BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

VAL R. FERRIN, Claimant, v. BECHTEL BETTIS, INC., Employer, and INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA, Surety, Defendants.	)	**IC 2006-001471** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** Filed: January 7, 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 March 3, 2010. Michael R. McBride of Idaho Falls represented Claimant. David P. Gardner of Pocatello represented Defendants. The parties submitted oral and documentary evidence. The parties took five post-hearing depositions and submitted post-hearing briefs. The matter came under advisement on July 23, 2010 and is now ready for decision.

ISSUES

The issues to be decided in this proceeding as set out at hearing are:

1. Whether the conditions for which Claimant seeks benefits were caused by the industrial accident;

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

A. Medical care;

B. Temporary partial and/or temporary total disability benefits (TPDs/TTDs);

C. Permanent partial impairment (PPI);

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

E. Attorney fees.

A third issue identified at the outset of the hearing, whether any of the benefits to which Claimant would normally be entitled should be suspended or reduced pursuant to Idaho Code § 72-435, was not argued by Defendants, and the Referee considers the issue waived.

CONTENTIONS OF THE PARTIES

It is undisputed that, while working for Employer, Claimant slipped on a patch of ice, fell, and struck his head, losing consciousness briefly. It is also undisputed that, as a result of the fall, Claimant sustained a scalp laceration, a concussion, and post-concussive syndrome. Defendants accepted the claim and paid benefits for most of the undisputed injuries.

Claimant asserts that, as a result of his fall and head injury, he suffers from a constellation of additional medical and psychological problems, including: Debilitating headaches that are only controlled by use of a spinal cord stimulator, vertigo, loss of balance, dizziness, nausea, cervical nerve damage, tinnitus, vision disturbance, short-term memory loss, and a non-epileptic seizure disorder. Claimant argues that Defendants unreasonably terminated his workers' compensation benefits while he remained in a period of recovery, denying him access to care for conditions that were the direct result of the work injury. Further, Defendants failed to pay PPI benefits to which Claimant was entitled. As a result of the work injury and all

of its natural sequelae, Claimant sustained disability in excess of his impairment and is totally and permanently disabled as an odd-lot worker.

Defendants contend that Claimant sustained a mild concussion as a result of his accident and that Defendants provided all of the care deemed reasonably necessary by his treating physicians until two independent medical evaluations determined that Claimant was medically stable from the effects of the accident. The conditions about which Claimant continues to complain are not causally related to the industrial accident, and are psychological in origin. Claimant was released to return to his time-of-injury position without restrictions, and sustained no permanent impairment as a result of his work injury. Defendants assert that Claimant pursued and obtained substantial additional medical care through his private insurance that was unnecessary, unreasonable, and perhaps even detrimental.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant, Debbie Ferrin, and Frank Dominick, taken at hearing;

2. Claimant's exhibits 1 (A through T), 2 (A through Y), and 3 through 24, admitted at hearing;

3. Defendants' exhibits 1 through 4, admitted at hearing, and 5 through 12, submitted post-hearing by agreement of the parties;

4. The post-hearing depositions of Robert H. Friedman, M.D., taken April 7, 2010; Douglas N. Crum, CDMS, taken April 7, 2010; Kathy G. Gammon, M.S., CRC, MPT, taken April 6, 2010; Kenneth Brait, M.D., taken March 22, 2010; and David C. Simon, M.D., taken April 6, 2010.

In the course of deposing the five experts, counsel for the parties interposed numerous

(more than one-hundred) evidentiary objections. In some instances, the verbal exchanges did not comport with the high level of professionalism that this Referee and the Commission have come to expect (*e.g.,* see Deposition of Dr. Brait, p. 67, line 23 through p. 68, line 25). Most of the evidentiary objections are not deserving of comment and are overruled. Objections with some merit are addressed with specificity below:

DEPOSITION OF DR. BRAIT

Page 44, ls. 13 through 20—Rule 10(E)(4) limits post-hearing deposition testimony to evidence *available to or known by the party at the time of the hearing*. Experts are entitled to rely on evidence admitted at the hearing, but not on evidence discovered, manufactured, or developed *after the hearing*. Dr. Brait's testimony relies upon evidence introduced at hearing. Objection overruled.

DEPOSITION OF KATHY GAMMON

Page 50, ls. 8 through 11—Ms. Gammon developed her testimony regarding Claimant's percentage of loss of access to the labor market from information she obtained after the hearing. Objections sustained.

DEPOSITION OF DR. SIMON

Page 33, ls. 10 through 17—Dr. Simon is offering testimony on evidence admitted at the hearing as to events that occurred after his involvement with Claimant. Objection overruled.

Page 36, ls. 11 through 13, and 22 through 23—The documents that Defendants are attempting to introduce through Dr. Simon were not part of the evidence admitted at hearing and clearly were discovered or developed after the hearing. Objections sustained, and Deposition exhibit 3 is excluded from the record.

Page 76, ls. 15 through 25; page 77, ls. 23 through 25; and p. 78, ls.10 through 20—The

documents that Claimant is attempting to introduce through Dr. Simon were not part of the evidence admitted at hearing, even though it was known and available to Claimant at that time. Objection sustained, and Deposition exhibit 5 is excluded from the record.

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

FINDINGS OF FACT

BACKGROUND

1. Claimant was fifty-five years of age at the time of the hearing. He resided in Idaho Falls with his wife, Debbie. Claimant and his wife are the parents of two adult daughters.

2. Claimant was born and spent most of his youth in Jackson Hole, Wyoming. His father died when Claimant was a teenager, his mother remarried, and the family moved to California, where Claimant graduated from high school in 1974.

3. After graduating from high school, Claimant briefly attended Ricks College in Rexburg, Idaho. He studied criminal justice, earned poor grades, and left college after two semesters.

WORK HISTORY

4. Claimant married Debbie in the summer of 1975 and they settled in the upper Snake River valley. Claimant worked briefly for Sears Roebuck in the Rexburg catalog store, then for a year as a salesman at Smith Chevrolet. In 1977, Claimant went to work for Bonneville County as a jailer.

5. From 1979 through 1985, Claimant and his family lived in Sandy, Utah, and Claimant worked as an HVAC installer and fabricator.

6. In 1985, Claimant went to work for Westinghouse as a security police officer II

(SPO II). At the time, Westinghouse was the general contractor for operations at the nuclear research and test facilities ("the Site") located in the desert west of Idaho Falls.[1] Bechtel Bettis, is a successor-in-interest to Westinghouse. Typically, long-time employees at the Site have performed the same work during their years of employment, but worked for many different employers.

7. Claimant's duties as an SPO II included, among other responsibilities, patrolling the secured facilities and escorting visitors. As an SPO, Claimant had the authority to make warrantless arrests pursuant to federal statutes governing nuclear facilities and was required to carry a sidearm, an M-16 rifle, and ammunition for both weapons. He received a promotion to SPO III when he took on additional duties as armor quartermaster. As armor quartermaster, Claimant maintained the inventory of weapons and uniforms and was responsible for proper care and maintenance of the arms.

8. At the time of his injury, Claimant earned $7,114.40 per month plus benefits, including life and health insurance, and a 401K with a fifty-percent Employer contribution. He worked the day shift from 7:30 a.m. until 4:20 p.m., and his primary workstation was at the Naval Reactor Facility (NRF) where the armory was located.

9. Throughout the proceedings, Claimant made it abundantly clear that he loved his job, considered his employer to be the best in the world, and thought of his co-workers as family. He particularly liked being the armor quartermaster, as he enjoyed working with firearms.

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

10. Claimant also operated a private business clearing snow in the winter. His customers included businesses and individuals who needed parking lots, sidewalks, and driveways cleared of snow. Claimant conducted his snow removal business on his own time (usually before catching the bus), and earned between $3,000 and $6,000 annually for the seasonal business.

PRIOR MEDICAL HISTORY

11. Claimant's pre-accident medical history includes: Appendectomy, right knee surgery (torn meniscus), gallbladder surgery, upper GI bleed, fractured pelvis, motor vehicle accident (MVA) with concussion, and two lumbar discectomies. Claimant recovered fully from each of his injuries and illnesses without any residual effects, and he had no work restrictions as a result of any of his prior medical conditions. Claimant was required to pass a rigorous physical fitness test annually to maintain his employment. There is no evidence in the record that Claimant had any prior medical conditions that affected or impeded his recovery from the industrial accident that is the subject of this proceeding.

THE INDUSTRIAL ACCIDENT

12. On January 27, 2006, Claimant took four hours of vacation leave in the morning in order to conduct his snow removal business. He arrived at the Site and clocked in for work around noon. Before driving to his regular station at NRF, he asked the duty sergeant if he needed any assistance. The sergeant asked Claimant to escort a visitor without security clearance, and to perform a security check at the expended core facility (ECF) before heading to the armory.

13. Claimant was in the process of completing the security check at the ECF when he slipped on a patch of ice. His feet went up, he uttered an expletive, and that is the last thing

Claimant remembers until he awoke in the hospital later that same day. Records indicate that a bystander heard a "thud," investigated, and found Claimant unconscious and unresponsive for fifteen to twenty seconds. An incident report prepared by Gary Godfrey, a nurse at NRF, states that the NRF medical department received a phone call at approximately 2:30 p.m. on January 27, 2006 reporting a security guard was down and bleeding at the east end of ECF. When Godfrey arrived, Claimant was lying on his right side on a sheet of ice and snow. Claimant was awake, alert, and oriented. A co-worker was applying pressure to stop the bleeding from a laceration on the back of his head. Following a general assessment of Claimant's condition, Claimant rolled himself over onto his back, whereupon he became nauseated with dry heaves. Medical personnel rolled Claimant back to his right side, at which point he became unresponsive and for a time thereafter only responded to pain stimulus.

14. The ambulance arrived at ECF at approximately 3:00 p.m., and transported Claimant to the NRF parking lot to await Life Flight. Nurse Godfrey described Claimant's condition:

> Patient continued to drift in and out of consciousness (mostly out), and only conciseness [sic] when stimulated with mild to moderate pain. When awakened he was confused.

Defendants' Ex. 3.

15. The Life Flight helicopter arrived at approximately 3:30. Nurse Godfrey noted that the "patient was having more moments of alertness, but continued to need tactile stimuli for arousal." *Id.*

16. Life Flight departed NRF at 3:43 p.m. and arrived at Eastern Idaho Regional Medical Center (EIRMC) at 4:03 p.m. Life Flight personnel administered morphine and an anti-nausea drug. Records indicate Claimant was responsive during transport.

MEDICAL CARE

Eastern Idaho Regional Medical Center

17. At EIRMC, emergency personnel assessed and treated Claimant. His initial score on the Glasgow coma scale was 11/15 (*See,* Defendants' Ex. 7, p. 3), improving to 13/15 (*Id.* at p. 7), and finally to 15/15 (*Id.*, at p. 6). CT scans of the head/brain and C-spine were all negative for acute injury as were chest and pelvic x-rays.

18. Claimant's wife arrived at EIRMC sometime around 4:30 or 5:00 p.m. She described her interaction with her husband:

> When I first saw him he was conscious and would hold my hand, and then he would just let go of my hand and he would go limp and then he would close his eyes (indicating). And then he would come – like he was going in and out of consciousness, because then he would hold my hand again tight and talk to me, and then he would just let go and slump again (indicating). And he did that most of the time we were there at ER.

Tr., pp. 168-169.

19. Emergency department personnel diagnosed Claimant with a concussion and a scalp laceration. Hospital staff monitored Claimant's mental condition, sutured his scalp laceration, and released him to his wife's care about 9:00 p.m. According to the discharge notes, Claimant's condition was "improved" at the time of discharge and he was ambulatory.

Follow-up Care—January through May 2006

20. Claimant's wife reported that once she got Claimant home, he experienced extreme pain, nausea, and vomiting. She reported that the slightest movement caused nausea and vomiting. The nausea was so bad that he could not sit up in bed.

21. On January 30, 2006, Claimant had his first follow-up appointment with Tony Roisum, M.D., his primary care physician. Claimant's presenting complaints included dizziness, nausea, vomiting, and headaches. Dr. Roisum diagnosed closed head injury, concussion, post-

concussion syndrome, dehydration, and headaches. He ordered skull x-rays and a brain MRI. Dr. Roisum expected Claimant to be feeling much better within a couple of weeks when all of the test results would be available. In the meantime, Dr. Roisum prescribed an anti-nausea medication.

