BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

MARY JANE DUENES, Claimant, v. CH2M WG IDAHO, LLC, Employer, and EMPLOYERS INSURANCE COMPANY OF WAUSAU, Surety, Defendants.	)	**IC 2006-512972** **FINDINGS OF FACT, CONCLUSION OF LAW, AND RECOMMENDATION** Filed: September 13, 2011

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Rinda Just, who conducted a hearing in Idaho Falls, Idaho, on August 18, 2010. Paul T. Curtis of Idaho Falls represented Claimant. E. Scott Harmon of Boise represented Defendants (Employer is hereinafter identified as CH2M, and Surety is hereinafter identified as Wausau). The parties submitted oral and documentary evidence and submitted post-hearing briefs. The matter came under advisement on March 18, 2011 and is now ready for decision.

ISSUES

The parties identified the issues to be decided as:

1. Whether Claimant suffers from a compensable occupational disease;

2. Whether Claimant's condition is due, in whole or in part, to a pre-existing and/or subsequent injury or condition;

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

A. Medical care;

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

C. Permanent partial impairment (PPI);

D. Retraining;

E. Disability in excess of impairment, including total permanent disability pursuant to the odd-lot doctrine; and

4. Whether apportionment for a pre-existing or subsequent condition is appropriate pursuant to Idaho Code § 72-406.

The Referee reviewed the entire record and found no evidence suggesting that Claimant suffers from any occupational disease. Claimant presented no medical opinion regarding occupational disease, and did not discuss or argue any of the elements of such a claim in her post-hearing brief. Neither did Claimant take up the issue of retraining. She presented no proposal for retraining, and did not address the subject in her briefing. The Referee considers both issues waived.

CONTENTIONS OF THE PARTIES

It is undisputed that on June 8, 2006, while exiting a CH2M vehicle on Employer's premises, Claimant suffered a right distal fibula fracture. Her industrial claim was accepted and she received treatment and benefits through July 12, 2007. Following the accident, CH2M gave Claimant light-duty work assignments until sometime in April 2007. Claimant took disability leave from April 2007 until October 2007, at which time CH2M terminated her employment.

Claimant contends that she continues to suffer from constant severe and incapacitating pain and hypersensitivity in her foot and ankle, such that she has not been able to return to gainful employment. Claimant asserts that, as a result of her fracture, she now suffers from peroneal tendonitis and, possibly, reflex sympathetic dystrophy (RSD), also known as complex regional pain syndrome (CRPS). Claimant argues that she is entitled to continuing medical care for her foot and ankle pain, TTD benefits during her period of recovery, PPI in excess of the 3% whole person impairment rating given by Richard T. Knoebel, M.D., and total permanent disability as an odd-lot worker. Claimant asserts that prior to her work injury she had no history of right foot and ankle pain, so apportionment of disability between the industrial injury and a pre-existing condition is inappropriate.

Defendants contend that Claimant is not entitled to additional medical care, because the medical evidence shows that Claimant's right distal fibula fracture healed and there are no objective medical findings to support her subjective pain complaints. Claimant's treating physicians all agree that Claimant's right foot and ankle are medically stable from her industrial accident and have released her from care without restrictions and without recommendations for further treatment. Claimant's on-going complaints and perceived disability are the result of pre-existing psychological and or psychiatric conditions unrelated to her industrial injury. Claimant has made only a desultory job search, and if she has disability in excess of her 3% impairment, it is as a result of pre-existing factors not related to her industrial injury. Defendants have paid all medical costs through the date Claimant reached maximum medical improvement, along with income benefits including 3% whole person PPI, and have met all of their obligations on this claim.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant and her mother, Marlene Hinckley, taken at hearing;

2. Claimant's exhibits 1 through 26, admitted at hearing; and

3. Defendants' exhibits A through O, admitted at hearing.

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

FINDINGS OF FACT

CLAIMANT

1. At the time of hearing, Claimant was 46 years of age. She lived in Idaho Falls, where she was born and has resided most of her life. She is divorced with four adult children.

Education

2. Claimant graduated from high school in Idaho Falls. She took additional training in the nursing field and achieved certification as a nurse assistant (CNA).

Work History

3. Claimant's work history is sketchy as to dates and particular job duties. After high school she worked at Burger King and Fred Meyer. While stationed in California with her military husband, she worked at a theater and for a company where she "made bread and did wrapping presents or whatever." Tr., p. 19. While in California, she did her CNA training and may have worked at a hospital for a brief time. After Claimant returned to Idaho in 1986, she went to work for Albertson's as a checker, where she remained until she went to work at the Site

in 1999.[1]

4. Claimant began work at the Site as a general laborer for an employer/contractor not identified in the record. In 2005, Claimant was hired by CH2M, also a contractor at the Site. She subsequently became a senior operator at the Radioactive Waste Management Complex (RWMC). Claimant's testimony as to the nature of her job was vague, but it involved manipulating low-level radioactive waste by means of a "glove box." Claimant would insert her hands into the "gloves," which extended through a barrier into a compartment where she used various tools to open and sort through barrels of disposable rags, clothing, and other items contaminated through use at the nuclear facilities.

PRIOR MEDICAL HISTORY

5. Claimant has an extensive and somewhat chaotic medical history with an extensive list of conditions for which she received evaluation or treatment prior to her industrial accident. Some of the conditions are documented by objective evidence in the exhibits of record, and others appear only through Claimant's subjective reporting. The list includes: Possible multiple sclerosis; possible lupus; possible fibromyalgia; narcolepsy; sleep apnea; arachnoid cyst; neck pain; headache; migraine; intracranial hypertension; chronic vomiting and nausea; depression; congenital fusion of cervical vertebrae C3-C4; chronic sinusitis; memory loss; psychiatric complaints; carpal tunnel syndrome; post-concussive syndrome; low back pain; fibromuscular dysplasia; gastrointestinal distress; cervical disc disease; chronic pain syndrome; shoulder pain; asthma; and chest pain.

---

[1] The federally-owned facility in the desert west of Idaho Falls has gone by a number of monikers and acronyms over the years, and is currently officially denominated as the Idaho National Laboratory or INL. Regardless of the official name, local residents have always called the various facilities that comprise the INL as "the Site."

6. Claimant has a remote history of dorsal bone spur excision on both feet. In September 2004, Claimant presented at the emergency room at Eastern Idaho Regional Medical Center (EIRMC) complaining of right ankle pain. She described the pain as "intermittent over the lateral malleolus, sharp, electrical-like in nature." Ex. G., p. 92. Although the ankle pain was her primary presenting complaint, the chart note deals primarily with her secondary complaint of chronic headache. However, the examination of her right ankle was unremarkable. The ER physician gave her an air splint, prescribed a muscle relaxer, and advised her to take OTC Naprosyn for the ankle. There was no record of follow-up care for the ankle complaint, and the records include no further right foot or ankle complaints until the industrial injury.

