BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

DAYLE ELLIS, Claimant, v. C-A-L STORES COMPANY, INC., dba CAL RANCH STORES, Employer, and CONTINENTAL CASUALTY COMPANY, Surety, Defendants.	**IC 2007-010399** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **Filed November 14, 2013**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Douglas A. Donohue, who conducted a hearing in Pocatello on April 12, 2012. Albert Matsuura represented Claimant. David P. Gardner represented Defendants. The parties presented oral and documentary evidence. The record was held open for limited purposes, including the submission of certain evidence regarding third-party payors. Post-hearing depositions were taken, and the parties stipulated to the admission of additional evidence. Briefs were later submitted. The matter came under advisement on July 24, 2013. The undersigned Commissioners have chosen not to adopt the Referee's recommendation and hereby issue their own findings of fact, conclusions of law and order.

ISSUES

The issues to be decided by the Commission as the result of the hearing are:

1. Whether the condition for which Claimant seeks benefits was caused by an industrial accident;
2. Whether Claimant is medically stable and, if so, the date thereof;
3. Whether and to what extent Claimant is entitled to the following benefits:

a) Temporary disability,
b) Medical care, and
c) Attorney fees.

All other issues were reserved.

CONTENTIONS OF THE PARTIES

There is no dispute that Claimant was injured in a compensable accident on March 17, 2007. Claimant attempted to drive a lawn tractor into a pickup up a ramp consisting of two planks. One plank shifted. The tractor capsized. Claimant was thrown off, injuring his right shoulder. After shoulder surgery, Claimant developed reflex sympathetic dystrophy (RSD) in his right upper extremity. Defendants accepted the claim and paid medical and TTD benefits. The RSD spread to Claimant's right lower extremity. Defendants accepted and paid this claim through the date of hearing. Defendants' post-hearing discontinuation of payment not having arisen as of the date of hearing, that issue is not considered here. That issue is among those reserved.

Claimant contends that he is entitled to additional medical care and TTD benefits for conditions arising as a compensable natural consequence of his injury and treatment for it. A multi-step, straight-line sequence of cause and effect shows as follows: The shoulder injury and surgery caused RSD; RSD required long-term pain medications; the medications caused xerostomia or dry mouth from the absence of sufficient saliva; insufficient saliva caused dental decay; dental decay caused tooth infection; tooth infection caused facial cellulitis; facial cellulitis required an antibiotic regimen; the antibiotics caused the spread of a Costridium difficile (C-diff) colitis; the C-diff required medical care and resulted in temporary disability. In addition, Defendants denied or delayed payment of medical bills relating to Claimant's oral care, cellulitis, and C-diff conditions without reasonable basis. They unreasonably delayed his claim for benefits related to lower extremity RSD. Claimant is entitled to attorney fees.

Defendants contend Claimant's tooth problems preexisted the accident. The oral and other problems were caused by other factors and are not compensable natural consequences of the accident and injury. Moreover, the evidence does not show that the rate of Claimant's preexisting tooth decay increased after the accident. Indeed, Claimant experienced significant tooth problems before he began taking pain medication for injuries from the accident. Claimant's failure to seek proper treatment is an intervening cause of his tooth and other problems. Defendants acted reasonably at all times. Finally, if Claimant is deemed entitled to additional benefits, recovery should be limited to amounts paid by Medicare and the Veterans Administration. The holding in *Aspiazu v. Homedale Tire Service*, 2012 IIC 0004 (January 18, 2012) should be overturned.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. Claimant's Exhibits A through V admitted at the hearing;
2. Defendants' Exhibits 1 through 4 admitted at the hearing;
3. The testimony of Claimant taken at the hearing;
4. The post-hearing deposition testimony of dentists Thomas Call, Errol Ormond, and Kim Smith, and of pain management physician Mark Miles Passey, M.D.;
5. Claimant's Exhibits W, X, and Y submitted post-hearing by stipulation.

All pending objections are overruled.

FINDINGS OF FACT
Accident, Shoulder Injury, and RSD

1. Claimant worked for Employer and suffered a compensable accident and injury on March 17, 2007. Claimant sought immediate medical care. The ER report described right posterior chest wall pain, abrasions and contusions. An initial examination revealed movement without pain in his right shoulder and elsewhere. Discharged 4½ hours later, Claimant had

received treatment for these injuries and for neck pain and a headache which developed during the stay. X-rays were negative for relevant acute injury.