22. Claimant saw Dr. Roisum on February 1, February 10, February 13, and February 24. Claimant continued to have the same complaints, and Dr. Roisum continued to offer the same diagnoses. Claimant's wife called Dr. Roisum on February 3, extremely concerned about Claimant's unremitting symptoms, and wondering how long they might continue. On February 13, Claimant presented with complaints of blurry vision and a blind spot in his right eye. Dr. Roisum noted that Claimant "is still having problems with this head injury thing," (Claimant's Ex. K, p. 148) and referred Claimant to Steven Marano, M.D., a neurosurgeon. On February 14, Karen Phillips, M.D., Employer's physician at the Site, contacted Dr. Roisum, inquiring why he referred Claimant to a neurosurgeon, and not a neurologist or an ENT.

23. As result of Dr. Phillip's intervention, Claimant began seeing William Domarad, D.O., a neurologist. Dr. Domarad diagnosed post-concussive syndrome, vertigo, and headache. He recommended vestibular rehabilitation at Regional Hearing and Balance Center. He prescribed some medications to help with the nausea, vertigo, and headaches.

24. Claimant began treating with Bryant Belnap, MPT, at Regional Hearing and Balance Center on February 21, 2006. On March 10, 2006, after five visits, Mr. Belnap reported that Claimant's balance was "profoundly improved." Claimant's Ex. P, p. 0421. Claimant continued therapy with Mr. Belnap through June 5, 2006. Although his balance and vertigo symptoms improved, they did not resolve and Claimant continued to complain of severe headaches and nausea.

25. Claimant desperately wanted to return to work despite his headaches and nausea, and on March 6, 2006, Dr. Roisum released Claimant to return to work. Claimant attempted a return to work on light-duty from early March until April 22. Often Claimant was too sick to work by the time he traveled to the Site on the bus. On occasion, he would have to lie down in the medical unit until he felt better. By April 22, it was clear to Claimant that he could not reliably perform his light-duty assignment, let alone his time-of-injury job.

26. On March 28, 2006, Claimant returned to Dr. Domarad for a follow-up visit. During the course of a physical therapy session, Claimant suffered what appeared to Mr. Belnap to be some type of a seizure. Dr. Domarad ordered an EEG, which was negative for epileptic seizure. Claimant continued to treat with Dr. Domarad for headache and nausea through April 27, 2006. Dr. Domarad tried Depakote, Toradol, Indomethacin, and Amitriptyline together and in combinations to relieve Claimant's headache symptoms, but none of the prescriptions provided relief. Claimant was uncomfortable with Dr. Domarad's care—he was not improving, and he objected to taking Depakote (an anti-psychotic) for his headaches. He asked Dr. Phillips if she could suggest a different neurologist for his care. Dr. Phillips referred Claimant to Robert Cach, M.D.

27. In early May, Claimant presented at the EIRMC emergency department with severe headache pain. On May 9, Claimant lost vision in his right eye. The loss of vision persisted overnight. Dr. Roisum sent Claimant to Scott Simpson, M.D., an ophthalmologist. Dr. Simpson described Claimant's exam as "unremarkable," and opined that, as described, Claimant's vision disturbance was consistent with a migraine-like episode.

28. Claimant saw Dr. Cach on May 15, 2006. He ordered a lumbar puncture and diagnosed a post-concussion headache. He opined that no further neurological intervention was

indicated. Dr. Cach's chart note concludes with a statement that Claimant wanted to see Dr. Brait.

29. Claimant saw Dr. Brait at his offices in Ketchum on May 23, 2006. Claimant related the history of his fall and the constellation of symptoms that he had experienced since that time. Claimant reported that the vertigo that began with the fall was substantially resolved as a result of his therapy with Mr. Belnap. However, his most disabling symptom—headaches so severe that they caused nausea and vomiting—persisted, as did the tinnitus that he reported immediately after the accident, balance problems, and some short-term memory loss that became apparent in the weeks after the accident. Dr. Brait identified the headache pain as originating in the right occipital region, radiating forward to a place behind Claimant's right eye. Claimant's neurological findings were entirely normal. A musculoskeletal evaluation identified localized neck spasm and tenderness over the right greater occipital nerve.

30. Dr. Brait recommended a referral to an ENT for a consultation on Claimant's tinnitus, though he was doubtful that much could be done about the problem. By Claimant's own report, the short-term memory loss seemed to be resolving on its own. Because Claimant had already had a normal EEG, Dr. Brait did not believe further neurological testing was a pressing issue. He diagnosed post-traumatic cervical spasm, post-traumatic greater occipital neuralgia on the right, and post-traumatic headache syndrome—probably with a migraine component. Dr. Brait recommended that Claimant continue physical therapy with Mr. Belnap, and injected Claimant's right greater occipital nerve with an anesthetic. The injection provided complete relief within minutes. Given Claimant's immediate response to the injection, Dr. Brait held off on prescribing migraine medications to see if repeated injections (four were

recommended) could permanently resolve the headaches. Dr. Brait suggested that Claimant should have the injections in Idaho Falls, rather than travel to Ketchum.

Follow-Up Care—June through October 2006

31. On June 1 2006, Claimant saw David Donaldson, M.D., for an audiology consult about his tinnitus. Claimant had regular hearing tests as part of his yearly employment-related physical, so Dr. Donaldson had previous tests for comparison. Dr. Donaldson found that Claimant's test results were fairly consistent with his previous tests, except for some additional loss of higher frequencies in the right ear. Repeat testing on July 6, 2006 showed that Claimant had significantly improved hearing in his right ear and had recouped much of the loss identified in June. Dr. Donaldson also suspected that Claimant had overt TMJ disorder, possibly due to chronic bruxism, but likely exacerbated by his fall. He recommended some conservative care (soft diet, heat treatment of joints, and anti-inflammatories), suggesting that the TMJ problem could be exacerbating Claimant's tinnitus. The possibility that Claimant had TMJ problems was never pursued.

32. At Dr. Brait's suggestion, Claimant began seeing Catherine Linderman, M.D., of Idaho Falls for pain management, including the greater occipital nerve injections that Dr. Brait had recommended.[2] Dr. Linderman is well known at the Commission and in the eastern Idaho medical community for her patient advocacy, her dogged efforts to relieve her patients' pain, and her strongly-held and unstintingly shared opinions.

[2] Dr. Linderman and Dr. Brait often worked together on cases—each referred to the other, and when Dr. Brait saw patients in Idaho Falls, he did so at Dr. Linderman's offices.

33. Claimant began a long medical relationship with Dr. Linderman on June 8, 2006.[3] On his first visit, Dr. Linderman described Claimant as "in severe distress," and as "lying on the bed on his right side with his eyes closed and an emesis basin" in front of him. Claimant's Ex. 1M, p. 376. The purpose of Claimant's visit to Dr. Linderman was to receive the fourth occipital nerve injection that Dr. Brait had recommended. Dr. Linderman noted:

> He was in such pain today, I had to do the block before I could have him participate in a physical exam. He was absolutely miserable, but after the block he was sitting up, talking and contributing to the conversation. He also saw an old friend from Jackson, Wyoming when he was leaving the clinic and was very animated and happy. This was a totally different presentation than when he came in today to be seen.

Id. at p. 379. As with each of the injections, Claimant reported almost complete relief from his headache within minutes of the injection. Dr. Linderman's chart note states:

> He has occipital neuralgia which was brought on by the injury to the occipital nerve as it progresses from the cervical spine up to the back of the head and over the top of the head. It is very clearly caused by the injury since he did not have this before the injury. He said that it started the same day as the injury and hasn't resolved until Dr. Brait did the first occipital nerve injection. Incidently, [sic] if the physicians that he saw had made the diagnosis early on, perhaps he would not have this problem now. The faster the diagnosis and treatment, the more likely it can be treated and won't recur.

Id.

34. As with each previous occipital injection, Claimant's relief lasted only as long as the anesthetic was effective. Dr. Linderman then embarked on a quest to cure Claimant's headache and nausea and get him back to work. Beginning with his initial visit in June 2006, Dr. Linderman performed multiple procedures, some multiple times, aimed at providing Claimant long-term relief from his unremitting headache pain. Treatments included:

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[3] Both Dr. Linderman and Claimant were originally from Jackson Hole, and their families were of long-standing acquaintance.

- Radiofrequency (RF) neurolysis of the third occipital nerve;
- RF neurolysis of medial branch nerves at C-2 through C-4 on the right;
- Cervical medial branch nerve blocks at C-4 through C-7;
- Facet injections from C-0 to C-7;
- Atlantoccipital and atlantoaxial facet joint injections;
- Trigger point injections (TPI); and
- RF neurolysis of C-4 through C-7 nerve roots.

In early August 2006, Dr. Linderman wrote to Frank Dominick, the claims adjuster on the case, to document a verbal denial of requested procedures and to state a case for authorizing the requested procedures. In the letter, Dr. Linderman noted the difficulty she had in contacting Mr. Dominick in July 2006. She recapped Claimant's treatment history, and opined that all of the treatments had been successful to some degree, but never for very long. The nerve blocks temporarily relieved Claimant's headache pain, but did nothing for the nausea. Trigger point injections provided temporary relief as well. By the time she wrote to Mr. Dominick, Dr. Linderman had narrowed her search for the source of Claimant's pain and sought authorization for additional procedures:

> I now feel that it is appropriate to do a selective injection over the C2 dorsal root ganglion [C2 DRG] which lies proximal to the occipital nerve. This ganglion is an aggregation of nerve cell bodies that lie within the central nervous system that acts somewhat like a relay station for the nerves. Research has shown that with whiplash injuries such as the one that [Claimant] experienced with the fall, the C2 dorsal root ganglion can be injured simply by a mechanical compression of the ganglion when the neck is hyperextended which causes a compression of the ganglion between the two vertebral bodies.

Id., at p. 199. In addition, Dr. Linderman also wanted to repeat the atlantoccipital and atlantoaxial facet injections to calm inflammation in those joints caused by the accident. Finally, Dr. Linderman referred to Australian studies showing that whiplash injuries cause microscopic changes in the facet joints and C2 DRG which cannot be seen on films, and that the procedures she was suggesting provided both beneficial treatment and diagnostic guidance.

35. Between August and November 2006, Dr. Linderman performed the following procedures:

- C2 DRG block;
- C2 DRG rhizotomy (times three); and
- Trigger point injections (multiple).

Between June 8, 2006 and the end of October 2006, Claimant saw Dr. Linderman on at least a dozen occasions for nerve blocks, TPIs, and RF neurolyses. During this same period, Dr. Linderman prescribed Oxycodone and then methadone to cover Claimant's pain when, inevitably, the effect of each treatment wore off. In late September, Dr. Linderman mused about the possibility of a spinal cord stimulator, noting that she should look into that option.

Follow-Up Care—November 2006 through January 2007

36. In early November 2006, Dr. Friedman performed a review of Claimant's medical records at the request of Surety. Dr. Friedman had relevant medical records, including Dr. Linderman's records through September 28, 2006. Dr. Friedman made three points in his letter/report to Surety:

- Dr. Linderman got the same results with her first occipital block as she got with all of her subsequent interventions. Dr. Friedman concluded: "Based on this there is no medical evidence to support that procedures done after the 6/08/06 occipital nerve block were medically indicated, or provided greater functional gain." Defendants' Ex. 5, p. 1.

- Dr. Linderman reports a four-hour loss of consciousness in her records (as related by Claimant), whereas the record makes it clear that there was a fifteen-to twenty-second loss of consciousness associated with the fall.[4] Claimant received morphine, which could account for memory loss, but such memory loss would be the result of the narcotics, not the traumatic brain injury.

[4] Dr. Friedman is correct, but both he and Dr. Linderman may have misinterpreted Claimant's statement. The medical records indicate that he slipped in and out of consciousness while awaiting transport, while being transported, and while being cared for at EIRMC—a period of about four hours.

- Dr. Friedman thought Claimant needed evaluation and treatment through a multidisciplinary chronic pain management program, such as the one offered at St. Luke's Idaho Elks Rehabilitation Hospital, where Dr. Friedman serves as the medical director.

37. Sometime in the summer or fall of 2006, Claimant applied for social security disability benefits. On November 15, 2006, Brent F. Baldree, Ph.D., performed a psychological evaluation of Claimant for purposes of determining his eligibility for SSD benefits. Dr. Baldree did not provide a summary of his findings, but noted the following:

- Claimant had major depressive disorder and pain disorder associated with psychological factors and a general medical condition;
- Claimant's performance on several tests suggests intellectual functioning ranging from average to extremely low average when compared to his peers;
- Claimant was a credible and reliable historical informant, though he tended to dissemble and had to be brought back on track;
- Claimant exhibited signs of impaired executive function and short-term memory loss;
- Claimant's testing was hampered by pain, but Dr. Baldree believed Claimant provided good effort; and
- Claimant's GAF (global assessment of functioning) score was 45, down from a high of 95 within the preceding year.