7. Claimant's testimony regarding her pre-accident medical history is hazy. Emergency room personnel provided a great deal of Claimant's primary care. Outside the ER, she had difficulty identifying who had treated her and for what conditions.

8. Claimant's medical records admitted into evidence document a long history of the use of opioid pain killers—initially prescribed for neck pain and headaches. After her work injury, Claimant frequently requested pain medication for her right foot and ankle, as well. At the time of hearing, Claimant was regularly taking methadone and hydrocodone for pain relief, wearing a Lidoderm patch, and taking additional medications for her other maladies. Claimant's reliance on narcotic pain medication was a concern raised by both treating and evaluating physicians.

THE ACCIDENT

9. On June 8, 2006, Claimant was at work at the RWMC facility. At about 8:00 a.m., she used a company van to return from the job site to the trailer where employees took their breaks. She does not recall the precise reason that she had to return to the break trailer, but

Defendants do not dispute that the trip arose out of and was in the course of her work for CH2M. When she arrived at the break trailer, Claimant hopped out of the van. When she landed, her right ankle rolled over and she heard a pop. Claimant had to wait for someone to come to her aid and help her into the trailer.

10. Claimant was first transported to the Site's on-site clinic and then to the INL's medical facilities at its Idaho Falls Research and Educational Campus (REC) for x-rays. Based on the imaging, John R. Best, D.O., diagnosed a right distal fibula fracture. Dr. Best referred Claimant to Gene Griffiths, M.D., an orthopedic surgeon.

MEDICAL CARE

Dr. Griffiths/OMP

11. Until CH2M terminated Claimant, CH2M's occupational medicine program (OMP) physicians followed Claimant's long course of treatment by outside medical providers. Except as otherwise noted, the chart notes from OMP are generally recaps of her outside medical visits. The OMP chart notes tend to focus on Claimant's restrictions, accommodations, and return-to-work issues.

12. On the date of injury, Claimant presented at Dr. Griffiths' office as directed by the OMP. Based on a review of the x-rays, the chart note describes "a transverse fracture involving the distal fibula, distal to the tibial talar articulation; representing Weber Type C injury. The fracture is non-displaced and non-angulated. Mortise remains intact." Ex. 3, p. 1. Reduced to simpler terms, the smaller of the two leg bones was broken straight across just before the place where it meets the foot bones in the ankle joint. It was a clean break, the bones remained in place, and the fracture did not derange the ankle joint. On palpation, Claimant was most tender over the lateral malleolus—the end of the fibula that corresponds with the bony bump on the

outside of one's ankle and articulates with the bones in the foot to create the ankle joint.

13. There was too much swelling in Claimant's ankle to allow for a cast or a cam boot, so a splint was applied to temporarily stabilize the fracture. Dr. Griffiths' physician assistant placed Claimant on crutches and told her to elevate and ice the ankle. The PA took her off work until Monday, June 12, and called in a prescription for hydrocodone for pain.

14. Claimant returned to Dr. Griffiths' office on Monday, June 12. After discussing her work situation, he applied a walking cast to immobilize the fracture. He took her off work "until she can tolerate the foot in a dependent position for prolonged periods," which OMP interpreted to mean one or two hours at a time. Ex. 3, p. 3. Dr. Griffiths believed that within a couple of days Claimant would be able to tolerate the bus ride to the Site and would be able to return to work in a light-duty capacity.

15. On June 21, Claimant saw Paul Johns, M.D., at OMP in Idaho Falls. She was wearing the short-leg cast applied by Dr. Griffiths on June 12. Claimant complained "bitterly of pain at the ankle level and states that it is very tight there and she feels that she just needs to get the cast off desperately." Ex. 1, p. 8. Dr. Johns opined that Claimant was too symptomatic to return to work. He advised that she see Dr. Griffiths again "in the very near future and have the fracture reevaluated." *Id.*

16. Claimant returned to Dr. Griffiths on June 28. Only a portion of the chart note for that visit is included in the record. After her appointment with Dr. Griffiths, Claimant went to OMP, where she saw Dr. Best. He noted that she was out of the short cast and into an orthopedic walking boot, and that she was complaining of "significant pain." *Id.*, at p. 10. Dr. Best returned Claimant to work with the restrictions imposed by Dr. Griffiths. Claimant expressed concern that she did not know how she would be able to drive to the location where she caught the INL

bus or tolerate the bus ride to the Site, since both activities required keeping her leg in a dependent position.

17. When Claimant returned to Dr. Griffiths on July 26, she was still wearing the cam boot, and reported that she had tried a regular shoe but had too much pain. Dr. Griffiths urged Claimant to stop using the cam boot and referred her to physical therapy for range-of-motion and ankle strengthening. On exam, she was moderately tender over the distal fibula. On August 8, when she returned to OMP, she reported throbbing pain in her foot and ankle at night and swelling during the day. On exam, Stewart Curtis, D.O., detected slight swelling of the lateral malleolus and tenderness just above the medial malleolus.

18. Claimant returned to Dr. Griffiths on August 16. He noted that she had been slow to progress, but had started physical therapy and it had helped, though Claimant complained of stiffness and pain about the ankle. Dr. Griffiths detected no significant swelling, and Claimant exhibited no tenderness at the fracture site. The August 23 chart note from OMP states that Dr. Griffiths sent Claimant to physical therapy because of "secondary Achilles tendonitis," Ex. 1, p. 12, but there is no mention of Achilles tendonitis in Dr. Griffiths' chart notes at this time.

19. When Claimant returned to see Dr. Griffiths on September 27, she reported "a lot of pain and popping diffusely about the ankle; mainly posterior to the fibula." Ex. 4, p. 5. X-rays showed that her fracture had healed with the exception of a bit of a gap on the lateral border of the fracture, which Dr. Griffiths did not believe was physiologically significant. Claimant was tender about the posterior peroneal tendons, and Dr. Griffiths detected some crepitus about the peroneal tendons and the extensor tendons anteriorly. Dr. Griffiths ordered an MRI to rule out a tear of the peroneal tendons. The MRI was negative for tearing of the peroneal tendons, but revealed a contusion of the medial cuneiform. In addition, the fracture was still

visible, leading Dr. Griffiths to suspect that Claimant might be developing a non-union. However, he believed that if she developed a non-union, it would be benign and asymptomatic. He did not believe that the possible non-union was the cause of Claimant's continued pain complaints. Dr. Griffiths administered a steroid injection and continued Claimant's physical therapy.

20. When Claimant returned to OMP on October 5, she reported that Dr. Griffiths had requested authorization for surgery to correct hypermobility of her tendons and chronic tendinitis in her right ankle—a report not corroborated by Dr. Griffiths' records.

21. In an effort to determine whether Claimant's pain originated from the fracture itself or tendonitis that was secondary to the fracture, Dr. Griffiths administered a second steroid injection on November 15. He proposed a review of the MRI at her next visit if the second steroid injection did not provide relief.

