BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

JOSEPH GERDON,

Claimant,

v.

CON PAULOS, INC.,

Employer,

and

LIBERTY NORTHWEST INSURANCE CORPORATION,

Surety,

Defendants.

IC 2008-019169

FINDINGS OF FACT, CONCLUSIONS OF LAW AND RECOMMENDATION

Filed: October 15, 2012

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee LaDawn Marsters, who conducted a hearing in Boise on January 30, 2012. Claimant was present and represented by Daniel J. Luker. E. Scott Harmon represented Con Paulos, Inc. and Liberty Northwest Insurance Corporation ("Defendants"). The parties presented oral and documentary evidence, took two post-hearing depositions and filed briefs. This matter came under advisement on July 26, 2012.

ISSUES

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

1. Whether Claimant is entitled to a change in attending physician and/or RSD/CRPS specialist;

2. The extent, if at all, to which Claimant is entitled to the following benefits:

a. Medical care including psychological care and counseling, orthopedic consultation for lower back and knee evaluation, physical therapy and prescription medications; and reimbursement for treatment-related travel expenses, meals and home modifications;

b. Permanent partial impairment (PPI); and

c. Disability in excess of impairment.

3. Whether Claimant is entitled to permanent total disability pursuant to the odd-lot doctrine; and

4. Whether Claimant is entitled to attorney fees pursuant to Idaho Code § 72-804.

At the hearing, Claimant contemplated including the issue of temporary disability benefits. He did not argue that issue in his briefing, however, so that issue is deemed waived.

CONTENTIONS OF THE PARTIES

There is no dispute that, on June 13, 2008, Claimant suffered a complex left ankle fracture in a car accident that occurred while a coworker was driving. Claimant has undergone extensive medical treatment by a number of providers, yet he continues to experience pain, instability and psychological problems that he believes render him totally and permanently disabled. Claimant's recovery was hampered by his weight and his addiction to narcotic pain killers, as well as by a low back injury he incurred in the STARS work hardening program approximately one year following his industrial accident.

Claimant contends that he is entitled to reimbursement for all of the treatment he has received, including food recommended by a nutritionist, as well as associated travel expenses, meals and home modifications. He also seeks on-going medical care, including psychological

care and counseling, physical therapy and prescription medication for chronic pain, as well as an order designating Daniel Marsh, M.D., as Claimant's treating physician. Claimant further asserts that, even if he is not found totally and permanently disabled, he is nonetheless entitled to partial permanent disability benefits and attorney fees for unreasonable practices in the adjustment of his claim. He relies chiefly upon the medical opinion of Dr. Marsh and the vocational disability opinion of Barbara Nelson, C.R.C.

Defendants counter that Claimant is not entitled to additional medical treatment or punitive attorney fees, and that he is not totally and permanently disabled. They argue that Claimant has been noncompliant with physicians in the past, leading to a number of care provider changes, and that his drug-seeking behavior and preexisting psychological issues are driving his reluctance to return to work and his desire for additional medical care. They also seek an order deeming Kevin Krafft, M.D., as Claimant's treating physician. Defendants rely upon the medical opinions of Dr. Krafft, Robert F. Calhoun, Ph.D., David Jensen, M.D. and others, and the vocational disability opinion of Mary Barros-Bailey, Ph.D.

OBJECTIONS

All pending objections are overruled.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. Exhibits admitted at the hearing:
    a. Claimant's Exhibits 1-52; and
    b. Defendant's Exhibits A-N;
2. Testimony taken at the hearing from:
    a. Claimant;

b. Rachel Gerdon, Claimant's wife;

c. Mickey Gerdon, Claimant's mother; and

d. Barbara Nelson, C.R.C., a vocational disability consultant; and

3. The post-hearing deposition testimony of:

a. Robert Friedman, M.D., taken on March 1, 2012; and

b. Mary Barros-Bailey, Ph.D., a vocational disability consultant, taken on April 18, 2012.

After having considered all the above evidence and 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 33 years of age at the time of the hearing and resided in Jerome, Idaho at all relevant times. He is a high school graduate, with some college coursework toward a degree in either psychology or social work.

2. Claimant's work history includes jobs in fast food service, call centers, landscape maintenance, arcade management and car sales. He has a felony conviction for forging a check when he was 19. At the hearing, Claimant, unpersuasively, explained that he did not really remember the incident that led to his conviction.

3. At his time-of-injury job with Con Paulos, Claimant was the floor manager supervising a team of car salespeople. "At the end I wasn't selling cars anymore…I was running the sales team and they were selling cars and I was making money off the cars they sold." Tr., p. 75. Claimant described the physical requirements of his job:

> You always have to be out walking the lot. Watching your guys. Watching other guys. You just have to be out walking the lot, making sure that your guys are - -

> had control of the customers, making sure that they are always ready for a turn and turns are like if they're losing control of a customer you can step in there and introduce yourself. You know, what I did really good was I had the ability to get somebody in a demo. You know, hey, blah, blah, blah, this car is really good for this, you know. Let's take it for a drive. Get them in a demo, start driving the car, and, then, getting them inside the dealership, you know, and you always had to be around outside walking, walking, walking and, then, when you were inside you had to be able to move fast, because it's like - - you only have so long to complete a deal…".

Tr., pp. 75-76.

PREEXISTING MEDICAL CONDITIONS

4. At ages 3 and 15, Claimant underwent bilateral eye surgeries.

5. On January 19, 2007, Claimant slipped and fell at home, injuring his low back. An urgent care center chart note indicates he had trouble sitting and standing for long periods. He was administered medications including a narcotic pain medication.

6. On October 22, 2007, Claimant sought treatment for lower back pain at an urgent care center. He complained of right leg numbness and left leg pain and reported a history of occasional lower back pain. Sciatica due to a bulging spinal disc was diagnosed and narcotic pain medications were prescribed. Subsequently, Claimant was referred to David Jensen, D.O., at the Spine Institute of Idaho for an October 25, 2007 appointment. There is no evidence in the record that Claimant ever followed up.

7. On May 6, 2008, Claimant sought emergent care at St. Benedict's Family Medical Center in Jerome for nausea and diarrhea. The chart note states he weighed 308 pounds. The record also evidences other conditions for which Claimant was treated or with which he was diagnosed, which are not directly relevant to the issues presented herein.

INDUSTRIAL INJURY AND RESULTING CONDITION

8. On June 13, 2008, Claimant was riding as a passenger in a vehicle driven by a coworker when it went off the road. Claimant reported to police that something was in the road so he told the driver to swerve. His medical records over time sometimes indicate that a deer jumped out in front of the car and sometimes that the driver fell asleep, sometimes that the vehicle rolled and, more often, that it did not. At the hearing, Claimant described the accident in vivid detail. He testified that he was awakened when the car drove over the rumble strips on its way off the road. Claimant thought the driver had fallen asleep, but the driver had told him he swerved to miss a deer. Claimant explained that the car rolled down a steep hill, caught air, and landed hard.

9. Claimant was transported to Weiser Memorial Hospital, where his only complaint was left ankle pain. The chart note states he weighed 280 pounds, apparently by Claimant's report. Claimant denied any other musculoskeletal complaints, as well as any loss of consciousness, chest pain, vision changes, or shortness of breath. X-rays confirmed a depressed tibial plafond fracture with multiple comminuted fragments in the distal tibia, for which surgery was performed. During surgery, fragments of Claimant's ankle were reassembled with orthopedic hardware through an open reduction and internal fixation procedure.

10. Claimant was discharged two days later, with crutches and a splint, in "excellent condition". CE-65. Medications were prescribed, including a prescription for narcotic pain medication, and Claimant was instructed to keep weight off of his left ankle and to follow up with an orthopedist.

11. Thereafter, through the hearing date, Claimant obtained a great deal of medical care from many different providers. A summary of this care follows. Ungainly as it may be, it is

necessary to provide a meaningful understanding of the basis for the parties' positions and the Referee's determinations.

INITIAL MEDICAL FOLLOW-UP: JULY 1-14, 2008

12. Claimant was treated during this period by Blake Johnson, M.D., an orthopedic surgeon at St. Luke's Clinic in Twin Falls; his practice partner, Mark B. Wright, M.D.; emergency department personnel at St. Luke's Magic Valley Regional Medical Center; and Douglas Stagg, M.D., an occupational medicine specialist. Claimant was diagnosed with knee pain consistent with a dashboard injury (with unremarkable x-ray findings), left ankle sores and a heel sore from his orthopedic boot, and anxiety about returning to work. Dr. Johnson prescribed no medications and instructed Claimant to stop taking anti-inflammatories. However, an emergency department caregiver later prescribed narcotic pain medication. "It sounds like he has been sitting in a wheel chair getting around and I think this is causing increased swelling which is obviously causing increased pain." CE-137. Dr. Stagg then prescribed more narcotic pain medication. By the time he saw Dr. Wright, Claimant was also taking lorazepam, an anti-anxiety medication. There is no evidence in the record that Claimant took anxiety medication prior to his industrial accident.

13. Claimant's mother, Mickey Gerdon ("Mickey"), is a registered nurse who assisted Claimant and his wife in Claimant's post-accident care. Claimant's wife was in late-stage pregnancy, coping with her own medical issues (cystic fibrosis) and, at four-foot-six inches and less than 90 pounds, physically limited in her ability to assist Claimant.

14. Mickey Gerdon spoke with an administrative employee at St. Luke's Clinic on July 14, 2008 because she wished to transfer Claimant's care from Dr. Johnson to Dr. Wright. She was concerned because Dr. Johnson's assistant had not immediately returned her call.

Dr. Wright, however, did not wish to take over Claimant's case because he had initiated care with Dr. Johnson. So, Mickey advised that they would probably seek care elsewhere.

MEDICAL TREATMENT AND RETURN TO SEDENTARY WORK: JULY 22-OCTOBER 8, 2008

15. During this period, Claimant was treated by Frederick L. Surbaugh, M.D., an orthopedic surgeon, in referral by Dr. Stagg; and, in referral by Dr. Surbaugh, Richard J. Hammond, M.D., a neurologist, and David Verst, an orthopedic spine surgeon.

16. Claimant reported to Dr. Surbaugh that his mother had been helping him since he is overweight and hadn't been able to get up much to use his walker, though he was using his wheelchair. Dr. Surbaugh recommended active range of motion exercises, prescribed more narcotic pain medication, and ordered blood testing which identified a mildly elevated concentration of C-reactive protein, an indicator of inflammation in the body.

17. On July 29, 2008, for the first time, Claimant reported to Dr. Surbaugh that he had experienced thoracic and lumbar spine pain since the accident. He also reported that he had suffered a blow to the head during the accident inducing unconsciousness for 30-45 minutes, and that he had experienced no back problems prior to his industrial car accident. Spine x-rays confirmed flattening of the lumbar lordotic curve with preserved lumbar vertebra and disc spaces and compression fractures at five, possibly six, levels in the thoracic spine. "He is so large he is somewhat difficult to penetrate but the compression fractures are in the mild to moderate range, i.e. 10-20% that are definite." CE-149. Also, Claimant had a positive Tinel's sign with pressure over his posterior and anterior tibial nerves causing paresthesias radiating into his foot.

18. Dr. Surbaugh recommended mobilizing the left ankle with 30% weight bearing (with a brace), and referred Claimant to Dave Little, physical therapist, for both spine and ankle

rehabilitation. He also requested authorization from Surety for a neurological consultation. In addition, Dr. Surbaugh recommended that Claimant, who he noted was anxious to return to work, should accept Employer's offer of 10-15 hours of work per week answering telephones. He believed this would help Claimant psychologically. Finally, Dr. Surbaugh recommended vitamins to aid Claimant with his poor nutrition.

19. Claimant returned to work, answering telephones at Con Paulos, pursuant to Dr. Surbaugh's recommendation. Employment records indicate he worked from July 31, 2008 through August 30, 2008. During his last seven days, he worked approximately 30 hours.

20. On August 19, 2008, Dr. Surbaugh wrote an open letter to Surety detailing Claimant's condition and recommending follow-up. Among other things, he observed that it was "obvious" Claimant was developing reflex sympathetic dystrophy ("RSD" or "CRPS"[1]) because his left foot was "sensitive to pressure, discolored, edematous, and reacts poorly to cold." CE-150. He also reported that Claimant continued to "experience rather severe mid and low back pain with radiation to the right lower extremity, the non-injured side, with paresthesias radiating into the dorsum of the foot." *Id.* Dr. Surbaugh recommended:

a. Consultation with Dr. Hammond regarding radicular pain;

b. Clonidine therapy;

c. Desensitization with hydrotherapy, preferably through a gym membership allowing access to a hot tub, or else a hot tub rental;

d. Consultation with a pain specialist for consideration of sympathetic block therapy;

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[1] Chronic regional pain syndrome, type 1, is another identifier for RSD.

e. An MRI of Claimant's thoracic and lumbar spine by a conventional GE 1.5 tessla magna machine or, if Claimant cannot fit, then by a large format 1.5 unit in Boise;

f. Future removal of the transverse screw;

g. Continuation of physical therapy with Dave Little;

h. Bariatric counseling because Claimant's excessive weight "is going to compromise his rehab" (CE-151); and

i. Continued narcotic pain medications at the rate of two 7.5 mg hydrocodone tablets daily.

21. On September 5, 2008, Claimant underwent a nerve conduction study by Dr. Hammond. Dr. Hammond opined the study was essentially normal, with a few fibrillations in the distally enervated muscles, probably secondary to focal trauma. The study evidenced no significant denervation, with intact-appearing peroneal and tibial motor activity.

22. On September 9, 2008, Dr. Surbaugh authored another open letter to Surety in which he reported that Claimant's symptoms persisted, though physical therapy was improving his ankle motion. Dr. Surbaugh noted Claimant was on Clonidine therapy, that his left ankle area was less hypersensitive, that he could bear about 35 pounds on his left lower extremity, and that he was still doing sedentary work. Claimant was still taking narcotic pain medication, though Dr. Surbaugh warned Claimant and his family against the risks of long-term dependence. He advised that Claimant had reduced his intake from five tablets per day to three; however, he had reported in his previous letter that Claimant was taking only two tablets per day, so it would appear that Claimant's use had actually increased. Dr. Surbaugh again requested approval for a spine MRI and referred Claimant to Dr. Jensen for additional follow-up on his back condition. A

chart note, also dated September 9, 2008, reflects that Dr. Surbaugh's office scheduled the recommended MRI for September 12, 2008 in Boise.

23. On September 10, 2008, without again seeing Claimant, Dr. Surbaugh took Claimant off work for two weeks due to increased ankle symptoms. On September 22, 2008, he reported that Claimant's MRI showed problems, possibly subacute, at Claimant's L3-4 disc.[2] He recommended a spine consultation and referred Claimant to a dietician for diet therapy.

24. On September 23, 2008, Dr. Hammond noted Claimant reported low back pain and "several compression fractures" but no pain radiating from his back to his legs. CE-428. On exam, among other things, Dr. Hammond found the temperature at the top of Claimant's right foot was 26.2 degrees, but 27.9 at the top of his left foot, even though the left foot appeared "duskier." CE-430. Dr. Hammond concluded that Claimant's left foot pain was mostly orthopedic in nature, with some trauma to his superficial nerves. He did not believe Claimant had CRPS, but recommended continued treatment in case he did. Dr. Hammond also assessed post-traumatic stress disorder, solely based on Claimant's reports of mood difficulties and thinking a lot about the accident. For this, he prescribed Seroquel.

25. On September 25, 2008, Dr. Surbaugh wrote an open letter to Surety in which he reported improvements in Claimant's CRPS signs but not in his ankle motion. He confirmed that Dr. Hammond had evaluated Claimant, recommending Neurontin and an anti-depressant for Claimant's accident-related CRPS and bilateral lower extremity pain, and urged Surety to reconsider its determination that the recommended treatment was unrelated to the industrial injury. Dr. Surbaugh also reaffirmed his recommendation for a spine consultation regarding

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[2] Claimant's September 12, 2008 thoracic and lumbar spine MRI report, prepared at Boise MRI, identified "1) No acute abnormalities or compression fractures. 2) Degenerative disk and facet disease is most pronounced in the lumbar spine at L3-4 where disk bulge causes moderate canal stenosis effacing CSF around the nerve roots and moderate left foraminal stenosis." CE-422. It also described a bulge causing moderate left foraminal stenosis at both L3-4 and L4-5.

Claimant's right lower extremity pain, which he believed was related to his lumbar spine problems, and recommended that Claimant continue his physical therapy and weight loss efforts.

26. On October 2, 2008, Claimant was evaluated by Dr. Verst for pain in his back and right leg, as well as headaches and pain in his neck and shoulders. The accompanying chart note states Claimant was 6"1', weighed 300 pounds, and smoked a half a pack a day. Claimant reported that his pain was worsening and that long periods of sitting, standing or walking increased it. Based on Claimant's answers to questions about his condition, Dr. Verst assessed a functional rating index score of 38, which placed Claimant in the "severe impairment" category. CE-439. The highest possible test score was 40 points, just two points "worse" than Claimant's score. In addition, Claimant demonstrated "[n]o evidence of depression, anxiety, and or psychological breakdown." CE-439. All five credibility tests assessed by Dr. Verst indicated Claimant was providing credible efforts on exam. Dr. Verst diagnosed a herniated disc at L3-4 based on exam and MRI findings. He recommended physical therapy "to stop the propagation of the spinal deconditioning and promote conditioning of the spine," and injection therapy. CE-441. Although he noted that approval from Surety was needed, he did not opine which of Claimant's conditions were (or were not) work-related.

27. On October 8, 2008 and November 25, 2008, Dr. Surbaugh authored additional letters to Surety. The contents of those letters are not in evidence. His final chart note regarding Claimant's condition is dated October 23, 2008. It states Claimant had improved and, specifically, that his ankle motion had increased with passive therapy. Also, he had undergone an epidural steroid injection with Dr. Dille for his right lower extremity pain (*see* below). Dr. Surbaugh recommended continuing physical therapy with Dave Little and joining a gym so he could swim, with the goal of losing weight.

MEDICAL TREATMENT: OCTOBER 9, 2008-JANUARY 28, 2009

28. Claimant was treated during this period by Clinton Dille, M.D., an anesthesiologist specializing in pain control (in referral by Drs. Verst and Surbaugh), Dr. Hammond, Dr. Verst and Mr. Little.

29. Claimant described his neck pain to Dr. Dille as both sharp and dull, among other descriptors, located at the midline of his posterior neck, with pain radiating to his head and causing occipital headaches constantly throughout the day. Only lying down and hydrocodone improved the pain. Claimant described his back pain as both dull and sharp, with burning and numbness, among other things. He explained that his pain originated in his low back and radiated down both legs, into both feet. Only lying down improved his back pain. Based on Claimant's reports, Dr. Dille believed both his neck and back pain were related to Claimant's industrial accident. In addition, Claimant complained of depression but denied anxiety. Claimant reported his weight as 300 pounds, but refused to be weighed because he could not stand long enough.

30. Dr. Dille noted Claimant's thoracic spine x-rays were suspicious for compression fractures from T7-12, but that the MRI report failed to note any fractures or edema. He opined that Claimant's mid back pain may be a result of mild compression fractures and, if so, he would expect them to heal with time. He found no cervical spine x-rays and advised Claimant to discuss with Dr. Surbaugh whether any should be taken.

31. On October 10, 2008, Dave Little summarized Claimant's condition and care to date. He confirmed that Dr. Surbaugh referred Claimant on July 30, 2008 for injuries he sustained in his industrial accident, with symptoms including "thoracic compression fractures; headaches; neck pain; bilateral upper extremity pain, numbness, and tingling; significant low

back pain; and numbness, tingling, and weakness to bilateral lower extremities." CE-240. Mr. Little also "recently received a referral from Dr. Verst for spinal care for his back and neck symptoms resulting from the trauma from the MVA." *Id.* Claimant's continuing limitations included inability to:

a. Ambulate more than 30-50 mini-steps at a time, using a walker;

b. Bear more than 65% of his weight on his left side (due to neck, back and bilateral upper and lower extremity injuries);

c. Achieve a neutral position with his left ankle (due to scar tissue and tightening); and

d. Return to work due to extensive injuries and trauma.

32. Mr. Little also noted Claimant had experienced frequent falls at home as a result of his right leg instability, and that after significant work, Claimant was finally able to self-transfer from bed to wheelchair or walker, and on and off the toilet.

33. Mr. Little, in an attempt to justify a higher fee limit for Claimant's treatment, reported to a third-party auditor (DxFee® Review) on October 10, 2008 that Claimant had worked diligently in physical therapy, but his many severe injuries would require significant additional rehabilitation and treatment. Mr. Little also opined that Claimant's difficulties obtaining approval for treatment from Surety had negatively impacted his recovery:

> We have also had complications with delays by the insurance company for approving proper medications prescribed by Dr. Hammond and Dr. Surbaugh. There was also a six to seven week delay for an MRI to be authorized that was ordered by Dr. Surbaugh. This significantly delayed our ability to progress this patient toward even minimal goals of full weightbearing and normal ADLs.