2. On March 29, 2007, Claimant reported right shoulder pain. An X-ray was negative.

3. Doctors Steven Coker, M.D., and Kenneth Newhouse, M.D., performed follow-up treatment. Right shoulder impingement syndrome developed. Physical therapy and injections provided only temporary relief. A subacromial decompression surgery was performed. Claimant experienced immediate partial improvement and progressed in the weeks following surgery. Some mild impingement remained.

4. On January 24, 2008, Claimant reported recent dermal blotching and increased shoulder pain. Dr. Newhouse diagnosed reflex sympathetic dystrophy (RSD). Subsequent injections and a Medrol Dosepak did not help much.

5. (Throughout the record doctors alternately referred to RSD and/or complex regional pain syndrome "CRPS" interchangeably. Hereinafter this decision will use RSD regardless of a doctor's particular choice on a particular record.)

6. On February 28, 2008, Claimant's shoulder was not much better. Still, he had improved enough for Dr. Newhouse to release him to light-duty, one-armed, office work.

7. On March 18, 2008, Claimant returned for treatment with the dermal condition now developing on his right leg as well. Dr. Newhouse suggested the rash might not be caused by RSD, but maintained his diagnosis of impingement and RSD in the shoulder. He referred Claimant to Clay Baker, M.D., for a consultation.

8. Dr. Baker examined Claimant and ordered some tests. When a biopsy ruled out other causes, Dr. Newhouse opined that the skin changes were integral to the RSD. Dr. Baker referred Claimant for hyperbaric treatment. That treatment did not help.

9. On April 3, 2008, Claimant visited pain specialist Pat Farrell, M.D., on referral from Dr. Newhouse. Stellate ganglion blocks and a prescription of Lyrica did not help much.

10. On May 14, 2008, Mary Himmler, M.D., reviewed records at Defendants' request. She opined the diagnoses of impingement syndrome and RSD were correct and related to the work accident. She opined Claimant was not at MMI, that he required additional treatment as outlined by Dr. Farrell, that Claimant could perform full-time, light-duty work, but not full duty, and that Claimant sustained permanent impairment which could not yet be rated.

11. On May 15, 2008, Employer terminated Claimant.

12. Doctors considered the use of a spinal cord stimulator. Psychologist Donald Whitely, II, Ph.D., evaluated Claimant's mental health and opined Claimant was a candidate for implantation. The stimulator trial showed it helpful to Claimant's RSD in his arm, but not so much in his shoulder. After permanent implantation in March 2009, adjustments in April 2009 allowed some right shoulder relief as well.

13. On July 31, 2008, Dr. Newhouse opined the RSD was "definitely related" to the surgery and original work injury.

14. On November 6, 2008, Dr. Newhouse referred Claimant to pain management specialist Holly Zoe, M.D. Dr. Zoe focuses her practice on RSD.

15. Dr. Zoe first examined Claimant on November 26, 2008. Claimant attended several visits with her as she attempted to manage his pain and RSD. On the 10 scale, Claimant reported gradually reducing levels of pain, especially after stimulator implantation. Dr. Zoe and her physician's assistant (PA) gradually reduced Claimant's narcotic pain medication in concert with his overall pain reductions.

16. Doctors Clark Allen, M.D., and Farrell performed the surgery for permanent implantation. Dr. Farrell opined Claimant became totally temporarily disabled due to the

stimulator implantation surgery as of March 2, 2009. He released Claimant to light duty, no lifting over 20 pounds, no extreme neck flexion or extension. These were imposed as permanent restrictions, although Dr. Farrell clearly did not consider Claimant to be at MMI. Soon after, Dr. Farrell took Claimant entirely off work again.

17. Intermittently Claimant experienced pain focussed at the stimulator leads. Dr. Farrell treated this as well.

18. On July 16, 2009, Dr. Newhouse opined Claimant was orthopedically fixed and stable. He recommended Claimant continue RSD treatment with Drs. Zoe and Farrell.

19. In Summer 2009 Claimant gradually developed some thoracic pain as well. Dr. Zoe considered and requested authorization for a thoracic sympathetic nerve block. Surety was slow to approve this. Surety discontinued authorization for Lidocaine cream for several months, and then reapproved it. In October 2009, Claimant's stimulator lead shorted out. Surety was slow to approve the revision necessary to fix it. As a result, Claimant's use of the stimulator became intermittent because of pain from the shorted lead. His pain levels rose and he lost ground on attempts to wean him from narcotic medications.

