BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

ELOYD HARRIS,	)	
	)	
Claimant,	)	**IC 2002-523145**
	)	**2004-507837**
v.	)	**2004-527260**
	)	**2005-522772**
SCALES UNLIMITED, INC., Employer, and **STATE INSURANCE FUND,** Surety,	)	**2007-004663**
	)	**2007-042051**
	)	
and	)	**FINDINGS OF FACT,**
	)	**CONCLUSIONS OF LAW,**
TOTAL SCALE SERVICE, Employer, and **ADVANTAGE WORKERS' COMPENSATION INSURANCE CO.,** Surety,	)	**AND RECOMMENDATION**
	)	
	)	**Final: July 14, 2011**
Defendants.	)	
	)	

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Rinda Just, who conducted a hearing in Boise, Idaho, on October 20, 2010. Richard S. Owen of Nampa represented Claimant. Susan R. Veltman of Boise represented Employer Total Scale Service (TSS) and Surety Advantage Workers' Compensation Insurance Co. (Advantage). Employer Scales Unlimited, Inc., and its Surety, State Insurance Fund, did not participate in this proceeding, as the issues were limited to matters arising solely out of IC 2007-042051, to which they were not party.[1] Claimant and TSS/Advantage submitted oral and documentary evidence. The record remained open for two post-hearing depositions and

[1] Subsequent to the hearing, but before this recommendation was submitted to the Commission, IC Nos. 2002-523145, 2004-507837, and 2007-004663 were dismissed without prejudice by stipulation of the parties.

thereafter the parties submitted post-hearing briefs. The matter came under advisement on January 27, 2011 and is now ready for decision.

ISSUES

By agreement of the parties prior to hearing, the issues to be decided in this proceeding are whether and to what extent Claimant is entitled to:

1. Medical care, specifically whether the cervical surgery Claimant requires is a result of the November 30, 2007 industrial accident; and

2. Attorney fees, pursuant to Idaho Code § 72-804, for unreasonable denial of workers' compensation benefits.

CONTENTIONS OF THE PARTIES

Claimant's physicians have advised him that he needs surgery on his cervical spine to relieve pain and radiculopathy into his right upper extremity. Claimant asserts that his undisputed need for cervical surgery is attributable to a fall that occurred on November 30, 2007, when he slipped in an icy parking lot while representing TSS at a trade show in Spokane, Washington. Claimant also contends that TSS and Advantage unreasonably denied him the cervical surgery he needs and should be liable for attorney fees, pursuant to Idaho Code § 72-804.

TSS and Advantage do not dispute Claimant's need for cervical surgery. However, they assert that Claimant has a history of trauma and degenerative disease in his cervical spine that pre-existed his November 30, 2007 industrial injury and is the reason he needs surgical intervention. TSS and Advantage are not liable for Claimant's cervical injury and, thus, are not liable for attorney fees for unreasonably denying his claim.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant and Susan Kennon, taken at hearing;

2. Claimant's exhibits 1 through 22;

3. TSS/Advantage exhibits 1 through 12; and

4. The post-hearing depositions of R. Tyler Frizzell, M.D., taken November 1, 2010, and Paul Montalbano, M.D., taken November 10, 2010.

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

FINDINGS OF FACT

1. Claimant was fifty-six years of age at the time of hearing. He lived in Nampa with his wife, Therese.

2. At all times pertinent hereto, Claimant worked as a sales representative for TSS. Claimant began working for TSS in 2006. TSS sells weighing devices of all kinds, including cattle scales, truck scales, railroad scales, and small counting and precision scales.

3. Before going to work for TSS, Claimant worked for Scales Unlimited, Inc., a similar business. At Scales Unlimited, Claimant was both a sales representative and an installer. He left Scales Unlimited when a low back injury prevented him from doing the installation portion of the job.