22. Claimant apparently saw Dr. Griffiths again on November 29, and may have seen him on January 10, 2007, but there is only a partial chart note for November 29, 2006 and no note for January 10, 2007. Claimant made two visits to OMP (January 4, and January 15, 2007) before her next documented visit to Dr. Griffiths. The OMP chart notes from the two visits discuss pain in a new location—her right heel and Achilles tendon. Claimant also discussed with OMP that she no longer needed temporary restrictions related to her work injury and was to address the issue of restrictions on her next visit to Dr. Griffiths.

23. Dr. Griffiths' next chart note is from January 17, 2007. It references Claimant's prior visit, her reports of pain in her right heel and Achilles tendon region, and Dr. Griffiths' recommendation to use a heel lift, return to physical therapy, and pursue an aggressive stretching regimen. Dr. Griffiths gave Claimant a steroid injection in her heel during the January 17 visit

and considered another MRI. There is no discussion of altering or removing Claimant's temporary work restrictions first imposed when she returned to work in late June 2006.

24. The next day, January 18, Claimant was at OMP to discuss her restrictions. Claimant localized her pain to her posterior ankle area along her Achilles tendon and up into the lower portion of her calf, but Dr. Curtis detected no tenderness on palpation and, with the exception of slightly decreased range-of-motion, the foot and ankle were normal.

25. On January 29, 2007, Claimant was back at OMP complaining of pain in the area of her heel that was worse than usual. She rated her pain at four out of ten on a scale of ten. Apart from slight tenderness at the heel inferior to the lateral malleolus, and slightly decreased flexion, the foot and ankle were normal.

26. On February 7, 2007, Claimant presented at Dr. Griffiths' office complaining of:

> . . . global right foot and ankle pain; both anteriorly and posteriorly to the lateral malleolus, posterior, medial and lateral retro-calcaneal bursal region, Achilles tendon region and pain globally about the foot.

Ex. 3, p. 8.

> On examination, the patient cannot do a single leg heel lift and [*sic*] possibly tender along the posterior tibial tendon sheath. No significant bony tenderness about her distal fibula. Moderately tender to palpation along her peroneal nerves. She is diffusely weak about her peroneals and posterior tibial tendon. The patient is mildly tender along the mid distal Achilles tendon, at the tendon and myotendinous junction.

Id. Dr. Griffiths expressed frustration—his own and Claimant's—with Claimant's persistent pain and symptoms. "Her initial injury was just a little non-displaced Weber C distal fibular fracture and could have been treated essentially with a modified shoe." *Id.* He noted that repeat radiographs showed that the fracture had healed. Dr. Griffiths concluded by expressing his view that a second opinion was appropriate if her scheduled MRI was still negative and the physical therapy did not help, stating: " . . . at this point, I do not have anything more to offer her and a

second opinion is probably appropriate for her." *Id.* This is the last medical record from Dr. Griffiths.

27. Claimant returned to OMP on February 8, 2007. Claimant reported:

> . . . this morning when she got up her right ankle seemed to move sideways and it was painful. She has this sensation that something moves inside the ankle, excruciating pain that comes with it as well as weakness in the ankle and a constant feeling that the ankle is not stable. These symptoms have continued since the ankle was fractured in June 2006.

Ex. 1, p. 27. On exam, Dr. Johns observed that the right ankle appeared normal. He noted that the distal fibula was tender to palpation and was "rough and irregular." Claimant had limited dorsiflexion and pain along the Achilles tendon and the posterior aspect of the anklebone. Dr. Johns scheduled Claimant for a repeat MRI and referred her to John Andary, M.D., for further treatment following the MRI.

28. Claimant had a repeat MRI on February 12, 2007. Comparison with her MRI from October 12, 2006 showed:

- "Abnormal edema in the distal fibula at the level of the previously identified lateral malleolar fracture, nondisplaced in nature. There is edema involving the medial aspect of the fibula. This may represent some residual traumatic change versus early degenerative change in this area." Ex. 6, p. 2.
- Tenosynovitis of the flexor hallucis longus.
- Resolution of the previously identified contusion or nondisplaced fracture of the intermediate cuneiform.

Dr. Andary/OMP

29. Claimant's first visit to Dr. Andary occurred on February 26, 2007. Claimant's subjective history as captured in Dr. Andary's chart note indicates:

> She continues to have ankle pain that is not getting better. She is very frustrated because she feels that nobody believes that she has ankle pain but she knows that she has it. She localizes it more laterally in her peroneal nerve region. It bothers her at night and rest and it is worsened with activities. She denies any instability

> in the ankle. She does complain of some sharp burning pains in her foot and some change in temperatures in her foot as well. Occasionally she has some numbness and tingling.

Ex. 5, p. 2. Claimant also told Dr. Andary that she believed CH2M was trying to get rid of her. On exam, Dr. Andary noted tenderness along the posterior aspect of her distal fibula and along her peroneal tendons posteriorly. There was no syndesmotic or medial tenderness, or tenderness in the forefoot, midfoot, or hindfoot. Her range-of-motion was "well maintained." Ex. 5, p. 2. Dr. Andary noted no obvious temperature difference between the left and right lower extremity, but noted some mottling of the skin of the right foot. Dr. Andary reviewed x-rays taken that day showing a healed fracture and well-maintained mortis. Dr. Andary also reviewed the MRI report, but did not have access to the images.

30. Based on his exam, and the imaging, he diagnosed right ankle pain of unknown etiology, possible CRPS, and possible peroneal tendonitis. He ordered a bone scan to evaluate for possible CRPS. He prescribed Elavil. On March 5, Dr. Andary called Claimant and reported that her bone scan was mildly positive for CRPS. The imaging report prepared by Michael C. Biddulph states: "The asymmetry is not as pronounced as would be expected in a patient with reflex sympathetic dystrophy. However, this may represent a mild form of RSD." Ex. 7, p. 1.

31. Claimant returned to Dr. Andary on March 16, 2007. Claimant complained of pain laterally over her peroneal tendons and along her Achilles. She also complained of cramping in her toes. She would not take the Elavil, as it made her sleepy. On exam, Dr. Andary noted some allodynia around her peroneal tendons and found significant tightness in her right Achilles tendon. Dr. Andary opined that Claimant needed "much more aggressive stretching of her Achilles." Ex. 5, p. 3.

32. Claimant saw Dr. Curtis at OMP on March 27. She advised him that her ankle was not getting better, but was getting worse. Claimant also reported that "there has been a lot of gossip about her at RWMC." Ex. 1, p. 30. Claimant was to continue working under her restrictions and to follow-up with Dr. Andary. This is the last chart note of record from OMP. Claimant returned approximately every two weeks as documented by OMP medical evaluation reports, but they provide no medical data, just information about work restrictions. Claimant asserts that OMP physicians gave her an extended work release beginning April 18, 2007, but there is nothing in the medical records to corroborate the work release.