Ultimately, Claimant's application for SSD benefits was approved.

38. In mid to late November 2006, Dr. Linderman detected significant muscle spasms in Claimant's neck, and wondered if the muscle spasms were contributing to his headaches. She began a series of Botox injections aimed at relieving the spasms. By mid-December, there was little indication that the Botox was helping. Claimant wanted to stop taking methadone, and complained of instances of blanking out. Claimant's wife reported that he had been irritable of late. Dr. Linderman and Claimant also discussed Mr. Dominick's suggestion that Claimant

participate in the outpatient program at St. Luke's Idaho Elks Rehabilitation Hospital. Claimant was amenable to Mr. Dominick's suggestion, but did not receive a referral to the program.

39. Based on the questionable efficacy of the Botox injections, Dr. Linderman scheduled Claimant for a fourth C2 DRG, along with another series of Botox while sedated so that the Botox could be placed with the help of the fluoroscope. She provided Claimant a plan to stop the methadone, prescribed Lexapro for his mood and anxiety, and sent him back to Dr. Brait for evaluation of his continuing vertigo and equilibrium problems, and to address the blanking-out episodes. In her chart note, Dr. Linderman noted some research that suggested that electrical stimulation of the spinal cord may help control the chronic pain caused by the whiplash injury to Claimant's C2 DRG. However, placement of a lead so high in the cervical spine was an unusual application for a cord stimulator and there was little literature about such use. Surgical resection of the DRG was also explored, but was not favored due to the severity of surgical complications. Dr. Linderman concluded the chart note with the thought that she would consider a nerve stimulator trial.

40. Dr. Linderman performed the C2 DRG and fluoroscopically guided Botox injections on November 18, and additional Botox injections on November 20, 2006. When Claimant returned to Dr. Linderman on January 9, 2007, his presenting complaints were constant headache originating in the neck and traveling up to his head on the right side behind his right eye varying from 7/10 to 10/10. These are the same symptoms that Claimant had been experiencing since the accident nearly a year previous. Claimant could not sort out the effects of the Botox injections from the C2 DRG procedures to identify which procedure was most helpful.

41. On the January 9, 2007 visit, Claimant also told Dr. Linderman that he wanted to hire an attorney to help with his workers' compensation claim and asked her for

recommendations. This note seems oddly timed, since Dr. Linderman had documented in her chart on December 14, 2006 that Claimant had legal representation and all bills should go to his legal counsel. Dr. Linderman advised that she had been researching C2 DRG injury and treatment, but there was scant information on the topic. She also restarted the TPIs, pretty much giving Claimant injections whenever he asked for them. At least fifteen TPI procedures (each involving multiple injections) are documented from January 9 through June 13, 2007.

Follow-Up Care—January 2007 through April 2007

42. Claimant saw Dr. Brait on January 10, 2007. Dr. Brait's record of the visit (a letter dated January 10, 2007) is barely understandable. It is not clear for whom the letter is intended, but the Referee is reasonably certain it was meant for Dr. Cach. The Claimant's name is wrong, and the letter is garbled. In the letter, Dr. Brait lauded Dr. Linderman's success in pinpointing the source of Claimant's pain. Dr. Brait thought that some neurological testing to pinpoint the nature and extent of Claimant's short-term memory loss was necessary, but that Claimant's pain needed to be under control before any meaningful testing could be done. Claimant was, at that time, too ill for testing. Dr. Brait expressed concern about Claimant's headaches:

> The headaches that he is having appear to be cervicogenic. If we can relieve the pain in his neck we are going to relieve his headaches. If not, there is no medication that is going to [make] any significant difference.

Claimant's Ex. 1B, p. 70. Dr. Brait went on to describe Claimant's on-going vestibular problems (disequilibrium, tinnitus, vertigo) as a "labyrinthian injury." Dr. Brait explained the term in his post-hearing deposition:

> The labyrinth, for our purposes, is kind of synonymous with the vestibular system. It's where the vestibular system lies. There are anatomical substrates in the labyrinth that are involved in the vestibular system. So let's think of it all as the vestibular balance system.

Dr. Brait Depo, p. 17. In his letter to Dr. Cach, Dr. Brait advised that he had discussed the traumatic labyrinthian injury with Claimant and his wife. No treatment was available, and if the problems had not resolved within the year, they likely would be permanent. Dr. Brait concluded by stating that he would continue to see Claimant on a PRN basis, as he was not providing much in the way of on-going care.

43. In mid-January, Claimant reported to Dr. Linderman that he was having more seizure-like incidents—some where he just blanked out for a brief period, and some that involved muscle rigidity and shaking throughout his body. Claimant stated that the events were more frequent and more severe. Claimant saw Dr. Brait in mid-February for an EEG. Dr. Brait described the EEG as abnormal, but with no evidence of epileptiform seizures.

44. On February 14, 2007, David C. Simon, M.D., a physiatrist, conducted an independent medical evaluation (IME) of Claimant at Surety's request. Dr. Simon took a history, reviewed medical records, and performed a brief exam. He concluded that Claimant undoubtedly sustained a concussion and had post-concussive syndrome as a result of his work accident. Dr. Simon opined that these conditions usually improve or resolve over time. Because Claimant was still symptomatic more than a year later, Dr. Simon suspected some psychological overlay or secondary gain issues related to Claimant's injury. He recommended full neuropsychological testing to evaluate these issues as well as to evaluate potential neuro-cognitive deficits related to the head injury.

45. Dr. Simon also opined that Claimant's headaches originated at the greater occipital nerve, were likely caused by the fall, and would resolve over time. As with the post-concussive symptoms, Dr. Simon believed that Claimant's on-going headache complaints were

the result of psychological overlay or secondary gain considerations. He was dismissive of Dr. Linderman's treatments:

> Since it has been confirmed via Dr. Brait's injection that this was the source of his headache, it has not been medically necessary to do the multitude of injections that Dr. Linderman has performed.

Claimant's Ex. 1E, p. 100. Dr. Simon concluded that there was a reasonable degree of medical probability that Claimant's initial complaints related to the reported injury. Neurocognitive testing was necessary to determine a causal relationship between the injury and Claimant's "ongoing subjective problems." *Id.* Because more testing was needed, Claimant was not medically stable, and was not ready for an impairment rating.

46. As a result of Dr. Simon's report, Dr. Linderman sent Claimant to Mark D. Corgiat, Ph.D., psychologist, for a neuropsychological assessment. Dr. Corgiat first saw Claimant on March 12, 2007 and scheduled the evaluation for March 20, 2007. Dr. Corgiat requested Dr. Linderman administer trigger point injections the morning of the testing so that Claimant's testing would not be sabotaged by pain.

47. Dr. Corgiat reported his findings via letter to Dr. Linderman dated March 23, 2007. He noted that Claimant did have some difficulties with the testing—particularly in the afternoon. Dr. Corgiat also noticed a fine motor tremor that worsened over the day. He described Claimant's concentration as poor to adequate. Dr. Corgiat reported the following relevant findings:

- Claimant scored below normal limits on most of the testing, which Dr. Corgiat described as "less functional than one would expect given his history." Claimant's Ex. 1C, p. 079;
- Claimant exhibited considerable variability in his test scores. His variability does not appear volitional, and Claimant seems to have given his best effort throughout the course of testing.

- Claimant's chronic pain is reflected in a reduction of overall cognitive efficiency, and those effects are exacerbated by his narcotic pain medication; however, testing would have been impossible without the medications;

- Claimant does not exhibit substantial traumatic brain injury (TBI) in that his scores did not show greater disability in those parts of the brain that are particularly susceptible to injuries of the type Claimant suffered. Nevertheless, Dr. Corgiat opined:

> . . . it is my opinion that [Claimant] did suffer a Traumatic Brain Injury given the duration of loss of consciousness. It is likely that he is making a spontaneous recovery of the Traumatic Brain Injury that allows him to function at a level that is commensurate with the overall suppression effect of the other factors in this assessment. I suspect that when the medications are no longer on board and the pain is more adequately managed, that some mild focal difficulties related to complex attention and executive function abilities will likely be more apparent. *Id.* at p. 80.

- Claimant's personality assessment inventory indicates Claimant's life is dominated by his pain; he scores high in somatization and in the physiological symptoms of depression; Claimant likes to be in control of his life but feels out of control in most aspects of his life; and

- Dr. Corgiat recommended biofeedback and cognitive-behavioral treatment in conjunction with his pain management and follow up with repeat neuropsychological testing in a year.

48. Claimant continued treating with Dr. Linderman for pain through the end of March. He continued to experience several types of seizures, and in late March, Dr. Brait ordered a seventy-two hour ambulatory EEG. The EEG captured fourteen "spells" that were clearly syncope. Claimant did not experience either blanking out or epilepsy-like seizures while he was monitored.

49. In mid-April 2007, Defendants sent Claimant to Robert F. Calhoun, Ph.D., for another neuropsychological evaluation. Dr. Calhoun reviewed Claimant's medical and social history and administered several tests, including the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), the Millon Clinical Multiaxial Inventory-III (MCMI-III), the State-Trait Anger Expression Inventory-2 (STAXI-2) and a Validity Indicator Profile (VIP).

50. Claimant's testing profile was valid, suggesting Claimant had been compliant with the testing protocol. Dr. Calhoun interpreted Claimant's MMPI-2 results to indicate that he was defensive in his approach to the test, a trait that can increase the risk for somatizing stress. Dr. Calhoun found no indication that Claimant was clinically depressed, but opined that if he was depressed, he would likely manifest the symptoms physically. Dr. Calhoun did not note significant anxiety, and opined that Claimant was not a person who acknowledges vulnerability, but uses repression and denial to deal with emotional distress.

51. MCMI-III testing suggests Claimant tried to present himself as psychologically stalwart and infallible. Dr. Calhoun explained that individuals with such a profile are likely to lack insight into their own psychological functioning, which can lead to overestimation of abilities and sensitivity to criticism. There was no suggestion of significant psychopathology or personality disturbance. Claimant's results on the STAXI-2 testing did not suggest difficulty with acute or chronic anger.

52. Based on the testing and his interview with Claimant, Dr. Calhoun offered his opinions:

- Significant psychological and behavior factors affect his pain and level of physical disability, particularly his frustration and anger, which is acute, and not chronic; he is more angry than depressed; Claimant has some insight into the way emotional distress exacerbates his pain, but lacks the resources to deal with either form of distress;

- Behaviorally, he is physically tense, demonstrating postural bracing and bruxing behavior when stressed;

- Claimant "has moved into a state of learned helplessness. He views himself as being disabled. . . . He also views the barriers associated with his return to work as insurmountable." Claimant's Ex. 1F, p. 111;

- Claimant has mild inefficiency in verbal short-term memory. Pain and opioid medications affect his neurocognitive efficiency; it is not likely he is still suffering from the neurocognitive sequelae of his mild brain trauma.

53. Dr. Calhoun concluded that Claimant would not benefit functionally from participation in a pain clinic, biofeedback training, or further invasive medical procedures. He thought that Claimant's headaches were rebound headaches secondary to his use of opioid analgesics and Claimant should be weaned off the narcotics. Finally, he found Claimant to be at maximum medical improvement (MMI) psychologically and without restrictions from a neuropsychological perspective.

54. Dr. Simon had an opportunity to review Dr. Calhoun's report and subsequently prepared an addendum to his own report. Dr. Simon concluded:

> Based upon the available information, to a reasonable degree of medical probability, there was causal relationship between the examinee's initial complaints and the injury reported. However, his current subjective problems are more due to his psychological issues and are not directly related to the slip and fall on 1/27/06.

Defendants' Ex. 4. Dr. Simon went on to find Claimant at MMI with no permanent impairment and no work restrictions either from physical or neuropsychological factors. The only additional medical care Claimant required was weaning off his narcotic analgesics.

Follow-Up Care—May 2007 through April 2008

55. On May 3, 2007, Claimant began a peripheral nerve stimulator (PNS) trial to see if the PNS relieved his headache pain. Dr. Linderman used a fluoroscope to place a percutaneous neurostimulator lead near the C-0 and C-1 joint space. Dr. Linderman wanted Claimant to try the PNS for two weeks. During that time, she wanted to be sure that he saw Drs. Brait and Corgiat to get their opinions as to whether the PNS trial was successful. Claimant returned to Dr. Linderman on May 8 to have the dressing that covered the PNS lead changed. He reported "excellent and significant relief" since the beginning of the trial. Claimant's Ex. 1M, p. 265. Claimant reported that his pain was 0/10 at the time of the return visit. He told

Dr. Linderman that he accidently turned the stimulator off and his pain began to return. When he saw that the stimulator was off, he turned it back on and had complete relief within ten to fifteen minutes. Claimant and Dr. Linderman were both pleased with the initial days of the PNS trial.