4. It is undisputed that Claimant slipped on ice and fell as he was leaving Spokane following a trade show. It is undisputed that immediately following the injury, Claimant sought care and complained of right shoulder, right elbow, right hip, and neck pain.

RELEVANT PRIOR MEDICAL HISTORY

5. Claimant has a history of right shoulder and neck complaints dating back to 1996. In May 1996, Claimant saw James D. Redshaw, M.D., a neurologist, regarding cervical complaints. Dr. Redshaw's chart notes are not part of the evidence offered at hearing, but on May 7, 1996, he referred Claimant to physical therapy for evaluation and treatment of "C-spine musculoligamentous strain." Cl. Ex. 1, p. 13. The subsequent physical therapy notes reflect that Claimant sustained his injury in January 1996, when he slipped on ice while attempting to enter his vehicle. Complaints included a nagging burning sensation at the base of his neck and occasional tingling in his right hand. In his letter to Dr. Redshaw following Claimant's initial visit, the physical therapist described Claimant's condition as:

> Upper thoracic musculoligamentous strain. Current problems include pain, weakness, poor posture, inability to work, and *sensory changes in the C4 dermatome.*

Id., at p. 004 (emphasis added). Claimant was still participating in physical therapy when he reinjured his neck and back, lifting a heavy bucket in mid-June of the same year. Dr. Redshaw ordered a cervical MRI which showed:

- Left side facet arthritis at C2-3;
- Slight degenerative osteophytic ridge at C4-5;
- Minimal endplate degenerative change at C5-6; and
- Minimal degenerative change at C6-7.

In all other respects, the cervical MRI was normal.

6. In November 1998, Claimant reinjured his right shoulder when he attempted to keep a box from falling to the floor. Just a week later, he was a passenger in a motor vehicle that was t-boned on the driver's side, causing the vehicle to roll onto the passenger side. Claimant's primary complaint was right shoulder pain. Claimant received treatment for his right shoulder through the end of April 1999. In late April 1999, Claimant reported to Steven G. Wynder,

M.D., that he had been seeing a chiropractor, Dr. Swanson, for *neck and shoulder* problems resulting from the motor vehicle accident (MVA).

7. In November 1999, Claimant began seeing Michael R. Djernes, M.D., for neck pain. Claimant reported that his neck pain had begun the previous year as a result of the MVA. Claimant described his pain as "an aching or hot sensation at the base of his neck which radiates laterally into the shoulders and inferiorly into the mid scapular region." Cl. Ex. 5, p. 004. Dr. Djernes's initial diagnosis was post-traumatic cervical strain with secondary myofascial pain or cervical radiculopathy. Dr. Djernes ordered a cervical MRI to clarify the differential diagnosis. The MRI, in relevant part, showed:

- At C3-4—a posterior disc bulge with anterior impression on the thecal sac, no involvement of the spinal cord, some attenuation of the left exiting nerve root;
- At C4-5—a posterior disc protrusion with anterior impression on the thecal sac and spinal cord with minimal flattening; and
- At C5-6—a posterior disc bulge without definite impression on the spinal cord and very minimal flattening of the thecal sac;

At a follow-up visit, Dr. Djernes opined that the disc pathology evident at C3-4 through C5-6 was likely the cause of Claimant's pain. He referred Claimant for an epidural steroid injection (ESI), noting that if the ESI did not relieve Claimant's discomfort, neurosurgical intervention might be necessary.

8. Claimant called Dr. Djernes' office on December 12, 14, and 15, complaining of aching and burning in his neck following the ESI. On December 15, 1999, Dr. Djernes referred Claimant to Dr. Frizzell for a neurosurgical consult.

9. Claimant saw Dr. Frizzell on January 31, 2000. Dr. Frizzell observed in his chart note that Claimant's MRI from November 1999 "was of poor quality, but shows no cord

compression. He may have some foraminal stenosis, but it is difficult to tell."[2] Cl. Ex. 6, p. 008. Dr. Frizzell noted that, despite a year of cervical complaints, Claimant had never had a full cervical workup. He recommended additional testing, including a myelogram CT of Claimant's cervical spine.