20. On January 14, 2010, Dr. Farrell performed injections and a nerve block for right SI and hip pain.

21. On April 5, 2010, Claimant's stimulator battery had to be moved because he had lost significant weight. Surety still had not approved repair of the shorted lead by this time.

22. On November 19, 2010, Brian Tellerico, M.D., reviewed records and examined Claimant at Defendants' request. He opined Claimant should continue with palliative medication, taper off narcotic medication, and that he was not a surgical candidate. He opined the RSD was related to the work accident. He opined Claimant was at MMI and rated PPI at 3% of the upper extremity.

23. At a January 10, 2011 visit to Dr. Zoe, Claimant reported RSD symptoms in his right hip and thigh. His leg above the knee showed skin discoloration as in his arm. Dr. Zoe now also recommended a lumbar sympathetic nerve block. In subsequent visits, Dr. Zoe documented decreases in strength and reflexes in the affected areas. She repeatedly requested authorization to proceed. The lumbar sympathetic nerve block was approved by Surety shortly before Claimant's December 14, 2011 visit to Dr. Zoe. The record does not explain Surety's delay in approving this procedure. The block provided significant relief for four or five days.

24. On January 12, 2012, Dr. Zoe performed a lumbar nerve ablation. Claimant reported immediate, significant relief. On January 19, 2012, Claimant reported a 50% reduction of his leg pain.

25. The record does not show whether the shorted lead was repaired. The record does not identify Surety's basis for delaying its decision not to approve the stimulator fix. The record does not show that thoracic nerve block was ever approved or performed. Eventually, Claimant declined to further seek approval for it. The record does not identify Surety's basis for this delay.

Oral Complications and C-diff Colitis

26. VA dental records begin November 1, 1994. The initial record involves a drill and fill on a cavity after a lost filling. A July 1996 record shows work on another tooth.

27. VA records show a July 1998 septoplasty performed to correct a deviated nasal septum.

28. Claimant's regular dentist is Thomas Call, DDS. His records begin in March 2006. His 2006 records show substantial work including several crowns. Early 2007 records refer to a partial denture. The records show no visits between April 2007 and July 15,

2009. On July 15, 2009, Claimant had a broken tooth which further fragmented upon extraction. This required an extension of his partial dentures.

29. On November 12, 2009, Dr. Call opined that the broken tooth and increased rate of caries on multiple teeth was directly caused by the long term use of narcotic analgesics prescribed for Claimant's shoulder condition and RSD. He listed the dates of narcotic prescriptions. He noted Claimant had complained of dry mouth (Xerostomia) which is a known risk of narcotic analgesics (7% risk) and Lyrica (15% risk). Claimant had been taking both chronically after the accident. Xerostomia increased the risk of caries. Dr. Call identified his treatment plan involving six teeth in addition to the broken one. Treatment included fillings, crowns and a root canal. Charges for services from July 2009 through May 24, 2010 amounted to $2,282.99. Dr. Call's opinion of causation does not reasonably include work performed between the date of accident and the end of May 2007.

30. On December 22, 2009, Surety was notified that Claimant associated his dental condition as having been caused by the use of narcotic medications prescribed for conditions relating to his work accident.

31. On August 11, 2010, Claimant first visited Errol Ormond, DDS. Dr. Ormond crowned a tooth and observed on X-ray a problem with another. He referred Claimant to endodontist Douglas Sutton, DDS, and sent the X-ray.

32. On August 18, 2010, Claimant was hospitalized through the ER for left facial cellulitis. The admitting differential diagnosis included meningitis, but this was eventually ruled out. The admitting physician wrote: "Left facial cellulitis, most probable source is all odontogenic and sinusitis and would be the possible source for the sepsis and the meningitis." Multiple antibiotics were prescribed. Throughout the hospitalization, it was evident that physicians related, by history, his facial swelling with the dental work performed the day before.

This was confirmed by "small purulence" obtained from the left canine space. Consulting physician Martha Buitrago, M.D., diagnosed "left facial cellulitis, likely odontogenic origin." Consulting physician Jeffrey DaBell, DMD, MD, diagnosed a canine space infection. Both doctors recommended continued antibiotics. A PIC line was placed for delivery of antibiotics. A CT showed chronic maxillary sinus thickening.