Dr. Andary/Dr. Simon

33. Dr. Andary referred Claimant to David C. Simon, M.D., a physical medicine and rehabilitation specialist. Claimant first saw Dr. Simon on April 18, 2007. Dr. Simon reviewed medical records from Drs. Griffiths and Andary and performed an examination. He noted no deformities, muscle atrophy, or asymmetry in Claimant's right foot. There was no tenderness on palpation, no joint instability, nor any rashes, lesions, ulcers, abnormal pigmentation or dystrophic changes evident. He noted that Claimant's range-of-motion was limited by complaint of pain. Neurologically, Dr. Simon found Claimant's deep tendon reflexes were symmetric in both lower extremities, with no focal weakness, though sensation to pinprick was reduced in the right foot as compared to the left. Dr. Simon concluded:

> I would agree with Dr. Andary that the bone should be healed by now. The exact cause of her subjectively severe pain is difficult to determine. The first thing to consider in someone with pain beyond what would be typically be expected from the injury would be a Complex Regional Pain Syndrome (formerly known as RSD). The bone scan was inconclusive. Clinically, there are no exam findings consistent with CRPS. Another possibility would be a nerve injury giving her neuropathic pain. I think electrodiagnostics testing would be helpful to look for something objective.

Ex. H, p. 137. Dr. Simon also suggested a trial of Neurontin, and provided a prescription.

34. Claimant returned to Dr. Andary on April 20, 2007. She reported that her ankle and foot pain were getting worse, despite heel cord stretching and physical therapy. She also reported that, "She was late for her appointment with Dr. Simon so she did not get to see him yet." Ex. 5, p. 4. Dr. Andary concluded that he had nothing further to offer Claimant by way of treatment, and he was transferring her care to Dr. Simon. A week later, Claimant called the office asking for pain medication, and Dr. Andary's office staff advised her she needed to consult with Dr. Simon.

Dr. Simon

35. On May 1, Claimant called Dr. Simon's office and asked for stronger pain medicine, because her Lortab was not helping. Claimant did not believe that the Neurontin was helping, either. Dr. Simon had Claimant come to the office. Her condition was unchanged, and he once again opined that electrodiagnostics testing would be helpful. He increased her dose of Neurontin and prescribed Ultram for her pain. On May 14, Dr. Simon performed electrodiagnostic testing, which was normal. Dr. Simon also gave Claimant some oral steroids to reduce potential inflammation.

36. Claimant missed her scheduled appointment with Dr. Simon on May 29. On the following day, she called the office to report that the oral steroids did not help. Dr. Simon concluded:

> I have nothing further to offer her. Her persistent ankle pain is likely a consequence of her initial ankle injury complicated by a propensity to develop chronic pain and psychosocial factors contributing to chronic dysfunction. She will likely need an IME/panel evaluation to sort out all of these issues and to determine her permanent impairment.

Id., at p. 138.

IME

37. Pursuant to Dr. Simon's recommendation, Wausau sent Claimant to Richard T. Knoebel, M.D. for an independent medical exam (IME). Claimant saw Dr. Knoebel on July 12, 2007. As noted in his report, Dr. Knoebel reviewed a comprehensive set of records of Claimant's treatment relating to her June 2006 injury. In addition, he reviewed a substantial number of pre-injury medical records dating as far back as 1993. Dr. Knoebel also obtained a subjective history from Claimant and performed a physical exam.

38. Claimant reported to Dr. Knoebel that she was currently treating with Daron L. Scherr, M.D., a board-certified sleep specialist, William Domarad, D.O., a neurologist, and Dan Dragotoiu, an internist—her primary care physician. Drs. Scherr and Dragotoiu were both prescribing hydrocodone. In addition, Claimant reported that she was taking Adderal, Topamax, Maxalt, Wellbutrin and indomethacin.

39. Claimant reported constant pain in her right foot. At the time of the visit, she rated her pain as six on a scale of ten. In addition, she complained of numbness and swelling in the right foot. She was able to weight-bear for only ten or fifteen minutes before limited by pain.

40. On exam, Dr. Knoebel made the following observations:

- Antalgic gait on the right with decreased weight-bearing, flat-footed, and no push off;
- Inability to heel-or toe-raise on either leg;
- Normal skin color, texture, temperature, hair growth, and peripheral pulse bilaterally;
- No muscle atrophy, and no hyperesthesia with palpation of the right leg; and
- No motion with dorsiflexion, plantarflexion, or eversion on the right and only 5 degrees of motion on inversion (compare with normal left ankle: 20 degrees, 40 degrees, 20 degrees, and 30 degrees, respectively).

41. Dr. Knoebel concluded that Claimant had a healed right lateral malleolus fracture, chronic pain syndrome with pre-existing history of same, and narcotic habituation with pre-existing history of same. Dr. Knoebel found no objective evidence of CRPS. He explained that the increased uptake evident on the bone scan could represent degenerative joint disease, infection, acute injury, or the residual effects of the known fracture. The increased uptake was neither as intense nor as diffuse as would be expected with CRPS. Claimant showed insufficient clinical evidence of the other criteria used to identify CRPS under the *AMA Guides to the Evaluation of Permanent Impairment*, 5th ed. (*AMA Guides*).

42. Dr. Knoebel determined that Claimant was medically stable. He rated her impairment at 3% whole person for the minimally displaced lateral malleolus fracture based on Table 17-33 of the *AMA Guides.* He did not award any impairment for Claimant's chronic pain, noting that she had a long history of chronic pain unrelated to the ankle injury. Dr. Knoebel stated:

> The patient's chronic pain syndrome reasonably is now manifesting itself in regards to the right ankle. Reasonably, this is a psychosocial condition and response to the industrial right ankle injury which is aberrant and non-industrial.

Id., at p. 152. Dr. Andary agreed with Dr. Knoebel's evaluation, including the July 12, 2007 stability date.

ADDITIONAL MEDICAL CARE

43. In September 2007, Claimant saw Gregory Biddulph, M.D., an orthopedic surgeon, regarding her right foot. Claimant complained primarily of numbness, tingling, and hypersensitivity. Dr. Biddulph did not have the benefit of Claimant's extensive medical history, but her subjective report was consistent with the medical evidence of record, though limited. Dr. Biddulph examined Claimant's foot, and agreed that she exhibited extreme hypersensitivity

about the right foot. She was so sensitive that it made an exam difficult. He appreciated no clinical signs of CRPS. The x-rays were unremarkable. He opined that her foot was not surgical, but suggested she see a neurologist. Claimant had seen Eric Garland, M.D., for her headaches in the past, so Dr. Biddulph referred Claimant to Dr. Garland. There are no medical records from Dr. Garland in the hearing record.