10. A myelogram CT done February 15, 2000 showed only mild neural foraminal narrowing on the left at C2-3 and "a mild anterior epidural defect suggesting a broad based bulge" at C3-4. *Id.*, at p. 013. The bulge at C3-4 "does not narrow the central canal nor does it come in contact with the cord itself." *Id.* Based on the myelogram CT, Dr. Frizzell opined that Claimant's cervical spine was non-surgical. He recommended a second opinion, however, and referred Claimant to Timothy Doerr, M.D.

11. Dr. Doerr saw Claimant in March 2000. He advised Claimant that there was no evidence of surgical lesions in his cervical spine. Dr. Doerr opined that the cause of Claimant's neck pain was "muscular strain on top of some underlying degenerative changes." Cl. Ex. 7, p. 02. He recommended a formal rehabilitation program, given the length of time Claimant had been dealing with his neck pain. In late March 2000, Dr. Frizzell wrote orders for Claimant for physical therapy two to three times per week for four weeks. In mid-April, Claimant contacted Dr. Frizzell's office, complaining of numbness in his left middle and ring fingers with increased neck pain. Frizzell recommended a consultation with James Morland, M.D., a rehabilitation specialist, and made the referral. There are no medical records from Dr. Morland in evidence.

12. In August 2000, Claimant continued to complain to Dr. Djernes of pain in his neck and right shoulder, along with numbness in his right middle and ring finger. In mid-

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[2] Neither the radiology report from November 16, 1999, nor Dr. Djernes' chart note makes mention of a poor-quality radiologic image.

October, Claimant returned to Dr. Frizzell, complaining of persistent pain and burning at the base of his neck. He also reported pain in his arms and down to his hands. Dr. Frizzell ordered bilateral upper extremity EMG and nerve conduction testing. The results were grossly normal. Dr. Frizzell reiterated that Claimant was not a surgical candidate and recommended prescription anti-inflammatories for his symptoms.

13. In late December 2000, Claimant contacted Dr. Frizzell with continued complaints of neck discomfort and also reported episodes of dizziness and nausea after prolonged extension of his neck. Claimant had not pursued rehabilitation or physical therapy as recommended, and had not tried the prescription anti-inflammatories given to him in early November. Dr. Frizzell wrote a prescription for Claimant to start physical therapy at Mercy Orthopaedic Sports Therapy clinic, but there is no evidence that he did so.

14. In mid-April 2001, Claimant presented at Mercy Ambu-Care Center, seeking an ESI for his cervical disc disease. He reported that:

> He has had one prior cervical epidural steroid injection approximately two years ago, with minimal benefit. He states that his pain has been progressively getting worse and at this time he is requesting a repeat injection.

Cl. Ex. 10, p. 002. Christopher Pierce, D.O., performed the ESI and advised Claimant to return in two weeks for a follow-up visit. On May 2, Claimant returned for a repeat ESI, at which time he reported to David Lee Wilson, M.D., that the ESI he had "approximately one month ago" had helped significantly. *Id.*, at p. 001. Dr. Wilson performed the repeat ESI. There is an eighteen-month break in the relevant medical records following the May 2, 2001 ESI.

15. On November 1, 2002, Claimant presented at Chandler Chiropractic. He reported two weeks of left-sided neck pain, which might have been the result of concrete work he had

done for his Employer the day before the onset of pain. There is no indication that he received any treatment that day, and this is the only record in evidence from Chandler Chiropractic.