33. On August 24, 2010, Claimant first visited Dr. Sutton. Dr. Sutton diagnosed an acute apical abscess. Having discovered further decay, they discussed replacement of crowns versus extraction and dentures.

34. Subsequent visits to Drs. Ormond and Sutton revealed more extensive decay. More procedures involving several teeth were performed.

35. On September 18, 2010, Claimant visited the ER with a complaint of abdominal pain. After initial testing he was admitted. The diagnosis was C-diff colitis secondary to antibiotics. Discharged on September 20, he was readmitted through the ER on September 28. The history for this second visit states "It was felt to be C. difficile colitis because he had recently had a rather extensive treatment with IV antibiotics for facial cellulitis." After treatment he was discharged on September 29. He returned to the ER on October 1 and was readmitted, this time to the intensive care unit (ICU). He was discharged on October 3.

36. In early October 2010, Claimant was admitted to the VA hospital in Salt Lake City. He underwent a conoloscopy and other tests to find the source of his abdominal pain and other intestinal symptoms.

37. After his VA admission, Claimant again visited Portneuf Medical Center ER on October 8, 2010 complaining of abdominal pain. He was again admitted to the ICU. Diagnosis was recurrent C-diff. Surgery was considered but deferred. He was discharged on October 9, but again visited the ER later that evening. He was readmitted, diagnosed

with recurrent C-diff colitis, treated and discharged on October 11.

38. On October 21, 2010, Claimant visited VA doctor Jean Bokelmann, M.D., who diagnosed recurrent C-diff colitis.

39. He returned to the ER on October 23 and was admitted with recurrent C-diff colitis. After treatment, he was discharged on October 25. He returned to the ER on October 29 and was admitted. Dr. Buitrago, in consultation, suggested he may have developed an antibiotic-resistant strain of C-diff. She suggested finding a donor to reintroduce "good" intestinal bacteria into Claimant's system. This was ultimately not accomplished. Claimant was discharged on November 6.

40. On November 19, 2010, Brian Tallerico, D.O., reviewed records and examined Claimant at the request of Defendants. He opined Claimant's shoulder and RSD conditions were related to the work accident. He did not recommend further treatment other than prescription medications with tapering of opioid narcotics. He opined Claimant at MMI and rated PPI at 3% of the upper extremity.

41. On December 6, 2010, Claimant again reported to the ER with abdominal pain. He was not admitted on this visit, but was counseled to keep scheduled appointments with Dr. Buitrago and others.

42. On December 9, 2010, Claimant visited Dr. Buitrago at her office. She referred him to the ER, concerned about a possible iliac colon rupture. The ER performed additional tests, examined Claimant, provided treatment, and sent him home.

43. On January 6, 2011, Claimant again visited the ER. This time, despite abdominal pain, workup was negative for recurrent C-diff colitis. He was discharged for followup with the VA. Claimant returned to the ER the next morning, having spent the night without relief from his symptoms. After another workup, no definitive diagnosis explained his symptoms.

Feeling somewhat better, he was sent home.

44. On January 27, 2011, Claimant again visited the ER. The C-diff test was again positive. He was again admitted overnight.

45. On March 28, 2011, Claimant again visited the ER. C-diff tests were ordered. Other objective indicia suggested it was recurring. Kenneth Ryan, M.D., an ER doctor well familiar with Claimant's various ER visits, noted that inadequate funding of antibiotic prescriptions by the VA had extended and complicated Claimant's C-diff treatment. Claimant was discharged home without admission. Later, the C-diff test was reported to be negative on this occasion.

46. On May 8, 2011, Claimant again visited the ER. The C-diff test was again negative, but a particular strain of E-coli was positive. He was discharged with instructions to followup with gastroenterologist Darryl Cook, M.D.

47. On May 24, 2011, Claimant again visited the ER for increased abdominal pain. He was tested, treated, and discharged.

48. On May 24, 2011, Dr. Ormond opined that Claimant's prescription medication regimen relating to his work accident was "complicating" his dental condition. He opined the medications were reducing saliva production which was influencing and increasing the occurrence of dental decay. He opined it unlikely that Claimant would be able to keep his teeth.