56. Claimant saw Dr. Corgiat on May 16, 2007. He reported that he was pain-free with the PNS. He continued to experience tremors and seizures. His dizziness was improved, and he had cut his dose of methadone in half and was off oxycodone completely. Dr. Corgiat noted:

> [Claimant's] presentation is markedly different than that observed in March of this year when I completed the evaluation. He is very active and socially interactive. He is affectively appropriate throughout the course of the examination. He is quite energetic. He is more articulate and more animated by far than he was during the initial evaluation.

Claimant's Ex. 1C, p. 078.

57. Dr. Linderman removed the percutaneous PNS lead on May 15, 2007. Dr. Linderman described Claimant's presentation before she removed the lead:

> [Claimant] is smiling more, talking more, joking and becoming part of the conversation today. His gait has improved, he is walking taller. His O2 saturation has increased from 88% to 96-97% and his blood pressure has decreased. He not only has had improvement in his pain, but his overall health has improved since the placement of the peripheral stimulator lead.

Claimant's Ex. 1M, p. 263. In a referral letter she sent to Dr. Marano, Dr. Linderman described what happened when she removed the trial PNS lead:

> . . . when I pulled the lead, within two minutes [Claimant] turned an ashen gray which is reminiscent of the past when he was having all the pain. His right eye became injected, his nose started to run in the right nostril and his headache came back. It was an amazing transition to see him go through this transformation.

Id., p. 184

58. By June 6, 2007, Claimant was asking for more TPIs to relieve his pain. When he presented at Dr. Linderman's office, she described him as "ashen gray and obviously not feeling

well," with his right eye injected, watering, and droopy. On the same date, Dr. Linderman sent the letter to Dr. Marano seeking a consultation for placement of a permanent spinal cord stimulator (SCS) for Claimant. Claimant saw Dr. Marano for an initial consultation on June 28, 2007.

59. Claimant saw Dr. Brait in early July with respect to his seizures. He reported to Dr. Brait that his vertigo was better, and Dr. Brait observed that Claimant was walking better and that his aggression since the accident seemed to improve with appropriate dosages of Lexapro. Claimant continued to complain of tinnitus. Dr. Brait discussed the shortcomings of the seventy-two hour ambulatory EEG, and decided that rather than put Claimant through another expensive EEG, he would treat him with anti-epileptic drugs to see if any improvement resulted. If Claimant did not improve with the drugs, then Dr. Brait anticipated ordering additional studies.

60. On August 23, 2007, Dr. Marano implanted an SCS above Claimant's right hip, and a cervical lead in the area of the right cranial C1 junction. Claimant returned to Dr. Marano for follow-up on September 4, 2007. He was doing well with the stimulator and it had relieved his headache. Dr. Marano released Claimant with instructions to return if he had any problems. In early September, Claimant's cervical lead had worked its way through Claimant's skin and had to be revised. Dr. Marano re-implanted the leads in early October. Claimant remained free of headache pain so long as the SCS was working, but his symptoms would return immediately whenever the stimulator was not in place or not working.

61. Claimant saw Dr. Brait in mid-September, reporting a dramatic decrease in his staring spells, but reported he continued to experience the nocturnal seizure-like events and the events that Dr. Brait described as syncope. Claimant returned in October 2007, reporting on-going seizure activity despite increasing dosages of Lamictal. Dr. Brait ordered a second

seventy-two hour ambulatory EEG. Dr. Brait noted in an addendum that Claimant reported short-term memory problems. He also documented that while Claimant's right eye symptoms (red, watery, and droopy) were significantly improved since the SCS had eliminated his headaches, he still experienced some watering in that eye. Dr. Brait suspected some autonomic dysfunction related to Claimant's traumatic work injury. Claimant's second ambulatory EEG did not capture any clinical events, though both Claimant and his wife reported that Claimant continued to have the nocturnal events and the staring spells. Dr. Brait had mixed feelings as to how to proceed—he did not want to continue Claimant on medication if the seizures were not neurological, but a four- to five-day study at an epilepsy facility was very expensive. Ultimately, he decided to increase Claimant's Lamictal dosage to see what happened. Claimant's staring spells abruptly stopped with the increased dosage of Lamictal.

62. In November 2007, Dr. Marano began to suspect that Claimant might have an infection related to the SCS. In December 2007, Claimant's cervical lead failed again. Dr. Marano re-implanted the lead in January 2008. In March 2008, Dr. Marano removed Claimant's SCS because of an infection.

63. During the times that Claimant was without the stimulator, the frequency of his seizures increased. Dr. Brait was unable to make any progress on the diagnoses and treatment because of Claimant's pain. Dr. Brait did address the issue of Claimant's right eye, which became red, inflamed, and droopy while he was without the stimulator. Dr. Brait discussed the issue with Dr. Linderman and confirmed that both had observed that Claimant's right eye problems resolved within minutes of the occipital blocks and when he was using the stimulator. Dr. Brait opined that Claimant's right eye problem was a pathological sympathetic response related to his work injury.

Follow-Up Care—May 2008 through March 2009

64. In May 2008, Dr. Brait referred Claimant to Robert Wechsler, M.D., for admission to the inpatient epilepsy-monitoring unit at St. Luke's Regional Medical Center (SLRMC). For whatever reason, this did not happen, and Dr. Brait continued to monitor Claimant's seizure disorder.

65. In May 2008, Dr. Marano re-implanted Claimant's stimulator. Later that same month, the lead failed and had to be surgically re-implanted. Claimant continued to experience complete or nearly complete relief of his debilitating headaches so long as the SCS was in place and functioning properly.

66. In March 2009, Claimant returned to Dr. Brait regarding his seizure disorder. Dr. Brait had ordered a third seventy-two hour ambulatory EEG at the end of January 2009, which captured seventeen episodes, none of them epileptiform. Claimant continued to complain of memory deficits and dizziness from his vestibular injury. Dr. Brait was convinced that he had not yet gotten to the bottom of Claimant's cognitive problems or the etiology of his seizures. Dr. Brait again suggested that the only way to fully evaluate the seizure disorder was to admit him to an epilepsy-monitoring unit such as the one run by Dr. Wechsler at SLRMC in Boise. Finally, he recommended another comprehensive neuropsychological evaluation to evaluate whether Claimant's short-term memory loss was organic or psychological.

Follow-Up Care—April 2009 through September 2009

67. On April 28, 2009, Claimant presented at the offices of Dr. Friedman for a defense-ordered IME. Prior to the appointment, Dr. Friedman's office provided Claimant with a new patient questionnaire, Beck's questionnaire, an Oswestry Functional Test, and a family demographics form, and asked Claimant to bring the completed forms to the IME. Claimant

declined to fill out the forms. Dr. Friedman took a patient history, and again presented the forms to Claimant. When Dr. Friedman left the room, he believes that Claimant called his attorney. When Dr. Friedman returned to the exam room, Claimant agreed to complete the Oswestry Functional Test and the Beck's questionnaire. Dr. Friedman filled out the new patient information form as he took Claimant's history. Claimant did not fill out the demographic form. Claimant audiotaped the history and examination portion of the IME. Dr. Friedman was clearly irritated by Claimant's behavior.

68. Dr. Friedman opined that Claimant was at MMI. Dr. Friedman also opined that the following diagnoses were a direct result of the slip-and-fall injury:

- Post-concussive syndrome (resolved);
- Occipital neuralgia (resolved by SCS); and
- Possible post-traumatic vertigo (currently asymptomatic).

Dr. Friedman was aware that Claimant would be seeing Dr. Wechsler regarding his seizure disorder, and deferred to Dr. Wechsler on that diagnosis. Dr. Friedman was also aware that Claimant would be evaluated by Dr. Beaver and looked forward to seeing Dr. Beaver's final neuropsychological evaluation.

69. Dr. Friedman found: Claimant sustained no permanent partial impairment as a result of his industrial injuries, noting that his headaches resolved; Dr. Calhoun found no significant cognitive issues; and no firm diagnosis had yet been made regarding Claimant's seizure disorder. He concluded that Claimant could return to work, but should avoid uneven surfaces and do no climbing. Until the issue of Claimant's seizures was clarified, he should not drive. Finally, Dr. Friedman imposed a medium work level (fifty pounds occasionally and twenty-five pounds repetitively) related *only* to his previous lumbar surgeries.

70. On April 28 and 29, 2009, Dr. Beaver conducted a neuropsychological examination of Claimant. Dr. Beaver administered a battery of eighteen neuropsychometric tests, reviewed Claimant's medical records, performed a clinical interview, and observed Claimant's behavior. Dr. Beaver's report, dated May 8, 2009, notes that Claimant put forth reasonable but inconsistent effort during the testing. Dr. Beaver saw no evidence of malingering, but noted Claimant became fatigued and had difficulty maintaining his attention at times. Dr. Beaver concluded that Claimant did have mild cognitive difficulty, which he attributed to three factors: Claimant's work-related post-concussive syndrome, a pre-injury history of dyslexia, and emotional/psychological factors related to his medical condition. Claimant showed some histrionic traits, but no personality disorder, and had no history of pre-existing mental or psychological problems.

71. Dr. Beaver offered the following opinions regarding Claimant's future care and treatment:

- The spinal cord stimulator worked well to eliminate Claimant's head pain, and the necessity of the SCS was work-related;
- The etiology of Claimant's seizure disorder remained an issue until Dr. Wechsler could make a definitive determination regarding the origin of the seizures;
- Dr. Beaver believed that Claimant would benefit from a two- or three-week stay in an outpatient traumatic brain injury treatment program that would address neurocognitive issues, vestibular issues, and help with strength and conditioning issues; Dr. Beaver was under the impression that Claimant had declined participation in just such a program in the past, and noted that if Claimant's attitude was unchanged, there was no reason to require his participation in such a program;[5] and
- Dr. Beaver deferred to Dr. Freidman regarding further treatment of Claimant's vestibular complaints, which Claimant still identified as problematic.

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[5] Industrial Commission Rehabilitation Division (ICRD) notes suggest that Claimant had been more than willing to participate in the neurorehabilitation program. It was Dr. Linderman who was opposed.

72. Dr. Beaver used the *AMA Guides to the Evaluation of Permanent Impairment,* 6th ed. (*AMA* 6th) to calculate Claimant's PPI. Dr. Beaver gave no rating for Claimant's headache since it was resolved with the SCS. Dr. Beaver relied on Section 13.3d to determine that Claimant had a Class I neurocognitive impairment, and awarded 4% whole person PPI. Dr. Beaver found no basis for awarding a PPI rating under Chapter 14 for mental health and behavioral issues. Finally, depending upon the outcome of testing by Dr. Wechsler, Claimant may have an impairment related to his seizure disorder.

73. Dr. Beaver recommended permanent restrictions including no work at unprotected heights, and no work around fast-moving machinery. Additional restrictions may be appropriate depending upon the outcome of Dr. Wechsler's testing.

74. Claimant participated in a multiple-day video-monitored seizure study under the direction of Dr. Wechsler in May 2009. The study confirmed that none of Claimant's seizures were epileptic.

75. Dr. Friedman reviewed the results of Dr. Wechsler's testing and by letter dated July 7, 2009, agreed with Dr. Wechsler that Claimant suffered from recurrent "transient episodes of neurocognitive dysfunction" which were not epileptic, and had previously been labeled as "pseudoseizures." Claimant's Ex. 1D, p. 34. Dr. Friedman did not believe there was any relationship between Claimant's seizures and his work injury and reaffirmed his original causation opinion.

76. In July, 2009, after having the opportunity to review the results of Dr. Wechsler's testing, Dr. Beaver prepared an update of his original report. Dr. Beaver noted that Dr. Wechsler's findings suggested a change in his DSM-IV diagnosis to include a psychological condition—either a conversion disorder or an anxiety or panic disorder which manifests as

pseudoseizure. In either event, it is clear that Claimant's seizure disorder is psychological, not neurologic.

77. With regard to the relationship of the seizures disorder to the work injury, Dr. Beaver opined that, absent evidence of a prior mental condition, and absent evidence that Claimant's history of treatment for a possible heart attack was not, in fact, evidence of an anxiety or panic disorder (it was not), Claimant's seizures were linked to his work injury. The seizures were not physically caused by the head injury, but represent Claimant's psychological reaction to the events combined with his personality style.

78. Dr. Beaver disagreed with Dr. Wechsler's suggestion that individual counseling might help Claimant with his seizure disorder. Dr. Beaver believed that the likelihood of success of such counseling under Claimant's circumstances was very poor. However, since he had recommended participation in a TBI rehabilitation program that would include twice-a-week counseling, Dr. Beaver relented and agreed that six individual counseling sessions would be reasonable and directly related to the industrial accident. Dr. Beaver remained pessimistic about the efficacy of individual counseling outside a structured TBI treatment program.