16. A little over a year after his visit to Chandler Chiropractic, in November 2003, Claimant called for an appointment with his primary care physician (PCP) for complaints related to his sinus, ears, upper back, and elbows. An appointment was scheduled, but there is no chart note for the office visit or exam in which Claimant more particularly explicated his complaints; however, cervical radiographic images were ordered. According to the clinical history in the radiology report, Claimant suffered an "apparent injury to the upper thoracic and lower cervical spine two months ago with continued pain." Cl. Ex. 3, p. 072.[3] The cervical x-rays showed mild narrowing of the C4-5 interspace with some involvement of C3-4, degenerative changes in the posterior facet joints at C3-4 (repeat left oblique view suggested due to poor quality image), and degenerative change of the posterior facet joints at C2-3 with moderately severe posterior encroachment on the posterior neural foramen. The radiology report recommends further evaluation of C2-3 by MRI. There is no evidence in the record that a new cervical MRI was ordered.

17. From November 2003 until August 2006, there are no medical records relating to cervical or shoulder pain complaints by Claimant, though he sought treatment for low back pain.

18. Between August 8, 2006 and early June of 2007, Claimant treated with a number of providers for right shoulder discomfort. On August 8, 2006, Stanley Stringam, M.D., Claimant's primary care provider (PCP), saw Claimant for evaluation. At that visit, Claimant evidently presented with complaints of right shoulder discomfort. Claimant's neurological exam

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[3] Chart notes from his PCP for September 12, 2003 and October 17, 2003 make no reference to any upper back or cervical injury.

was thought to be normal. However, on examination of the right shoulder, Claimant was found to have some pain in the deltoid musculature and shoulder joint with abduction at about 130 degrees. X-rays taken the same date were read as normal.

19. On August 21, 2006, Claimant again presented to his PCP with complaints of right shoulder pain, and without a history of any inciting event. Claimant complained of pain laterally, and had pain with abduction and overhead activities. He denied neck pain, although he did admit to "some neck pain" in the ten years since an earlier motor vehicle accident. Mr. Washychyn, the physician's assistant who saw Claimant, noted the following relevant findings following his exam of Claimant's cervical spine and right shoulder:

> **Cervical Spine Exam Rheumatology:**
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> Normal neck contour and posture. There is no overlying swelling, erythema, rash. Range of Motion of the cervical spine reveals full flexion, extension, rotation, lateral bending, without apparent pain or discomfort.
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> **Right Shoulder Examination:**
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> Normal shoulder contour with no obvious atrophy. The shoulder appears atraumatic with no overlying swelling, erythema, increased skin temperature, or rash. Neurovascular status intact with good distal sensation and pulses. The range of motion is fluid and mechanics appear to be normal. External rotator strength is 4/5. Deltoid strength is 4/5. Neer impingement test is positive. Hawkins impingement test is positive. Speeds test is equivocal. He has pain with rotator cuff strength testing.

D. Ex. 9, p. 128. Physician's Assistant Washychym felt that Claimant had evidence of an impingement syndrome. On August 21, 2006, he performed a subacromial injection of Claimant's right shoulder, which relieved virtually all of Claimant's discomfort.

20. Claimant returned to the clinic for follow-up for his right shoulder complaints on October 6, 2006. Claimant saw Andrew Curran, D.O., the orthopedic specialist in the practice. Dr. Curran noted the following significant findings:

Right Shoulder Examination

> Normal shoulder contour with no obvious atrophy. The shoulder appears atraumatic with no overlying swelling, erythema, increased skin temperature, or rash. Neurovascular status intact with good distal sensation and pulses. The range of motion is fluid and mechanics appear to be normal. External rotator strength is 4/5. Deltoid strength is 4/5. Neer impingement test is positive. Hawkins impingement test is positive. Speeds test is equivocal. He has pain with rotator cuff strength testing.
> /dvCircumduction/adduction impingement test is positive. O'Brien's test for SLAP lesions is positive.

D. Ex. 9, p. 131. Suspecting a rotator cuff abnormality, Dr. Curran ordered an MRI of the right shoulder. That study was performed on October 9, 2006, and was read by the radiologist as being significant for "rotator cuff tendinopathy without a focal rotator cuff tear of the intratendinous gap involving the supraspinatus tendon."