CE-240. Chart notes indicate Mr. Little obtained some of his information during an October 8, 2008 telephone call with Dr. Surbaugh.

34. On October 13, 2008, DxFee® Review, represented by Susan Mann, R.N., wrote to Mr. Little:

> Based on these findings, it is my determination that the treatment rendered to Mr. Joseph Gerdon has been of appropriate therapeutic value in assisting him in recovery from is injury/surgery and improving his overall functional status. As a result of these findings, DxFee® assignment has been lifted secondary to the extensive amount of physical therapy required for the patient to recover from his/her injury/surgery.

CE-248.

35. Also on October 13, 2008, Claimant underwent an epidural steroid injection by Dr. Dille for his lower spine symptoms. On the following day, Claimant called and reported some improvement in his pain, but continued numbness in his legs. On October 22, 2008, Dr. Dille evaluated Claimant, whose lower back pain had returned. He had minimal to no radicular pain, however, and his right leg numbness had resolved. Claimant requested more narcotic pain medications, which Dr. Dille provided.

36. On October 27, 2008, Claimant underwent another epidural steroid injection into his lumbar spine by Dr. Dille, since Dr. Dille estimated Claimant's prior injection had produced a 10% improvement. On November 6, 2008, Claimant reported at a follow-up appointment with Johnny Urrutia, a physician assistant in Dr. Dille's office, that the injection was not helpful. As well, he advised that Surety had not paid for this treatment. He reported continuing back, neck and left leg pain. Mr. Urrutia arranged for a third epidural steroid injection and noted that he did not refill Claimant's pain medication because it was not yet time to do so. He also reported that Claimant's CRPS was improving; however, if the progress in that regard stalls, a lumbar sympathetic block should be considered.

37. On October 28, 2008, Claimant followed up with Dr. Hammond, who noted that Claimant had undergone an MRI which identified a herniated disc at L4-5 (he does not mention L3-4) and was now having numbness down both of his legs. In addition, Claimant reported Dr. Verst had recommended surgery. Claimant was still in his wheelchair, and he could rub his left leg without pain or difficulty, but he still had trouble with dorsiflexion in his left foot. Dr. Hammond continued Claimant's medications, increasing his Seroquel. Although he instructed Claimant to follow up in six to seven weeks, Claimant apparently never did.

38. On December 4, 2008, Claimant was again assessed by Dr. Verst. Claimant reported no change in his subjective complaints, and that the epidural injections had worsened his pain. Dr. Verst recommended a discectomy at L3-4 since conservative methods of treatment had failed, and Claimant wished to proceed. On January 8, 2009, however, Dr. Verst retracted his surgical recommendation after again evaluating Claimant. He confirmed that Claimant still had back pain related to his herniated disc, but noted that "[i]t is difficult to discern if this is related to a herniated disc or disc annular protrusion." CE-444. He now believed the best plan was to allow Claimant's left ankle to heal and then reevaluate Claimant later, if necessary. Although Dr. Verst recommended that Claimant follow up on an as-needed basis, he saw "no need for future follow up unless he continues to have back and leg pain." *Id.* Further, "I am not going to provide any further treatment and/or pain medications for Mr. Gerdon." *Id.*

39. Claimant asserts that Dr. Verst's revised treatment plan was improperly influenced by Surety. The Referee finds insufficient evidence in the record to support this allegation.

MEDICAL TREATMENT: JANUARY 29, 2009 – APRIL 9, 2009

40. During this period, Claimant was treated by Brian Johns, M.D., an occupational medicine specialist; Michael J. Coughlin, M.D., an orthopedic surgeon; William G. Binegar, M.D., pain specialist; Fred Friel, physician assistant to Dr. Binegar; Doug Morton, P.T.; and Mr. Little.

41. On January 29, 2009, Claimant reported to Dr. Johns that he had sustained seven compression fractures in his neck, disc injuries in his back and a left ankle fracture as a result of the industrial accident. He said the driver had fallen asleep. He also reported he was taking medication for CRPS and PTSD, and that he had been out of the wheelchair for ten days, attending physical therapy three days per week. Claimant advised he would need lumbar surgery in the future, after his ankle condition resolved. Following examination, Dr. Johns concurred with the CRPS diagnosis and prescribed additional narcotic pain medication. He noted Claimant would need to wean off this medication in the future, but that it would not be a good idea to discontinue his pain medication until after he was walking for awhile longer. Dr. Johns also recommended follow-up with a physiatrist regarding CRPS treatment. Claimant was again released to work in a wheelchair, with no weight-bearing on his left ankle.

42. A January 29, 2009 chart note by an assistant at St. Luke's Clinic states that surety approved a referral to a physiatrist.

43. On February 17, 2009, Claimant was evaluated by Dr. Coughlin, at Surety's request. There is no language in his resulting report to indicate he was acting as an independent medical evaluator, and he closed by offering to treat Claimant. "I would be willing to treat him at this point because he needs a quarterback to follow him and he seems to have fallen through the cracks in the medical treatment plan." CE-482. To clarify Dr. Coughlin's relationship with

Claimant, it would appear that Dr. Coughlin initially provided a second opinion, and then became his primary treating physician.

44. Claimant's wife and Martha Peterson, nurse case manager for Surety, were also present at Claimant's initial evaluation by Dr. Coughlin. Claimant used a cane or walker to ambulate, having been out of the wheelchair for a month. He reported that his only other physician was Dr. Verst, as he had been discharged from care by Dr. Surbaugh.[3] Claimant was frustrated that he was not getting better and was not working, and he reported his pain as a "10", the highest degree on the pain scale.[4] Claimant was smoking 15 cigarettes per day but wanted to quit, and weighed 310 pounds. Claimant had muscle pain, decreased sensation in his feet, difficulty walking, depression and anxiety. On exam, Dr. Coughlin noted Claimant walked with an antalgic gait and a marked limp. In addition, Claimant had marked erythema of his lower extremities, marked coolness of his left leg from the midcalf down, and Claimant was hypersensitive when Dr. Coughlin ran his hand up and down the leg.

45. Dr. Coughlin diagnosed "significant sympathetic dystrophy post injury." CE-482. He recommended consultation with William Binegar, M.D., a pain specialist (specifically mentioning sympathetic nerve blocks), and aggressive physical therapy. Dr. Coughlin also strongly recommended that Claimant move to Boise to obtain this treatment. "He will have to live here in Boise on a regular basis for (I am assuming) four to six weeks. He and his wife just had a newborn baby and I just feel to try to turn the corner on this he is going to have to come to Boise and be treated." CE-482. In addition, Dr. Coughlin opined that there was "no possibility" that Claimant could return to work until his CRPS was resolved, and that Claimant should

[3] No explanation for Dr. Surbaugh's discharge is noted. Dr. Coughlin reports, "There are no other notes regarding Dr. Surbaugh's evaluation and treatment over the ensuing four to five months." CE-481.
[4] Claimant regularly, throughout his treatment, reported his pain at levels of 8, 9 or 10. He rarely reported a lower level.

receive treatment "expeditiously." *Id.* Along those lines, Dr. Coughlin invited a call from Surety to arrange Claimant's care.

46. Claimant continued to attend physical therapy sessions with Mr. Little. On February 17, 2009, Mr. Little noted that Dr. Surbaugh had released Claimant from care and, as a result, he was now seeing Dr. Coughlin. Claimant reported that a “case worker” named “Marsha”[5] was present at his evaluation. He also reported:

> Dr. Coughlin feels he has a severe case of CRPS and that this should have been addressed months ago…[and] is very concerned about the extent of the CRPS and the length of the extended time frame for appropriate medical followup [*sic*]. He is recommending a possible 10 week stay in Boise to set Joe up with a Physician [*sic*] (whose name may be Dr. Bilingsley) for undergoing multiple nerve blocks and to go through aggressive Physical Therapy [*sic*]…Patient was very upset again today about the chronic ongoing nature of his poor medical follow up because of his work comp insurance company denying proper medications, and delaying his appropriate medical care, not only for his foot and ankle but also for his back as was discussed in the past.

CE-295.

47. Claimant continued to treat with Mr. Little until March 6, 2009. Thereafter, he resumed treatment, in referral by Dr. Krafft, on July 17, 2009. (See below).

48. Also on February 17, 2009, Claimant was evaluated at the Pain Care Center in Boise by Mr. Friel, in referral by Ms. Peterson.

49. According to Mr. Friel (in a letter to Dr. Coughlin), Claimant reported CRPS symptoms and related inability to work, as well as other information about his condition. Claimant was smoking a pack a day and reported a 60-pound weight gain since the accident[6], but no weight for Claimant on that day was recorded. Claimant also reported depression and anxiety. On exam, Mr. Friel noted CRPS signs on Claimant's left ankle area, including abnormal swelling, color, temperature, sweating, allodynia, hyperalgesia to light touch, decreased range of

[5] Apparently, Claimant was referring to Martha Peterson, Surety’s nurse case manager.
[6] Note that, on the same day, Dr. Coughlin recorded Claimant’s weight at 310 pounds, two pounds heavier than his pre-accident weight recorded on May 6, 2008.

motion, decreased sensation to the lateral aspect of the foot, and significantly decreased motor to the foot dorsiflexion, plantar flexion, and great toe flexion and extension. Claimant also had neck tenderness and pain in his low back and hips. Claimant had normal sensation in his right lower extremity, and no knee pain. Mr. Friel also reviewed Claimant's imaging studies, which did not include a cervical spine study.

50. Mr. Friel diagnosed lower left extremity CRPS, low back pain radiating into the lower right extremity, myofascial pain, cervical pain and thoracic pain. Mr. Friel recommended five left-side lumbar sympathetic injections at approximately one-week intervals, providing that they improved Claimant's symptoms. He also recommended physical therapy with Doug Morton, P.T., as directed by Dr. Coughlin. Claimant entered into a pain contract specifying that only the Pain Care Center would prescribe his medications, and Mr. Friel prescribed hydrocodone, Seroquel and Neurontin.

51. On March 9, 2009, Claimant began physical therapy with Doug Morton, P.T., in Boise. His last session took place on June 30, 2009. Claimant's condition did not significantly improve during this period, as further detailed herein.

52. Also on March 9, 2009, Claimant received his first left lumbar sympathetic block by Dr. Binegar. The procedure was repeated on March 26, 2009. On April 13, 2009, Claimant followed up with Dr. Binegar, reporting no significant lasting change in his pain. Ms. Peterson was also present. Dr. Binegar discontinued Claimant’s sympathetic block series because he did not do well with the second injection. He recommended the STARS work hardening program and, if that did not improve Claimant's condition, then he believed it would be appropriate to consider a spinal cord stimulator trial. He discontinued Claimant's Seroquel, because Claimant

did not think it was helping, and increased his Neurontin. He planned to follow up with Claimant in two weeks.

53. On April 9, 2009, Claimant returned to Dr. Coughlin. On exam, Claimant's hypersensitivity over his lower left extremity had decreased, but he still had discoloration and a slight temperature change. Claimant was "still not using his Prozac." CE-483. Dr. Coughlin kept Claimant off work and noted that he was waiting to receive a progress report from Dr. Binegar regarding his "game plan." *Id.*

EVALUATION FOR THE STARS PROGRAM

54. On April 14, 2009, Claimant was evaluated by Kevin Krafft, M.D., a physiatrist, for the STARS work hardening program. At the time, Claimant could walk 7-10 minutes with a cane or five minutes without one. Dr. Krafft noted that Claimant did not smoke. Following examination and review of Claimant's imaging studies (which did not include any cervical spine imaging), Dr. Krafft recommended the work hardening program, a neuropsychology assessment and an Industrial Commission Rehabilitation Division (ICRD) job assessment. He also recommended neuropathic pain medication and walking on a treadmill to improve Claimant's functional gait pattern. In addition, Dr. Krafft wrote a letter to Surety in which he assessed Claimant with CRPS symptoms, set forth his above-described recommendations, and agreed to serve as Claimant's primary care physician so long as Claimant did not receive pain medications from any other source. He also opined that, if Claimant was planning on weight loss surgery, then the work hardening program should be postponed.

55. On April 15, 2009, Claimant was evaluated by Peggy S. Wilson, P.T., for STARS program candidacy. Claimant reported ongoing left and right lower extremity symptoms, low back pain, and occasional pain in his neck since March 2009. After extensive examination and

testing, in which Claimant participated with good effort but only fair tolerance to activity, Ms. Wilson deemed Claimant a "fair" candidate for the work hardening program. "The client demonstrates fair potential for improvement by receiving these services." CE-537. She recommended participation at the rate of 2-4 hours per day, five days per week, for 4-6 weeks.

56. On April 22, 2009, Claimant was evaluated by Robert F. Calhoun, Ph.D., a neuropsychologist, for eligibility for the STARS program. Dr. Calhoun took Claimant's history and reviewed the available medical records. Claimant reported he stopped smoking two months ago, that he had diagnoses of RSD, PTSD and injuries to his lumbar spine and left ankle, and that spine surgery had been recommended. He also advised that his mother is a nurse and had been counseling him on his medical care. Claimant described his frustration with his pain, as well as his emotional distress and his ongoing anger toward past physicians. He also reported that he did not have an attorney or lawsuit pending.

57. Dr. Calhoun administered tests, all of which produced valid profiles.[7] Claimant's test results demonstrated that he was:

a. Experiencing psychological distress, lassitude and malaise;

b. Significantly depressed, sad and blue;

c. Highly anxious;

d. Acutely angry, responding to a wide variety of situations with anger and irritability;

e. Tempestuous, cynical and hostile, with chronic issues concerning cynicism and hostility;

f. Pessimistic about his future and not easily trusting of others;

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[7] Dr. Calhoun administered the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), State-Trait Anger Expression Inventory – (STAXI-2), and the Detailed Assessment of Posttraumatic Stress (DAPS).

g. Feeling insecure in his world and tending to ruminate over his problems;

h. Highly somatically focused and at risk for somatizing stress;

i. Likely experiencing intensified pain while under emotional stress; and

j. Reexperiencing his accident, avoidant of stimuli associated with it, and at risk for hyperarousal, all of which are indicative of PTSD.

58. Dr. Calhoun opined that Claimant had "significant psychological and behavioral factors impacting his pain problem and level of rehabilitation." CE-668. "Most notable is this patient's heightened state of emotional distress characterized by symptoms of posttraumatic stress disorder, anxiety, short frustration tolerance, and propensity toward anger and hostility." *Id.* He thought it likely that Claimant's left lower extremity pain intensified when he was under emotional stress, and that Claimant was at risk for sympathetic system overreactivity, which could also exacerbate his pain. Dr. Calhoun also opined that Claimant's inability to relax and his alteration of his gait were likely contributing to his pain, and that Claimant lacked sufficient coping skills.

59. Because Claimant appeared to be motivated to get better, Dr. Calhoun recommended him as a reasonable candidate for the Work Star Program. He also recommended an antidepressant with anxiolytic properties, a beta blocker to aid with sympathetic nervous system overreactivity, and 10-12 counseling sessions.

60. Dr. Krafft examined Claimant on April 27, 2009 and reaffirmed his CRPS diagnosis and his STARS program referral.

STARS PROGRAM – APRIL 28, 2009 – JUNE 12, 2009

61. Claimant's initial STARS session took place on April 28, 2009. He was punctual, cooperative and set forth good effort; however, he demonstrated low tolerance for activities.

Claimant's progress was monitored at interdisciplinary staffing meetings, all of which were attended by Ms. Peterson, and one of which was attended by Mickey Gerdon. When Claimant attended, he was cooperative and punctual. However, he missed several days due to various reasons, and on many days that he attended, his lifting activities were curtailed due to pain flare-ups.

62. Reports in evidence indicate that Claimant underwent cardiac consultations,[8] in referral by the STARS panel, which cleared him medically for that program, from a cardiac standpoint.

63. In early May 2009, the panel discussed Claimant's weight loss issues and Ms. Peterson suggested that the team move forward with a recommendation to a nutritionist. After Claimant saw, but did not like, Vicki B. Graf, R.D., of Humphreys Diabetes Center, Ms. Peterson approved a change from Ms. Graf to his wife's nutritionist. Claimant complained that Ms. Graf had not helped, but had only recommended he stop drinking Gatorade. However, Ms. Graf's May 26, 2009 chart note indicates she advised him to commit to a 2,200 calorie low-fat meal plan and to eat more than once per day, among other things. Claimant continued to see Ms. Graf and at one point reported improvements based upon her recommendations.

64. Although Dr. Krafft had early suspicions that Claimant's wife may be enabling him, he ultimately backed off this notion, ultimately believing that she was only very concerned. "Dr. Krafft concluded that he believes the client really wants to step up to the plate and do [*sic*] best that he can." CE-551. Throughout his STARS participation, Dr. Krafft treated Claimant's various pain flare-ups and monitored his overall condition. On May 7, 2009, Claimant reported

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[8] On May 1, 2009, Claimant was evaluated by Mark Parent, M.D., cardiologist, for shortness of breath, dizziness, chest tightness and pain shooting down his left arm. Claimant reported he had gained 150 pounds since his injury, was very sedentary and was under increasing stress. He also reported that he did not smoke. At the time, he was residing temporarily in Boise while he attended the STARS program. Dr. Parent ordered a stress nuclear scan, which ruled out coronary artery ischemia.

that he hurt his back doing a twisting activity and that he had an episode of full right leg numbness for a day and a half that resolved with physical therapy. On May 13, 2009, Claimant reported that the TENS unit was not helping, but that his back was improved and his right leg symptoms had resolved. He rated his pain as a constant "5". Dr. Krafft decreased Claimant's hydrocodone and refilled his Seroquel for PTSD. He adjusted Claimant's other medications and prescribed Paxil, an antidepressant with anti-anxiety properties, at Dr. Calhoun's recommendation. On May 20, 2009, Claimant reported that he did not believe he would be able to return to work in the next six months because he did not think he could beat the other salesman out to greet customers, operate a clutch or stand for extended periods. Dr. Krafft reviewed "hurt versus harm" thinking with Claimant and discussed potential treatment options. CE-592. Claimant responded that he is "mentally soft at this time and does not know if he can get to the point that he envisions himself returning to his previous employment." *Id.* On May 28, 2009, Claimant again followed up with Dr. Krafft. Claimant was now taking Cymbalta for depression, which was helping. Dr. Krafft continued to taper Claimant off hydrocodone and to adjust his other medications.

65. By June 3, 2009, Claimant had worked up to standing for 70 minutes and 35 seconds in job simulation exercises. There was uncertainty as to Claimant's return-to-work prospects at Con Paulos. Dr. Calhoun was still working with Claimant on pain management strategies. Dr. Binegar had released Claimant to work and Dr. Coughlin had recommended no further surgery on Claimant's left foot. Ms. Peterson believed Claimant's mother was stoking his fear of returning to work, and recommended that he return to work on a part-time, full-day basis, working into full-time, full-day. Mr. Taylor advised that Con Paulos would let Claimant return as a salesperson on a part-time, but full-day basis, but there was no way to modify the job.

Ms. Peterson agreed that Claimant should continue to treat with Dr. Krafft and Dr. Calhoun after completing the STARS program. She also noted that Claimant had lost 32 pounds, and that he was still welcome to work with his wife's nutritionist.

66. Claimant attended counseling sessions with Dr. Calhoun seven times following his initial evaluation, between May 12, 2009 and August 19, 2009. He worked on cognitive restructuring techniques to aid in his pain control. Claimant was slowly improving until June 9, when he reported being scared and overwhelmed at times, and more stressed out lately, thinking about returning to work. Thereafter, Dr. Calhoun’s records indicate that Claimant regressed to baseline and made no additional improvement. On his last visit, Claimant was advised to follow-up in 2-3 weeks, but he apparently never returned.

67. Mickey Gerdon participated in the June 10, 2009 staffing meeting. She asked if Claimant would be released without restrictions and, due to the lack of lifting and freedom of movement associated with Claimant's job, Dr. Krafft said he would be. Claimant was on his feet 2-3 hours out of each recent 4-hour session. He could walk 1.6 miles per hour on the treadmill (his ultimate goal was 2 miles per hour), and he could go 50 feet in 22-23 seconds (his ultimate goal was 15-20 seconds). Dr. Krafft was concerned that Claimant needed to be quick to compete with the other salesmen for customers and encouraged Ms. Wilson to continue working on his cadence and gait. Dr. Calhoun noted Claimant was better able to calm himself when he was experiencing pain and estimated that he would need to see him 3-4 more times over the summer. Ms. Peterson approved a three-month gym membership in Jerome to help keep Claimant in shape, and Dr. Krafft wrote the prescription. Claimant's discharge was planned for June 12, 2009.