44. In December 2007, Claimant saw Stephen G. Vincent, M.D., a neurologist. Dr. Vincent's report was in the form of a letter to Dr. Biddulph, implying that Dr. Biddulph referred Claimant to Dr. Vincent. Like Dr. Biddulph, Dr. Vincent did not have the medical records relating to either Claimant's industrial injury, or her pre-injury medical history. The history provided by Claimant was consistent with the medical evidence of record, if lacking in detail. Dr. Vincent noted that Claimant exhibited breakaway pain when he was testing her hip flexor and quadriceps on the right lower extremity. Claimant's testing behavior did not parse with her complaint, which was limited to ankle pain. When Dr. Vincent explained that she had only complained of ankle pain and he was not testing that, she was able to retest the muscle strength in the lower extremities with normal strength bilaterally. Dr. Vincent twice noted that Claimant exhibited so much pain behavior that it was difficult to know whether the strength testing gave valid results. Dr. Vincent offered a "working diagnosis" of CRPS, but made no clinical findings of CRPS. He prescribed Lidoderm patches, and ordered one physical therapy visit so that Claimant could have her TENS unit programmed to use on her right ankle.[2]

45. In April and May of 2008, Claimant sought care from the behavioral health division of the Idaho Department of Health and Welfare. Timothy Thompson, L.M.S.W.,

[2] Claimant did not follow through with the TENS unit, and in her deposition she seemed unaware that Dr. Selznick had recommended using the TENS unit on her foot as well as on her neck and back.

performed an intake assessment, and Chad Murdock, M.D., performed a diagnostic evaluation. Dr. Murdock's chart note identified Claimant's self-reported medical history, as well as complaints of depression, memory loss, and inability to concentrate. He noted that it was difficult to sort out Claimant's mental health issues from her physical health issues. He considered diagnoses of bipolar illness versus depression/anxiety disorder. Dr. Murdoch arranged for a neuropsychiatric consult with Dr. Harper. There is no indication that Claimant returned to Dr. Murdock for follow-up. There is some indication in the record that she did see Dr. Harper, but there are no supporting medical records.

46. In February 2009, Claimant sought an evaluation of her right foot and ankle from Hugh Selznick, M.D., on referral from Dr. Garbarini, who was treating her chronic back pain. Claimant complained of pain at seven or eight on a scale of ten, primarily the lateral right ankle, adjacent to the fibula. Dr. Selznick noted that Claimant was taking Wellbutrin, Ambien, methadone, oxycodone, Adderall (for narcolepsy) and Maxalt (for migraine). Dr. Selznick also noted that Claimant had a history of migraine headaches, brain cyst, chronic pain, insulin resistant diabetes, mental illness, ophthalmologic disease, depression, and degenerative disc disease. At the time, Dr. Garbarini was treating Claimant's degenerative disc disease with radiofrequency ablation.

47. On exam, Claimant had good dorsiflexion of the right foot, symmetric to the left ankle. Plantar flexion was about 30 degrees. Dr. Selznick located the tenderness to the area around the peroneal sheath and noted mild swelling consistent with peroneal tendonitis. Dr. Selznick noted that x-rays showed a well-healed fracture without evidence of arthritis in the joint. He ordered an MRI to rule out longitudinal tears in the brevis and longus tendons. If the MRI was negative, he proposed to treat Claimant for peroneal tendonitis.

48. Claimant had the MRI on February 25, 2009. Imaging showed some fluid in the flexor hallucis longus tendon and minor cystic degenerative changes in the distal fibula. All of the other tendons and ligaments were normal in appearance, as was the skeletal structure of the foot and ankle. The MRI showed the healed fracture in "excellent alignment." Ex. 16, p. 3. When Claimant returned to Dr. Selznick for follow-up, he noted that her exam was unchanged, with symmetric dorsiflexion and plantarflexion. He offered a steroid injection and physical therapy, both of which Claimant declined. Dr. Selznick concluded:

> At this point, there is nothing I could offer her in the way of operative intervention to correct this atypical right ankle problem. I felt bad that I could not find something objective per MRI evaluation to corroborate her reported symptomatology.

Id., at p. 4.

GARY COOK, M.D., IME

49. At the request of Claimant's counsel, Dr. Cook performed an IME on April 14, 2009. Claimant's presenting complaints included: Right ankle pain (constant, rated eight on a scale of ten); depression; anxiety attacks (daily); memory problems; low back pain; neck pain; and migraine headache. Dr. Cook's exam notes pertaining to the right foot and ankle are limited to findings of antalgic gait on the right, no central or peripheral nervous system deficits, no gross atrophy, and the ability to heel-and-toe walk. Dr. Cook also performed a paraspinal thermal scan and a static paraspinal surface electromyographic scan. Dr. Cook opined that Claimant reached maximum medical improvement July 12, 2007. Dr. Cook was of the opinion that Claimant suffered from chronic pain syndrome in her right foot and ankle which was caused by her industrial injury. Using Table 17-33 of the *AMA Guides*, Dr. Cook rated Claimant's PPI at 6% whole person. In addition, he awarded 3% whole person impairment related to Claimant's pain. Using the Combined Values Chart, Dr. Cook calculated total PPI as 9% of the whole person.

50. In October 2009, Dr. Cook sent a letter to Claimant's counsel, evidently in response to correspondence from counsel. Dr. Cook's letter included the following points:

- Claimant was medically stable on July 12, 2007;
- Claimant would have additional PPI related to her neuropsychological deficits;
- Claimant would have permanent restrictions related to her neuropsychological deficits;
- Claimant is not likely to return to work due to her emotional, psychological and cognitive status;
- Claimant needed on-going medical care related to her pain, medication management, psychiatric condition, and a complete neurological workup relating to her brain cysts;
- It is more likely than not that Claimant will need cervical or lumbar surgery in the future; and
- Claimant is totally and permanently disabled as a result of her current cognitive and physical impairments.

51. By letter to Claimant's counsel dated August 3, 2010, Dr. Cook once again revised his impairment rating of Claimant. In this document, Dr. Cook determined that Claimant had sufficient evidence of CRPS to diagnose and rate her for that condition, concluding that Claimant's whole person PPI was 39% based on Table 13-15 of the *AMA Guides.*

VOCATIONAL EVIDENCE

52. Claimant retained Douglas N. Crum, C.D.M.S., to prepare an evaluation of Claimant's permanent partial or total disability. Defendants did not retain a vocational expert. The bulk of Mr. Crum's report consists of the review of Claimant's voluminous medical records, including, as noted previously, a number of records that were not a part of the hearing record. Mr. Crum interviewed Claimant in September 2009, and noted: "[Claimant] was very difficult to interview as she was not able to give much factual information. She appeared to be over medicated, or perhaps suffering from some very significant psychiatric illness." Ex. 25, p. 2.

53. Mr. Crum determined that, prior to her injury, she had access to 9.8% of the jobs in her labor market. He based this on her work as a checker, a medium physical capacity job, which Claimant had performed *before* she went to work at the Site in 1999. Presumably, Mr. Crum relied on this remote employment history, because he was unable to learn much about her time-of-injury position.

> [Claimant] was able to provide me with just the most basic description of the job she performed at the time of injury. When I queried her, she typically just said she could not remember or was not sure of information and facts.