21. Curiously, in his follow-up note of October 17, 2006, and after his review of the aforementioned MRI, Dr. Curran posited that Claimant might still have a ruptured rotator cuff. On October 17, 2006, Claimant's right shoulder was noted to be somewhat improved, however, he still had some weakness and pain with both external rotation strength testing and abduction strength testing.

22. Claimant returned to Dr. Curran with right shoulder complaints on December 6, 2006, at which time Dr. Curran recorded the following:

Right Shoulder Examination

> Normal shoulder contour with no obvious atrophy. The shoulder appears atraumatic with no overlying swelling, erythema, increased skin temperature, or rash. There is no tenderness to palpation of the bony landmarks and surrounding soft tissue. Normal gross motor strength in all major muscle groups. Neurovascular status intact with good distal sensation and pulses. Neer impingement test is positive. Hawkins impingement test is positive.

D. Ex. 9, p. 142. Dr. Curran opined that Claimant *did not* have a right rotator cuff tear.

23. On December 20, 2006, Claimant underwent bilateral subacromial joint injections.

24. On April 27, 2007, Claimant was evaluated by Dr. Stringam, who noted the following concerning Claimant's neck: "The neck is supple. The carotid pulses are equal. There are no masses, bruits, jugular venous distension, lymphadenopathy, tenderness, or thyromegaly." D. Ex. 9, p. 149.

25. On June 8, 2007, Claimant returned to Dr. Curran with complaints of right shoulder pain. On that date, Dr. Curran made the following notation concerning the right shoulder:

> Right Shoulder Examination
>
> Normal shoulder contour with no obvious atrophy. The shoulder appears atraumatic with no overlying swelling, erythema, increased skin temperature, or rash. There is no tenderness to palpation of the bony landmarks and surrounding soft tissue. Normal gross motor strength in all major muscle groups. Neurovascular status intact with good distal sensation and pulses. Neer impingement test is positive. Hawkins impingement test is positive.

D. Ex. 9, p. 151.[4] Following his exam of Claimant, Dr. Curran opined that Claimant was suffering from an impingement of the right shoulder. He noted that Claimant had recently fallen down the stairs, and Dr. Curran proposed that it was possible that he had suffered further injury to his rotator cuff. He recommended a repeat of subacromial injection.

TREATMENT FOR NOVEMBER 30, 2007 INJURY

26. After his fall in Spokane on November 30, 2007, Claimant returned home and went straight to his PCP. Eric Wells, PA, provided Claimant's initial treatment. Claimant initially complained of right elbow, right shoulder, and neck pain. On exam, Mr. Wells noted

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[4] The identical language appears in the chart note for December 6, 2006, D. Ex. 9, p. 142.

tenderness consistent with the mechanism of injury. He ordered right shoulder and elbow x-rays, which were negative for fracture and joint effusion. Mr. Wells diagnosed contusion of shoulder and arm at multiple sites, right shoulder joint pain, and right elbow contusion. He recommended conservative treatment consisting of anti-inflammatories, rest, and ice.

27. On December 5, 2007, Claimant returned for follow-up care and Ben Terry, D.O., recorded the following findings after examining Claimant's right shoulder:

> Right shoulder:
>
> Inspection: no muscle asymmetry, no scapular winging, no atrophy, tenderness about the ACJoint area.. ROM: passive forward elevation (R/L):, passive ext. rotation @ 90 degrees elevation (R/L):, active forward elevation significantly less than passive, full ROM but reduced dut [sic] to pain when extending his rt hand behind his neck.

D. Ex. 9, p. 160.

28. Similar findings were recorded by Dr. Terry on December 12, 2007 and December 26, 2007. None of Dr. Terry's chart notes make any reference whatsoever to neck pain. However, because of the persistence of Claimant's right shoulder symptoms, Dr. Terry ordered an MRI of the right shoulder, which was performed on or about December 27, 2007. In pertinent part, the MRI was read as showing a subtle, small partial articular side tear of the rotator cuff involving the anterior fibers of the supraspinatus tendon, some 8mm proximal to its insertion.