MEDICAL TREATMENT: JUNE 12, 2009 STARS INJURY

68. On June 12, 2009, during Claimant's exit testing on his last day at the STARS program, he injured his back. He was initially evaluated by Dr. Krafft. "He reports that he was doing a lift at work hardening when he felt a pop in his back. His right leg went numb. He reports pain that reaches as high as an 8½ or 9 out of 10." CE-601. Claimant's left foot discomfort was unchanged. Dr. Krafft planned to obtain an MRI of Claimant's lumbar spine and recommended that Claimant stay in work hardening for another week.

69. On June 16, 2009, Claimant's spine condition was evaluated by Timothy Floyd, M.D., an orthopedic surgeon, in referral by Dr. Krafft. Claimant reported he was lifting a sixty-pound box when he felt a pop in his back, his right leg went numb and he fell to the ground. Since then, Claimant was having trouble walking due to weakness and pain radiating down the posterior thigh and calf, and the dorsum of the foot, of his right lower extremity. Claimant also reported that he had lost 40 pounds and quit smoking in the prior two months, and that he was anxious, moody and depressed, among other things. Claimant weighed 375 pounds.

70. Dr. Floyd ordered spine x-rays,[9] which were difficult to visualize, and an MRI, which showed no change in Claimant's L4-5 disc herniation when compared to his prior MRI, and a worsened herniation at L3-4 that was significantly displacing the thecal sac. Dr. Floyd attributed the worsened L3-4 condition to the STARS injury. He also diagnosed congenital spinal stenosis and explained to Claimant that this, combined with his herniations, put him at risk for loss of bladder and bowel control. Nevertheless, Dr. Floyd recommended conservative management of Claimant's spinal conditions due to several contraindications, including no evidence of motor control deficit, the potential for Claimant's pain to be controlled by steroid

[9] The MRI was conducted on June 15, 2009, at Gem State Radiology.

injections, Claimant's obesity, the potential for surgical intervention to exacerbate Claimant's CRPS, and the extensive nature of the surgery in question. "Surgically, to adequately decompress this, would require a rather extensive resection of the spinal elements with potential destabilization leading to lumbar fusion at a later date." CE-739. Dr. Floyd arranged for a steroid injection and recommended follow-up in two to three weeks.

71. On June 17, 2009, Claimant met with Ms. Graf regarding his nutrition. He was eating healthier, had lost six pounds, and was happy with the new meal plan.

72. On June 19, 2009, Claimant followed up with Dr. Krafft regarding his low back pain with right lower extremity involvement. Following examination and, presumably, review of Claimant's imaging studies, Dr. Krafft diagnosed L3-4 disk extrusion with right lower extremity radicular symptoms and recommended an epidural steroid injection for pain relief, which he administered on June 22, 2009.

73. On June 24, 2009, Claimant reported additional symptoms to Dr. Krafft that Claimant attributed to his June 12 back injury and/or the subsequent epidural steroid injection:

> In regards to his epidural, he reports that he had some incontinence of bladder initially, but this has resolved. He has had trouble with his bowels, but he reports he had more trouble after he initially injured himself at the time of his original injury in June of 2008. He reports that his current bowel problem was more related to being unable to make it to the bathroom on time. He did note that it was coming. He has some numbness in the upper pelvic region. He can feel his penis, but he indicates there may be some decrease. He's able to feel his anal region. He has some numbness in the back of his right leg. He reports a knot-like sensation which is new since the injection. He previously had the numbness in the right lower extremity prior to the injection. He describes some burning numbness that does not occur with any particular activity.

CE-610. Medical records indicate no history of bowel problems following Claimant's industrial accident until this chart note.

74. Claimant also advised Dr. Krafft that he did not believe he could return to work and disagreed with some of the data about his functionality reported by his work hardening treatment providers:

> He reports that the most he can stand is 16 minutes. I'll clarify this with his therapist regarding if this is continuous versus intermittent with breaks. He also indicates that the highest he got on the treadmill was 2 miles per hour instead of 2.3, as was reported. He would like to have this clarified as well. We discussed the philosophy of hurt versus harm. We discussed our goal for him to become more functional. He continues to state that he does not think that he can stand like he would need to in order to be competitive in the car business. He had other concerns which will be further discussed with the therapy team.

CE-611.

INDEPENDENT MEDICAL EVALUATION: DR. O'BRIEN

75. On July 8, 2009, Claimant's treatment course was evaluated by Michael O'Brien, M.D., at his own request. Following an examination and review of Claimant's treatment records related to his accident, Dr. O'Brien made the following recommendations:

a. <u>Cervical spine:</u> Claimant reported a Twin Falls physician, based on x-rays, had diagnosed compression fractures in Claimant's cervical spine. However, Dr. O'Brien did not have records regarding this diagnosis. Commenting that compression fractures of the cervical spine are rare, and believing Claimant's inaccurate report that cervical imaging had been taken, Dr. O'Brien strongly recommended that the films should be reviewed or repeated to determine whether Claimant actually has cervical compression fractures.

b. <u>Lumbar spine:</u> Dr. O'Brien reported that Claimant had been told he needs spine surgery to address his two herniated discs, one worse than the other.[10] Noting Claimant had a significantly diminished knee jerk test on the right side as

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[10] This note misconstrues Dr. Floyd's recommendation for conservative care.

compared to the left, Dr. O'Brien recommended follow-up care, though he did not specify exactly what, if anything, should be done immediately.

c. Left foot: Dr. O'Brien recommended additional neurological follow-up to identify the extent, if any, of peroneal nerve involvement. If neurological tests establish that the peroneal nerve is involved, then he recommended a decompression of the nerve at the head of the fibula to restore foot motion. If not, then he recommended follow-up by an orthopedist to rule out or treat an ankle fusion.

d. CRPS: Noting that three sympathetic nerve blocks have failed to alleviate Claimant's symptoms, he recommended that Claimant should consult with a specialist in California who he did not identify by name.

e. Obesity: Dr. O'Brien was apparently under the impression that Claimant was not morbidly obese prior to his accident. He recommended that Claimant lose weight immediately to reduce his contraindications for surgery.

f. Medical stability: Dr. O'Brien opined that Claimant was not medically stable.

g. Home health care: Dr. O'Brien recommended home health care, without specifying the extent of the care.

76. Dr. O'Brien followed up with letters to Claimant's attorney on July 20, 2009 and October 2, 2009. These letters reconfirmed Dr. O'Brien's weight loss recommendation for health reasons and his related opinion that Claimant's weight prevented him from being a surgical candidate.

MEDICAL TREATMENT: JULY 10, 2009 – AUGUST 18, 2009

77. Claimant was treated by Drs. Krafft and Floyd during this period. Claimant advised Dr. Krafft that his left ankle was hurting all of the time and that his left leg sometimes gave way. His back pain was reduced, but not greatly, by the epidural steroid injection and a Lidoderm patch. His right calf and foot discomfort was improved. His bowel and bladder symptoms were resolved, except for some urgency. Dr. Krafft performed a left lower extremity EMG, which revealed no evidence of left lower extremity radiculopathy, myopathy or plexopathy. Claimant was still attending physical therapy with Mr. Morton.

78. Four days later, Claimant reported to Dr. Floyd that his pain was divided between his back and his right leg and that if he could eliminate one source, it would be his leg pain, which he described as burning, with some numbness on the lateral aspect of the calf and down the dorsum of his foot. Dr. Floyd did not examine Claimant, but told him frankly that he is too obese to operate on, unless he develops a significant condition like cauda equina syndrome. He recommended that Claimant "do whatever he needs to do to get a gastric stapling, lap band or whatever the appropriate method of weight loss is." CE-744. Claimant did not see Dr. Floyd again. He noted that Claimant was returning to Twin Falls that day and provided a prescription for physical therapy with Mr. Little. He noted that he would refill medications as needed and would see Claimant back for the panel evaluation on August 19, 2009.

79. On July 20, 2009, Dr. Krafft responded to a check-the-box letter from Greg Taylor, ICRD consultant, indicating that Claimant could eventually return to work as a car salesman, that modified duty for one month would be appropriate, and that further medical care was still warranted. Permanent medical restrictions were still pending.

80. On July 22, 2009, Claimant was again treating with Mr. Little. Mr. Little prepared an extensive chart note regarding Claimant's treatment history to date. According to that note, Claimant believed the physical nature of the STARS program had worsened his symptoms. Following that event, his back and lower extremity symptoms significantly increased and a spine MRI demonstrated "apparently 2 additional ruptured discs." CE-306. Claimant also reported gaining 120 pounds, then losing 35, since the accident. "He states he has been chronically discouraged with the nature of the injury symptoms, and continued and significant complications with his care with the insurance company and medical care at times." *Id.*

81. On July 28, 2009, Claimant called Dr. Krafft's office after accidentally placing too much weight on his left foot, eliciting pain and swelling which gave way to numbness. Narcotic pain medication was prescribed and a neurology consultation with Dr. Hammond was scheduled for September 23, 2009. Surety approved the consultation on September 30, 2009. (*See* CE-149).

82. On August 4, 2009, Dr. Coughlin commented upon Dr. O'Brien's evaluation and Dr. Krafft's nerve conduction study in a letter to Lynn Green, claims adjustor for Surety. He reaffirmed his opinion that Claimant has CRPS as a result of his industrial injury, that he does not have EMG evidence of a peroneal nerve injury, that he is not a candidate for left foot surgery and that, while Claimant needs to lose weight, he would not advocate bariatric surgery until his CRPS is effectively treated. Along those lines, Dr. Coughlin opined, "The real issue at this point is finding someone who would treat him. I am a surgeon and can diagnose this but I don't treat it and I made that very clear." CE-478. Dr. Coughlin also disagreed with Claimant's counsel's implication in documents provided by Surety that Martha Peterson, nurse case manager, had unduly influenced Claimant's treating physician. "I found over the last twenty-five years that

Ms. Peterson has been very involved in trying to be the advocate for patients. She has never and will not influence me so I am not sure who indeed Mr. Goicoecchea [*sic*] was referring to. I hope that is not me because I find that phrase somewhat deprecative." CE-479.

PANEL EVALUATION

83. On August 19, 2009, Claimant underwent a panel evaluation by Drs. Calhoun, Binegar, O'Brien and Krafft, and Ms. Wilson. In its report, the panel set forth a detailed history of Claimant's treatment since his industrial accident which is consistent with his medical records in evidence, as well as its conclusions, which were not always unanimous. The panel concluded, based upon documented signs and symptoms, and his response to his sympathetic nerve block, that Claimant had nonsympathetic responsive type 1 CRPS as a result of his industrial left ankle fracture. It also opined that his lumbar spine disc herniation at L3-4 and subsequent worsening of that condition were related to the industrial injury and treatment therefor. In addition, the panel opined that Claimant had not yet reached medical stability.

84. Further, the panel:

a. Recommended a follow-up functional capacity evaluation since Claimant's functionality may have changed following his June 12, 2009 back injury;

b. Declined to recommend a wheelchair or power scooter until Claimant loses greater than 100 pounds because his current rehabilitation efforts should be focused on mobilization and conditioning;

c. Opined that Claimant did not require a home health care nurse, either at that time or previously, when he resided in temporary housing in Boise because he was observed and adjudged to be able to adequately toilet and dress himself

except, perhaps, during the short period in which he had bowel and bladder problems;

d. Opined that Claimant, notwithstanding his statements to the contrary, likely suffered back pain prior to his industrial accident because most overweight individuals in the general population do;

e. Declined to recommend a spinal cord stimulator because, from a psychological perspective, he is "recalcitrant to any type of medical procedure" (CE-625);

f. Recommended further pain medication management, modalities and an ongoing home exercise program;

g. Strongly recommended weight loss in excess of 100 pounds before considering any interventional/surgical procedures;

h. Opined that Claimant's "weight is likely an exacerbating and prolonging cause of his symptoms. It was not judged to be primarily related to his injury, but pre-existing status" (CE-626);

i. Opined that, from a psychological perspective, Claimant used pain medications to alleviate emotional distress, exhibited disincentives to improve, demonstrated emotional decompensation and that his emotional distress was a significant contributor to his ongoing symptoms and pain;

j. Opined that Claimant was motivated by a number of secondary gain considerations, including current pending litigation;

k. Recommended continuation of medications including Lyrica, Cymbalta, narcotic pain medications (to be weaned off in six months to one year), and consideration of weight loss medication; and

l. Opined that Claimant could sit and drive his own vehicle, so he could return to car sales.

MEDICAL TREATMENT, WORK RELEASE RESTRICTIONS, MMI, PPI: SEPTEMBER 2, 2009 – FEBRUARY 3, 2010

85. Claimant was treated by Drs. Krafft and Coughlin, and Mr. Little during this period. He also received emergent care after slipping in the tub.

86. On September 2, 2009, Claimant followed up with Dr. Krafft for left leg swelling and soreness. He advised Dr. Krafft that he was not interested in changing physicians and would like to continue treating with Dr. Krafft. Dr. Krafft recommended a duplex ultrasound to rule out deep vein thrombosis; however, Claimant did not pursue this test for financial reasons. Dr. Krafft prescribed medications and sought approval from Surety for follow-up on the panel's recommendations.

87. On September 18, 2009, Dr. Krafft issued a work release authorization after speaking to Claimant about his concerns and following up with Dr. Floyd regarding his restrictions. Dr. Krafft released Claimant to work with restrictions including no pushing, pulling or lifting more than 20 pounds; position changes whenever necessary; no unprotected heights; no walking on rough, uneven ground; and no jumping.

88. On October 1, 2009, Dr. Krafft advised Claimant not to take hydrocodone or other medications that cause drowsiness while driving.

89. On October 22, 2009, Mr. Little wrote to Dr. Coughlin. He advised of Claimant's progress and recommended further treatment, including additional physical therapy, an AFO for his left shoe to assist with gait, local pain control by Dr. Dille and physiatry treatment by Jonathan Myers, M.D., (so that Claimant could reduce his trips to Boise for care), and follow-up at a CRPS clinic. He also noted that Claimant continued to participate in physical therapy diligently and that he had, on his own, joined the YMCA to swim three to four times per week.

90. On October 27, 2009, Claimant followed up with Dr. Coughlin, apparently on his own referral (he was still treating with Dr. Krafft). Dr. Coughlin noted that he had believed that, following the panel evaluation, it was determined that Claimant was sedentary unless he could lose 100 pounds over the next year. Given that this is a wholly inaccurate understanding of the panel's recommendations (see above), it is apparent that Dr. Coughlin had not reviewed the report but, more likely, was relying upon Claimant's statements about the report's contents.

91. In any event, Dr. Coughlin disagreed that Claimant could return to work. "In looking at his ambulatory capacity, I think that I certainly would never buy a car from him if he hobbled up in that fashion. He can hardly walk in a reasonable fashion at this point." CE-484. Following examination and review of imaging studies taken that day, Dr. Coughlin ruled out degeneration of the ankle joint as the reason for Claimant's continued pain and functional deficits. He confirmed his CRPS diagnosis and recommended that Claimant: 1) continue physical therapy three times per week with Mr. Little; 2) not pursue an AFO at this point; 3) do regular gym work three times per week at Surety's expense; 4) follow up with Dr. Krafft monthly; and 5) obtain assistance in losing weight, though he did not specify the nature of such assistance. "I have said that I would see him back in follow up in four months for recheck but Dr. Krafft will be his main doctor." CE-485.

92. On November 8, 2009, Claimant was treated at St. Benedict's for lower back pain and right leg numbness after stumbling at a physical therapy session. Claimant reported prior MRIs had identified significant lumbar disc disease with, apparently, herniations at L3-4, L4-5 and L5-S1. He also reported that he had "fracture [*sic*] a cartilaginous part of a disk and the way he describes it, it sounds as though it is actually loose in the spinal canal." CE-46. The caregiver noted, "I am not sure how that would happen but he has chronic pain in the left extremity with fused left ankle and CRPS in that extremity." *Id.* As well, it was noted that Claimant had been attending physical therapy for back issues due to his 2008 accident and that he had been trying to taper himself off of Norco. Medications, including a narcotic pain medication, were prescribed and bed rest for a few days was recommended.

93. On November 10, 2009, Dr. Krafft treated Claimant after he slipped in the bathtub and injured his back. He was initially treated in an emergency room with Demerol, which Claimant reported took away his pain, and OxyContin, which Claimant reported alleviated his pain more than his usual regimen of Norco and Lyrica. His left foot was still his main concern, and he wished to see a counselor about life stressors and his discomfort. Dr. Krafft prescribed OxyContin, short-term, pursuant to a pain contract. He discussed Claimant's physical therapy, which seemed to be at a plateau, and his return to work. Claimant was concerned that Dr. Krafft had not provided a direct referral to Dr. Anderson (regarding bariatric surgery) and revealed that he had been recording conversations with Dr. Krafft, unbeknownst to Dr. Krafft. Nevertheless, Claimant wished to continue treating with Dr. Krafft.

94. <u>MMI/PPI.</u> On November 11, 2009, Dr. Krafft completed a check-the-box letter, signed it, and returned it to Surety. The letter indicated Claimant was not yet medically stable. Although Claimant's condition was not ripe for a PPI assessment, since Claimant had not yet

reached MMI and his CRPS could not authoritatively be assessed until June 2010, Dr. Krafft provided one anyway, for settlement purposes. He also indicated that Claimant could return to work, with restrictions.

95. Dr. Krafft assessed PPI of 23% of the left lower extremity for Claimant's CRPS, which converts to 9% of the whole person, and 6% of the whole person for his L3-4 spinal disc bulge. After combining these ratings, Dr. Krafft assessed a total PPI rating of 14% of the whole person as a result of his industrial injuries, with no apportionment (based on Claimant's reports of no related preexisting conditions). Along with the PPI rating, Dr. Krafft recommended physical therapy for four weeks, narcotic pain medications for 4-6 months, Cymbalta for six months to one year, and Lidoderm patches as needed. He recommended no further diagnostic testing.

96. On November 16, 2009, Mr. Little wrote a status update letter to Dr. Krafft with recommendations. He recommended orthotics, specifically by Dale Perkins at Rehab Systems, psychological workup, continuing physical therapy, and a transfer of Claimant's medical care. "When Joe completes his care with you I feel it would be of great benefit for Joe to have his medical care transferred to Dr. Jonathan Myers, who is a Physiatrist [*sic*] in Twin Falls and with Dr. Clinton Dille' [*sic*] of the Pain Institute of Idaho for his continued pain control and assessment for his medications." CE-345.

97. On December 11, 2009, Claimant followed up with Dr. Krafft. He was taking OxyContin, plus Norco for breakthrough pain. Cold air exacerbated his pain and he reported continuing nightmares from the accident, as well as occasional right leg numbness. Dr. Krafft encouraged Claimant to resume a relationship with a nutritionist and advised he would write an order for it. He agreed with Claimant's request to be treated by a Twin Falls physician and to see

Dr. Krafft just once every three months. Dr. Krafft recommended Dr. Myers and reconfirmed Claimant's unchanged medical restrictions. As with many, if not all of Dr. Krafft's chart notes, this one was copied to Ms. Peterson.

98. On December 14, 2009, Claimant's physical therapy records (apparently by Mr. Little) were provided to Claimant's attorney.

99. On January 6, 2010, Claimant was evaluated for Social Security Disability Insurance benefits and was found, among other things, to be relegated to sedentary work due to his functional limitations. No physician had yet opined that Claimant had reached medical stability.

100. On January 25, 2010, Dr. Krafft responded to an inquiry from Claimant's attorney about bariatric surgery. Dr. Krafft opined that Claimant would benefit from the surgery, if he were deemed to be an appropriate candidate. However, he declined to comment on the existence (or lack thereof) of a causal relationship between the industrial accident and Claimant's need for such surgery.

101. On January 19, 2010, Claimant reported right hip discomfort, as well as pain in his left calf and left knee, and continuing discomfort related to CRPS. Dr. Krafft prescribed more OxyContin and Norco, recommending that Claimant reduce his intake over time, and continuing physical therapy.

102. On February 3, 2010, Dr. Krafft wrote a letter to Claimant discharging him from care, effective March 3, 2010. No reason for the discharge was given.

MEDICAL TREATMENT, RECOMMENDATIONS BY MR. URRUTIA FOR A POWER CHAIR, HOME MODIFICATIONS AND SPINAL CORD STIMULATOR: FEBRUARY 12, 2010 – MAY 7, 2010

103. During this period, Claimant was treated by Jonathan Myers, M.D. (a physiatrist), Patrick Farrell (an anesthesiologist, specializing in pain control), and Dr. Dille/Mr. Urrutia.