Id., at p. 36. Relying on Dr. Cook's evaluations, and his diagnosis of CRPS in particular, Mr. Crum concluded that:

> . . . the left [sic] foot/ankle injury has resulted in a very significant pain syndrome, requiring long term, possibly life-long narcotic medications, possibly resulting in increased depression and reduction in her mental state, and so limiting her activities that it is unlikely that she is employable. Dr. Cook's confirmation of the RSD/CRPS diagnosis, with ongoing and very intense symptoms, leads me to conclude that [Claimant] is totally and permanently disabled.

Id., at p. 39.

CREDIBILITY

54. Claimant is not a reliable witness. As evidenced in her deposition testimony, her testimony at hearing, and as noted by Mr. Crum in his interview with Claimant, she was unable to answer even simple questions about work she had performed for years. Claimant repeatedly stated that she could not remember facts or events. In fact, loss of memory is included as one of her presenting complaints in visits with health care providers. The record hints both that Claimant's memory had been tested and found wanting, and that she had psychiatric/mental health issues. The references were second-hand, and no probative medical records regarding

Claimant's actual mental health and cognitive functioning were included in the record.[3] Claimant also has a long history of dependence and/or habituation to narcotic pain medication. This history makes it difficult to discern to what extent her physical complaints constitute a pretext for obtaining narcotic prescriptions. Finally, Claimant's medical history includes a host of self-reported diagnoses for which there is no supporting documentation in the record. Finally, Claimant's subjective complaints were highly variable, as were objective findings. While there is no suggestion that Claimant has intentionally lied or misrepresented relevant facts, her inability to recall relevant information is so pervasive as to suggest that her testimony and her self-reported history are not generally reliable, and one should focus on objective findings and substantiated reportage in making factual findings and legal conclusions.

DISCUSSION AND FURTHER FINDINGS

THEORY OF THE CLAIM

55. At the outset of the hearing in this matter, the Referee and the parties reviewed the issues as set out in the Notice of Hearing and restated herein. Although the parties stipulated that one of the issues is whether Claimant suffered a compensable occupational disease, it is clear that Claimant's claim is actually for a discrete industrial accident occurring June 8, 2006. The parties agreed that the primary issues were PPI and PPD, but medical care and TTDs remained as subsidiary issues. At hearing and in her briefing, Claimant focused her arguments on her pain complaints and how her ankle pain necessitated on-going medical care and left her unable to work. In their briefing, Defendants focused on causation, arguing that the benefits Claimant

[3] The record did include a mental health intake assessment and an initial evaluation performed by Dr. Murdock, and several of Claimant's treating physicians provided *pro forma* mental status assessments regarding her social security claim. These documents provide limited insight regarding mental health or cognitive diagnoses, and none of them establish a temporal or medical causal nexus between the mental/cognitive complaints and Claimant's industrial injury.

sought were not related to the industrial accident, but were the result of her pre-existing conditions, including chronic pain, and psychiatric and psychosocial conditions. Essentially, the parties briefed and argued different issues. This oblique approach by the parties unnecessarily complicated what should be a simple and straightforward matter.

COMPENSABILITY

56. The Idaho workers' compensation statutes place an emphasis on the element of causation in determining whether a worker is entitled to compensation. Not only must a Claimant establish that an accident caused an injury, but also that a particular injury or condition is medically referable to the industrial event.

> The claimant carries the burden of proof that to a reasonable degree of medical probability the injury for which benefits are claimed is causally related to an accident occurring in the course of employment. Proof of a possible causal link is insufficient to satisfy the burden. The issue of causation must be proved by expert medical testimony.

Hart v. Kaman Bearing & Supply, 130 Idaho 296, 299, 939 P.2d 1375, 1378 (1997) (internal citations omitted). "In this regard, 'probable' is defined as 'having more evidence for than against.'" *Soto v. Simplot*, 126 Idaho 536, 540, 887 P.2d 1043, 1047 (1994). Once a claimant has met his burden of proving a causal relationship between the injury for which benefits are sought and an industrial accident, then Idaho Code § 72-432 requires that the employer provide reasonable medical treatment, including medications and procedures.

57. An employer is not responsible for medical treatment that is not related to the industrial accident. *Williamson V. Whitman Corp./Pet, Inc*., 130 Idaho 602, 944 P.2d 1365 (1997). The fact that a claimant suffers a covered injury to a particular part of his or her body does not make the employer liable for all future medical care to that part of the employee's body, even if the medical care is reasonable. *Henderson v. McCain Foods, Inc*., 142 Idaho 559, 563,

130 P.3d 1097, 1101 (2006). Similarly, an employer is not liable to an employee for other workers' compensation benefits unless the time loss, impairment, or disability is the result of the industrial accident or occupational disease.

58. Here there is no dispute that Claimant fractured the fibula in her ankle in an industrial accident. Her claim was accepted, and Wausau paid for Claimant's medical care related to treating the fracture from the date of injury through July 12, 2007, the date Claimant reached medical stability.[4] Regardless of how one frames the issues, this proceeding is really about determining whether Claimant's on-going foot and ankle complaints were caused by her industrial fibula fracture. Such a determination necessarily begins by identifying the condition that is the predicate for the award of benefits.

PHYSICAL CONDITION

59. In this matter, Claimant saw a number of medical professionals about her ankle and foot complaints.[5] On the whole, her treaters expressed their desire to identify the physical cause of Claimant's symptoms to identify treatment that would give her relief from her pain. Despite their best efforts, not a single physician, not even Dr. Cook, could make a medical diagnosis that explained Claimant's symptoms.

---

[4] Claimant suggests in her briefing that Defendants improperly terminated Claimant's benefits based on the reports of Drs. Simon and Knoebel, both described as "well-known defense IME" doctors. Claimant's Opening Brief, p. 5. The Referee notes first that Claimant was referred to Dr. Simon by Dr. Andary, with whom Claimant sought a second opinion. Dr. Simon was not retained by Wausau for an IME. Second, even Claimant's own IME physician, Dr. Cook, agreed that Claimant was medically stable from her fracture by July 12, 2007.

[5] Claimant identifies the physicians at OMP as among her treating physicians, and asserts that she continued receiving treatment from them after she was found medically stable. The physicians at OMP did not provide treatment for Claimant's ankle injury—rather, they followed and helped to manage the treatment that she received. Additionally, much of their involvement concerned return-to-work and restriction issues. As noted in the findings, Claimant did see the physicians at OMP a number of times after July 2007. There are no clinical notes from those visits, merely documentation of restrictions.

60. Several physicians theorized that Claimant's symptoms arose as a result of tendon or ligament injuries that lingered after the fracture had healed. Repeated imaging was negative, and no radiologist or orthopedist found radiographic evidence of a tear. Some of Claimant's physicians considered a diagnosis of tendonitis or tendonosis, and even treated her with steroid injections and physical therapy. But Claimant's symptoms were transient, did not respond to therapy, and were not confirmed by imaging.