29. Following the MRI, Claimant returned to Dr. Curran on January 2, 2008. On that visit, Dr. Curran recorded the following concerning his exam of Claimant's right shoulder:

> Right shoulder:
>
> He has full range-of-motion of the right shoulder. He is tender over the AC joint. His [sic] pain and weakness with abduction. There is positive Neer's sign. Positive Hawkins sign. Mild pain with speeds testing and O'Brien's maneuver. Neurovascular exam is intact.

MRI findings:

> MRI shows degeneration of the AC joint. Small partial thickness rotator cuff tear on the articular side.

D. Ex. 9, p. 170.

30. Dr. Curran diagnosed Claimant as suffering from a sprain of the AC joint. He performed an AC joint injection of Claimant's right shoulder and prescribed physical therapy.

31. By February 8, 2008, Claimant reported that his right shoulder complaints had improved by 60 – 70%. On exam, Dr. Curran noted the following:

> General Examination:
>
> He has full range of motion both actively and passively. He still has a mildly positive Neer sign and Hawkins sign. He has mild pain with O'Brien's maneuver as well. Also some discomfort with resisted abduction. He is not significantly tender at the AC joint on today's exam. Neurovascular exam is intact.

D. Ex. 9, p. 173. Dr. Curran continued to diagnose an AC joint strain.

32. By March 18, 2008, Dr. Curran noted that Claimant continued to express improvement of his right shoulder symptoms. On exam, he noted the following:

> General Examination:
>
> He has full range of motion of the right shoulder. 5/5 strength is noted. He has mild tenderness over the AC joint. Mildly positive Neer sign. Negative speeds test. Negative O'Brien's maneuver. No ecchymosis or erythema noted. Neurovascular exam is intact.

D. Ex. 9, p. 175. On March 18, 2008, Dr. Curran released Claimant to a home exercise program.

33. Dr. Stringam saw Claimant on May 6, 2008. Dr. Stringam's note of that date does not reflect that Claimant presented with either neck or right shoulder pain. In fact, Dr. Stringam specifically noted that Claimant had no musculoskeletal complaints. Notably, Dr. Stringam examined Claimant's neck and noted the following: "Normal neck: no masses,

adenopathy or thyromegaly found. Trachea is midline." D. Ex. 9, p. 176. Finally, Dr. Stringam noted that Claimant's motor strength was grossly normal, as was his sensory exam.

34. On June 24, 2008, Claimant saw Joseph Verska, M.D, for evaluation of low back and bilateral hip pain. That note is of interest only because it contains no reference to complaints of shoulder or neck pain. Claimant's cervical spine evidently was examined on the occasion of that visit, since Dr. Verska noted that examination of the cervical spine was normal. (*See*, D. Ex. 9, p. 179).

35. Following Claimant's initial evaluation on November 30, 2007, the very first reference to complaints of neck pain appears in Dr. Curran's September 30, 2008 chart note. On that date, Claimant returned to Dr. Curran with complaints that his right shoulder pain had worsened.

36. In addition to his shoulder complaints, Claimant reported that "he gets pain in his neck as well." D. Ex., p. 182. Dr. Curran ordered a cervical MRI, which showed:

- Degenerative disc disease at C4-5;
- Mild to moderate central spinal canal stenosis at C3-4 and C4-5;
- Broad-based posterior osteophyte/disc with cord entrapment at C4-5;
- Degenerative joint disease in the facets at C2-3 and C3-4;
- Left neural foraminal stenoses at C2-3 and C3-4; and
- Right neural foraminal stenosis at C4-5.

Based on the MRI, Dr. Curran diagnosed cervical radiculopathy and recommended a referral to a cervical spine surgeon.