104. On February 12, 2010, Claimant again began treating with Dr. Dille/Mr. Urrutia, apparently on his own referral, for pain at the midline of his low back radiating into the right leg and foot, as well as left leg pain, numbness and CRPS. He requested pain medication and reported that he had previously been obtaining it from Dr. Krafft. Claimant entered into a new Narcotic Agreement, and Mr. Urrutia made a plan to taper Claimant down from the excessive amount of hydrocodone he was taking and also adjusted his other prescriptions in light of his weight. (Claimant reported a 145-pound weight gain since the accident, and the chart note indicates he weighed 350 pounds that day.)

105. On February 23, 2010, Claimant established care with Dr. Myers for treatment of chronic pain. Dr. Myers was concerned about Claimant's use of narcotic pain medication and his weight, among other things. He prescribed narcotic pain medications pursuant to a strict use contract, an antidepressant, and other medications. Dr. Myers was initially encouraged by an eight-pound weight loss.

106. On March 12, 2010, Claimant sought additional pain medications from Mr. Urrutia. He had lost six pounds, was using less pain medication, but reported continuing low back pain radiating to the right leg and foot. Mr. Urrutia refilled Claimant’s hydrocodone, continuing to taper down the prescription, and increased his Topamax.

107. On April 1, 2010, Claimant was evaluated by Dr. Farrell for left foot pain, on Claimant’s own referral. The accompanying chart note shows Claimant weighed 300 pounds.

Dr. Farrell had no prior medical records to review, but Claimant related his prior treatment. Dr. Farrell diagnosed CRPS II, equinus and limb length inequality. Dr. Farrell referred Claimant to Jeremy Curry, M.D., a pain medicine specialist in Yuma, Arizona, to be evaluated for a spinal cord stimulator. He also discussed bariatric surgery, but made no referral. Dr. Farrell specifically recommended no additional left foot surgery. He provided orthotics and written instructions for home exercises. Although Dr. Farrell recommended follow-up in three weeks, Claimant never returned.

108. On or around April 15, 2010, Dr. Myers authorized a sleep study, but Surety refused to pay for it. Dr. Myers later opined that the sleep study was to assess sleep apnea which he related to Claimant's industrial injuries because he believed they were the impetus for Claimant's morbid obesity.

109. On his April 19, 2010 visit to Mr. Urrutia, Claimant's weight was up 22 pounds because he had been down with the flu. He was unhappy about not being able to do much and requested a prescription for a power chair and a pain medication refill. Claimant still had low back pain, on this day radiating into both legs and feet. Mr. Urrutia prescribed hydrocodone, at a decreased rate, and again increased his Topamax prescription. He also wrote a prescription for a power chair, with the caveat that "he will continue to lose weight and not become totally dependent on this." CE-469.

110. On April 28, 2010 Dr. Myers discharged Claimant from care for breaking his pain medication contract, as he was also receiving pain medications pursuant to a separate pain medication contract from Mr. Urrutia. While he treated Claimant, Dr. Myers recommended counseling by a cognitive mental therapist and continued physical therapy and hot tub soaking for pain relief.

111. On May 7, 2010, Claimant reported to Mr. Urrutia that his family had conducted an "intervention" and flushed his hydrocodone because Claimant had episodes of confusion and they did not think the medication was helping him. CE-470. He was having frequent falls and asked for a prescription for handicap-accessible modifications to his house. Claimant reported worsening right leg pain. Mr. Urrutia addressed the CRPS in his left leg, however, in his plan note. Since conservative measures had failed to relieve his CRPS pain, Mr. Urrutia referred Claimant for a psychological evaluation to determine if he may be a candidate for a spinal cord stimulator. He also increased Claimant's antidepressant medication and prescribed other medications, as well as handicap-accessible modifications for Claimant's house.

EVALUATION FOR SPINAL CORD STIMULATOR AND OTHER TREATMENTS, MMI, PPI - MAY 14, 2010 – SEPTEMBER 2, 2010

112. Claimant was treated or evaluated during this period by Drs. Krafft, Calhoun, Dille and Hammond, as well as Mr. Urrutia, David Jensen, D.O. (a physiatrist) and Trevor Satterfield, M.D. (a family practitioner).

113. On May 12, 2010, Teresa Nolen, claims analyst, sought Dr. Krafft's opinion regarding Mr. Urrutia's medication and home modifications prescriptions, as well as his recommendations for a spinal cord stimulator and a power chair. Dr. Krafft responded, in an undated letter, that Claimant was aware that home modifications, a spinal cord stimulator and a power chair had all been rejected by prior physicians:

> The above requests are not indicated per his physicians and psychologist, and his previous panel evaluation. I suspect Mr. Urrutia ordered these at the behest of Mr. Gerdon and his family; however, his physicians and neuropsychologist disagree with these recommendations. He has been counseled by myself, Dr. Jensen, and the panel physicians about the importance of increasing his activity and using his leg more or he will experience the deleterious health effects of ongoing deconditioning.

DE-74. Dr. Krafft recommended that Claimant finish his neuropsychometric counseling and testing with Dr. Calhoun.

114. On May 14, 2010, Dr. Krafft examined Claimant, notwithstanding that he had previously discharged him from care. His note indicates Claimant was having CRPS symptoms and was considering Methadone, among other things. Dr. Krafft recommended Topamax and, if that was ineffective, then Methadone could be considered. He also specifically declined to recommend a power chair or spinal cord stimulator, and advised Claimant to continue exercising.

115. Also on May 14, 2010, Dr. Calhoun evaluated Claimant for eligibility for a spinal cord stimulator. Claimant reported he had taken himself off pain medication and was smoking again. His wife and child were living in Boise and he was feeling "just mad at everybody." CE-680. In addition, he was now experiencing neck and head pain. He was attending physical therapy, but Claimant described his progress as "hit and miss." CE-681.

116. Dr. Calhoun noted that Claimant had been discharged by Dr. Myers for violating his pain contract, and that Claimant's pre-accident smoking indicates he had a propensity toward addictive behavior before his accident. "The patient does remain at high risk for using opioids to self-medicate for ongoing emotional distress as much as pain." CE-681.

117. Dr. Calhoun reviewed Claimant's recent medical records and provided him with the MMPI-2, STAXI-2 and the Pain and Impairment Relationship Scale to complete at home, then return. However, by the time Dr. Calhoun authored his report, Claimant had still not returned the test results, notwithstanding a follow-up call from Dr. Calhoun's office staff. As a result, Dr. Calhoun opined that Claimant was noncompliant with his psychological evaluation and that "[t]he probability of him following through with psychological treatment and being amenable to intervention is very low." CE-682.

118. Dr. Calhoun opined that Claimant was not an appropriate candidate for a spinal cord stimulator "given his ongoing anger, frustration, depression, opioid dependence, manipulative behaviors, and sense of entitlement and control that he tries to maintain while being involved in the workers' compensation system." CE-682. Dr. Calhoun recommended no further invasive treatment unless emergent, because Claimant's "probability of improving functionally is very low given his personality disorder which certainly shows antisocial trends, treatment noncompliance, and propensity to be manipulative." *Id.* He also recommended that Claimant's workers' compensation claim be concluded "to remove ongoing secondary gain factors and any disincentive for him to get better and move forward functionally." *Id.*

119. Sleep study. On May 25, 2010, Claimant underwent a sleep study by Dr. Hammond, as recommended by Dr. Myers. Dr. Hammond determined that Claimant's sleep study was moderately indicative of obstructive sleep apnea and severe limb movement not necessarily associated with respiratory events. He recommended CPAP titration and noted that Claimant's limb movements may need additional treatment.

120. On June 2, 2010, Claimant was evaluated by David J. Jensen, D.O., in referral from Dr. Krafft. Dr. Jensen had also spoken with someone in Dr. Myers's office about Claimant's violation of his pain contract, and he agreed to treat Claimant on the condition that he would not prescribe any narcotic pain medications. Claimant had left foot and right knee pain. Following examination and records review, Dr. Jensen diagnosed CRPS II of left lower extremity (based on signs and symptoms), depression, obesity and, apparently, complications related to his left ankle surgery. He advised Claimant that his best chance for pain improvement would be through increased use of his foot, even though it is painful. He also planned to confer with Claimant's physical therapist about treatment goals.

121. Claimant's mother accompanied him on this visit, and Dr. Jensen noted they were interested in referrals to an RSD treatment center and for a spinal cord stimulator. Based on Claimant's August 2009 panel evaluation, Dr. Jensen declined to make either referral and noted, "If they continue to persist with that request he would need to be seen again, particularly by the psychologist as any of those recommendations would be based on I think the panel and particularly by the psychologist for further recommendations." CE-792. He also opined that Claimant was "essentially reaching MMI." *Id.*

122. On June 7, 2010, Claimant was treated by Dr. Satterfield, at St. Luke's Care Clinic, on his own referral. He reported falling three days previously, causing left knee pain and popping, and advised that Dr. Jensen had refused to see him. Claimant's weight was recorded as 383.6 pounds, and he reported a pain level of 9. Dr. Satterfield ordered bilateral knee x-rays, which demonstrated bilateral subpatellar inflammatory changes, but nothing else out of the ordinary.

123. Dr. Satterfield, upon review of Claimant's x-rays and medical records for the prior two months, diagnosed degenerative joint disease, dysuria and depression. He declined to prescribe narcotic pain medication, and Claimant responded that he was not asking for any. He continued Claimant's anti-inflammatory and anti-depressant medications.

124. On June 9, 2010, Claimant and Mr. Urrutia again discussed the possibility of a spinal cord stimulator. On that day, Claimant complained of low back pain that sometimes radiated down his right leg, bilateral knee pain radiating into his feet, and left foot pain. Claimant apparently reported weighing 362 pounds. Mr. Urrutia planned to obtain Dr. Binegar's records and noted that a spinal cord stimulator seemed like a reasonable pain relief option.

125. On June 11, 2010, Dr. Krafft completed, signed and returned a check-the-box letter to Ms. Nolen. He indicated that Claimant's sleep study (for apnea), his need for a nutritionist, and his need for weight loss were all unrelated to his industrial injuries, with the caveat that Claimant had been less active due to the pain from those injuries. He also noted that Claimant was obese prior to his industrial injury: "He has been less active due to the pain, but needs to become more active. He also had preexisting obesity prior to the injury." DE-77. Dr. Jensen completed the same letter on June 15, 2010, indicating without qualification that none of the above-mentioned treatment was related to Claimant's industrial injuries.

126. On June 21, 2010, Claimant followed up with Dr. Jensen:

> He reports physical therapy has been somewhat helpful but generally he wishes to discuss multiple items about my last visit and his disagreement to essentially everything that I said. Apparently he states he has been in contact with an "RSD experts" [*sic*] who feel like he needs more treatment.

CE-794. Dr. Jensen examined Claimant and diagnosed degenerative joint disease, CRPS II (left lower extremity) and depression. It is indiscernible from his chart note why degenerative joint disease appears as the primary diagnosis, when Dr. Jensen did not formerly make that assessment and no new testing or medical findings were made. Dr. Jensen's chart note concludes:

> Based on my reading of the panel, and particularly the psychology report that he states he is adverse to further medical treatments, I would not recommend any of them. I told him I have nothing else to offer him. I will not have a contentious debate with him as he wishes to do so, and he is discharged from my care. My recommendation is to follow up with the medical panel. I would feel he is at MMI and should be rated.

CE-795.

127. On July 7, 2010, Claimant reported to Dr. Dille that he had been denied a spinal cord stimulator trial because "[t]hey are unsure that it will help." CE-474. Claimant reported

right knee pain, left leg pain and low back pain without radiculopathy. Dr. Dille noted he would obtain some scientific articles concerning CRPS treatment via spinal cord stimulators.

128. MMI. On July 30, 2010, Dr. Jensen completed, signed and returned a check-the-box letter to Ms. Nolen. He opined that Claimant had reached medical stability as of June 21, 2010, that his condition would merit a PPI rating (however, he did not make an assessment), and that he did not know whether any of Claimant's PPI should be attributed to a preexisting cause.

129. On August 4, 2010, Mr. Little sent an update letter to Dr. Jensen in which he noted, "Joe will have follow-up care with Dr. Krafft as I was notified by Liberty Northwest Ins. Co. and I will forward copies of this to Dr. Krafft, as well. We will continue additional physical therapy as ordered by Dr. Krafft or any authorized physicians at this time." CE-399. Thereafter, Claimant did not see Mr. Little for physical therapy for several months.

130. MMI/PPI/Permanent restrictions. On September 2, 2010, Dr. Krafft again, without explanation, sent Claimant a letter, by certified mail, discharging him from care. On that same day, he prepared an impairment rating assessment with a history of Claimant's treatment which did not restate his own significant involvement in Claimant's care as his primary care physician for over a year. Dr. Krafft relied upon Dr. Jensen's opinion that Claimant had reached MMI, and Claimant's self-reports that he had no preexisting back or left foot conditions. Dr. Krafft assessed 5% whole person PPI for Claimant's left foot condition, and 7% PPI for his back pain and radicular complaints, for a total combined PPI of 12%, all attributed to his industrial injuries. Dr. Krafft recommended a functional capacity evaluation to determine Claimant's work restrictions. "He, however, has been previously able to ambulate short distance, was given a 20 pound lifting restriction, recommended to avoid unprotected heights, walking on rough, uneven ground, and jumping. These are reasonable pending his FCA." CE-

662. Noting that Dr. Jensen did not prescribe further narcotic pain medications, Dr. Krafft recommended Topamax. He also recommended continuing exercise and weight loss. He deferred to Dr. Calhoun regarding ongoing antidepressants.

131. On September 10, 2010, Dr. Krafft completed, signed and returned a check-the-box letter to Ms. Nolen. He indicated that Claimant's condition became fixed and stable as of September 2, 2010, and that he had suffered PPI of 12% of the whole person, completely attributable to Claimant's industrial injuries.

EXPERT MEDICAL REVIEW: DR. KAPLAN

132. On September 13, 2010, Richard Kaplan, M.D., a physiatrist working as an expert consultant, authored a report of his opinions regarding several questions posed by Ms. Nolen. In preparation, he reviewed some of Claimant's medical and other records, and spoke with Dr. Krafft.

133. Dr. Kaplan's take-away from his conversation with Dr. Krafft is that Claimant had missed many medical appointments, that Dr. Krafft strongly disagreed that a power chair is indicated for Claimant and that Dr. Krafft believed Claimant instead needed to increase his activity and use his left lower extremity as he was taught in work hardening. Dr. Krafft also advised Dr. Kaplan that Claimant had been released to work as a car salesman with occasional breaks.

134. Dr. Kaplan concurred with the opinions advanced in the August 19, 2009 panel evaluation report. "I fully concur with that document as clearly representing a very high level and highly professional assessment of the claimant's situation." DE-117. He also believed Claimant's treatment to date "has been reasonable, necessary, and appropriate." DE-118. He did not agree with Dr. Dille's opinion that CRPS was Claimant's primary diagnosis, however.

Instead, he opined that "the key issues to address are weight loss and vocational rehabilitation." *Id.* As such, he disagreed with approaching Claimant's case from a pain management perspective, with injections and medications.

135. Dr. Kaplan opined that Claimant was not responding to his current treatment because he had not accepted and complied with recommendations to lose weight and focus on improving his functional capabilities. "The records indicate that the claimant has not focused on those items but has been non-compliant or resistant to treatment recommendations so far and as a result he has worsened rather than improved." *Id.* He further opined that no additional treatment or diagnostic tests were necessary. Dr. Kaplan recommended a program including weight loss, functional restoration and vocational rehabilitation, and advised against further pain management (including invasive pain management) or prescriptions for mobility devices, as these measures were likely to worsen Claimant's condition.

136. Dr. Kaplan opined that Claimant has reached MMI "unless or until he is willing to follow through with the recommendations that have been made by multiple physicians." DE-119. "If the claimant wishes to proceed with an active functional restoration program as above, then he is not at maximum medical improvement." *Id.*

137. Dr. Kaplan authored a letter to Dr. Krafft confirming his understanding, in which Dr. Krafft concurred by a return note on September 15, 2010. In his note, Dr. Krafft added:

> His functional status has been outlined under question 6 in my Panel Evaluation report dated Aug 9, 2009. [*sic*][11] He does have limitations as noted and would need a manual wheel chair for long distances. I do not however encourage power mobility. He could return to work as a car salesman within his outlined restrictions which may need to be interfaced with a job site evaluation.

DE-122.

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[11] The panel evaluation report is dated August 19, 2009.

138. On October 5, 2010, Dr. Kaplan wrote a follow-up letter to Ms. Nolen clarifying that he does not believe referral to a CRPS specialist is warranted, and recommending further evaluation, if desired, by Dr. Walker:

> It is my opinion that the claimant would not get better treatment than what was recommended by Dr. Krafft at any tertiary care center. I do not feel that an "RSD Specialist" is indicated. That said, if another PM&R opinion is desired, a list of providers can be found at https://www.e-aapmr.org/imis/imisonline/findphys/find.cfm. In particular, if the claimant is willing to travel to Idaho Falls IA [*sic*], I would highly recommend Drs. Eric or Gary Walker, who trained with me at Mayo Clinic."

DE-123.

COUNSELING WITH MR. HARVEY

139. From October 5, 2010 through November 8, 2010, Claimant attended four counseling sessions with Peter S. Harvey, M.A. Mr. Harvey recorded Claimant's complaints about his circumstances and his desire to be better. Claimant requested hypnotherapy for pain and mood control, which Mr. Harvey agreed could help. However, he also stressed that focusing attention on the future, as opposed to the alleged wrongs he has experienced in the past would also help. Mr. Harvey's notes do not identify who referred Claimant to him.

INDEPENDENT MEDICAL EVALUATION: DR. FRIEDMAN

140. On November 11, 2010, Robert H. Friedman, M.D., a physiatrist, performed an independent medical evaluation ("IME") at Claimant's request. In preparation, he reviewed:

a. Claimant's post-accident medical records, including imaging studies dated July 1, 2008 (right knee, left ankle x-rays), September 12, 2008 (thoracic and lumbar spine MRIs), June 15, 2009 (lumbar spine MRI), and June 7, 2010 (bilateral knee x-rays);

b. Claimant's pre-accident medical records from 1994 (regarding Claimant's eye surgery) and May 6, 2008 (abdominal issues); and

c. Barbara Nelson's February 16, 2010 vocational disability evaluation report (see below).

141. In addition, Dr. Friedman met with and thoroughly examined Claimant. Claimant weighed 352 pounds and was smoking 10 cigarettes per day. He lived with his wife and child, and he reported his sole income sources were his and his wife's SSDI benefits. Claimant's chief complaint was left lower extremity pain, numbness and burning. He also had burning pain in the supraclavicular area and across the top of both shoulders, achy pain in his bilateral buttocks (more limited as to location in the left), and pain in his right thigh and calf, as well as in both knees. Claimant rated his pain level at 9 and reported that on his best day, it is a 7.

142. Due to the industrial ankle injury, Dr. Friedman diagnosed CRPS of the left lower extremity (based on signs and symptoms), limited left foot motion due to an extremely tight anterior tibialis tendon that limited his dorsiflexion and plantar flexion, and right lower extremity L5-S1 radiculopathy and pain due to acute herniation at the STARS program "superimposed on preexisting herniated disk with resultant right lower extremity symptoms."[12] CE-811. He also opined that Claimant has significant myofascial pain in his cervical spine, depression and perceived disability, obesity, sleep apnea, and bilateral knee pain without instability, but he did not specifically attribute these to the industrial accident.

[12] Dr. Friedman opined that Claimant "does have evidence of a right lower extremity L5-S1 radiculopathy with symptomatic pain with straight leg raising into his right calf and leg." CE-811. Note, however, that no other physician has attributed Claimant's STARS injury to L5-S1.

143. Dr. Friedman recommended:

a. An aggressive weight loss program (possibly including anorectic medications or bariatric surgery), a gentle exercise/activity program, and continuation of Topamax, which suppresses appetite;

b. No splinting or bracing which might limit his motion and activity;

c. Aggressive depression treatment, including perhaps increasing his Cymbalta, adding a second medication and/or counseling to address Claimant's mood disturbance and PTSD.

144. Dr. Friedman also assessed permanent restrictions to reduce exacerbation of Claimant's CRPS including limited standing and walking, continued use of a single point cane. He also opined that a medium-duty work restriction would be appropriate as a result of Claimant's low back disc herniations, but was equivocal as to whether that would be permanent. ("He is not yet at that capacity, but permanent work restrictions would be appropriate given his known preexisting herniated disks, which were aggravated by the STAARs [*sic*] program, with resulting radiculopathy.") CE-812.