61. Claimant's interaction with Dr. Selznick is illustrative of the elusive nature of Claimant's complaints. Claimant saw Dr. Selznick on February 1, 2009. He was sympathetic to her complaints, and was optimistic that he could identify the cause or causes which he could then treat to give her some relief. On exam, he thought that the peroneal sheath felt "a little bit boggy on palpation on the right versus the left." Ex. 16, p. 1. Dr. Selznick concluded: "She definitely has peroneal tendonitis." *Id.* In her brief, Claimant cites to this statement as proof that she had peroneal tendonitis. However, an MRI performed on February 25, 2009 was unremarkable, and when Dr. Selznick re-examined her after the MRI, her right peroneal sheath was normal. Over the years that she sought care for her foot and ankle, many different diagnoses were posited, but none were confirmed. The Referee has carefully reviewed the hearing record in this proceeding, and has found no evidence that any physician has recommended any further testing, procedure, or treatment of Claimant's right foot and ankle.

Complex Regional Pain Syndrome

62. When no anatomic cause of Claimant's pain was identified, several of Claimant's physicians suggested, considered, or posed a working diagnosis of RSD or CRPS. As Dr. Simon explained:

> The first thing to consider in someone with pain beyond what would typically be expected from the injury would be a Complex Regional Pain Syndrome (formerly known as RSD).

Ex. H., p. 137. But Dr. Simon also noted that Claimant did not have clinical findings to support a CRPS diagnosis and the radiologic evidence (bone scan) was inconclusive. Dr. Simon considered it more likely Claimant suffered a nerve injury resulting in neuropathic pain, but electrodiagnostics testing was normal. In fact, no credible medical professional ever diagnosed Claimant with CRPS.

63. While the Referee does not have the benefit of post-hearing testimony from the medical experts regarding the diagnosis of CRPS, the *AMA Guides* address the criteria for this diagnosis in some detail. The quintessence of CRPS is:

> . . . a characteristic burning pain that is present without stimulation or movement, that occurs beyond the territory of a single peripheral nerve, and that is disproportionate to the inciting event. The pain is associated with specific clinical findings, including signs of vasomotor and sudomotor dysfunction and, later, trophic changes of all tissues from skin to bone.

AMA Guides, p. 495. The *Guides* set out with specificity the clinical criteria for diagnosing CRPS:

> Since a subjective complaint of pain is the hallmark of these conditions [CRPS, CRPS II], and many of the associated physical signs and radiologic findings can be the result of disuse, the differential diagnosis is extensive; it includes somatoform pain disorder, somatoform conversion disorder, factitious disorder, and malingering. Consequently, the approach to the diagnosis of these syndromes should be conservative and based on objective findings. The criteria listed in Table 16-16 predicate a diagnosis of CRPS upon a preponderance of objective findings that can be identified during a standard physical examination and demonstrated by radiologic techniques. *At least eight of these findings must be present concurrently for a diagnosis of CRPS.* Signs are objective evidence of disease perceptible to the examiner, as opposed to symptoms, which are subjective sensations of the individual.

Id., at p. 496 (emphasis added). Table 16-16 of the *AMA Guides* (p. 496) identifies the following signs for objective diagnosis for CRPS:

Clinical signs

Vasomotor changes:

Skin color (mottled or cyanotic)
Skin temperature (cool)
Edema

Sudomotor changes:

Skin dry or overly moist

Trophic changes:

Skin texture (smooth, non-elastic)
Soft tissue atrophy
Joint stiffness and decreased passive motion
Nail changes (blemished, curved, talonlike)
Hair growth changes (falling out, longer, finer)

Radiographic signs

Radiographs:

Trophic bone changes
Osteoporosis

Bone scans:

Findings consistent with CRPS

64. The only physician who offered an opinion that Claimant suffered from CRPS attributable to the industrial accident was Dr. Cook. The Referee did not find Dr. Cook's opinions persuasive for a number of reasons.

Credentials

65. As the Commission has noted in two prior decisions,[6] Dr. Cook's medical credentials, including his certifications or specialties, remain unknown to the Commission, and no party has taken his deposition in any case decided by the Commission. A well-analyzed and explained disagreement between medical experts with known credentials can be extremely helpful in making medical findings in workers' compensation cases. Here, we do not have the benefit of any analysis or explanation from either Dr. Knoebel or Dr. Cook. But Dr. Knoebel's qualifications are well-known, and the qualifications of the other expert are entirely unknown.

---

[6] See, *Javier Hernandez v. Bob's Insulation*, 2011 IIC 0016, (02/25/2011); and *Carmen Licano, v Community Council of Idaho, Inc.*, 2010 IIC 0377 (2008-029193).

Multiple Inconsistent Reports

66. Dr. Cook saw Claimant and had the opportunity to examine her on one occasion—April 14, 2009—nearly three years after her industrial injury. At that time, Dr. Cook's examination of Claimant's right foot and ankle was limited to findings of antalgic gait on the right, no central or peripheral nervous system deficits, no gross atrophy, an ability to heel and toe walk, and the ability to ambulate without assistive devices. Dr. Cook also discussed and diagnosed a number of other conditions not related to Claimant's industrial injury. In his report, he included a lengthy discussion, taken from the *AMA Guides*, regarding the difficulty of diagnosing CRPS. He did not diagnose Claimant with CRPS at that time and, as discussed herein, his exam findings did not support such a diagnosis at that time. Dr. Cook concluded that:

> [Claimant's] pain fits the diagnosis of *chronic pain syndrome (CPS)*. "Although not official nomenclature, it is frequently used to describe an individual who is markedly impaired by chronic pain with substantial psychological overlay. CPS is largely a behavioral syndrome that affects a minority of those with chronic pain. It may be best understood as a form of *abnormal illness behavior* that consists mainly of excessive adoption of the sick role." *AMA Guides,* 5th ed., p. 567.

Ex. 17, p. 5 (emphasis in original).

67. Dr. Cook revisited Claimant's case in an October 2009 response to a letter from Wausau. There is nothing to suggest that Dr. Cook saw Claimant a second time before preparing his response. In that response, he reiterated some of what was included in his original report, including Claimant's stability date of July 12, 2007. In his initial report, he had awarded Claimant whole person PPI of 6% for her ankle fracture and an additional 3% for pain. In his October letter, he included a lengthy discussion of additional impairment related to Claimant's diagnosed cognitive and psychiatric problems based on reports evidently provided to him by Wausau, but not made part of this record. He did not offer an actual rating, however. He also

opined that because of Claimant's emotional, cognitive, and psychological status, she would have significant permanent work restrictions and would be unlikely to be able to return to work. He concluded his October 2009 missive with his opinion that Claimant would require on-going medical care for her psychological problems and pain management, that it was more likely than not that she would require orthopedic spinal surgery (lumbar or cervical) sometime in the future, and that she was totally and permanently disabled.