49. On June 29, 2011, internist and pain specialist Mark Miles Passey, M.D., evaluated records and examined Claimant at Claimant's request. He opined Claimant's facial cellulitis was caused by the root abscess, that the antibiotics used to treat the cellulitis caused the amelioration of "good" bacteria in Claimant's intestine which allowed the C-diff to overwhelm his system, and that while a small amount of C-diff is present in everyone, it should not be considered a "smoldering infection" in Claimant once he goes 18 months

without symptoms, that Claimant's lingering abdominal pain is not unusual given the intestinal trauma of the C-diff infection, and that intermittent tests for C-diff which were reported as negative did not represent separate incidents, merely that the C-diff problem waxed and waned depending upon treatment. Dr. Passey did not opine about narcotics as a cause of Claimant's dental problems, but accepted Dr. Call's opinion on that point. In post-hearing deposition, Dr. Passey well explained the bases for his opinions.

50. On July 6, 2011, Claimant was admitted to Bingham Memorial Hospital for abdominal pain. Testing confirmed Claimant's new complaint of blood in his stool. The C-diff test was positive.

51. In a March 21, 2012 letter, Kim Smith, DDS, set forth Claimant's dental care history and explained generally about dental decay. Dr. Smith opined Claimant's dental decay was caused by many factors and that "Xerostomia can be completely circumvented with effective oral care and the help of dental professionals." He further opined:

> In my opinion, Mr. Ellis' condition of a dry mouth may have been a contributory factor in the extensive carious activity, that seems evident in the record. However, I think it is naïve to conclude that is was the sole or even the major contributor to this condition. Dental Decay is a multifactorial disease and it can't be simplified to a single causatory factor.

52. In post-hearing deposition, Dr. Call explained the bases for his opinions. He treated Claimant's dental conditions as they arose. He well explained the clinical basis for his observation that Claimant's decay rate increased—"skyrocketed"—after the work accident. Dr. Call considered the various causes of dental decay, including smoking, excessive sweets, etc. He concluded the significant difference was likely the use of narcotic medications and Lyrica following the work accident. Dr. Call observed Claimant's dental hygiene for several months in 2006 and considered it to be "very, very good."

53. In post-hearing deposition, Dr. Ormond well explained the bases for his opinions.

He confirmed that narcotics were associated causally with dry mouth, but would not opine a "percentage" of likelihood to Claimant's case. He also acknowledged potential alternate causes of tooth decay, but similarly would not opine a percentage.

54. In post-hearing deposition, Dr. Smith explained the bases for his opinions. He had performed a records review. He questioned Claimant's reported dental hygiene regimen. He noted the absence of professional dental care between April 2007 and July 2009. He identified generally possible alternative causes of xerostomia. He noted that xerostomia exists on an unquantifiable scale from person to person. He questioned how Dr. Call could state that Claimant's cavity rate increased.

55. Claimant receives Social Security Disability.

56. VA and Medicare have made medical care payments.

DISCUSSION AND FURTHER FINDINGS

57. The provisions of the Idaho Workers' Compensation Law are to be liberally construed in favor of the employee. *Haldiman v. American Fine Foods*, 117 Idaho 955, 956, 793 P.2d 187, 188 (1990). The humane purposes which it serves leave no room for narrow, technical construction. *Ogden v. Thompson*, 128 Idaho 87, 88, 910 P.2d 759, 760 (1996). Facts, however, need not be construed liberally in favor of the worker when evidence is conflicting. *Aldrich v. Lamb-Weston, Inc.*, 122 Idaho 361, 363, 834 P.2d 878, 880 (1992).

Causation

58. In order to obtain workers' compensation benefits, a claimant's disability must result from an injury, which was caused by an accident arising out of and in the course of employment. *Green v. Columbia Foods, Inc.*, 104 Idaho 204, 657 P.2d 1072 (1983); *Tipton v. Jannson*, 91 Idaho 904, 435 P.2d 244 (1967). The claimant has the burden of proving the condition for which compensation is sought is causally related to an industrial accident.

Callantine v. Blue Ribbon Supply, 103 Idaho 734, 653 P.2d 455 (1982). Further, there must be medical testimony supporting the claim for compensation to a reasonable degree of medical probability. A claimant is required to establish a probable, not merely a possible, connection between cause and effect to support his or her contention. *Dean v. Dravo Corporation,* 95 Idaho 558, 560-61, 511 P.2d 1334, 1336-37 (1973), *overruled on other grounds by Jones v. Emmett Manor, 134 Idaho 160, 997 P.2d 621 (2000). See also Callantine, supra.* An employee may be compensated for the aggravation or acceleration of a preexisting condition, but only if the aggravation results from an industrial accident as defined by Idaho Code § 72-102(18)(b).