145. <u>MMI/PPI.</u> On December 18, 2010, Dr. Friedman supplemented his IME opinions. He opined that Claimant had reached MMI and assessed PPI due to the industrial injury, with no apportionment, of 8% of the whole person in consideration of Claimant's CRPS, 3% of the whole person for his knee osteoarthritis, 3% of the whole person for his obstructive sleep apnea due to obesity, 5% of the whole person for his depression (as a result of his industrial injury, chronic pain, psychosocial disturbance and disability), and 0% for his narcotics abuse. Utilizing the combining table, Dr. Friedman opined that Claimant has incurred PPI of 19% of the whole person.

146. Permanent restrictions. He also issued permanent restrictions including medium-duty work (due to lumbar spine condition); no kneeling, squatting, or crawling (as a result of his osteoarthritis); and limited walking and standing (due to his CRPS). "These are permanent restrictions, and attributable to the consequences of his lower extremity injuries, surgical intervention, obesity." CE-833. At his deposition, Dr. Friedman further opined that a 50-pound occasional lifting maximum should also be imposed to protect Claimant from further injury as a result of his lumbar disc herniation.

147. Even though Dr. Friedman opined that Claimant was at MMI, he recommended ongoing therapy and treatment including, for his herniated disc and CRPS, a daily exercise program with access to an athletic facility and a personal trainer to do stretching and gentle aerobic conditioning such as walking, swimming or bicycling; and, for his chronic pain management, long-term close medical supervision by a physician specializing in pain management, but no narcotic pain medications:

> Given Mr. Gerdon's difficulty with opiates in the past, these are contraindicated. He has had dependency and abuse issues. He is managing his pain without opiate medications. He may benefit from nonopiate pain modulating medications such as antidepressants, membrane stabilizing drugs, and nonsteroidal antiinflammatories. These medications will require direct physician supervision, management and prescription. It is, in my medical opinion, reasonable for him to follow with Dr. Dille, or similar treating physician with the proviso that the patient not be restarted on opiates.

CE-833.

148. On October 21, 2011, Dr. Friedman supplemented his prior opinions after reviewing his updated records, including ICRD records. He added 7% whole person impairment as a result of Claimant's lumbar spine herniation at the STARS program, noting that he

inadvertently left it out of his prior reports. He also noted that, based on Dr. Marsh's notes, Claimant appeared to be doing better from a pain management standpoint.

149. Dr. Friedman's PPI assessments are based on the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*, and his methodology is well-documented.

150. On January 19, 2012, Dr. Friedman again supplemented his earlier opinions, this time after reviewing Claimant's FCE and records regarding related medical treatment for ankle swelling, including a prescription for antibiotics. Dr. Friedman opined that the FCE was not accurately reflective of Claimant's physical capacity.

> Certainly, he was able to perform at that level for one day. Unfortunately, the [FCE] caused sufficient exacerbation of his ankle symptoms that he required a visit, and medical treatment, for what was thought to be an infection of his ankle. This was as a direct result of the [FCE], which far exceeded safety margins for him.

CE-835.

MEDICAL TREATMENT: DECEMBER 1 - 9, 2010

151. During this period, Claimant was treated by Drs. Coughlin and Dille, and Mr. Little.

152. On December 1, 2010, Dr. Coughlin prescribed additional physical therapy.[13] On December 27, 2010, Mr. Little wrote to Dr. Coughlin and, among other things, described Claimant's current functional limitations:

> His functional limitations include only being able to walk for 5-10 minutes per day and above this time frame increases right LE symptoms as well as increase [*sic*] back pain. He has problems with his right leg giving way. Prior to discontinuing physical therapy approximately 6 months ago he was falling approximately 1 time per month and now reports falling up to 2-3 times per day. Patient reports that he has no other health or medical issues. He feels his health is

[13] Claimant sought treatment at his own expense because Surety had denied further treatment.

> digressing, being good prior to accident and now poor at this time since the accident…
>
> Patient's weight is approximately 345# which is close to 50# less than his max weight that he gained at one time. His gait is poor due to no functional AROM to the left ankle and he has to stand and walk with his left hip externally rotated since he cannot bend the ankle well enough to do a step through gait pattern. Pain is constant at 9/10…
>
> Functional mobility is adequate for ADLs, walking within his home short distances but outside his home for any activities he has to use his scooter for transportation if his is going to be on his feet for more than 5-10 minutes. He also uses a shower chair for bathing. He feels his balance has digressed, as discussed above that he is quite discouraged with. Palpation to the toes on the left foot are cool, but fairly equal to the right toes and the foot, ankle and leg is warm to touch, fairly equal to the right side.

CE-403.

153. Dr. Coughlin signed the letter on January 2, 2011 and returned it to Mr. Little. Claimant only went to a few sessions before ceasing physical therapy. He resumed in March 2011, under Dr. Dille's January 11, 2011 prescription. Claimant was out of town with his wife, who was receiving medical treatment in Salt Lake City, during the interim.

154. On December 3, 2010, Claimant sought emergent care for a left ankle injury after falling on ice. An x-ray of his left foot on December 10, 2010 showed no acute fracture, but revealed findings suspicious for osteonecrosis.

155. On December 8, 2010, Claimant reported to Mr. Urrutia that even though Surety had ceased paying for his treatment, he wished to proceed out-of-pocket for treatment of neck pain radiating into his left shoulder, upper arm and thoracic spine, and low back pain radiating into both legs, feet and his thoracic spine. Claimant weighed 341 pounds. Mr. Urrutia planned to obtain Claimant's cervical spine imaging (which appears from the record to be nonexistent) and scheduled a follow-up with Dr. Dille to discuss the possibility of cervical spine injections and a spinal cord stimulator. Apparently, Claimant did not return.

156. On December 9, 2010, Claimant followed up with Dr. Coughlin, for the last time. Claimant had injured himself in a fall on December 5. Claimant rated his pain as a "10" and weighed 335 pounds. Dr. Coughlin noted that no physician had seen Claimant, that he still had CRPS, and that he needed to be followed by a pain specialist. Dr. Coughlin recommended physical therapy and provided a one-time prescription for hydrocodone.

MEDICAL TREATMENT AND FURTHER SPINAL CORD STIMULATOR EVALUATION: JANUARY 19, 2011 – MAY 6, 2011

157. During this period, Claimant was treated or evaluated by Daniel R. Marsh, M.D., a pain specialist; Ronald Cantone, Psy.D., a psychologist; Matthew Jolley, M.D., a psychiatrist; Jeremy S. Curry, M.D., a pain management specialist; Mark E. Snow, Ph.D., a psychologist; and Dr. Dille.

158. On January 19, 2011, Claimant was evaluated by Dr. Marsh, apparently on his attorney's referral. He walked with a cane and rated his pain as a 16 on a scale of 1-10. Claimant reported his relevant history regarding his left ankle and low back injuries. Some of the facts Claimant reported to Dr. Marsh are inconsistent with his prior medical records, such as that he weighed over 400 pounds when he was evaluated by Dr. Floyd, and that he had actually been scheduled for lumbar spine surgery ("but thankfully that was delayed"). CE-838. According to the chart note, Claimant also reported that he had attended two RSD conventions, that he was single and that he was a smoker.[14] There is no indication which, if any, of Claimant's prior relevant medical records Dr. Marsh reviewed.

159. Dr. Marsh diagnosed CRPS based on signs and symptoms and low back pain from multilevel degenerative disc disease, both related to his industrial accident. He recommended a spinal cord stimulator and apparently concurred in Claimant's preexisting plans to travel to

[14] Claimant disputes that he ever reported he was single.

Yuma, Arizona to be evaluated by Dr. Curry for treatment via ketamine coma and subanesthetic ketamine. He also prescribed NPS cream and Methadone, a narcotic pain medication associated with substantial health risks if used improperly, which Dr. Marsh discussed. Claimant entered into a treatment agreement related to the Methadone prescription.

160. Also on January 19, 2011, Claimant was evaluated by Dr. Cantone for a spinal cord stimulator trial. Dr. Cantone opined that, notwithstanding his depression and PTSD, Claimant was an appropriate candidate. "Certainly, relief from his chronic pain would prove very helpful in relieving Mr. Gerdon of his depression." CE-854. There is no indication that Dr. Cantone had reviewed any of Claimant's prior medical records or, importantly, Dr. Calhoun's records.

161. From approximately January 18, 2011 through December 27, 2011, Claimant obtained counseling services and various medications from Dr. Jolley and his nurse practitioner. There is no evidence that Dr. Jolley ever tested Claimant or otherwise evaluated him for initial diagnosis purposes. Nevertheless, he treated Claimant for depression and PTSD. When Dr. Jolley died, Claimant received care from Dr. Jolley's nurse practitioner. Claimant reported stress due to his workers' compensation issues, among other things, during this period.

162. On February 7, 2011, Claimant consulted with Dr. Curry. Claimant reported, among other things, that he had "trialed" hydrocodone, as well as lumbar sympathetic blocks in the past. They were helpful for pain relief, but they did not improve his ability to move his foot. *See* CE-864. Apparently, Claimant gave no indication of his addiction issue. As to Methadone, Claimant complained that it caused nausea and constipation, and did not help with his pain. Claimant also reported to Dr. Curry that he got no benefit from physical therapy or

desensitization therapies. There is no indication that Dr. Curry reviewed any of Claimant's relevant medical records.

163. Following examination, Dr. Curry diagnosed CRPS, type 2, of the left lower extremity (based on signs and symptoms), lumbar degenerative disc disease, and lumbar spine pain and radiculopathy. In addition, he noted that there is no identifiable explanation as to why Claimant could not move his left foot. Dr. Curry advised Claimant to stop taking Methadone and prescribed hydrocodone, Colace, Phenergan and Neurontin. He also recommended two lumbar sympathetic injections on the left side and provided Claimant with a DVD about spinal cord stimulation. Dr. Curry opined that if conservative measures failed, a spinal cord stimulator may need to be considered.

164. On March 2, 2011, Claimant underwent a psychological evaluation for Lap-Band bariatric surgery by Dr. Snow. Dr. Snow interviewed Claimant and administered psychological tests.[15] There is no indication that Dr. Snow was aware of any of Claimant's relevant records regarding his physical or psychological conditions.

165. Claimant reported to Dr. Snow that he had no weight problems before his industrial accident and that he had lost 58 pounds through medication changes, the assistance of a nutritionist, and trying to exercise and diet. He also reported that he was arrested at age 19 for forgery, but has not had legal problems since then, and that he is a smoker. Claimant advised Dr. Snow that he is limited because of his medical problems and wants to be more active.

166. Dr. Snow opined that none of Claimant's test results contraindicated Lap-Band surgery. However, he noted that they did demonstrate some compulsive behaviors, somatic problems, and somatic and neurological complaints. In addition, a validity scale on Claimant's

[15]Dr. Snow administered the Millon Clinical Multiaxial Inventory II, the Minnesota Multiphasic Personality Inventory -2, the Brief Symptoms Inventory, the Beck Depression Inventory II (RF), and the Beck Anxiety Inventory.

MMPI-II (RF) results showed he may have under-reported problems, and his Millon Multiaxial Inventory III results indicated he may have been making a conscious effort to appear socially acceptable. "My overall impression is that he probably tried to present himself in a positive light with few psychological problems. However, he is being treated and appears to be functioning fairly well. He appeared highly motivated, positive and excited about the proposed surgery." CE-872.

167. On March 7, 2011, Claimant followed up with Dr. Marsh after returning from Arizona. He reported Dr. Curry did not recommend ketamine coma because of Claimant's weight and lack of insurance coverage for that treatment. He also reported that Dr. Curry recommended ceasing Methadone in favor of hydrocodone and Neurontin, a spinal cord stimulator, and a series of sympathetic blocks. Claimant advised Dr. Marsh that he had previously undergone sympathetic blocks with Dr. Binegar and that they were somewhat helpful, that the NPS cream was not helpful, and that Dr. Jolley changed his Cymbalta and Elavil to Xanax, mirtazapine and prazosin to better address his anxiety, and prescribed Lunesta for sleep.

168. Dr. Marsh recommended fish oil for Claimant's CRPS, continued his Methadone, advised that a sympathetic block could be ordered whenever Claimant wants, and planned to move forward on obtaining a spinal cord stimulator.

169. On March 27, 2011, Mr. Little wrote to Dr. Dille. He noted Claimant was able to ambulate without assistive devices, but he did not say how far or how long. He also reported a setback due to a fall in the shower and outlined treatment recommendations for the next 12 weeks. Dr. Dille signed the letter on April 4, 2011 and returned it. On April 21, 2011, Mr. Little again updated Dr. Dille:

> Joe continues to respond with decreased severe pain to the left distal LE with resumption of physical therapy with the use of the vibration therapy, massage

> mobilization to the scar joint and toes 1-5. Joe has also progressed to a more advanced gym exercise to work on his balance, gait and stretching. Joe reported a moderate digression when he was out of therapy and is pleased to return and will continue with this present program 2 days per week.

CE-417. On April 25, 2011, Mr. Little followed up on his recent letter to Dr. Dille. He revised his treatment goals in light of an interim telephone conversation with Dr. Dille, failure to reach past goals and another falling episode.

170. On May 6, 2011, Claimant followed up with Dr. Marsh. Claimant rated his pain level at 8½ and was apparently discouraged. "He states that he feels he has fractured his foot but nothing can be done about it, so he has not done anything." CE-843. Claimant had stopped going to physical therapy due to dissatisfaction with details involved with Mr. Little's transition from a solo practitioner to a group practice. He reported feeling good about his use of fish oil and that his whole family was now taking dietary supplements. He also reported, apparently for the first time, his prior hydrocodone addiction, and that he did not wish to take that medication again. Dr. Marsh continued to prescribe Methadone, ordered an MRI to determine if he was a candidate for injection therapy and, apparently, determined not to recommend further physical therapy.

INDEPENDENT MEDICAL EVALUATION: GARY C. WALKER, M.D.

171. On May 9, 2011, Claimant underwent an IME by Gary C. Walker, M.D., at Surety's request. In preparation, Dr. Walker reviewed Claimant's post-accident medical and psychological care records, interviewed Claimant, and performed an examination. Dr. Walker did not include any records from Drs. Marsh, Cantone or Curry on the list of records he reviewed.

172. Claimant reported, among other things, that he was down to 340 pounds from 395, that he smoked a half pack a day and that he was taking Methadone 15 mg three times per

day. Dr. Walker noted that there were several versions of the facts involved in Claimant's industrial accident, but he believed the most likely is that the car in which Claimant was riding went off the road, and that there was no rollover of the vehicle.

173. Dr. Walker diagnosed a post-tibial and fibular fracture with open reduction and internal fixation, with appropriate positioning; and CRPS-II of the left ankle and foot due to the ankle fracture. He also diagnosed depression, morbid obesity, and herniation of the L3-4 disc with extrusion and decreased right knee reflex, but he did not indicate whether he attributed these conditions to the industrial accident or injury.

174. Concerning treatment to date, Dr. Walker opined, "At this time it appears that he has gone through extensive and very appropriate treatments." CE-897. As to ongoing treatment, Dr. Walker recommended no further physical therapy "at this time," and opined that "the only other consideration would be that of a dorsal column stimulator trial." *Id.* He also recommended that Claimant increase his activity and that Surety pay for a health club membership for 3-6 months to encourage Claimant to exercise, provided that Claimant would go. In addition, Dr. Walker advised that Claimant should continue his current medications "without any other suggestions given the host of medications that have been tried to this point." *Id.* Following trial of a spinal cord stimulator, Dr. Walker opined that Claimant will have exhausted his treatment options.

175. Claimant (with his wife) followed up with Dr. Marsh on June 3, 2011. Claimant rated his pain level at 9 and reported that Dr. Walker had recommended a spinal cord stimulator trial, but Claimant had refused. Claimant was satisfied with Methadone for pain control and reported he had lost weight. He was also attending physical therapy, at his own expense. Dr. Marsh noted Claimant was still making poor food choices and smoking, and that he needed a

Topamax refill. Dr. Marsh again recommended a spinal cord stimulator, but Claimant was content with Methadone. Dr. Marsh also advised Claimant to lose weight and stop smoking.

MEDICAL TREATMENT: JUNE 25, 2011 – JANUARY 13, 2012

176. On June 25, 2011, Claimant was treated for an infectious rash on his bilateral lower legs. He weighed 337 pounds.

177. On September 2, 2011, Claimant (with his mother) followed up with Dr. Marsh. Claimant rated his pain level at 7. Claimant's mother expressed her gratitude for improving Claimant's condition, and Claimant gave Dr. Marsh the prescription for hydrocodone he received from his dentist to demonstrate that he was not obtaining pain medications from other sources. Dr. Marsh noted Claimant's improvement:

> His mother is here to express her gratitude, as her son is doing much better than he has been doing with his previous pain physicians, and I must say that Joe does have a pleasant demeanor and I do find that it is easy to work with and our personalities seem to work fairly well together. He notes that the Topamax and Methadone are working. He has lost 9 pounds. The Methadone has made him more functional. He is going to the fair. He is doing things. He is doing activities, and the other medications that he was on had some psychosocial implications affecting his mood. Nonetheless, he is doing much better.

CE-847. Dr. Marsh made no new diagnoses or recommendations.

178. On November 29, 2011, Claimant followed up with Dr. Marsh. The accompanying chart note restates the history of Claimant's treatment following his industrial accident, stating, among other things, that he had shattered his left ankle and also injured his neck, back and knee. Dr. Marsh reported that Claimant weighed 332, down from a previous high of 427 (as reported by Claimant). Claimant advised that he was "meeting with the Industrial Commission" at the end of the year so, apparently, Dr. Marsh decided to address some potential litigation issues. He opined that Claimant's low back pain is related to his industrial accident and, strongly, that Claimant should not be pressured into a spinal cord stimulator trial.

179. Claimant followed up with Dr. Marsh again on December 28, 2011. He was down to 311 pounds, and his pain level was 7-8. Regarding his weight, Claimant reported a history that appears misleading based on his medical records in evidence. "His high school weight was 185. He was about 210 at some point in time and after his injury ballooned up over 400 pounds." Claimant's high school weight is not in question. However, any inference that Claimant expanded from 210 to 400 pounds as a result of his industrial injury is refuted by persuasive evidence in the record that Claimant weighed closer to 300-310 pounds at the time of his accident.

180. Dr. Marsh reviewed Claimant's June 2009 lumbar spine MRI, noting anomalies at L3-4 and L4-5, with the former being more significant. He opined it may be necessary to update this imaging. They discussed Claimant's workers' compensation case, as well as adding Savella, a selective serotonin and norepinephrine reuptake inhibitor, for pain control. Claimant's psychiatry nurse practitioner was researching Savella for him.

181. On January 13, 2012, Dr. Marsh evaluated Claimant for the final time before the hearing. Claimant's pain level was at a rare low of 6½, which he attributed to the addition of Savella, and he had quit smoking. His weight was down to 303 pounds. Dr. Marsh and Claimant's mother, who was also present, agreed that Claimant seemed sedated and that his speech was affected. Also, Claimant reported getting "a lot of cotton mouth." CE-852. So, Dr. Marsh reduced his Savella dosage. Dr. Jolley had died by this time, so Claimant was looking for a new psychiatrist.

182. Claimant was still falling a lot, but he reported being able to walk about 25 yards with a cane before taking a break, and could stand with a cane for 10-15 minutes at a time. Dr. Marsh again reviewed the details of the industrial accident with Claimant and reported them

in his chart note. Again, Claimant's recollection does not jibe with his medical records in evidence with respect to his weight at the time of the accident and subsequent weight gain. Claimant reported to Dr. Marsh that he weighed 235 pounds (contradicting his report on the day of his accident that he weighed 280 pounds, and his medical record from a month or so prior to his accident that pegged his weight at 308 pounds) and that his weight had increased to 400 pounds over the ensuing 15 months. In addition, Claimant reported that, although he got significant (but brief) relief from Dr. Binegar's sympathetic nerve blocks, Dr. Binegar ceased these treatments after speaking with Surety's nurse case manager.

183. Dr. Marsh noted Claimant's significant successes with weight loss and diet, opioid medication reduction, smoking cessation, strict compliance with his Methadone regimen without aberrant drug behaviors, and his desire to hold off on a spinal cord stimulator. He also attested to Claimant's truthfulness and overall compliance:

> He has been truthful and consistent and has not resisted any of my recommendations. I am pleased with his progress. He is trying his best to be conservative and avoid interventional care, and we will do that if possible. If not, he is willing to concede that he may in the future need spinal cord stimulation, but at this point in time, he still wants to hold off and try to do in his mind the right thing, which is to continue to lose weight and continue to maximize his health.

CE-853.