79. Dr. Beaver revisited the matter of his impairment rating, and citing to Idaho Code,[6] ultimately declined to award Claimant a rating for his psychological condition, because he did not believe that the psychological condition was "caused by the industrial injury, predominately above all other causes." Claimant's Ex. 1T, p. 445. Dr. Beaver made no changes to his permanent work restrictions as a result of Dr. Wechsler's findings.

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[6] Dr. Beaver did not specify what section of Idaho Code he was relying upon, but it appears he was referring to Idaho Code § 72-451.

80. In late July, 2009, John L. Christensen, Ph.D., Dr. Corgiat's practice partner, saw Claimant for follow-up. Since his last visit with Dr. Corgiat, Claimant had completed the seizure study with Dr. Wechsler and been evaluated by Dr. Beaver. Dr. Christensen commented that Dr. Beaver's findings were in line with those made previously by Dr. Corgiat. He also agreed that Dr. Beaver's impairment rating was appropriate. Dr. Christensen saw no need for further neuropsychological testing of Claimant.

81. When Claimant returned to Dr. Brait with the results of the seizure study in August 2009, Dr. Brait took Claimant off the seizure medication. Dr. Brait discussed with Claimant the possibility that long-term counseling could help with the pseudoseizures. Dr. Brait also noted that, for some individuals, just knowing they had some control over the pseudoseizures led to a drop-off in the number of episodes. Dr. Brait observed that since leaving the monitoring program three months earlier, Claimant had only one minor pseudoseizure. Claimant declined counseling at that time, but knew that he could contact Dr. Brait in the future should he change his mind.

82. On August 8, 2009, Dr. Brait determined that Claimant was at MMI with regard to his industrial injuries and released him from care. On September 14, 2009, Dr. Brait authorized a return to work with the following restrictions:

- Standing limited to two hours at a time and six hours per day;
- Sitting limited to four hours at a time and eight hours per day;
- Walking limited to two hours at a time and four hours per day;
- May lift up to ten pounds frequently and occasionally carry up to twenty pounds;
- No repetitive pushing or pulling with either upper extremity or both together;
- No repetitive reaching above shoulder bilaterally;
- No bending, kneeling or climbing; occasional squatting is permitted as is frequent overhead reach;
- No working at heights; and
- Dr. Brait predicated all restrictions on a functioning SCS.

83. Dr. Brait used the *AMA Guides to the Evaluation of Permanent Impairment*, 5th ed. (*AMA* 5th) to rate Claimant's PPI. Dr. Brait determined that Claimant's cervical injury rated 18% whole person impairment, and his cognitive and vestibular impairments rated 25% whole person.[7] Using the *AMA* 5th Combined Tables, Claimant's total whole person PPI as determined by Dr. Brait is 39%.

VOCATIONAL EVIDENCE

84. Both parties retained vocational experts to address the extent of Claimant's disability in excess of his impairment, if any. Claimant retained Douglas N. Crum, C.D.M.S. The Commission is well-acquainted with Mr. Crum and his qualifications. Defendants retained Kathy Gammon, M.S., C.R.C., M.P.T. Ms. Gammon was a practicing physical therapist from 1976 until 1995. She returned to school and graduated with a master's degree in rehabilitation counseling in 1998. Thereafter, she worked for the Idaho Department of Vocational Rehabilitation and a private firm before starting her own company, Rehab All, in 2002. In her business, Ms. Gammon provides physical therapy consultation, case management, return-to-work counseling, private rehabilitation services, and forensic disability assessment.

Douglas Crum

85. Claimant retained Mr. Crum in the spring of 2009. Mr. Crum reviewed medical records, ICRD case notes (including a job site evaluation for Claimant's time-of-injury job), and Claimant's wage information. Mr. Crum met with Claimant and interviewed him in April 2009. Mr. Crum's report is dated December 16, 2009. In his analysis, Mr. Crum noted there was a

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[7] On a form he signed and dated on August 5, 2009 (Claimant's Ex. 1B, p. 32), Dr. Brait initially rated Claimant's cervical injury at 15-18% whole person, crossed that out, and wrote in 8%. By the time of his deposition, he concluded he had been correct the first time, and returned to his 18% whole person rating. (Dr. Brait Depo., p. 37.)

wide disparity in opinion among Claimant's physicians and evaluators with respect to the issues of impairment and disability. He noted that Dr. Simon found no impairment and no disability, while Drs. Brait and Linderman believe that Claimant has "fairly significant sequela associated with the industrial injury of January 27, 2006." Claimant's Ex. 3, p. 705.[8]

86. Mr. Crum ultimately concluded that if the finder of fact accepted the opinions of Drs. Brait, Linderman, and Christensen, then Claimant was totally and permanently disabled, and it would be futile for him to seek work. Mr. Crum noted that Claimant's age, presentation, his inability to drive, and the poor state of the local labor market were also factors contributing to Claimant's total disability. Mr. Crum noted that, at the time of his interview, Claimant was receiving Social Security Disability income in the amount of $1,961.00, long-term disability of $1,628.00, and a pension of $479.00 per month for a total of $4,068.00 monthly. Claimant's pre-injury wage was $1,778.60 per week or $7,114.40 per month plus the additional income he received from his seasonal snow removal business.

87. In his deposition, taken in early January 2010, Claimant expressed an interest in retraining to become a gunsmith—a craft he believed he could turn into a home-based business, and one that was consonant with his knowledge and love of firearms. Claimant asked Mr. Crum to review some literature from a training program and to opine as to whether the training might be a good fit for Claimant. By letter dated February 11, 2010, Mr. Crum advised that, while the training program might give Claimant a much-needed hobby, his research indicated that it was not a viable vocational option.

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[8] Mr. Crum makes no mention of Dr. Friedman's opinions, nor does he discuss the findings of Drs. Wechsler or Beaver. Neither are they listed in the records that Mr. Crum reviewed, though they were all available prior to the date of his report.

Kathy Gammon

88. Defendants retained Ms. Gammon in early 2010 to prepare a vocational assessment for Claimant. Ms. Gammon reviewed a much-more complete medical record, but was denied an opportunity to interview Claimant personally. Ms. Gammon used two methodologies in her analysis: Vocational Diagnosis and Assessment of Residual Employability (VDARE) and the RAPEL method which considers an individual's rehabilitation plan, access to the labor market, placeability, earnings capacity, and labor force participation.

89. Ms. Gammon looked at functional physical restrictions imposed by Claimant's various physicians and evaluators, and at functional neuropsychological restrictions identified by Drs. Corgiat, Calhoun, Beaver, and Christensen. Ms. Gammon concluded that Claimant had no neuropsychological functional limitations. His physical restrictions precluded him from returning to his time-of-injury job, but left him capable of performing sedentary and light exertional levels of work. Ms. Gammon noted that light work that required extensive walking would require some job accommodation. Claimant was restricted from jobs that required climbing, balancing, repetitive pushing or pulling with hands, bending, and kneeling.

90. Ms. Gammon next considered Claimant's transferable skills and found that he was precluded from returning to any of his pre-injury jobs with the exception of car sales. However, Ms. Gammon believed that Claimant's work experiences qualified him for a number of positions that were within his physical capacity, including: Security guard, merchant patroller, bailiff, radiation monitor technician (rad con tech), general hardware sales, sporting goods and gun sales, and probation/parole officer. Entry-level wages for these types of positions ranged from $7.72 per hour to nearly $29.00 per hour for the rad con tech jobs. Ms. Gammon observed that between 60 and 100 rad con tech jobs would be opening up at the Site as a result of

federal job stimulus money. Ms. Gammon also identified several positions for which Claimant could qualify without transferrable skills. These included: Telemarketer, convenience store clerk, counter clerk, and desk clerk. Entry-level wages for these positions ranged from $7.25 per hour to $10.55 per hour. Ms. Gammon also considered gunsmithing, with an entry-level wage of $12.73, to fit with Claimant's skills and limitations.

91. Finally, Ms. Gammon assessed Claimant's earning capacity. Prior to his workplace injury, Claimant earned an average weekly wage of $1778.60 as a security protective officer, plus a small amount of income from his snow removal business. Ms. Gammon opines that Claimant was qualified for any of the listed positions and would be making anywhere from $7.72 to $28.96 to start, and would be making the mid-range wage of $8.88 to $31.11 per hour within one or two years. Even in the lower semi-skilled positions, Claimant could be earning from $7.25 to $11.72 within six months of starting employment. Ms. Gammon did not offer her opinion on percentage loss of wage-earning capacity or loss of access to the labor market.

DISCUSSION AND FURTHER FINDINGS

CAUSATION

92. It is undisputed that Claimant's slip and fall in January 2006 was a compensable industrial accident in which Claimant sustained head and neck injuries. The purpose of this proceeding is to tease out which of Claimant's subsequent maladies and symptoms are causally connected to the industrial accident and, therefore, compensable. As suggested by the lengthy findings, Claimant's post-injury medical history is massive. Attempts to diagnose and/or treat Claimant's intransigent symptoms eventually involved more than a dozen physicians—not including hospital personnel—and five neuropsychologists.

93. The burden of proof in an industrial accident case is on the claimant.

> 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).

94. Immediately following his accident, or as soon thereafter as he regained his senses, Claimant complained of tinnitus, headache, vertigo, and nausea. All of these symptoms were consistent with post-concussive syndrome, and Surety provided treatment, including vestibular therapy, analgesics, and anti-nausea drugs. What remains in dispute is whether Claimant's seizure disorder, his visual complaints, his reliance on an SCS, and his neurocognitive deficits are causally related to his industrial injury.

Seizure Disorder

95. All of the care Claimant received for his seizure disorder centered on the question of whether the seizures were neurological or psychological. Any discussion of a causal relationship between the seizures and Claimant's industrial injury prior to a definitive finding on the source of the seizures was purely speculative. Once Dr. Wechsler determined that Claimant's seizure disorder was psychological, four of Claimant's treaters or evaluators offered causation opinions.

96. **Dr. Brait**. Dr. Brait investigated the etiology of Claimant's pseudoseizures. He concurs with the finding that Claimant's seizures are psychological rather than neurological in nature. Dr. Brait opined that Claimant's pseudoseizures were related to the trauma of the industrial injury due to the existence of a temporal relationship between the accident and the

onset of the psuedoseizures, and his belief that Claimant's emotional makeup set him up for a traumatic reaction to the event. However, Dr. Brait readily acknowledged at his deposition that he was not a psychiatrist, and declined to delve into psychiatric diagnoses. Thus, Dr. Brait's opinions about Claimant's psychological reaction to his industrial injury are given little weight.

97. **Dr. Friedman**. Dr. Friedman opined that Claimant's psychologically induced seizure disorder bore no relationship to his industrial injury. Dr. Friedman did not elaborate on this issue in his written report, nor was he asked to explain the basis of his opinion during his deposition.

98. **Dr. Beaver.** Dr. Beaver opined that, in the absence of any prior history of psychological or mental health problems, Claimant's seizure disorder was "linked to the January 2006 accident. Again, they were not caused by the head injury itself. Rather the pseudoseizures reflect a psychological reaction to events combined with his personality style." Claimant's Ex. 1T, p. 444.

99. As described by Dr. Beaver, Claimant's seizure disorder was a sequelae of his injury combined with his particular psychological makeup. Dr. Beaver does discuss that the pseudoseizures support an additional diagnosis of a psychological condition such as conversion disorder or an anxiety or panic disorder, but he made no additional diagnoses. There is no evidence in the record to suggest that any of these disorders pre-existed Claimant's work injury.

100. **Dr. Christensen.** Dr. Christensen agreed with Dr. Beaver's findings.