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

60. Here, to accept the proposition that Claimant's C-diff infection is a natural and probable consequence of the industrial accident is initially somewhat challenging. However, a careful review of the evidence shows Claimant has met his burden of establishing by a preponderance of medical opinion that each causal link is likely true. There is no dispute that Claimant's work accident caused his shoulder injury which, in turn, caused Claimant to develop RSD. For this condition, Claimant was treated with narcotic analgesics and Lyrica over a long period, and the medical evidence establishes that, while there are other causes of dry mouth, it is more likely that in this case the medications he took for RSD caused him to develop dry mouth. It is argued that dry mouth is implicated in accelerating Claimant's rate of tooth decay. Claimant's dental problems led to an infection of odontogenic origin, which required treatment with antibiotics. These medications upset the balance of microbiota in his gastrointestinal tract,

causing him to develop a C-diff infection, for which Claimant has required significant medical treatment. As the Commission has reviewed the record and considered the opinions of the experts who have testified on the issue of causation, the weakest link in the causal chain, and the one on which the resolution of this matter turns, is the assertion that Claimant's dry mouth accelerated his already impressive dental problems. Drs. Call, Smith and Ormond are in agreement that a patient with dry mouth has a greater risk of developing caries than a person without. As explained by these experts, the enemy of dental enamel is plaque. Plaque is a biofilm consisting of bacteria which excrete acid. The acid attacks tooth enamel and degrades it, leading to eventual decay. Saliva helps wash this biofilm from the teeth, and is also an acid neutralizer. Therefore, a mouth bathed in saliva is at lower risk for the development of caries than a dry mouth. The real crux of the instant matter is whether this generalization can be said to apply to Claimant. Although the experts are in general agreement that the dry mouth increases the risk of carie formation, the question that is more difficult to answer is whether Claimant's dry mouth did in fact increase the rate at which he developed caries. The peculiar facts of this case make this question difficult to answer.

61. First, to understand whether or not Claimant's dry mouth had an impact on his rate of carie formation, it is important to know something about Claimant's prior dental history. In other words, how is it possible to opine that dry mouth caused a deleterious change in Claimant's dental health without knowing something about his dental history prior to his development of dry mouth?

62. None of the dentists who treated or evaluated Claimant had access to any dental records generated prior to Claimant's first visit with Dr. Call in March of 2006. However, it is abundantly clear that Claimant had significant dental problems prior to March of 2006, which had resulted in the loss of nine permanent teeth in addition to his four wisdom teeth. The record

reflects that Claimant lost his first tooth in 1988 and his second tooth in 1996. The record does not reveal when Claimant lost seven additional teeth, although this took place sometime between 1996 and 2006. The record does not disclose whether those extractions took place closer to 2006 than 1996, and knowing the distribution of these extractions would allow some inferences to be made about the rate at which Claimant's dental health was declining.

63. In rendering his opinion that Claimant's dry mouth accelerated the decline in Claimant's dental condition, Dr. Call downplayed the significant problems noted at the time of Dr. Call's initial exam of Claimant in 2006, explaining that Claimant had "some caries rate and fractured teeth" prior to March of 2006. (Call Deposition 31/16-22). Both Dr. Smith and Dr. Ormond were more accurate in proposing that Claimant had significant dental problems prior to March of 2006, which suggested a history of poor dental hygiene. (Smith Deposition 15/6-16/19; Ormond Deposition 29/5-11). According to Dr. Call's notes, Claimant was seen on approximately 16 occasions between March 9, 2006 and April 26, 2007 for repair and restoration work. During the period of time that he treated Claimant in 2006 and 2007, Dr. Call testified that Claimant's condition was "stable", with evidence that Claimant's dental hygiene during this period was good. Dr. Call released Claimant in April of 2007 and thought that the outlook for Claimant's dental condition was "very very good". (Call Deposition p. 12/ 22–13/ 3).

64. It was during the period April of 2007 through July of 2009 that Claimant was prescribed narcotic analgesics and Lyrica for the purpose of treating his RSD. When Claimant was next seen by Dr. Call in July of 2009, Dr. Call noted a significant and alarming deterioration of Claimant's dental health. The fact that none of Claimant's other bad habits had evidently changed after April of 2007 led Dr. Call to conclude that the deterioration of Claimant's condition was due to the one variable that had changed; i.e. Claimant's use of the aforementioned medications, which caused him to develop dry mouth. Although Dr. Call

acknowledged that he did not know anything about the timing of Claimant's deterioration prior to March of 2006, he did follow Claimant extensively between March of 2006 and April of 2007 and noted that Claimant's dental presentation was stable over that time period. From this he concluded that Claimant's new condition of dry mouth must be implicated in causing an acceleration of Claimant's dental deterioration, where all other variables were apparently the same both before and after April of 2007.