FUNCTIONAL CAPACITY EVALUATION: MS. ALBRECHTSEN AND DR. PAQUETTE

184. On December 15, 2011, Claimant underwent a Functional Capacity Evaluation ("FCE") by Randi Beth Albrechtsen, a physical therapist assistant.[16] Claimant's mother was also present, having signed an Observation Agreement which prevented her from making any type of recording of any of the assessment activities. Utilizing a job description provided by ICRD,

[16]The report is dated December 15, 2012, which is obviously in error. The body of the report states the correct date (December 15, 2011).

Ms. Albrechtsen determined the functional capabilities Claimant needs to return to his job as a car salesman, then administered standardized performance testing to measure his related abilities.

185. Following a four-hour testing session, Ms. Albrechtsen opined that Claimant's test results were valid and comprised an accurate reflection of his current functional abilities, and that he had exerted full effort. In addition, according to his test results, Claimant could do light-medium duty work. He had good eye-hand coordination, dexterity and manipulation capabilities; however, he demonstrated poor overall body mechanics and his cardiac feedback showed he was severely deconditioned.

186. Concerning his job-related abilities, Claimant demonstrated he could perform the critical work demands of a car salesman, but only on a part-time basis. Ms. Albrechtsen opined Claimant should be able to return to work 4-5 hours per day, then gradually progress to a full (9½-hour) work day over 2-3 weeks.

187. On December 19, 2011, Claimant sought treatment from an urgent care clinic for left ankle pain, swelling, and a "small 'squishy' bump" that developed following his FCE. CE-918. Claimant also testified at the hearing that his pain flared following the FCE. X-rays of the left ankle demonstrated moderate degenerative joint disease of the tibiotalar joint with well-healed fractures and no evidence or acute fracture or dislocation, ankle mortise injury, joint effusion or soft tissue swelling.

188. On January 18, 2012, Sonia Paquette, OTD, a doctor of occupational therapy from Downington, Pennsylvania, in consultation with Claimant, provided her opinion of the usefulness of Ms. Albrechtsen's FCE in establishing Claimant's ability to return to work. In developing her opinion, Ms. Paquette reviewed Claimant's FCE report, related ICRD job site evaluation, and a chart note of Claimant's medical treatment for ankle pain, swelling, etc., dated

four days after the FCE. Ms. Paquette notes a number of internal and external inconsistencies apparent from the materials she reviewed. She concluded:

> Despite the presence of a few informative statement in the FCE report, the inference that Mr. Gerdon can stand for 4-5 hours in 60 minutes [*sic*] increments, walk for 1-2 hours or sit for 4-5 hours in 60 minutes [*sic*] increments is not supported by Mr. Gerdon's reported performance in testing done, as reported. Furthermore, elements such as transferring in and out of the car or using the clutch in a manual transmission car along with their associated postural/physical demands are not addressed.

CE-922. Dr. Friedman also opined that the FCE results were overly optimistic about Claimant's functionality.

189. Dr. Paquette's excoriation of the foundation for Ms. Albrechtsen's FCE opinions, as supported by Dr. Friedman, is persuasive. Ms. Albrechtsen's FCE opinions are not credible and will be afforded no weight.

VOCATIONAL DISABILITY CONSULTANT OPINIONS

190. <u>Greg Taylor, ICRD consultant.</u> Claimant obtained vocational assistance from Greg Taylor, vocational consultant with the Industrial Commission Rehabilitative Division ("ICRD"), from June 30, 2008 through July 27, 2010. During his initial interview, Claimant reported he was injured when the driver of the car swerved to miss a deer. He weighed 300 pounds and was unable to drive or regularly use crutches, so he was in a wheelchair. He had a friend build him a ramp to his front door for wheelchair entry.

191. During the first part of July 2008, Claimant was speaking with coworkers daily and planning to return to work upon his recovery, and someone at Con Paulos indicated to Mr. Taylor that it would allow Claimant to return to work on a temporary basis, making telephone calls while he was confined to a wheelchair. Further, at such time that he received a

light-duty work release, Con Paulos would allow him to return to his time-of-injury job; however, due to slow business, there would be no need to replace Claimant absent an upswing.

192. Mr. Taylor documented Claimant's work responsibilities at his time-of-injury job as a sales associate/team leader:

> Works as a team leader with several younger sales associates. Occasionally meets and greets customers who come onto the sales lot. Occasionally takes demo ride with customers. Moves vehicles around lot for different positions on the lot. Salespersons will refer customers to team leader for closing sales or to assist with sale. Places sales signs on vehicles on lot. Writes contracts on closed sales. Locks vehicles at the end of day and opens vehicles at the beginning of the workday.

CE-942. He also noted Claimant's recollection of his responsibilities at the car salesperson position he held for 2 ½ years just prior to his time-of-injury job:

> Sold new and used Honda automobiles to customers at dealership. Explained features and demonstrated operation of vehicle in showroom or on road. Suggested optional equipment for customer to purchase. Computes and quotes sales price, trade-in allowance, license fee, and requirements for financing payment of vehicle on credit.

Id.

193. On July 8, 2008, Claimant made some changes to the job site evaluation ("JSE") prepared for the driver in the accident so that it would apply to his position.

194. Claimant returned to light-duty work on July 30, 2008 generally in accordance with Dr. Surbaugh's 15-hour recommendation. On October 7, 2008, Mr. Taylor noted that Claimant was off work, but anxious to get back. Mr. Taylor noted Claimant seemed "well motivated and is anxious to improve but his rehabilitation process is going to be complicated, expensive and multi-factorial." CE-967.

195. On May 27, 2009, Mr. Taylor spoke with someone at Con Paulos. She said sales people must be able to walk around the lot speaking with customers and go for demonstration

rides, as well as climb two flights of stairs to reach the training room. She was uncertain whether there was a position for Claimant without knowing more about his capabilities. There was no sales position available at that time due to the economic downturn.

196. In October 2009, Mr. Taylor tried, unsuccessfully, to find suitable jobs for Claimant.

197. On March 9, 2010, Claimant and his wife met with Mr. Taylor. Claimant reported he could stand for 15-20 minutes before needing to sit down and that he could walk 5-10 minutes consecutively. They discussed Dr. Krafft's restrictions of no pushing, pulling or lifting in excess of 20 pounds; position changes as needed; no walking on rough or uneven ground; no jumping; and limit walking to short distances. In addition, they discussed how Claimant had applied for work as a car salesman at three area dealerships, but had not been offered a position because of his limited ability to walk, stand and drive. He also applied at Shopko, Target, Tru-Green LawnCare, Mr. Gas, Wilson-Bates Furniture, Phone Base Research (telemarketing) and Teleperformance (Boise, telemarketing), all to no avail.

198. Based on Claimant's education, training and work experience, Mr. Taylor opined that, with training, he would be eligible for jobs such as credit checker at furniture or jewelry stores based on his experience with customers and financing as a car salesman. However, he believed other sedentary work "in the community would be difficult for the Claimant to obtain because of his lack of experience, lack of skills for sedentary work, medical factors and non-medical factors such as the downturn in the economy and nearly 9% unemployment rate in the Magic Valley area. Dell Computers has lain [*sic*] off nearly 500 workers in the Magic Valley area which increases the amount of job seekers in the labor market who have clerical skills."

CE-950. He affirmed these opinions on May 10, 2010. Also, on May 10, 2010, Claimant notified Mr. Taylor that he had been approved for SSDI and was drawing benefits.

199. On July 27, 2010, Claimant reported that Dr. Jensen discharged him from care for being argumentative and that no further appointments with Dr. Dille had been approved. He felt that he no longer had a treating physician, but he continued physical therapy with Mr. Little. His attorney planned a meeting with a Surety representative to clarify who is Claimant's treating physician. Also, Claimant was under the impression that Surety wanted him to repeat the STARS program.

200. On that same day, Claimant's ICRD file was closed because Claimant was receiving SSDI and temporary total disability benefits, still attending physical therapy, and did not have a treating physician. Mr. Taylor concluded there was nothing of benefit ICRD could offer at that time.

201. Barbara K. Nelson, C.R.C. On or about February 16, 2010, Claimant was evaluated by Barbara K. Nelson, vocational disability consultant, at Claimant's request. Her evaluation report indicates that Ms. Nelson reviewed Claimant's medical and vocational records, interviewed Claimant and administered vocational testing.

202. During the interview, Claimant reported that he weighed 250 pounds at the time of the accident. According to Ms. Nelson, "Prior to his industrial injury, he was big and strong and healthy." CE-1092. She also reported that Claimant enjoyed participating in a variety of sports, that he had done volunteer work with the Special Olympics program, and that he had no known physical limitations or restrictions. She was under the impression that, by the time Claimant was ending the STARS program, he had gained over 100 pounds.

203. As for the accident, Claimant reported that he woke up as the car was rolling down a ravine after his coworker swerved to miss a deer in the road. Thereafter, he was taken to Weiser Memorial Hospital. Ms. Nelson summarized the medical records pertaining to that and Claimant's follow-up medical care through the date of her evaluation. Curiously, she underlined statements throughout this rendition all of which, if accurate, would place Claimant in either a neutral or a more favorable light. She underlined no statements that would likely place Claimant in a less favorable light. Apparently, Ms. Nelson was signifying that she placed more weight on the facts in the underlined statements.

204. As for Claimant's physical condition at the time of the interview, he told Ms. Nelson that he continues to have pain and functional limitations due to his industrial injuries. His left foot pain was aggravated by prolonged sitting, standing, walking, cold, wearing shoes for too long, bed covers touching his foot, going up and down more than a few stairs, frustration and stress. His back pain was aggravated by twisting, bending, lifting, and prolonged standing, sitting and walking. His medication made him light-headed and interfered with his driving. He did not drive on the freeway or with his wife or daughter in the car. He was continuing to go to the gym five days per week, and to physical therapy three days per week. He was working on losing weight, having lost 21 pounds since leaving the STARS program, and was looking into bariatric surgery. He reported he had been permitted to transfer his medical care to Drs. Myers and Dille. (Note that one week following this interview, Claimant established care with Dr. Myers, signing a pain contract in violation of his existing pain contract with Dr. Dille/Mr. Urrutia, which eventually resulted in Dr. Myers discharging him from care.) Claimant also disclosed that he was just finishing up probation on a felony conviction from approximately 2005.

205. Ms. Nelson administered two vocational tests; the Wide Range Achievement Test (WRAT4), a normed test "intended for use by those professionals who need a simple, psychometrically sound assessment of important fundamental academic skills", and the Wonderlic Personnel Test (WPT), a short-form measure of general intelligence that "provides quantitative insight into how easily individuals can be trained, how well they can adjust and solve problems on the job, and how well satisfied they are likely to be with the demands of a job." CE-1105. Claimant's WRAT4 scores placed him in the 87th percentile of the population for sentence comprehension (above grade level 12.9); in the 58th percentile of the population for word reading and math computation (above grade level 12.9 for math and at that level for reading); and in the 25th percentile for spelling (at grade level 9.6). They also placed him in the 75th percentile of the population on the reading composite component, which does not correlate with a grade level. On his WPT, Claimant scored in the "Bright Normal" category. Job potential for this category is described as, "General clerical and first line supervisors; able to train others for routine positions; gathers information; may require help with making decisions." CE-1107. Claimant's training potential was described as, "Able to learn routines quickly; train with combination of written materials with actual on the job experience." *Id.* At the hearing, Ms. Nelson commented:

> He's quite bright. He has an above average intelligence. Good ability to learn. And although he didn't complete a lot of college, he's achieving at a high school graduate level, at an entry level college in his ability to read and understand what he reads and his ability to calculate math problems. He is a little bit low in spelling, more like about between the 9th, 10th grade high school level. But that's not very unusual. I have found that pattern to be kind of common.

Tr., pp. 145-146.

206. Ms. Nelson identified Claimant's relevant medical factors as his left lower extremity CRPS-I, psychological problems (PTSD, depression, anger, frustration and general anxiety) obesity which she presumes is due to the industrial accident based on Claimant's representation that he weighed 250 pounds before the accident, then gained 100 pounds, and back pain with occasional numbness and radiculopathy into his right lower extremity. Ms. Nelson identified Claimant's relevant non-medical factors include his age (31 at the time), education (high school diploma plus some college), good learning ability, felony conviction, and depressed Magic Valley labor market. Only the last two non-medical factors, Ms. Nelson opined, would negatively impact Claimant's ability to obtain work.

207. Relying on Dr. Coughlin's opinion that Claimant is medically unable to work in his current (February 2010) condition, Ms. Nelson opined that Claimant is totally and permanently disabled. She also addressed whether or not Claimant's condition was likely permanent. Her opinions on this point are given no weight because Ms. Nelson is not a physician.

208. Relying on Dr. Krafft's restrictions of limited walking, frequent position changes, no pushing/pulling/lifting in excess of 20 pounds, sitting for no more than two hours at a time, no working at unprotected heights, and no jumping, Ms. Nelson opined Claimant could theoretically perform some clerical jobs even though his clerical skills would not qualify him for most jobs in this classification. She thought he was capable of call center or bill collecting work. However, she ultimately opined that, given the weak labor market, Claimant was not likely to be able to obtain either of these jobs or, if he were hired, the call center work would likely not provide a full-time position and would prove unsustainable due to the high stress involved.

209. In providing her opinion, Ms. Nelson relied entirely upon her professional experience with the Magic Valley labor market without consulting any authoritative sources to support her opinions. She also critiqued Dr. Krafft's opinion. Her observations along these lines are given no weight because, again, she is not a physician.

210. Even if Claimant was not totally and permanently disabled based upon his medical and nonmedical factors alone, Ms. Nelson opined that Claimant was an odd-lot worker because it would have been futile for him to attempt to find work. "As explained in my report, there are so few jobs for which he can presently qualify, given his restrictions, transferable skills and the current economy, and his history of felony conviction that a reasonable labor market simply does not exist for him." CE-1113. Ms. Nelson does not specifically identify all Claimant's transferrable skills or define all of the jobs available to Claimant in his labor market before or after his accident using any authoritative sources or surveys. She also did not attempt to locate work for Claimant.

211. On January 20, 2012, Ms. Nelson prepared an addendum to her 2010 report after reviewing Claimant's updated relevant records, including the December 17, 2010 disability evaluation of Dr. Barros-Bailey, Claimant's FCE report and related critique by Dr. Paquette, and others. Ms. Nelson's vocational opinions did not change after reviewing these materials, but the tone of her report did. The adversarial tone of this report, along with her underlined statements and other legal references in her first report, places Ms. Nelson's objectivity as an expert witness in question.

212. Ms. Nelson did not update her assessment of the labor market following her 2010 opinion. At the hearing, she continued to rely upon 2010 information except with respect to the FCE findings, which she addressed in her 2012 report.

213. Mary Barros-Bailey, Ph.D. On December 17, 2010, Claimant underwent an evaluation by Mary Barros-Bailey, Ph.D., a vocational disability consultant, documented elsewhere in the record. In preparation, Dr. Barros-Bailey reviewed Claimant's medical and vocational records and interviewed Claimant. Claimant reported that he had lost 70 pounds over the prior six months through physical therapy and medication modifications. He reported he had no preexisting conditions that impacted his ability to work. He also listed what he believed were his limitations.

214. Claimant told Dr. Barros-Bailey that he can type 20-25 words per minute, and there is mention elsewhere in the record that he can type 40 words per minute. He also affirmed that he was aware he could pursue training through the Idaho Division of Vocational Rehabilitation, but, nevertheless, he had not explored this option.

215. Utilizing O*NET software, Dr. Barros-Bailey identified Claimant's transferrable skills into the following components: material moving, structural fabricating-installing-repairing, cooking-food preparation, accommodating, merchandising-sales, investigating, information giving, stock checking, plant cultivating, structures, janitorial services, portering services, household appliances, meals services (except domestic), financial services, sales promotion services, amusements/recreation services, retail trade, motor vehicles, motor vehicle equipment and miscellaneous services.

216. Dr. Barros-Bailey pointed out that there are a number of opinions regarding Claimant's functional abilities and permanent medical restrictions and, appropriately, she did not attempt to persuade the Commission to adopt any particular opinion. Instead, she opined that there were jobs Claimant could perform in the sedentary and light-duty categories in customer service positions, as well as inside sales and office clerk jobs. These jobs pay less than what

Claimant was making at Con Paulos, however, so Dr. Barros-Bailey opined he had likely suffered a 25% loss of wage earning capacity due to his industrial injuries, for an overall disability of 28% to 59% inclusive of impairment. She did not explain in her report how she calculated her overall opinion; however, at her deposition, Dr. Barros-Bailey explained how she based her calculations on both wage loss and loss of labor market access analyses.

217. Notwithstanding her above opinions, Dr. Barros-Bailey opined that, due to the overlay of his current mental/cognitive functioning, Claimant was unlikely to be placeable in employment at that time (December 2010).

218. On November 21, 2011, Dr. Barros-Bailey supplemented her earlier vocational evaluation report. Based upon Dr. Calhoun's opinion that Claimant's psychological barriers to returning to work had lifted, she now opined that Claimant was placeable. She confirmed her prior opinion of Claimant's disability to the extent that his physical condition was unchanged from December 2010.

219. On January 17, 2012, Dr. Barros-Bailey revised her opinion based upon Ms. Albrechtsen's FCE findings, which indicated Claimant was more functional than what she had assumed in preparing her initial evaluation opinions. As a result, without further analysis, she opined that Claimant's disability was 8%, inclusive of impairment.

TESTIMONY OF CLAIMANT'S WIFE AND MOTHER

220. Rachel Gerdon, Claimant's wife, and Mickey Gerdon, Claimant's mother, both provided testimony under oath at the hearing. Rachel Gerdon testified credibly that she was frustrated with Surety's adjustment of Claimant's claim because it has still failed to pay some bills. She also testified that when the whole family had to move to Boise so Claimant could participate in the STARS program, they were twice placed in two-story housing that was clearly

inappropriate for Claimant, and on at least one occasion, they travelled from Jerome to Boise for an MRI, only to be turned away because Surety had not yet approved the procedure. Mickey Gerdon, as stated above, is a registered nurse who was a strong advocate for Claimant throughout his treatment, guiding some of his medical care choices and participating in at least one STARS panel discussion.

221. The Referee finds both Rachel's and Mickey's concern for Claimant's well-being and frustration with some aspects of his medical care to be sincere. On these points, they are each credible witnesses.

CLAIMANT'S CREDIBILITY

222. According to the evidence in the record, Claimant has experienced a number of life-changing events since approximately the beginning of 2008. Aside from his industrial accident, which has clearly had a significant impact on both his health and his employment, he has also gotten married, had a child, and grieved through the deaths of his brother and father. These circumstances could account for a lack of clear-headedness that may have contributed to *some* of Claimant's many inconsistent statements about his industrial accident and his weight, and his inability to recall the details regarding his behavior leading to his felony forgery conviction, for example. However, these circumstances fail to rebut the weight of evidence in the record that tends to establish Claimant is not a reliable historian and that he is motivated by secondary gain factors to maintain his disability until these proceedings have concluded (Dr. Calhoun's opinion, in particular). Therefore, the Referee must conclude that Claimant's statements about the accident and his subjective symptoms cannot reliably be taken at face value. Where Claimant's statements about the accident, or his physical or mental condition, are not supported by sufficient credible evidence in the record, they will be afforded little weight.

DISCUSSION AND FURTHER FINDINGS

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

CHANGE IN PHYSICIAN

223. The parties couched their first issue in terms of "whether Claimant is entitled to a change in attending physician and/or RSD/CRPS specialist". Along these lines, Idaho Code § 72-432 provides that:

> [T]he employer shall provide for an injured employee such reasonable medical, surgical or other attendance or treatment, nurse and hospital services, medicines, crutches and apparatus, as may be reasonably required by the employee's physician or needed immediately after an injury…and for a reasonable time thereafter. If the employer fails to provide the same, the injured employee may do so at the expense of the employer.

224. As explained in *Reese v. V-1 Oil Co.,* 141 Idaho 630, 115 P.3d 721 (2005), where an employer wrongfully fails to provide reasonable medical treatment, the injured employee may do so at the expense of the employer. Once an employer makes the decision to curtail treatment, the injured worker is not required to seek permission from employer to change physicians under Idaho Code § 72-432(4). Here, the question is not whether Claimant is entitled to a change of physician. Rather, the question is whether Employer/Surety wrongfully terminated care, and the answer to that question lies in a determination of whether or not the care rendered by Dr. Marsh is causally related to the subject accident.

CAUSATION

225. The nature of Claimant's industrial injuries must be ascertained to determine the extent to which Claimant is entitled to benefits. Claimant does not succinctly itemize which medical conditions he alleges are due to the industrial accident. The record, however, reveals that Claimant has attributed a number of conditions, over time, to that event. The Idaho Workers' Compensation Act places an emphasis on the element of causation in determining whether a worker is entitled to compensation. In order to obtain workers' compensation benefits, a claimant's disability must result from an injury, which was caused by an accident arising out of and in the course of employment. *Green v. Columbia Foods, Inc.*, 104 Idaho 204, 657 P.2d 1072 (1983); *Tipton v. Jannson*, 91 Idaho 904, 435 P.2d 244 (1967).