101. In order to evaluate whether Claimant's pseudoseizures are compensable, the Referee looks to the provisions of Idaho Code § 72-451, which provide:

> Psychological injuries, disorders or conditions shall not be compensated under this title, unless the following conditions are met:

(1) Such injuries of any kind or nature emanating from the workplace shall be compensated only if caused by accident and physical injury as defined in section 72-102(18)(a) through (18)(c), Idaho Code, or only if accompanying an occupational disease with resultant physical injury, except that a psychological mishap or event may constitute an accident where: (i) it results in resultant physical injury so long as the psychological mishap or event meets the other criteria of this section, and (ii) it is readily recognized and identifiable as having occurred in the workplace, and (iii) it must be the product of a sudden and extraordinary event; and

(2) No compensation shall be paid for such injuries arising from conditions generally inherent in every working situation or from a personnel related action including, but not limited to, disciplinary action, changes in duty, job evaluation or employment termination; and

(3) Such accident and injury must be the predominant cause as compared to all other causes combined of any consequence for which benefits are claimed under this section; and

(4) Where psychological causes or injuries are recognized by this section, such causes or injuries must exist in a real and objective sense; and

(5) Any permanent impairment or permanent disability for psychological injury recognizable under the Idaho worker's compensation law must be based on a condition sufficient to constitute a diagnosis using the terminology and criteria of the American psychiatric association's diagnostic and statistics manual of mental disorders, third edition revised, or any successor manual promulgated by the American psychiatric association, and must be made by a psychologist, or psychiatrist duly licensed to practice in the jurisdiction in which treatment is rendered; and

(6) Clear and convincing evidence that the psychological injuries arose out of and in the course of the employment from an accident or occupational disease as contemplated in this section is required.

Nothing herein shall be construed as allowing compensation for psychological injuries from psychological causes without accompanying physical injury.

This section shall apply to accidents and injuries occurring on or after July 1, 1994, and to causes of action for benefits accruing on or after July 1, 1994, notwithstanding that the original worker's compensation claim may have occurred prior to July 1, 1994.

102. The testimony of Dr. Beaver establishes that the requirements of Idaho Code § 72-451(1) are satisfied; Claimant's pseudoseizures are shown to be causally related to the subject accident. Although Dr. Beaver found a causal relationship, he testified that the subject accident was not the "predominant cause," as compared to all other causes combined, of Claimant's pseudoseizures. He opined that Claimant's "personality style" was more important than the accident in explaining the development of Claimant's seizure disorder. Therefore, according to Dr. Beaver, Claimant does not satisfy the requirements of Idaho Code § 72-451(3) and Claimant's pseudoseizures are not compensable.

103. However, as developed below, the finding that Claimant failed to meet his burden of proving that his pseudoseizures are a compensable consequence of the industrial accident is not particularly significant to the outcome of this case. No physician diagnosed a recognized psychological condition, even though Dr. Beaver hypothesized that such a diagnosis could be made, and no physician issued an impairment rating for any psychological condition. Finally, the medical testimony is equivocal on the question of whether Claimant requires any future medical care for his pseudoseizures.

104. The Referee does, however, find that even though Claimant's pseudoseizures have not been found to be compensable, Claimant is entitled to the payment of all medical expenses incurred in connection with arriving at a proper diagnosis of his condition. This includes all medical bills connected with treatment and diagnosis of Claimant's pseudoseizure activity through the date on which Dr. Beaver rendered his opinion that Claimant's pseudoseizures are not compensable under Idaho Code § 72-451.

Visual Complaints

105. Claimant has complained of several different visual problems since the original

injury. The complaints have included blurry vision, a blind spot, a temporary loss of vision, and the pathological sympathetic response to his pain that resulted in a red, watery, and droopy right eye. Claimant sought care from Dr. Simpson at the Retinal Institute in June 2006 because of his blurry vision and the blind spot he perceived, and from the Center for Sight in August 2006 regarding the temporary vision loss. Neither doctor found evidence of pathology, and Claimant's vision was normal. However, vision disturbances are a common symptom of post-concussive syndrome, and it was not unreasonable for Claimant to seek professional care for his visual disturbance. Claimant's pathological sympathetic response symptoms were caused by his cervical injury and resolved with the use of the SCS.

Neurocognitive Loss

106. Five separate psychologists or neuropsychologists evaluated Claimant following his industrial accident. Brent Baldree, Ph.D., evaluated Claimant in November 2006 for purposes of his SSD application. Dr. Corgiat performed a full neuropsychological evaluation in March 2007, followed by Dr. Calhoun's evaluation in April 2007. Dr. Beaver conducted his comprehensive neuropsychological evaluation in late April 2009, and Dr. Christensen followed up on Dr. Corgiat's behalf. Claimant's test scores remained fairly consistent across the thirty-month interval and despite the variety of evaluators. The evaluators, however, did interpret the test results a bit differently. Drs. Baldree, Corgiat and Calhoun all recognized that Claimant's test results were impacted by his pain, and Drs. Corgiat and Calhoun both believed that Claimant's pain medications also affected his scores. Drs. Corgiat and Calhoun also agreed that Claimant had mild cognitive deficits, but both evaluators felt that the deficits were neither consistent, nor were they in the areas ordinarily associated with traumatic brain injury. Neither doctor related the cognitive deficits to Claimant's industrial injury, and both suggested that the

deficits were the result of psychological and behavioral factors.

107. Dr. Beaver is the only neuropsychologist to do a comprehensive work-up on Claimant after implantation of the SCS, and at a time when the SCS was fully functional. Unlike the evaluations done by Drs. Corgiat and Calhoun fairly early in Claimant's course of treatment, Dr. Beaver's evaluation was done after the etiology of most of Claimant's complaints had been identified and were being managed. It is for these reasons that the Referee finds Dr. Beaver's opinion that Claimant sustained mild cognitive loss as a result of his injury to be the more persuasive opinion.

MEDICAL CARE

108. 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. Most of the disputes in this proceeding relate to the issue of medical care. In particular, Claimant asserts entitlement to payment of or reimbursement for the following medical services, devices, and prescriptions:

- Costs associated with the SCS (equipment, hospital, surgical, prescriptions, anesthesia, Dr. Marano, Dr. Linderman);
- Costs associated with diagnosing Claimant's seizure disorder (Dr. Brait, Dr. Wechsler, diagnostic tests, hospitalization, prescriptions);
- Dr. Donaldson, ENT;
- Dr. Simpson, ophthalmologist;
- Dr. Linderman (all charges except 7/18/06 date of service);[9]

[9] Mr. Dominick's ledgers indicate that Surety paid that particular Linderman invoice.

- Dr. Roisum (for services on 1/30/06, 2/24/06, 5/5/06, 5/10/06, 5/17/06, and 5/31/06);[10]
- Drs. Corgiat and Christensen;
- Prescription medication; and
- Imaging (brain, head, cervical spine).

The medical benefits in dispute fall into several general categories, each of which is discussed in the following paragraphs.

Spinal Cord Stimulator

109. Surety initially declined to pay for the costs associated with Claimant's spinal cord stimulator on grounds that Claimant's head pain was not related to his industrial injury. By the time this matter went to hearing, even Defendants' own expert, Dr. Friedman, conceded that Claimant sustained a physical injury to nerves in his neck that caused his unremitting headache pain, and that implantation of the SCS effectively stopped the pain. In fact, by the date of hearing, there was a general consensus that the headache symptoms from Claimant's neck injury were treated successfully with the SCS. Surety is responsible for all costs associated with the SCS, including Dr. Linderman's trial, the services of Dr. Marano, the cost of the unit, and the costs associated with initial implantation, re-implanting leads, treating infections, relocating the generator, etc. Pursuant to Idaho Code § 72-432, this includes past and future medical care.

Seizure Disorder

110. As discussed, *supra.,* all of the claimed costs associated with Claimant's seizure disorder related to diagnosis and treatment pending diagnosis. Dr. Brait ordered multiple EEGs to try to capture the seizure events so he could identify their etiology. He used medication both

[10] Claimant also claims entitlement to services provided on 3/31/06 and 5/8/06, but there are no medical records for services provided on those dates.

to assist with diagnosis and to try to control the seizures while seeking a definitive diagnosis. If Claimant's seizures were determined to be neurological in origin, there was little doubt among the neurologists and neuropsychologists that they were the result of the physical injury to Claimant's brain caused by his industrial accident. Ultimately, Dr. Wechsler's in-patient seizure screening program made a definitive diagnosis that the seizures were psychological, not neurological. Until that determination was made, however, Defendants were responsible under Idaho Code § 72-432 to provide all reasonable medical care deemed necessary by Claimant's treating physicians. Defendants are liable for cost of or reimbursement for the costs associated with diagnosis of Claimant's seizure disorder, including the services of Dr. Brait, Dr. Wechsler, diagnostic testing, prescription medication, and hospitalization.

Hearing and Vision

111. Claimant has tinnitus as a result of his fall. No treatment is available. However, it was reasonable for Claimant to seek a consultation with Dr. Donaldson, ENT, regarding his complaint. Even though Claimant suffered no permanent hearing loss as a result of the accident, and nothing could be done to relieve Claimant's ringing ears, the consultation with Dr. Donaldson was reasonable and necessary medical care and is compensable.

112. Similarly, Claimant experienced visual disturbances following his accident. He was diagnosed with post-concussive syndrome, and vision disturbances are a common symptom of concussion. It was reasonable and necessary for Claimant to seek an ophthalmologic consultation concerning his vision problems. The fact that the doctors found no pathology does not mean that the care was unreasonable or unnecessary. Defendants paid for some of the vision services, but did not pay for the services of Dr. Simpson at the Retinal Institute, or for services provided by the Center for Sight, both of which are compensable. There is no evidence to

suggest that Claimant will need future vision care related to this claim.

Imaging

113. Defendants paid for some, but not all, of the imaging ordered to identify the source of Claimant's unremitting head pain. Having reviewed all of the medical records, the Referee found no orders for imaging, whether x-ray, MRI or CT, that appeared unreasonable, unnecessary, or duplicative. The Referee finds all of the head, neck, and brain imaging compensable.

Prescriptions

114. During the course of his treatment, Claimant's treating physicians prescribed a variety of drugs, including but not limited to: oxycodone, methadone, amitriptyline, Depakote, Lamictal, Lexapro, antibiotics, and phenergan. Any prescription medications related to Claimant's head pain, seizures, nausea, or behavioral changes directly related to the work injury are compensable.

Medical Providers

115. Defendants did not pay for services from Dr. Roisum and Dr. Cach that were directly related to Claimant's care in the first few months following his injury. Dr. Roisum's treatment on 1/30/06, 2/24/06, 5/5/06, 5/10/06, 5/17/06, and 5/31/06 related directly to his headache, nausea, and vertigo and are compensable. Claimant saw Dr. Cach on one occasion upon referral by Dr. Phillips. Dr. Cach ordered a spinal tap to see if he could identify the cause of Claimant's headache pain. Both Dr. Phillips' services and the diagnostics he ordered are compensable.

116. Dr. Simon, who performed the first defense IME, concluded that Claimant needed a neuropsychological workup. Dr. Linderman sent Claimant to Dr. Corgiat, who did perform a

full neuropsych evaluation. Defendants then sent Claimant to Dr. Calhoun, who observed that since Claimant had already seen Dr. Corgiat, a second neuropsych evaluation seemed unnecessary. Defendants paid for Dr. Calhoun's services, but not Dr. Corgiat's. If Claimant had retained Dr. Corgiat as a medical expert for hearing, then certainly Claimant would bear the costs. However, Claimant was not sent to Dr. Corgiat in order to obtain the benefit of his expertise at hearing. Rather, Claimant was sent to Dr. Corgiat by his treating physician, Dr. Linderman, because Defendants' IME doctor said Claimant needed to have a neuropsych evaluation. On these facts, Dr. Corgiat's services, and subsequently those of his partner Dr. Christensen, are compensable.

117. The compensability of Dr. Linderman's treatments is a bit more difficult to determine. During the time that Dr. Linderman practiced in Idaho Falls, she held herself out as a specialist in pain management. Dr. Linderman was not board certified as a pain management specialist, nor was she board certified in anesthesiology, her initial area of practice. Dr. Linderman was often at odds with the local medical establishment. She did not hesitate to express her opinion about physicians who disagreed with her, and many frequently did. Both Drs. Simon and Friedman opined that Dr. Linderman's treatment was unnecessary. Similarly, her practices were not always viewed by this Commission as "reasonably necessary treatment," particularly when they involved repetitive invasive protocols that did not lead to gradual improvement in the patient's condition (See*, Marlene Barnes v.Wal-Mart Stores, Inc.,* 2004 IIC 04980 (7/20/2004); *Kathy J. Raymond v. Snake River School District No. 52*, 2006 IIC 0834 (12/21/2006)).

118. On the other hand, in this particular matter, Dr. Linderman was the only physician actively treating Claimant who was actually looking for a cause for Claimant's head pain so she

might find a solution. She was the physician who proposed the SCS when all other methods of pain control failed. And, ultimately, her patient advocacy gave Claimant and his family a respite from Claimant's constant pain and its insidious effects. In the meantime, the treatments that she provided Claimant constituted the only pain control that was effective, even though the effectiveness was short-lived.