65. Dr. Smith was critical of Dr. Call's opinion in this regard. Perhaps in recognition of the fact that the record is devoid of any information regarding the progression of Claimant's dental deterioration between 1996 and 2006, Dr. Smith offered the following comments when asked to explain his views on what caused the sudden increase in the rate of deterioration after April of 2007:

> Q. So based upon your education, your experience, your training in the field of dentistry, as well as your review of all the records, do you have an opinion as to what was the cause of Mr. Ellis's increase in his cavity rate during that period of time? Specifically between 2007 and 2009.
>
> A. Well, I don't know if I can explain – I'd be hard pressed to explain that he had an increase in cavity rate. I don't know how we – cavity rate, I don't even know what that is. Okay? I mean, he had more in '09 that '07.
>
> But my opinion is is Mr. Ellis had a lot of issues going forward. And he – he'd had extensive procedures done on a lot of teeth. He had lost several teeth. And he – and once you have a lot of procedures done on a tooth, it's – it's more likely to end badly, you know.
>
> I mean, if – if you do something to a healthy tooth, it sometimes can survive. If you do ones that have had a root canal buildup in the crown and – and you don't have great hygiene, that one's going to break before the other one. It's just a fact of life.
>
> And so he's – he's further down on the – the chain of – of natural events of – of loosing his teeth, which now we found out he's actually lost his teeth. Okay? But I think he was towards the end of that, racking up on a lot of teeth.
>
> And the unfortunate problem is, it just kind of cascades as things – you know, you – you get a lot of procedures done. And – and it's difficult for patients

> because they spend a lot of money. They're trying get ahead of it, but it – it's a real challenge to – to get in front of this ongoing problem.
>
> And – and he was kind of at the last parts of this with a lot of teeth. And then, you know, they're like dominos. They – one falls, one falls, and then – then he reaches the -- the end result, which did happen, is he lost all his tooth. And – and it's unfortunate. But I just think he was nearing the – the – the end of that.
>
> Q. Okay.
>
> A. You know, I mean, it's kind of a generalization, but – but I see it happen every day. I – I know people that have multiple restorations and lots of restorations, and they've been on this thing. It – it ends this way often.
>
> Smith Deposition, pp. 21, l. 3 - 23, l. 1.

Per Dr. Smith, it may be pointless to discuss the change in the rate of decay when you do not know what the rate of decay was between 1996 and 2006. More importantly, Dr. Smith posits that the trajectory of Claimant's decline in dental health was plotted by the time he began to have so many procedures on so many of his teeth. Although Dr. Smith acknowledged that Claimant's dry mouth is a factor to be considered in explaining Claimant's current dental problems, its importance is impossible to quantify. (Smith Deposition 37/17-38/19).

66. In resolving this dispute, we think it important to note that all three experts have opined that Claimant's dry mouth is likely a factor which contributed to the dental problems noted by Dr. Call in July of 2009. Although we are troubled by a lack of information concerning the progression of Claimant's difficulties prior to March of 2006, Dr. Call's testimony that Claimant was relatively stable between March of 2006 and April of 2007 stands uncontradicted in the record. We know that among the activities/habits which can detrimentally impact dental health, the only variable we know of that changed between March of 2007 and July of 2009 was the onset of Claimant's dry mouth. Based on the foregoing, we conclude that Claimant has met his burden of establishing by competent medical evidence that it is more probable than not that the significant deterioration in his dental condition noted in July of 2009 is causally related to the

fact that he developed dry mouth from medications used to treat his RSD.

Medical Care

67. Idaho Code § 72-432(1) obligates an employer to provide an injured employee reasonable medical care as may be required by his or her physician immediately following an injury and for a reasonable time thereafter. It is for the physician, not the Commission, to decide whether the treatment is required. The only review the Commission is entitled to make is whether the treatment was reasonable. *See Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989).

68. Defendants' sole challenge to providing medical care benefits was based upon a presumed lack of a sufficient causal link between the work accident and the arising conditions. As demonstrated above, the evidence shows the required causal links have been proved.