226. The claimant has the burden of proving the condition for which compensation is sought is causally related to an industrial accident. *Callantine v. Blue Ribbon Supply*, 103 Idaho 734, 653 P.2d 455 (1982). Further, there must be medical testimony supporting the claim for compensation to a reasonable degree of medical probability. A claimant is required to establish a probable, not merely a possible, connection between cause and effect to support his or her contention. *Dean v. Dravo Corporation*, 95 Idaho 558, 560-561, 511 P.2d 1334, 1336-1337 (1973), *overruled on other grounds by Jones v. Emmett Manor*, 134 Idaho 160, 997 P.2d 621 (2000).

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

228. When the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury likewise arises out of employment, unless it is the result of an independent intervening cause attributable to claimant's own intentional conduct. *Larsons, The Law of Worker's Compensation,* § 13.

229. Left ankle fracture/CRPS. The Referee finds sufficient evidence to establish that Claimant's left ankle fracture and left lower extremity CRPS are related to his industrial accident. Multiple physicians, including (but not limited to) Drs. Krafft, Coughlin, Dille, Walker and Friedman, documented signs and symptoms of CRPS throughout Claimant's care leading them to diagnose that condition, and there is no evidence from which it could be determined that this condition resulted from any condition other than the industrial ankle fracture. Only Dr. Hammond, early on, opined that there may be some other explanation for Claimant's CRPS symptoms. That opinion is outweighed by the contrary medical evidence in the record.

230. Lumbar spine pain/right lower extremity radiculopathy pre-STARS. Claimant experienced right lower extremity radiculopathy and lumbar spine symptoms before his STARS spine injury which he attributes to the accident. According to the record, Claimant did not complain of lumbar spine pain or radiculopathy immediately following the accident. Instead, he waited until July 29, 2008, even though he had ample opportunity to make such a report during the intervening six weeks. In fact, before July 29, Claimant reported knee symptoms consistent with a dashboard injury, concern that his ankle wound had developed an infection, and anxiety about returning to work which led to additional medical and occupational therapy evaluations, but no back issues.

231. Additionally, along with Claimant's first report of lumbar symptoms on July 29, he also reported two facts which are inconsistent with the weight of evidence in the record. First,

Claimant reported that he had suffered a blow to the head and lost consciousness for 30-45 minutes following his industrial accident; however, he reported no loss of consciousness at his initial emergency department evaluation and no treatment obviously consistent with such report (like head imaging) was rendered. Second, he reported that he had never experienced back problems prior to his industrial accident. However, a chart note in the record establishes that, on October 22, 2007, Claimant sought treatment for low back pain that he characterized as "occasional" as well as left leg pain and right leg numbness, diagnosed as a bulging disc. Most likely, Claimant was intentionally exaggerating the circumstances of his accident and underplaying his preexisting lumbar spine problems. These circumstances raise the question of whether, in the same breath, Claimant was also untruthful when attributing his low back symptoms to his industrial accident.

232. Looking at the medical evidence, Claimant's treating physicians treated his low-back symptoms as industrially-related. On October 9, 2008, Dr. Dille noted that"[t]he cause of injury is from a motor vehicle accident," and Defendants have not advanced any specific argument why Claimant's low back condition prior to his STARS injury should not be deemed compensable. CE-446. In addition, the most recent evidence of Claimant's low back symptoms was from six months prior to his industrial injury, and there is insufficient evidence from which to conclude that some event following the accident was the cause of his relevant symptomatology.

233. The Referee finds, based upon the medical evidence in the record, that Claimant has established that his lumbar spine pain and right leg radiculopathy symptomatology are related to his industrial accident. However, the evidence also establishes that not all of the pathology identified on the September 12, 2008 MRI resulted from that event. According to

Dr. Surbaugh's interpretation of the MRI, only the disc bulge at L3-4 was, possibly, subacute. Later, Dr. Verst opined that an L3-4 discectomy may be an option, but only if Claimant could lose weight. He did not recommend surgical intervention at any other level.

234. Given Claimant's medical history, prior disc pathology diagnosis, identical symptom complaints pre- and post-accident, evidence from Dr. Floyd of congenital spinal stenosis, and MRI findings, it is most likely that the industrial accident worsened a preexisting L3-4 disc bulge. However, the medical evidence fails to establish that any other lumbar spine level was permanently affected.

235. Lumbar spine pain/right lower extremity radiculopathy post-STARS. Following his STARS injury on June 12, 2009, Claimant complained of increased low back pain and right lower extremity radiculopathy. According to Dr. Floyd, MRI imaging taken June 15, 2009 confirmed an acute worsening of the L3-4 disc bulge previously identified on his September 12, 2008 MRI. Due to Claimant's weight, surgery to repair the herniation remains contraindicated (as per Drs. Verst and Floyd, chiefly), and his lumbar spine condition has not resolved on its own.

236. Claimant has proven that his L3-4 disc bulge was permanently aggravated as a result of participating in rehabilitation therapy related to his industrial accident. Therefore, he is entitled to workers' compensation benefits for this injury. As noted above, however, this injury overlays a preexisting disc bulge.

237. Thoracic spine symptoms. Drs. Surbaugh and Dille noted possible mild to moderate compression fractures in Claimant's thoracic spine from T7-12; however, Dr. Dille acknowledged that the MRI report did not include this diagnosis. Dr. Dille opined that the mid-back pain Claimant was experiencing in late summer/early fall 2008 may be the result of thoracic

spine compression fractures and, if so, he expected them to heal without further intervention. No further opinions, treatment or complaints regarding Claimant's thoracic spine appear in the record. As per Dr. Dille, the Referee finds that Claimant's mid-back pain was a temporary condition, now healed, attributable to his industrial accident. He is entitled to benefits for this temporary condition.

238. Knee pain. Claimant also complained of knee pain consistent with a dashboard injury. The evidence in the record establishes Claimant's knee pain resulted from the industrial injury, and there is no evidence in the record of a relevant preexisting condition. Dr. Friedman opined, without opposition, that Claimant developed bilateral knee osteoarthritis as a result of his industrial injury. Claimant is entitled to benefits related to his bilateral knee osteoarthritis.

239. Neck pain. Claimant first reported neck pain on October 2, 2008. Further, Claimant inaccurately reported, on several occasions, that he had been diagnosed with compression fractures in his cervical spine, which is unsupported by the evidence in the record. No cervical imaging was ever taken, and no chart notes document this diagnosis. Claimant has failed to establish that he suffered a neck injury as a result of his industrial accident and he is not entitled to benefits related to any cervical spine condition.

MEDICAL CARE

240. Pursuant to Idaho Code § 72-432, Claimant is entitled to reasonable and necessary medical care for his left ankle fracture, lower left extremity CRPS, L3-4 disc herniation, bilateral knee osteoarthritis and thoracic spine symptoms (temporary, now healed).

241. Reimbursement for past medical care. Prior to the hearing, Claimant received a great deal of medical care. Defendants generally and vaguely deny liability for some of this care because Claimant was either non-compliant or because his treatment was obtained outside the

chain of referral of his treating physician. However, the only pre-hearing care to which Defendants *specifically* object is Dr. Marsh's, because he was outside Dr. Krafft's chain of referral, and obesity treatments in general, because they are not related to Claimant's industrial injury.

242. As determined above, Dr. Marsh was Claimant's treating physician at the time of the hearing and, in any event, at this stage in these proceedings, the designation of a treating physician is beside the point.[17] The only inquiry the Commission may make is whether the treatment rendered by Dr. Marsh was reasonable and necessary. *See Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989). In *Sprague*, three factors were found relevant to the determination of whether the particular care at issue is reasonable. First, the claimant should benefit from gradual improvement from the treatment rendered; second, the treatment must have been required by the claimant's treating physician, and third, the treatment must have been within the physician's standard of practice, at fair and reasonable cost.

243. Defendants did not argue that the care Claimant received from Dr. Marsh was not reasonable. However, they did assert that Methadone therapy is inappropriate because Claimant has demonstrated narcotics addiction issues. A number of physicians, including Dr. Friedman in his post-hearing deposition, opined that Claimant should not be given any narcotics, including Methadone. However, the record establishes that Claimant's condition has improved with Dr. Marsh. He lost a significant amount of weight, bringing him back to his time-of-injury baseline, and his symptoms and mental state have markedly improved. Defendants posit that these improvements are solely due to the fact that Claimant now has what he wants (narcotics),

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[17] The parties are apparently arguing about treating physicians because they believe that all treatment ordered by a treating physician is deemed reasonable and, thus, compensable. However, where the weight of medical evidence in the record establishes that the care is not reasonable, even if it is ordered by a treating physician, Surety is not necessarily liable for the cost.

so he is pacified and, thus, more agreeable. If this is the only reason Claimant is showing improvement currently, however, why was Claimant not similarly agreeable, previously, when he was receiving more narcotics? Even though Claimant is not a credible witness, the Referee is persuaded that he has improved and is closer to returning to work with the Methadone treatment than he was without it. Clearly, health risks are associated with continuing this treatment, but there are also health and well-being risks associated with chronic pain. Defendants must take Claimant as he is; the narcotics route is working for him, whereas the tough-it-out, work-through-the-pain route did not, in spite of monumental effort on the part of a number of caregivers. Given Claimant's apparent improvement and, importantly, Dr. Walker's concurrence in May 2011 that Methadone therapy should be continued, the Referee finds Dr. Marsh's treatment, including Methadone therapy, was reasonable. Therefore, the Referee finds that Defendants are liable for reimbursement for the cost of Dr. Marsh's care.

244. As for bariatric counseling and treatment, the Referee finds the Claimant was morbidly obese, weighing 300-310 pounds on the day of his industrial accident. Therefore, Claimant's obesity problems preexisted his industrial injuries. During the course of his rehabilitation, the record establishes that Claimant most likely gained 80-90 pounds, then lost it by the time of the hearing. Medical evidence establishes that Claimant's weight gain was likely related, at least in part, to his inactivity from his industrial injuries. Thereafter, Martha Peterson approved, on at least two occasions and without reservation, Claimant's consultations with Ms. Graf, a nutritionist at the Humphreys Diabetes Center. In addition, Rachel Gerdon persuasively testified that she was told the cost of protein shakes and special food recommended by Ms. Graf would be covered and that she would not have purchased these items, had she not received such assurance, because Claimant could not afford them. Under these circumstances, it

would be unjust to require Claimant to assume these costs, regardless of whether they were industrially-related, which the Referee also finds they were. Therefore, Defendants are liable for reimbursement of the cost of Ms. Graf's services and the special shakes and food Claimant purchased for himself on her recommendation.

245. Although Claimant lost weight under Dr. Marsh's care, the focus of this treatment was pain relief and rehabilitation from his industrial injuries. Whatever amount of time was spent in bariatric counseling was rolled into the cost of compensable care; therefore, Defendants have not established that they should be credited any amounts against Dr. Marsh's charges for treatment, even though he continues to work with Claimant on his weight issue.

246. Defendants' objection to liability for reimbursement of other expenses can be inferred from the fact that they did not pay such costs as they were incurred and claim to owe Claimant no further benefits in their brief. Claimant has argued extensively that he is entitled to reimbursement for certain past unpaid medical care expenses not already addressed above, including costs associated with his cardiac workup by Dr. Parent, urgent care on December 19, 2011 following his FCE, urgent care on December 5, 2010 following a fall on ice, physical therapy with Dave Little approved by Dr. Coughlin in December 2010 and thereafter, $500 in home modifications, and reimbursement for mileage for nine round-trips to Boise from Jerome for medical treatment. Defendants do not argue why these specific expenses should not be reimbursed. Therefore, Defendants are liable for reimbursement of each expense for which Claimant can establish a *prima facie* case under *Sprague.*

a. Cardiac workup: This treatment was required to clear Claimant for participation in the STARS work hardening program, approved by Surety. Claimant is entitled to reimbursement for associated medical expenses.

b. December 19, 2011 urgent care: This care was required, according to the treatment record and Dr. Friedman, as a result of exertion during a Surety-ordered FCE. Claimant is entitled to reimbursement for associated medical expenses.

c. December 5, 2010 urgent care and follow-up with Dr. Coughlin: Claimant fell on the ice, which could have happened to anyone. However, according to Dr. Friedman and common sense, it was more likely to happen to Claimant because he is unstable on his feet, in part, due to his industrial injuries. Claimant is entitled to reimbursement for associated medical expenses.

d. Treatment by Dave Little approved by Dr. Coughlin in December 2010: Claimant treated with Mr. Little, off and on, beginning in 2008. Mr. Little provided physical therapy services, but also took an extraordinary interest in Claimant's care, recommending physicians at times and encouraging certain types of care outside of the physical therapy realm. It is easy to see why Claimant appreciated Mr. Little's attention and assistance. However, Dr. Krafft and others persuasively recommended that Claimant should discontinue physical therapy before December 2010 because it had not improved Claimant's condition. Indeed, Claimant reported on a number of occasions, that physical therapy was not helpful. By the time of the hearing, apparently Claimant was no longer in physical therapy, yet he was quite content with Dr. Marsh's regimen of medication, sympathetic nerve blocks "a couple of times a year" and overall health and nutrition guidance. Tr., p. 113. There is inadequate proof in the record to establish that Claimant improved from Mr. Little's physical therapy in or after

December 2010. Defendants are not liable for reimbursement of costs associated with that care.

e. Home modifications and wheelchair: Idaho Code § 72-432(1), requires that such assistive apparati must be "reasonably required by the employee's physician" to be a compensable expense. Many physicians in this case eventually opined that Claimant should focus on moving more and, therefore, refused to recommend a wheelchair or power chair later in his rehabilitation. However, the circumstances of his weight, combined with his wife's medical conditions (pregnancy and cystic fibrosis) which prevented her from assisting him during the first part of his rehabilitation, rendered his choice to utilize a wheelchair during that period reasonable. Although Claimant's mother was instrumental in obtaining the wheelchair, its use was approved by Dr. Surbaugh, Claimant's treating physician. In order to get in and out of the house unassisted in the chair, Claimant needed a ramp built to his front door. Claimant is entitled to reimbursement for expenses associated with the wheelchair and the ramp, to the extent he can establish he is liable for the expense. Mickey Gerdon testified that she paid the contractor with a credit card. If Claimant cannot establish he is liable to Mickey Gerdon for the payment, then Defendants are not similarly liable to Claimant. Claimant also testified that handle bars had been installed in his shower and elsewhere in his house for fall prevention. Defendants are liable for reimbursement of the reasonable actual costs of installing these devices.

f. Mileage reimbursement: Claimant is entitled to mileage reimbursement pursuant to Idaho Code § 72-432(13) for his expenses of necessary travel in

obtaining medical care. Claimant alleges, and Defendants do not object, that he made eight unreimbursed round-trips between Jerome and Boise for medical treatment associated with his industrial injuries. He further alleges that he is entitled to reimbursement for a trip to Boise for an MRI which was not performed because, although Dr. Surbaugh had arranged the appointment, Surety had not previously approved the procedure so he was turned away upon arrival. Claimant made this trip in pursuit of medical care related to his industrial injuries. He is entitled to reimbursement for mileage, consistent with the statute, for nine round-trips.

247. Although he claims there may be additional compensable costs that Defendants failed to pay, Claimant has failed to adduce sufficient evidence to establish he is entitled to reimbursement for any other past medical expenses not addressed herein.

FUTURE MEDICAL CARE

248. The *Sprague* standard anticipates a situation in which treatment has already been rendered, and the *Sprague* analysis is not readily applicable to care, like that at issue in the instant matter, that is prospective in nature. *See*, *Richan v. Arlo G. Lott Trucking, Inc.,* IC 2007-027185 (Feb. 2011); *Ferguson v. CDA Computune, Inc., et. al.,* consolidated cases numbers IC 2001-005778, IC 2001-021764, IC 2004-504577 and IC 2004-000161 (filed Feb. 2011). To determine whether the care sought by Claimant is "reasonable," the Commission must ascertain whether the required care was required by his physician and whether it is likely to be efficacious. In other words, if, from the medical evidence adduced by Claimant, it appears that it is more probable than not that the care will improve Claimant's condition, then the care is "reasonable."

249. <u>Palliative care for left lower extremity pain.</u> As discussed, above, the opinions of Dr. Krafft and others who all recommended against further narcotic pain medications,

particularly given Claimant's addiction problem, were well-founded when rendered. However, it cannot be denied that Claimant's condition has dramatically improved, both physically and psychologically, under Dr. Marsh's regimen of Methadone and other medications. Further, Dr. Marsh's approach is not without support in the record. In May 2010 (just prior to Claimant's admission of his addiction issue), Dr. Krafft opined that if Topamax did not provide Claimant adequate relief, then Methadone should be considered. Also, Dr. Walker in May 2011 concurred in Claimant's continued use of Methadone and other medications Claimant was taking at that time, all of which were being prescribed by Dr. Marsh. Claimant has established entitlement to on-going palliative care for his left lower extremity pain due to his industrial injury, including Methadone prescribed and monitored as necessary through evaluation and examination by Dr. Marsh.

250. Claimant has failed, however, to establish that periodic sympathetic nerve blocks are likely to improve his condition. Although he reported to Dr. Marsh that these had helped him in the past, the medical records of Dr. Binegar from March 2009 indicate Claimant reported no significant relief, and the sympathetic block was discontinued. Claimant is not entitled to future medical benefits for sympathetic nerve blocks.

251. <u>Spinal cord stimulator.</u> At the time of hearing, Claimant was uninterested in a spinal cord stimulator. Therefore, this point is moot and no determination as to his entitlement to such intervention will be made herein. If Claimant changes his mind in the future, any determinations as to his eligibility should be rendered based upon Claimant's condition at that time.

252. <u>Bariatric care.</u> As to future bariatric care, there is inadequate evidence of a causal link between a permanent industrially-related weight problem and Claimant's industrial accident

such as to justify further treatment. Defendants are not liable for future expenses related to treatment of Claimant's obesity.

253. Gym membership. A gym membership has occasionally been recommended for Claimant, most recently by Dr. Walker in May 2011. Dr. Walker saw this as a tool to encourage Claimant to exercise, provided he would go. At the time of the hearing, Claimant was doing well under Dr. Marsh's care, without a Surety-sponsored gym membership. The Referee finds Claimant is not entitled to benefits for this purpose.

254. Power chair. The only individual who recommended a power chair was Mr. Urrutia, and this recommendation was qualified on the condition that Claimant would not become dependent upon it. Every other physician who addressed the topic, including Dr. Friedman, opined that this was not necessary. Defendant is not liable for providing Claimant with a power chair.

255. Physical therapy. As addressed above, Claimant has failed to establish that physical therapy is likely to improve his condition. He is not entitled to benefits for future physical therapy.

256. Psychological care and counseling. Although Claimant seeks a determination that he is entitled to future psychological care and counseling, he has failed to address any of the requirements to prove such entitlement under Idaho Code § 72-451. Further, no on-going psychological care has been prescribed. Claimant has failed to establish entitlement to benefits for future psychological care and counseling.

257. L3-4 disc herniation. Claimant is entitled to further reasonable and necessary medical care for his L3-4 disc herniation, determined, above, to be related to his industrial accident. No further care, other than palliative care, was recommended at the time of the

hearing. However, this issue may resurface at such time, if any, that Claimant's weight drops to 250 pounds, the point at which one or more physicians opined surgery may be indicated.

258. Bilateral knee osteoarthritis. Claimant is entitled to further medical care, as reasonable and necessary, for any permanent/on-going knee conditions as determined, above, to be related to his industrial accident. No further care was recommended at the time of the hearing.

MEDICAL STABILITY, PPI, AND MEDICAL RESTRICTIONS

259. Medical stability. Several medical stability opinions have been rendered over time. Neither party argues for the selection of a particular date, nor that Claimant was not medically stable at the time of the hearing. Further, identification of a specific date is not necessary to the determination of Claimant's pending claims. Therefore, no medical stability date is determined herein.

260. Permanent restrictions. In January 2010, Claimant was evaluated for Social Security Disability Insurance benefits and, among other things, was determined to be relegated to sedentary work due to his physical limitations.

261. On September 2, 2010, Dr. Krafft recommended a functional capacity evaluation to determine Claimant's work restrictions. "He, however, has been previously able to ambulate short distance, was given a 20 pound lifting restriction, recommended to avoid unprotected heights, walking on rough, uneven ground, and jumping. These are reasonable pending his FCA." CE-662. Claimant subsequently underwent an FCA which, as determined above, failed to yield reliable results.