68. It appears that Claimant asked Dr. Cook to perform a records review of her case in 2010. Dr. Cook prepared a letter report dated August 13, 2010. (Ex. 24). There is nothing in the record to suggest that he examined Claimant prior to issuing his report, though it had been some fifteen months since he had last examined Claimant. In his August 2010 report, Dr. Cook concludes that Claimant has CRPS. He based his opinion in part on the 2007 chart notes of Drs. Andary, Curtis, Biddulph, Vincent, and Dragotoiu, together with the 2007 bone scan which was termed "inconclusive" by the radiologist, Dr. Simon, and Dr. Knoebel, among others. All of this information was available to and reviewed by Dr. Cook when he first saw Claimant in April 2009. Of particular interest in the August 2010 report is Dr. Cook's statement:

> On physical examination by this examiner on 04/14/2009, right lower extremity clinical signs were noted:
> - Her right lower extremity skin was mottled and reddish/cyanotic.
> - Her skin temperature was cool to touch. Capillary return was slow and persistent blanching was noted.
> - Moderate edema was noted.
>
> Sudomotor changes:
> - Her skin was dry to the touch.
>
> Trophic changes:
> - Her skin was smooth and thinned.
> - She had joint stiffness and secondary reduced motion.
> - Her nails were thickened, curved and blemished.
> - No hair was apparent on the extremity.

Ex. 24, p. 2. He went on to state that Claimant could not ambulate without two crutches. As discussed, *supra,* these findings do not appear in the April 2009 IME report, and Dr. Cook specifically discussed and dismissed a CRPS diagnosis at that time. Yet, fifteen months later, and without re-examining Claimant, Dr. Cook avers that she cannot ambulate without two crutches and offers, as conclusive, a diagnosis he previously rejected because there was insufficient medical support at the time.

69. Based on these "new" clinical findings, Dr. Cook awarded Claimant a whole person PPI rating of 39% as determined by using the *AMA Guides*, table 13-15.

70. Dr. Cook's qualifications are unknown, and his opinions are internally inconsistent and unsupported by medical records, including his own. Set against the myriad of other contrary opinions contained in this lengthy record, the Referee declines to give Dr. Cook's opinion any weight.

PHYSICAL/MENTAL INJURY

71. Scattered throughout the briefing are suggestions (primarily from Defendants) that Claimant seeks compensation for a "physical/mental" claim pursuant to Idaho Code § 72-451, where her industrial injury triggered a psychological condition that accounts for her pain complaints. In 1994, the Idaho State Legislature adopted Idaho Code § 72-451, providing for the compensability of certain types of psychological injuries. Generally, the statute recognizes the compensability of "physical/mental" and "mental/physical" injuries, and forecloses claims for "mental/mental" injuries. Compensable psychological claims, because of their subjectivity, must meet certain elements to be recognized.

72. Idaho Code § 72-451 outlines the requirements for a compensable "physical/mental" injury as follows:

- The injury was caused by an accident and physical injury or occupational disease or psychological mishap accompanied by resultant physical injury;

- The injury did not arise from conditions generally inherent in every working situation or from a personnel-related action;

- Such accident and injury must be the predominant cause as compared to all other causes combined of any consequence;

- The causes or injuries must exist in a real and objective sense;

- The condition must be one which constitutes a diagnosis under the American Psychiatric Association's most recent diagnostic and statistics manual (DSM), and must be diagnosed by a psychologist or psychiatrist licensed in the jurisdiction in which treatment is rendered; and

- A claimant must prove by clear and convincing evidence that the psychological injury arose out of and in the course of employment from an accident or occupational disease.

See, Idaho Code § 72-451, *Luttrell v. Clearwater County Sheriff's Office*, 140 Idaho 581, 97 P. 3d 448 (2004), and *Jock Johnson v. Paradise Valley Fire District*, 2011 IIC 0037, (06/07/2011).

73. The record in this proceeding may include sufficient evidence to make affirmative findings on some of the enumerated elements; however, there is insufficient evidence to find that:

- A licensed psychologist or psychiatrist has assessed any DSM diagnosis;

- The industrial injury was the predominant cause, above all other causes, of Claimant's supposed psychological condition; or

- That she has any psychological injury that arose out of and in the course of her employment.

74. Claimant has failed to establish the elements necessary to prevail on a claim that she sustained a "physical/mental" injury pursuant to Idaho Code § 72-451.

75. The upshot of this extensive discussion about the diagnosis of Claimant's condition is this: There is insufficient evidence to establish that Claimant has any diagnosed condition, physical or mental, beyond that for which she has already received benefits.

TTDs/TPDs

76. Defendants paid Claimant time loss benefits during her period of recovery, terminating the time-loss benefits after July 12, 2007, when Claimant undisputedly reached medical stability. Claimant is not entitled to additional time-loss benefits, because she failed to provide sufficient evidence that her inability to return to work for CH2M after July 12, 2007 was the result of her industrial injury.

IMPAIRMENT

77. Defendants paid Claimant a 3% whole person impairment as determined by Dr. Knoebel. Claimant has failed to provide sufficient evidence to support a finding that she is entitled to additional PPI. Dr. Knoebel's impairment calculation is consistent with the methodology set out in the *AMA Guides* for a healed extra-articular fracture with a normal range of angulation. The only other physician who offered an impairment rating was Dr. Cook. As discussed herein, Dr. Cook's opinion lacks credibility and is given no weight. The Referee finds Claimant has failed to prove she is entitled to additional PPI benefits in excess of 3% of the whole person.

DISABILITY

78. Claimant has failed to establish that she has disability in excess of her impairment as a result of her industrial injury. Claimant's physical and/or mental conditions may preclude her from gainful employment. However, there is insufficient evidence to support a finding that Claimant's disability, to the extent it may exist, is the result of her industrial injury.

CONCLUSION OF LAW

1. Claimant has failed to prove that she is entitled to benefits related to her right foot and ankle after she reached medical stability on July 12, 2007.

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 7 day of September, 2011.

INDUSTRIAL COMMISSION

/s/_____
Rinda Just, Referee

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

MARY JANE DUENES, Claimant, v. CH2M WG IDAHO, LLC, Employer, and EMPLOYERS INSURANCE COMPANY OF WAUSAU, Surety, Defendants.	)	**IC 2006-512972** **ORDER** Filed: September 13, 2011

Pursuant to Idaho Code § 72-717, Referee Rinda Just submitted the record in the above-entitled matter, together with her proposed 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 failed to prove that she is entitled to benefits related to her right foot and ankle after she reached medical stability on July 12, 2007.

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

matters adjudicated.

DATED this 13 day of September, 2011.

INDUSTRIAL COMMISSION

/s/_____
Thomas E. Limbaugh, Chairman

/s/_____
Thomas P. Baskin, Commissioner

/s/_____
R.D. Maynard, Commissioner

ATTEST:

/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 13 day of September, 2011, a true and correct copy of the foregoing **FINDINGS, CONCLUSION,** and **ORDER** were served by regular United States Mail upon each of the following persons:

PAUL T CURTIS
598 N CAPITAL AVE
IDAHO FALLS ID 83402

SCOTT HARMON
PO BOX 6358
BOISE ID 83707-6358

djb /s/_____