69. At every step and for each successive condition, Claimant is entitled to medical care benefits.

70. Of particular issue here is Defendants' claim that they should be entitled to pay some amount less than actual billed totals. Defendants argue that because of contractual agreements among Medicare, the VA, and the various health care providers Claimant will receive a windfall unless his award is adjusted downward to the subrogation amounts claimed.

71. They distinguish the facts underlying *Neel v. Western Construction, Inc.*, 147 Idaho 146, 206 P.3d 852 (2009) to assert it should not apply. They frankly request that the holding in *Aspiazu v. Homedale Tire Service*, 2012 IIC 00004 (January 18, 2012) should be overturned. We decline to contradict our prior holdings. Whether a claimant may receive a windfall after a surety has chosen not to pay for covered benefits is less important than providing incentive for a surety to pay according to statutory requirements in the first place.

See, *Rice v. Basic American Foods*, 2005 IIC 0460 (June 24, 2005) (self-insured employer which waived subrogation by its health insurance arm ordered to pay in full under workers' compensation despite potential windfall). Moreover, the concept of "windfall" does not account for the financial and emotional burden Defendants left Claimant to bear as he was forced to seek other sources of payment, to choose how much and how expensive medical care he could afford, and how long he was forced to suffer from conditions that were Defendant's obligation to pay.

72. Defendants are required to pay in full as set forth in *Neel*, *supra*.

Temporary Disability Benefits

73. Idaho Code § 72-408 provides that income benefits for total and partial disability shall be paid to disabled employees "during the period of recovery." The burden is on a claimant to present evidence of the extent and duration of the disability in order to recover these income benefits. *Sykes v. C.P. Clare and Company*, 100 Idaho 761, 605 P.2d 939 (1980).

74. Claimant seeks specific periods of TTD benefits. In briefing, Claimant alleged he was seeking TTD benefits only for those dates upon which he was hospitalized. This is a reasonable and limited claim. The medical records show that Claimant's visits to the ER, whether he was admitted overnight or not, establish that he was totally temporarily disabled on every day he received medical treatment at a hospital. Such TTD benefits are compensable.

Attorney Fees

75. Idaho Code § 72-804 requires defendants to pay a claimant's attorney fees where they have unreasonably denied or delayed a claim.

76. Defendants were made aware of Claimant's claims for additional compensable consequences no later than December 22, 2009 when Claimant's attorney wrote Surety

and included Dr. Call's opinion regarding the causal link. The record shows Surety's "temporary" denial pending investigation dated September 15, 2010. This delay is too long to be considered reasonable. Claimant is entitled to attorney fees for the time period between the initial correspondence of Claimant's attorney and Surety's written response.

77. The Commission is reluctant to award attorney fees on a bifurcated matter. Often an analysis of all facts and issues are deemed prerequisite to a determination of whether defendants have been unreasonable in handling a matter. Thus, where substantial issues remain reserved, the Commission also reserves a decision upon whether Surety's denial of Claimant's claims was unreasonable. Concerns include the lack of response to Dr. Zoe's request for authorization for a thoracic sympathetic nerve block, lidocaine cream, and other treatment. This reservation does not alter the finding that the delay was unreasonable as discussed immediately above.

CONCLUSIONS OF LAW AND ORDER

1. Claimant proved it likely that his C-diff colitis and intermediate conditions following the work accident were compensable consequences of his work accident;

2. Claimant is entitled to medical benefits for all compensable conditions in amounts as set forth by the analysis in *Neel*;

3. Claimant is entitled to TTD benefits for every date he presented to or was admitted in the hospital;

4. Claimant has not been established as being at MMI for every condition; he is deemed to remain in a period of recovery despite the fact that some portions of his conditions may have resolved;

5. Claimant is entitled to an award of attorney fees incurred from the date of December 22, 2009 to September 15, 2010, for an unreasonable delay in addressing Claimant's

claim for dental conditions; consideration of additional attorney fees is reserved with other issues for a full hearing.

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

DATED this 14th day of November 2013.

INDUSTRIAL COMMISSION

_/s/_____
Thomas P. Baskin, Chairman

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

_/s/_____
Thomas E. Limbaugh, Commissioner

ATTEST:

_/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 14th day of November 2013, a true and correct copy of **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** were served by regular United States Mail upon each of the following:

ALBERT MATSUURA
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_/s/_____