119. Some of Dr. Linderman's treatment is clearly compensable—the initial occipital nerve block (the fourth of four prescribed by Dr. Brait), prescription pain medications, and the costs associated with the PNS trial among them. Additionally, nerve blocks and RF procedures were of demonstrated efficacy with the potential for long-term relief, and are compensable. The compensability of trigger point injections and Botox injections is less clear. The Referee is mindful, however, that had Surety made even minimal efforts to monitor this claim, and had the adjuster made any effort to obtain medical records for care that he knew was ongoing, the medical management of this case might have been more straightforward.

120. The doctors who opined that Dr. Linderman's treatments were unnecessary (Drs. Friedman and Simon) offered their opinions early in Claimant's course of treatment. In part, their opinions were based on their notion that Claimant's head pain was psychological and not physical—a point upon which they were ultimately proven wrong. The record also suggests that, in part, their opinions were influenced by their previous dealings with Dr. Linderman and a personal and professional discomfort with her approach to care. These factors lessen the persuasive power of Dr. Friedman's and Dr. Simon's opinions as to the reasonableness of Dr. Linderman's treatment. Without more compelling evidence that her treatment was inappropriate, the Referee finds Dr. Linderman's care to be compensable on the facts of this case.

121. Having made general findings on compensability of medical care, the Referee

includes some caveats:

- The Referee does not assert that the bills, payment ledgers, and summaries of medical care costs made a part of the record are necessarily accurate or complete. It is for the parties, not the Referee, to correlate invoices with chart notes and review all billings from and payments to providers to calculate amounts owed to providers, Claimant, and third-party payors. The Referee notes that some chart notes may be difficult to correlate. For example, Dr. Linderman's records occasionally include two chart notes for a particular visit that are not identical. Other chart notes appear to have been billed or dictated prior to the actual date of service and some were transcribed long after the date of service;

- The categories of charges identified in parentheses are not a comprehensive enumeration of what items are compensable, but are intended to provide some guidance to the parties regarding providers whose charges are or may be compensable under this decision;

- Dr. Marano is Claimant's treating physician for issues pertaining to the spinal cord stimulator. At least at the time of hearing, Dr. Roisum was Claimant's primary care physician. It does not appear from the records in this proceeding that Dr. Roisum is well-equipped to provide on-going care for *all* of Claimant's post-injury health concerns. The Surety may wish to work with Claimant to designate a mutually acceptable physician to assist in managing Claimant's care for conditions, other than the SCS, that relate to his industrial injury.

TTDs/TPDs

122. Pursuant to Idaho Code § 72-408, a claimant is entitled to income benefits for total and partial disability during a period of recovery. The burden of proof is on the claimant to present expert medical evidence to establish periods of disability in order to recover income benefits. *Sykes v. C.P. Clare & Compan*y, 100 Idaho 761, 763, 605 P.2d 939, 941 (1980).

123. Although both Dr. Simon and Dr. Calhoun found Claimant to be at MMI in the spring of 2007, subsequent events proved both doctors wrong. Claimant was not at MMI until he had a properly functioning SCS, and the etiology of his seizure disorder was identified. Dr. Beaver issued his updated report on July 13, 2009, taking into account information about Claimant's seizure disorder gleaned from Dr. Wechsler's testing. Dr. Brait found Claimant at MMI on August 5, 2009. Although Claimant, subsequently, had a lead re-implanted in October,

2009, the Referee finds that Dr. Brait's determination of medical stability is consistent with the medical evidence and Claimant's own reports of his condition.

PPI

124. "Permanent impairment" is any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved and which abnormality or loss, medically, is considered stable or non-progressive at the time of the evaluation. Idaho Code § 72-422. "Evaluation (rating) of permanent impairment" is a medical appraisal of the nature and extent of the injury or disease as it affects an injured worker's personal efficiency in the activities of daily living, such as self-care, communication, normal living postures, ambulation, elevation, traveling, and non-specialized activities of bodily members. Idaho Code § 72-424. When determining impairment, the opinions of physicians are advisory only. The Commission is the ultimate evaluator of impairment. *Urry v. Walker Fox Masonry Contractors*, 115 Idaho 750, 755, 769 P.2d 1122, 1127 (1989).

125. In light of the findings regarding causation, there are three relevant impairment ratings to consider: Cervical, cognitive, and vestibular. Dr. Brait rated Claimant's cervical injury as 18% whole person impairment, and his cognitive and vestibular impairments at 25% whole person.[11] Using the *AMA* 5th Combined Tables, Claimant's total whole person PPI as determined by Dr. Brait is 39%. Dr. Beaver did not rate Claimant's cervical injury, because it was "resolved" with use of the SCS. He did award Claimant a 4% whole person PPI for his neurocognitive impairment.

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[11] On a form he signed and dated on August 5, 2009 (Claimant's Ex. 1B, p. 32), Dr. Brait initially rated Claimant's cervical injury at 15-18% whole person, crossed that out, and wrote in 8%. By the time of his deposition, he concluded he had been correct the first time, and returned to his 18% whole person rating. (Dr. Brait Depo., p. 37.)

Cervical Injury

126. Both Drs. Friedman and Beaver gave Claimant 0% PPI for his cervical injury because the pain from his cervical injury was controlled with the SCS. This approach may be technically correct. Given the invasive nature of the SCS, the potential for serious side effects, the inherent risks associated with multiple surgical procedures, and the very real possibility that Claimant may have to forego the benefits of the appliance for periods of time, it seems unreasonable to conclude that there is no impairment associated with the device.

127. Dr. Brait vacillated between 8% and 18% whole person PPI related to Claimant's cervical injury. Dr. Brait did not discuss whether the use of the SCS was calculated into either of those figures. Neither calculation is supported by the *AMA Guides* 6th. The highest rating is for injuries to the greater occipital nerve that cause severe neurogenic pain, such as Claimant experiences when his SCS is not working. Table 13-20, p. 344 places symptoms like Claimant's in Class 3 with 4% to 5% whole person impairment.

128. On the facts of this case, a whole person PPI of 0% is unreasonable, but so is Dr. Brait's most conservative rating (8%). A 4% whole person PPI rating for Claimant's occipital nerve injury is reasonable.

Cognitive Deficits

129. Dr. Beaver awarded Claimant a whole person PPI of 4% for his cognitive deficits, in accordance with Section 13.3d of the *AMA* 6th. Dr. Brait awarded 25% whole person PPI, but included both cognitive and vestibular impairments in the total. He did not elaborate on how he reached either rating. According to Table 11-4, p. 258 of the *AMA* 6th, Claimant's vestibular complaints fall into the upper end of Class 1. His vestibular symptoms are well documented, and at least as to equilibrium and balance, are chronic and not responsive to treatment. The

vestibular problems interfere with work activities and complex tasks, supporting a whole person PPI rating of 9% for his vestibular deficits. This would leave Dr. Brait's rating for cognitive deficits somewhere around 12% to 15%, depending on whether the ratings were added or combined. The maximum rating for cognitive deficits for Class 1 impairments in the *AMA* 6th is 10%. Dr. Brait's rating is high, but Dr. Beaver's is on the low side. Averaging the highest rating from *AMA* 6th with Dr. Beaver's rating provides a whole person rating for cognitive deficits of 7%.

Summary of Impairment Ratings

130. Claimant's impairment ratings are summarized below:

System	Rating	Combined Rating
Vestibular:	9%	
Cognitive:	7%	15%
Cervical:	4%	18%

PPD

131. Under the Idaho worker's compensation law, a "disability" is defined as "a decrease in wage-earning capacity due to injury or occupational disease, as such capacity is affected by the medical factor of physical impairment, and by pertinent nonmedical factors." Idaho Code § 72-102(11). A claimant's permanent disability rating is determined by appraising the combined effect of those medical and nonmedical factors on the "injured employee's present and probable future ability to engage in gainful activity." Idaho Code § 72-425. Among the pertinent nonmedical factors are the following: the nature of the physical disablement; the cumulative effect of multiple injuries; the employee's occupation; the employee's age at the time of the accident; the employee's diminished ability to compete in the labor market within a reasonable geographic area; all the personal and economic circumstances of the employee; and

other factors deemed relevant by the Commission. Idaho Code § 72-430. The case of *Baldner v. Bennett's, Inc.*, 103 Idaho, 458, 461, 649 P.2d 1214 (1982) is instructive on the relationship between impairment and disability. In *Baldner*, the Supreme Court wrote:

> A claimant's impairment evaluation or rating is one component or element to be considered by the Commission in determining a claimant's permanent, partial disability, I.C. § 72-425, and is not the exclusive factor determinative of the disability rating fixed by the Commission. I.C. § 72-427. A disability rating may exceed the claimant's impairment rating. (Citations omitted.)

132. In order to establish that he has sustained disability in excess of his impairment, Claimant must prove, by a preponderance of the evidence, that he has sustained a loss of earning capacity or a reduced ability to engage in gainful activity. *Ball v. Daw Forest Products Company,* 136 Idaho 155, 30 P.3d 933 (2001). "[T]he Workmen's [sic] Compensation law does not require any particular method of proof." *Baldner*, 103 Idaho at 461, 649 P.2d at 1217.

133. Opinions about Claimant's disability in excess of his impairment run the gamut from zero to nearly 100%. According to Kathy Gammon, Claimant could go to work as a rad con tech at the Site and be closing in on his pre-injury wage within a year or two. According to Doug Crum, Claimant's disability is so substantial that there is no point in even looking for work. Generally, the best place to begin an analysis of disability is with the restrictions imposed by Claimant's treating and evaluating physicians. Drs. Friedman, Brait, and Beaver all recommended restrictions.

Dr. Friedman

134. Dr. Friedman's restrictions included no climbing, limited activity on uneven surfaces, and medium work restrictions. The first two restrictions relate to Claimant's industrial injury and recognize his balance and equilibrium difficulties. The medium exertion restriction is not related to Claimant's industrial injury. It was imposed because of Claimant's prior low back

surgeries. Claimant's low back was asymptomatic prior to his industrial injury and remained so afterward—it was never a part of this workers' compensation claim. As such, the lifting restrictions are not relevant to Claimant's disability associated with his industrial injury, and are not considered in this decision.

135. Dr. Beaver's restrictions related only to Claimant's vestibular problems—no working at unprotected heights, and no work near fast-moving machinery. Neither Dr. Beaver nor Dr. Friedman imposed any restrictions relating to Claimant's cognitive deficits, or his use of an SCS to remain functional. Given his documented cognitive difficulties with executive functions, is it reasonable to put Claimant in a work situation that requires decision-making, multi-tasking, and frequent interruption? At hearing, Claimant demonstrated an inability to focus and stay on task. When asked a simple question, Claimant often digressed or wandered from the topic and had to be brought back to the question. He speaks slowly and has difficulty with word finding. He walks slowly with a shuffling gait. These limitations make Claimant an unlikely candidate for sales jobs or direct customer service positions. Claimant depends upon a spinal cord stimulator to function at even a minimal level. Dependence on such a device will exclude Claimant from some types of work and, at the very least, requires some job accommodations. Part of the difficulty in relying on the restrictions imposed by Drs. Friedman and Beaver is that each only looked at a part of the picture. It is like putting together twenty or thirty pieces of a 1000-piece jigsaw puzzle and believing that you have seen the completed image.

136. Dr. Brait provided the most comprehensive listing of restrictions for Claimant, including limitations on standing, sitting, walking, lifting, bending, kneeling, climbing, repetitive reaching, and working at heights. All of these restrictions relate to the industrial injury, and all

assumed a functioning SCS. But even Dr. Brait's more comprehensive restrictions do not address the issues related to Claimant's cognitive problems.

137. In his report, Mr. Crum relied upon Dr. Brait's restrictions, together with a number of non-medical factors affecting Claimant's ability to find employment in a competitive labor market. Those factors include Claimant's age, his presentation (particularly, his weight and his slow shuffling gait), his inability to drive, his limited transferrable skills, and the poor state of the local labor market. Mr. Crum did not calculate a loss of access to the labor market or a loss of wage-earning capacity for Claimant. As was pointed out in his deposition, his report was long on conclusions, but short on analysis.

138. Ms. Gammon's report was not without flaws, either. She did not take into account Claimant's cognitive impairments or his permanent use of the SCS. Ms. Gammon based much of her report on the assumption that Claimant could obtain a rad con tech position and approach his time-of-injury wage within a relatively short period of time. During the course of her deposition, Ms. Gammon admitted that she had not seen specific job descriptions for the rad con tech positions and did not know the physical and mental demands of the job. She was not certain when, or even if, the positions would become available, where the positions would be located, who would be hiring for the positions, or how the positions would be filled. Ms. Gammon could not state whether Claimant would qualify for the positions, whether the jobs would be within his restrictions, or whether he would be a competitive candidate. With the exception of the rad con tech positions, the positions Ms. Gammon identified as suitable for Claimant paid minimum wage or slightly more than minimum wage. If these were the only jobs Claimant was likely to obtain, then his loss of wage-earning capacity was enormous—somewhere near 80% to 85%. Ms. Gammon did not offer an opinion as to Claimant's loss of

access to the labor market, but he undoubtedly lost access to medium exertion positions that were available to him before his injury. It is true that Ms. Gammon did not have the benefit of having actually met Claimant. Had she been able to observe him, as did the Referee, over the better part of a day, her enthusiastic optimism about Claimant's employability might have been somewhat tempered.