262. On December 18, 2010, Dr. Friedman issued permanent restrictions including medium-duty work (due to lumbar spine condition); no kneeling, squatting, or crawling (as a

result of his knee osteoarthritis); and limited walking and standing (due to his CRPS). "These are permanent restrictions, and attributable to the consequences of his lower extremity injuries, surgical intervention, obesity." CE-833. Dr. Barros-Bailey subsequently opined that, taken together, these restrictions would relegate Claimant to sedentary to light-duty work.[18] At his deposition, Dr. Friedman also explained that a 50-pound (occasional) lifting restriction is also appropriate, to protect Claimant's lumbar spine.

263. On December 15, 2011, Claimant underwent an FCE which, as discussed above, failed to yield reliable results. On January 13, 2012, Dr. Marsh reported that Claimant could walk 25 yards without a cane before needing a break, could stand with a cane for 10-15 minutes at a time, and was experiencing less pain with the addition of Savella to his medications.

264. The Referee finds Dr. Friedman's and Dr. Marsh's opinions of Claimant's capabilities most persuasive because they are closer in time to the hearing date than Dr. Krafft's. As a result, the Referee further finds Claimant had permanent medical restrictions at the time of hearing, due to his industrial injuries, relegating him to sedentary to light-duty work with no kneeling, squatting, or crawling; walking limited to 25 yards with a cane; lifting of up to 50 pounds on an occasional basis; and standing limited to 10-15 minutes with a cane.

265. PPI. "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 nonprogressive at the time of evaluation. Idaho Code § 72-422.

[18] The Referee finds that, even though Dr. Barros-Bailey's opinion did not specifically include a 50-pound lifting restriction, her opinions relegating Claimant to sedentary or light-duty work are, nevertheless, consistent with that requirement.

266. On September 2, 2010, Dr. Krafft assessed 5% whole person PPI for Claimant's left foot condition and 7% PPI for his back pain and radicular complaints, for a total combined PPI of 12%, all attributed to his industrial injuries. On December 18, 2010, Dr. Friedman assessed PPI due to the industrial injury, with no apportionment, of 8% of the whole person in consideration of Claimant's CRPS, 3% of the whole person for his knee osteoarthritis, 3% of the whole person for his obstructive sleep apnea due to obesity, 5% of the whole person for his depression (as a result of his industrial injury, chronic pain, psychosocial disturbance and disability), and 0% for his narcotics abuse problem. Utilizing the combining table, Dr. Friedman opined that Claimant has incurred PPI of 19% of the whole person. He added 7% for low back impairment due to the STARS herniation in October 2011, for a combined total of 25% PPI of the whole person.

267. Dr. Friedman's assessment is more comprehensive, thus, more persuasive than Dr. Krafft's. However, not all of the conditions assessed by Dr. Friedman have been proven to be due to the industrial accident and injuries. Specifically, Claimant has failed to prove a sufficient causal link with his sleep apnea or on-going depression. In addition, Claimant had the same low back and radiculopathy symptoms, diagnosed as the result of a preexisting disc bulge, prior to his industrial accident. Therefore, it is appropriate to apportion 3.5% (half) of Claimant's lumbar spine PPI assessment due to his L3-4 herniation to his preexisting condition.

268. The Referee finds Claimant suffered PPI due to his industrial injuries in the amount of 13.5% of the whole person (8% (CRPS) + 3% (knee) +7% (spine) after utilizing combining table), after apportioning 3.5% to his preexisting lumbar spine condition.

PERMANENT DISABILITY

269. "Permanent disability" or "under a permanent disability" results when the actual

or presumed ability to engage in gainful activity is reduced or absent because of permanent impairment and no fundamental or marked change in the future can be reasonably expected. Idaho Code § 72-423. "Evaluation (rating) of permanent disability" is an appraisal of the injured employee's present and probable future ability to engage in gainful activity as it is affected by the medical factor of permanent impairment and by pertinent nonmedical factors provided in Idaho Code § 72-430. Idaho Code § 72-425. The test for determining whether a claimant has suffered a permanent disability greater than permanent impairment is "whether the physical impairment, taken in conjunction with nonmedical factors, has reduced the claimant's capacity for gainful employment." *Graybill v. Swift & Company*, 115 Idaho 293, 766 P.2d 763 (1988).

270. Idaho Code § 72-430(1) provides that, in determining percentages of permanent disabilities, account should be taken of the nature of the physical disablement, the nature of any disfigurement, the cumulative effect of multiple injuries, the occupation of the employee, and the employee's age at the time of the relevant accident or occupational disease manifestation. In addition, consideration should be given to the diminished ability of the affected employee to compete in an open labor market within a reasonable geographical area in light of all of the personal and economic circumstances of the employee, and other factors as the Commission may deem relevant. The focus of a determination of permanent disability is on the claimant's ability to engage in gainful activity. *Sund v. Gambrel*, 127 Idaho 3, 7, 896 P.2d 329, 333 (1995).

271. **Time of disability determination.** The Idaho Supreme Court in *Brown v. The Home Depot,* WL 718795 (March 7, 2012) this year reiterated that, as a general rule, Claimant's disability assessment should be performed as of the date of hearing. Under Idaho Code § 72-425, a permanent disability rating is a measure of the injured worker's "present and probable future ability to engage in gainful activity." Therefore, the Court reasoned, in order to assess the

injured worker's "present" ability to engage in gainful activity, it necessarily follows that the labor market, as it exists at the time of hearing, is the labor market which must be considered. Although the Commission is afforded latitude in making alternate determinations based upon the particular facts of a given case, the parties have not argued that Claimant's disability should be determined as of any other point in time; therefore, it will be determined as of the hearing date.

272. **Non-medical factors.** Based upon the record and the vocational rehabilitation consultant opinions, Claimant's relevant nonmedical factors contributing to his disability at the time of the hearing are his high school education, transferrable skills, work experience, age, and felony conviction.

273. **Credibility of vocational disability consultant opinions.** Ms. Nelson and Dr. Barros-Bailey are each well-qualified and well-known to the Commission. Ms. Nelson's opinions in this case, however, are founded upon inaccurate information provided by Claimant (regarding his weight issues and pre-accident functionality, in particular), outdated medical opinions, an understanding of the relationship between Claimant's abilities and the Magic Valley labor market which she did not corroborate with authoritative statistics or sources, and an overtly sympathetic view toward Claimant and his legal case. As a result, Ms. Nelson's ultimate opinions are unpersuasive. Dr. Barros-Bailey's opinions were formulated utilizing O*NET software and the *Dictionary of Occupational Titles*, as well as her professional experience with the Magic Valley labor market. Dr. Barros-Bailey performed both a loss of access analysis and a loss of earning capacity analysis, based on both sedentary and light-duty work restrictions, consistent with Claimant's permanent medical restrictions. Although her ultimate opinion in her January 17, 2012 report is unpersuasive because it fails to explain why 8% permanent disability

"inclusive of impairment" is appropriate in Claimant's case, in which the lowest PPI rating rendered is 12% of the whole person, Dr. Barros-Bailey's overall reasoning and analysis up to that point is credible and persuasive. Also, because it was determined that the FCE is not assistive to the Commission's determination in this case, the January 12, 2012 report is moot because it was prepared to address findings in the FCE.

274. The Referee finds Dr. Barros-Bailey's opinion, that Claimant has suffered 28%-59% disability, persuasive. Claimant is not totally and permanently disabled based upon his medical and non-medical factors.

275. **Odd-lot.** Claimant argues that he is totally and permanently disabled as an odd-lot worker. An odd-lot worker is one "so injured that he can perform no services other than those which are so limited in quality, dependability or quantity that a reasonably stable market for them does not exist." *Bybee v. State, Industrial Special Indemnity Fund,* 129 Idaho 76, 81, 921 P.2d 1200, 1205 (1996). Such workers are 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." *Carey v. Clearwater County Road Department,* 107 Idaho 109, 112, 686 P.2d 54, 57 (1984). Claimant carries the burden of proof to establish total permanent disability under the odd-lot doctrine, which may be established in any one of three ways:

a. By showing that the claimant has attempted other types of employment without success;

b. By showing that the claimant or vocational counselors or employment agencies on his behalf have searched for other work and other work is not available; or

c. By showing that any efforts to find suitable work would be futile.

Lethrud v. Industrial Special Indemnity Fund, 126 Idaho 560, 563, 887 P.2d 1067, 1070 (1995).

276. First *Lethrud* method. Claimant concedes that he has not looked for work recently. He has stated that he would work if he were physically capable of doing so, but he believes that he is not.

277. Second and third *Lethrud* methods. Greg Taylor, ICRD consultant, assisted Claimant, unsuccessfully, in summer 2009 in his attempt to regain his time-of-injury position and again, in spring 2010, to place him in a different job. Mr. Taylor's job search attempts were sincere, but inadequate in terms of proximity to the hearing date and scope of the search, to establish that, at the time of hearing, no work was available to Claimant. No others searched for work on behalf of Claimant. Claimant has failed to establish he is an odd-lot worker under the second *Lethrud* method.

278. Ms. Nelson and, at one point, Dr. Barros-Bailey, opined that it would be futile for Claimant to attempt to find work. By the time of the hearing, however, Claimant's condition had improved, according to Dr. Krafft and Dr. Calhoun, in particular, and Dr. Barros-Bailey revised her opinion to reflect that she believed Claimant could return to work with 28%-59% disability. As noted above, Ms. Nelson's ultimate opinions, in this case, that an employment search would be futile, are unpersuasive. Claimant has failed to establish that it would be futile to conduct a job search. Claimant has failed to prove by a preponderance of the evidence that he is totally and permanently disabled as an odd-lot worker.

279. **Permanent partial disability.** Prior to his industrial accident, Claimant had developed transferrable skills in: material moving, structural fabricating-installing-repairing, cooking-food preparation, accommodating, merchandising-sales, investigating, information

giving, stock checking, plant cultivating, structures, janitorial services, portering services, household appliances, meals services (except domestic), financial services, sales promotion services, amusements/recreation services, retail trade, motor vehicles, motor vehicle equipment and miscellaneous services. He also has keyboarding and some computer skills.

280. Following his industrial injury, Claimant was no longer able to engage in more than sedentary to light-duty work (Dr. Barros-Bailey persuasively testified that Dr. Friedman's restrictions, when taken together, relegate Claimant to this category); to kneel, squat, or crawl (as a result of his knee osteoarthritis); or to walk or stand for long periods (due to his CRPS). As a result, his employment opportunities were limited by his industrial injuries, both in terms of access to the labor market and wage-earning capacity.

281. Although Claimant is limited in his ability to walk and stand, he has a significant array of skills transferrable to light-duty and sedentary work, if he decides to apply them. The Referee finds Claimant has suffered 50% permanent partial disability, inclusive of impairment, due to his industrial injuries.

ATTORNEY FEES

282. Idaho Code § 72-804 provides that if the Commission determines that the employer contests a claim for compensation made by an injured employee without reasonable grounds or the employer neglected or refused within a reasonable time after receipt of a written claim for compensation to pay to the injured employee the compensation provided by law, or without reasonable grounds discontinued compensation as provided by law, the employer shall pay reasonable attorney fees in addition to the compensation provided by law.

283. Claimant seeks attorney fees for unreasonable denial of payment of a number of items, addressed below.

284. **Nutritionist costs.** Claimant asserts that Surety unreasonably denied, or failed to pay, benefits for the cost of consultations with the nutritionist, Ms. Graf. Surety was or should have been aware that this treatment was recommended through the STARS program and specifically approved by its nurse case manager, Martha Peterson, yet at the time of hearing, this provider remained unpaid. Surety's failure to pay, or delay in paying, Ms. Graf was unreasonable. Claimant sought reimbursement for this cost so, apparently, Claimant paid it. Claimant is entitled to attorney fees incurred in connection with obtaining reimbursement for the cost of Ms. Graf's services. Curiously, Claimant sought reimbursement for costs associated with his cardiac workup for the STARS program but did not request attorney fees related to this nonpayment. Because Claimant did not seek attorney fees, none are granted with respect to nonpayment related to his cardiac workup.

285. **Temporary housing costs.** The temporary housing in Boise during Claimant's STARS participation, arranged by Surety, was inadequate because it required Claimant to climb stairs. After Claimant complained, Surety provided an alternative, which was equally unsuitable. Thereafter, Claimant secured his own temporary, handicap-accessible, housing (through the assistance of his wife), and Surety failed to pay the costs associated with that housing for "many months." Cl. Brief, p. 36. No documentary or other evidence supports Claimant's estimate of the payment delay. These events were upsetting and frustrating to Claimant and his wife; however, they did not result in a lack of necessary medical care to Claimant and there is inadequate evidence from which to determine any financial detriment (credit reporting or otherwise) he suffered due to Surety's failures. Apparently, Claimant did not prepay this expense, so it was actually the lessor left holding the bag during Surety's delay, and the facts in the record are inadequate to determine the extent to which the lessor (or

Claimant) was financially harmed, if any. While Surety's actions in this regard are questionable, Claimant has failed to establish a right to attorney fees under Idaho Code § 72-804 on these grounds.

286. **Treatment by Dr. Marsh.** Claimant asserts that Defendants unreasonably denied treatment by Dr. Marsh. The Referee disagrees. By the time Claimant sought Dr. Marsh's care, Claimant had been determined medically stable by Drs. Jensen, Krafft and Friedman. Further, Dr. Calhoun had cleared him for work from an industrially-related psychological standpoint. Dr. Krafft recommended ongoing Topamax for Claimant's pain upon his final discharge of Claimant from care. However, he, along with Drs. Jensen and Friedman, had all recommended against further narcotic pain medications for Claimant due to his addiction problem. Based upon Dr. Krafft's opinion (in September 2010), apparently, Surety denied further benefits. Thereafter, when Claimant established care with Dr. Marsh, he did not initially inform him of his prior addiction to narcotic pain medications. Dr. Marsh prescribed Methadone, a narcotic pain medication, which is a treatment Surety had a reasonable basis for denying through May 9, 2011, the date Claimant underwent an IME by Dr. Walker, at Surety's request. Sufficient, though conflicting, medical evidence in the record compiled before Claimant began treating with Dr. Marsh establishes adequate grounds for Surety's denial of benefits for ongoing care through that date. After considering Claimant's medical history and examining Claimant, however, Dr. Walker recommended ongoing Methadone therapy, which both confirmed that palliative care was reasonable and, more specifically, that Methadone therapy was reasonable. Thereafter, the only medical records compiled were Dr. Marsh's, which confirmed that the treatment was continuing to be effective. Following Dr. Walker's report, Surety had a duty to review the case for its position that ongoing care and Methadone were

unreasonable, but it failed to obtain any before continuing to deny benefits. Surety's denial of Claimant's claim for treatment by Dr. Marsh, including Methadone therapy, was unreasonable following May 9, 2011. Claimant has proven his entitlement to attorney fees, incurred following May 9, 2011, for unreasonable denial of benefits related to Dr. Marsh's care.

287. **Surety's "redirecting" care.** Claimant has failed to prove that Surety inappropriately redirected his care such as to warrant an award of attorney fees under Idaho Code § 72-804. Specifically, his allegations of improper conduct by Martha Peterson are unsupported by the weight of evidence in the record.

288. Claimant has proven entitlement to attorney fees under Idaho Code § 72-804 for unreasonable denial of his claims for treatment by Ms. Graf and Dr. Marsh as set forth above.

CONCLUSIONS OF LAW

1. Claimant's treating physician is Dr. Marsh.

2. Claimant has proven that, as a result of his industrial accident, he suffered injuries including left ankle fracture, CRPS of the left lower extremity, L3-4 disc herniation, bilateral knee osteoarthritis, and temporary thoracic spine pain (now healed).

3. Claimant has proven that he is entitled to reimbursement for past medical care for his industrial injuries including, specifically, reimbursement for:

   a. Past medical care by Dr. Marsh;

   b. STARS cardiac workup by Dr. Parent;

   c. December 5, 2010 urgent care and follow-up with Dr. Coughlin;

   d. December 19, 2011 urgent care;

   e. Physical therapy before December 2010;

f. The actual reasonable cost incurred by Claimant of Claimant's wheelchair (if not already paid by Surety), wheelchair ramps and handle bars installed in his house; and

g. Mileage reimbursement for nine roundtrips from Jerome to Boise for medical treatment, consistent with Idaho Code 72-432(13).

4. Claimant has failed to prove he is entitled to any additional past medical care.

5. Claimant has proven entitlement to future palliative medical care from Dr. Marsh, including Methadone therapy for pain relief; as well as periodic monitoring and evaluation of his left ankle, CRPS, L3-4 herniation, and bilateral knee osteoarthritis conditions.

6. Claimant has failed to prove he is entitled to future care consisting of sympathetic nerve blocks, a spinal cord stimulator, bariatric care, gym membership, a power chair, physical therapy, or psychological care or counseling.

7. Claimant has proven he suffered PPI due to the industrial accident in the amount of 13.5% of the whole person after apportioning 3.5% to his preexisting lumbar spine condition.

8. Claimant has failed to prove that he is totally and permanently disabled under the odd lot doctrine.

9. Claimant has proven he is 50% permanently partially disabled, inclusive of impairment, as a result of his industrial injuries.

10. Claimant has proven he is entitled to attorney fees for unreasonable denial of Claimant's claim for reimbursement of costs associated with consultations with Ms. Graf, nutritionist, and Dr. March's care following May 9, 2011. 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 the time expended or the hourly charge claimed, or any other representation made by Claimant's counsel, the objection must be set forth with particularity. Within seven (7) days after Defendants' counsel files the above-referenced memorandum, Claimant's counsel 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 on 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 __12th____ day of September, 2012.

INDUSTRIAL COMMISSION

_/s/________________________________
LaDawn Marsters, Referee

ATTEST:

_/s/________________________________
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __15th_____ day of __October_____, 2012, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSION OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

JERRY J GOICOECHEA
DANIEL LUKER
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HARMON & DAY
PO BOX 6358
BOISE ID 83707-6358

sjw

_/s/___________________________________

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

JOSEPH GERDON, Claimant, v. CON PAULOS, INC., Employer, and LIBERTY NORTHWEST INSURANCE CORPORATION, Surety, Defendants.	**IC 2008-019169** **ORDER** Filed: October 15, 2012

Pursuant to Idaho Code § 72-717, Referee LaDawn Marsters submitted the record in the above-entitled matter, together with her recommended 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 recommendations of the Referee. The Commission concurs with these recommendations. 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 treating physician is Dr. Marsh.

2. Claimant has proven that, as a result of his industrial accident, he suffered injuries including left ankle fracture, CRPS of the left lower extremity, L3-4 disc herniation, bilateral knee osteoarthritis, and temporary thoracic spine pain (now healed).

3. Claimant has proven that he is entitled to reimbursement for past medical care for his industrial injuries including, specifically, reimbursement for:

a. Past medical care by Dr. Marsh;

b. STARS cardiac workup by Dr. Parent;

c. December 5, 2010 urgent care and follow-up with Dr. Coughlin;

d. December 19, 2011 urgent care;

e. Physical therapy before December 2010;

f. The actual reasonable cost incurred by Claimant of Claimant's wheelchair (if not already paid by Surety), wheelchair ramps and handle bars installed in his house; and

g. Mileage reimbursement for nine roundtrips from Jerome to Boise for medical treatment, consistent with Idaho Code 72-432(13).

4. Claimant has failed to prove he is entitled to any additional past medical care.

5. Claimant has proven entitlement to future palliative medical care from Dr. Marsh, including Methadone therapy for pain relief; as well as periodic monitoring and evaluation of his left ankle, CRPS, L3-4 herniation, and bilateral knee osteoarthritis conditions.

6. Claimant has failed to prove he is entitled to future care consisting of sympathetic nerve blocks, a spinal cord stimulator, bariatric care, gym membership, a power chair, physical therapy, or psychological care or counseling.

7. Claimant has proven he suffered PPI due to the industrial accident in the amount of 13.5% of the whole person after apportioning 3.5% to his preexisting lumbar spine condition.

8. Claimant has failed to prove that he is totally and permanently disabled under the odd lot doctrine.

9. Claimant has proven he is 50% permanently partially disabled, inclusive of impairment, as a result of his industrial injuries.

10. Claimant has proven he is entitled to attorney fees for unreasonable denial of Claimant's claim for reimbursement of costs associated with consultations with Ms. Graf, nutritionist, and Dr. March's care following May 9, 2011. 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 the time expended or the hourly charge claimed, or any other representation made by Claimant's counsel, the objection must be set forth with particularity. Within seven (7) days after Defendants' counsel files the above-referenced memorandum, Claimant's counsel may file a reply memorandum. The Commission, upon receipt of the foregoing pleadings, will review the matter and issue an order determining attorney fees.

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

DATED this 15th day of October, 2012.

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 __15th__ day of __October______, 2012, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

JERRY J GOICOECHEA
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__/s/____________________________