunnel surgeries and is entitled to all benefits associated with the care and treatment of that condition.

CONCLUSION OF LAW

Claimant has proven that she developed bilateral CRPS following one or both of her work-related carpal tunnel release surgeries.

RECOMMENDATION

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

DATED this __6th__ day of August, 2010.

INDUSTRIAL COMMISSION

___/s/_____
Michael E. Powers, Referee

ATTEST:

__/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __24th___ day of __August___, 2010, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSION OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

KEITH E HUTCHINSON
PO BOX 207
TWIN FALLS ID 83303-0207

ALAN R GARDNER
PO BOX 2528
BOISE ID 83701

ge

Gina Espinosa

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

FRANCES DENNIS, Claimant, v. DELL COMPUTER CORPORATION, Employer, and ACE AMERICAN INSURANCE COMPANY, Surety, Defendants.	)	**IC 2004-012556** **ORDER** Filed August 24, 2010

Pursuant to Idaho Code § 72-717, Referee Michael E. Powers submitted the record in the above-entitled matter, together with his recommended findings of fact and conclusion of law to the members of the Idaho Industrial Commission for their review. Each of the undersigned Commissioners has reviewed the record and the recommendation of the Referee. The Commission concurs with this recommendation. Therefore, the Commission approves, confirms, and adopts the Referee's proposed findings of fact and conclusion of law as its own.

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

1. Claimant has proven that she developed bilateral CRPS following one or both of her work-related carpal tunnel release surgeries.

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

DATED this __24th___ day of ___August____, 2010.

INDUSTRIAL COMMISSION

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

__/s/_____
Thomas E. Limbaugh, Commissioner

___/s/_____
Thomas P. Baskin, Commissioner

ATTEST:

__/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __24th___ day of ___August_____ 2010, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

KEITH E HUTCHINSON
PO BOX 207
TWIN FALLS ID 83303-0207

ALAN R GARDNER
PO BOX 2528
BOISE ID 83701

ge _Gina Espinosa_