139. In sum, Mr. Crum's conclusions were realistic, but not well-supported by his analysis, while Ms. Gammon's conclusions were strong on analysis, but not very realistic. Neither expert provided any opinion on Claimant's loss of access to the labor market, and neither explicitly discussed the non-medical factor of his seizure disorder. The Referee determined that Claimant's physical impairments were rated at 18%. Pertinent non-medical factors include: A significant loss of wage earning capacity; Claimant's age; his psychological problems, including his seizure disorder, limited transferrable skills; an inability to drive safely; and his multiple medical problems not related to the accident, including a recent diagnosis of diabetes. Considering all of the relevant factors, the Referee finds that Claimant has sustained disability inclusive of his impairment of 85%.

ODD LOT

140. Claimant asserts that, as a result of his industrial injury, he is totally and permanently disabled as an odd-lot worker. When a claimant cannot make the showing required for 100% disability, then a second methodology is available:

> The odd-lot category is for those workers who are so injured that they can perform no services other than those that are so limited in quality, dependability or quantity that a reasonably stable market for them does not exist.

Jarvis v. Rexburg Nursing Center, 136 Idaho 579, 584 38 P.3d 617, 622 (2001) citing *Lyons v. Industrial Special Indem. Fund*, 98 Idaho 403, 565 P.2d 1360 (1977). The worker need not be physically unable to perform any work:

> They are simply not regularly employable in any well-known branch of the labor market absent a business boom, the sympathy of a particular employer or friends, temporary good luck, or a superhuman effort on their part.

Id., 136 Idaho at 584, 38 P.3d at 622.

141. A claimant seeking odd-lot status carries the burden of proof that he is an odd-lot worker. An employee may prove total disability under the odd lot worker doctrine in one of three ways: (1) by showing that he has attempted other types of employment without success; (2) by showing that he or vocational counselors or employment agencies on his behalf have searched for other work and other work is not available; or, (3) by showing that any efforts to find suitable employment would be futile. *Hamilton v. Ted Beamis Logging & Const.*, 127 Idaho 221, 224, 899 P.2d 434, 437 (1995).

142. As discussed, *supra,* Mr. Crum's vocational report was inadequate, but the Referee believes that he was correct on one point—that it would be futile for Claimant to look for work. Claimant may very well be able to work on a limited and sporadic basis. Mr. Crum even noted that it would be good for Claimant to find something he could do as an avocation, if not as a vocation. But the Referee finds it extremely unlikely that Claimant is a competitive candidate for the jobs for which he is qualified. If he did find an employer willing to hire him, his many health problems, and especially his dependence upon the SCS, would result in many missed days of work. Claimant's situation is precisely the type of situation for which the concept of an odd-lot worker exists.

ATTORNEY FEES

143. Attorney fees are not granted to a claimant as a matter of right under the Idaho worker's compensation law, but may be recovered only under the circumstances set forth in Idaho Code § 72-804, which *requires* the Commission to award attorney fees when:

- An employer or surety contests a claim for compensation made by an injured employee without reasonable grounds; or
- An employer or surety neglects or refuses to pay to the injured employee or his dependents the compensation provided by law within a reasonable time after receipt of a written claim for compensation; or
- An employer or surety stops paying compensation provided by law and justly due without reasonable grounds.

The decision that grounds exist for awarding a claimant attorney fees is a factual determination that rests with the Commission. *Troutner v. Traffic Control Company*, 97 Idaho 525, 528, 547 P.2d 1130, 1133 (1976).

144. In some respects, Defendants behaved reasonably in administering Claimant's claim. For example, it was not unreasonable to initially deny the medical care relating to the SCS and the seizure diagnostics testing, because the causal relationship between the industrial accident and those medical services was not definitively determined until late spring of 2009. The Referee also understands the reluctance to pay for much of the care offered by Dr. Linderman.

145. Other aspects of this proceeding beg for the imposition of attorney fees on Defendants. Defendants' failure to pay any of the invoices of Drs. Cach and Brait (according to Mr. Dominick's payment ledger, Claimant's Ex. 5 and Claimant's Ex. 22) and some of Dr. Roisum's bills, *Id.,* is inexplicable. Failure to pay Claimant's medical bills related to the spinal cord stimulator, more than a year after both doctors hired by Defendants opined that the

need for the stimulator related to the industrial accident, is indefensible. Defendants' failure to pay Claimant the PPI benefits awarded by Dr. Beaver almost a year before the hearing is unjustifiable. Defendants' termination of Claimant's TTD benefits based upon Dr. Simon's release is at least understandable, though not excusable. The hearing testimony of Frank Dominick, the adjuster in this case, merely confirmed that Surety and/or its representative were sloppy at best and derelict at worst.

146. Mr. Dominick first explained away the failure to pay the PPI rating given by Dr. Beaver in the spring of 2009 by blaming it on Glenna Christensen, counsel for Defendants during the initial preparation of the case. He offered no explanation as to why the PPI had not been paid nearly a year later, at the time of hearing. Mr. Dominick also blamed Ms. Christensen for his failure to review medical records relating to Claimant's on-going treatment following the termination of benefits. Mr. Dominick had no explanation for why he had not paid Claimant's medical bills related to the SCS, or Dr. Wechsler's diagnostic testing:

> Q: [By McBride] Let me just talk about a couple of other matters here. In Dr. Beaver's notes he does in fact say that the spinal cord stimulator has worked well for this gentleman, eliminating his head pain. The necessity of this appears to be work related. You read that, didn't you?
> A: I read Dr. Beaver's report that said that, that's right.
> Q: Then you still chose not to pay for any treatment relating to the stimulator?
> A: I have never received a bill associated with the stimulator.
> Q: Well, you didn't ask for a bill, did you?
> A: No.
> Q: Likewise, you knew that [Claimant] was being seen by Dr. Wechsler for seizures?
> A: That is correct. I did not receive a bill from Dr. Wechsler either.
> Q: And then Beaver says given the history of difficulties [Claimant] reports, this would also appear to be reasonable, you read that; correct?
> A: From Dr. Wechsler?
> Q: No, from Dr. Beaver referring to Dr. Wechsler.
> A: Yes.

Tr., pp. 218-219. Later during his testimony, Mr. Dominick responded to a question from the Referee:

> Q: [By Referee Just] But he [Dr. Beaver] did give a PPI and at least there was some reason to think that the treatment that claimant [sic] had received at least with regard to the spinal cord stimulator nobody was saying was inappropriate or not related. But your answer was you didn't pay those because you didn't receive those bills.
> A: That's correct.
> Q: So explain to me why today [March 3, 2010] you still haven't paid the PPI.
> A: I have no good answer for you.

Id., at pp. 226-227.

147. Based on the foregoing facts, the Referee finds that Claimant is entitled to an award of attorney fees for Defendants' unreasonable conduct with regard to the following items:

- Delay in paying for all compensable medical care related to the SCS following Dr. Beaver's and Dr. Friedman's causation opinions;
- Delay in paying for all compensable medical care related to Claimant's seizure diagnosis following Dr. Beaver's causation opinion (this includes services from Drs. Brait and Wechsler, diagnostic testing, hospitalization, and prescription medications);
- Delay in paying the impairment award assigned by Dr. Beaver in the spring of 2009;
- Failure to make inquiry into Claimant's on-going medical care following the termination of benefits in May 2007; and
- Failure to pay those back TTD benefits following Dr. Beaver's causation opinion in late spring 2009.

CONCLUSIONS OF LAW

1. Claimant's need for a spinal cord stimulator and diagnostic testing for a seizure disorder, and his neurocognitive and vestibular conditions, were the result of his industrial accident and are compensable.

2. Claimant is entitled to medical care as set out more specifically herein, but

generally including: The services of Drs. Donaldson, Simpson, Corgiat, Christensen, Roisum, Cach, Brait, Marano, Wechsler, and Linderman that relate to the work injury; prescription medications prescribed by treating or evaluating physicians or neuropsychologists for symptoms and conditions arising from the work injury; hospitalization related to the work injury, including hospitalizations related to diagnosis of the seizure disorder and the implantation of the SCS; and imaging of the neck and head that related to the industrial injury.

3. Claimant is entitled to temporary total disability benefits from the date they were terminated in May 2007 until Claimant was declared medically stable on August 8, 2009.

4. Claimant is entitled to PPI benefits corresponding to a rating of 18% whole person.

5. Claimant is entitled to total permanent disability benefits from the date of August 9, 2009.

6. Claimant is entitled to attorney fees and costs incurred in the prosecution of this proceeding as set out more particularly in Paragraph 147, *supra*. Unless the parties can agree on an amount for reasonable attorney fees, Claimant's counsel shall, within twenty-one (21) days of the entry of the Commission's decision, file with the Commission a memorandum of attorney fees incurred in counsel's representation of Claimant in connection with these benefits, and an affidavit in support thereof. The memorandum shall be submitted for the purpose of assisting the Commission in discharging its responsibility to determine reasonable attorney fees in this matter. Within fourteen (14) days of the filing of the memorandum and affidavit thereof, Defendants may file a memorandum in response to Claimant's memorandum. If Defendants object to any representation made by Claimant, the objection must be set forth with particularity. Within seven (7) days after Defendants' response, Claimant may file a reply memorandum. The

Commission, upon receipt of the foregoing pleadings, will review the matter and issue an order determining attorney fees.

RECOMMENDATION

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

DATED this 24 day of November, 2010.

INDUSTRIAL COMMISSION

/s/_____
Rinda Just, Referee

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

VAL R. FERRIN, Claimant, v. BECHTEL BETTIS, INC., Employer, and INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA, Surety, Defendants.	)	**IC 2006-001471** **ORDER** Filed: January 7, 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 conclusions 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 conclusions of law as its own.

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

1. Claimant's need for a spinal cord stimulator and diagnostic testing for a seizure disorder, and his neurocognitive and vestibular conditions, were the result of his industrial accident and are compensable.

2. Claimant is entitled to medical care as set out more specifically herein, but generally including: The services of Drs. Donaldson, Simpson, Corgiat, Christensen, Roisum, Cach, Brait, Marano, Wechsler, and Linderman that relate to the work injury; prescription medications prescribed by treating or evaluating physicians or neuropsychologists for symptoms and conditions arising from the work injury; hospitalization related to the work injury, including hospitalizations related to diagnosis of the seizure disorder and the implantation of the SCS; and imaging of the neck and head that related to the industrial injury.

3. Claimant is entitled to temporary total disability benefits from the date they were terminated in May 2007 until Claimant was declared medically stable on August 8, 2009.

4. Claimant is entitled to PPI benefits corresponding to a rating of 18% whole person.

5. Claimant is entitled to total permanent disability benefits from the date of August 9, 2009.

6. Claimant is entitled to attorney fees and costs incurred in the prosecution of this proceeding as set out more particularly in Paragraph 147, *supra*. Unless the parties can agree on an amount for reasonable attorney fees, Claimant's counsel shall, within twenty-one (21) days of the entry of the Commission's decision, file with the Commission a memorandum of attorney fees incurred in counsel's representation of Claimant in connection with these benefits, and an affidavit in support thereof. In particular, the parties must discuss the factors set forth by the Idaho Supreme Court *Hogaboom v. Economy Mattress*, 107 Idaho 13, 684 P.2d 990 (1984). The memorandum shall be submitted for the purpose of assisting the Commission in discharging its responsibility to determine reasonable attorney fees in this matter. Within fourteen (14) days of the filing of the memorandum and affidavit thereof, Defendants may file a memorandum in

response to Claimant's memorandum. If Defendants object to any representation made by Claimant, the objection must be set forth with particularity. Within seven (7) days after Defendants' response, Claimant may file a reply memorandum. The Commission, upon receipt of the foregoing pleadings, will review the matter and issue an order determining attorney fees.

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

DATED this 7 day of January, 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 7 day of January, 2011, a true and correct copy of the foregoing **FINDINGS, CONCLUSIONS,** and **ORDER** were served by regular United States Mail upon each of the following persons:

MICHAEL R MCBRIDE
1495 E 17TH ST
IDAHO FALLS ID 83404

DAVID P GARDNER
PO BOX 817
POCATELLO ID 83204-0817

djb /s/_____