37. On November 6, 2008, at the request of Surety, Claimant saw Beth Rogers, M.D., a spinal surgeon and practice partner with Dr. Verska, for an independent medical exam (IME). Dr. Rogers reviewed medical records related to the treatment of Claimant's November 2007 injury, and saw Claimant in her office for an exam. Following her record review and an exam, Dr. Rogers diagnosed right rotator cuff tear, moderate central spinal stenosis at C4-5, right C5

vs. C6 radiculopathy, and lumbar spondylosis. Dr. Rogers answered several causation-related questions posed by Surety. In particular, Dr. Rogers opined that it was more probable than not that cervical radiculopathy was a component of Claimant's right shoulder pain following his industrial injury. She noted that the mechanism of injury was consistent with a cervical injury, and nothing in the medical records suggested that any cervical assessment at that time had ruled out a cervical injury. Dr. Rogers also opined that Claimant was not medically stable, as he needed treatment for his C5 or C6 radiculopathy consisting of an ESI or possibly a surgical consult. Dr. Rogers calculated that Claimant was entitled to 2% whole person impairment for his right shoulder injury, but opined that it was too early to assign permanent partial impairment to his cervical injury.

38. Although Dr. Rogers's involvement with Claimant's case was as an independent medical examiner, not a treating physician, she referred him to William Binegar, M.D., a pain specialist, for evaluation of potential right C5 and C6 nerve root injections. Claimant saw Dr. Binegar December 22, 2008, and the doctor performed right C5 and C6 transforaminal ESIs with fluoroscopic assistance.

39. On January 14, 2009, Claimant returned to Dr. Rogers and reported that the ESIs resulted in 60% improvement. Dr. Rogers noted that Claimant wanted to proceed with a second round of ESIs. Dr. Binegar performed a second series of right C5 and C6 transforaminal ESIs with fluoroscopic assistance on February 3, 2009. Claimant returned to Dr. Rogers on February 16, 2009, reporting that he did not get relief from the second series of ESIs and, in fact, his symptoms were worse. Dr. Rogers opined that, given the severity of findings at C4-5, Claimant needed referral for a surgical consult. She referred Claimant to Dr. Montalbano.

Dr. Montalbano

40. Claimant presented to Dr. Montalbano on February 18, 2009. Susan Kennon, a nurse case manager who contracts with Surety's adjuster, accompanied him. At the outset of the appointment, Ms. Kennon provided Dr. Montalbano with copies of the medical records in her possession. The records were not complete, but included Dr. Curran's chart notes after the date of injury and the 2008 MRI. Ms. Kennon could not state with any certainty whether Dr. Montalbano reviewed the records before he examined Claimant.

41. According to Dr. Montalbano's February 19, 2009 report to Dr. Rogers, Claimant's primary complaints were neck pain and right shoulder discomfort with numbness and tingling as well as weakness radiating to his deltoid, anterior forearm, wrist, and little finger. Claimant also told Dr. Montalbano that his symptoms started on November 30, 2007 when he slipped on ice and fell.

42. Dr. Montalbano opined that Claimant needed surgical intervention for his cervical spine—in particular, a C4-5 anterior cervical decompression, fusion, and instrumentation (ACDFI). He further opined that the need for the ACDFI related back to Claimant's work injury on November 30, 2007. In his letter to Dr. Rogers, and subsequently in his deposition, Dr. Montalbano identified the factors that led him to his initial opinion, including:

- The mechanism of injury and Claimant's symptomatology were consistent with the radiographic findings;
- Claimant reported he was asymptomatic *vis-à-vis* his neck and right upper extremity prior to the November 2007 fall; and
- Claimant reported an MVA in the distant past that required only chiropractic care.

43. Ms. Kennon contacted Dr. Montalbano several days after Claimant's appointment at the request of the adjuster. The adjuster asked Ms. Kennon for clarification from Dr. Montalbano regarding the lengthy (nine or ten months) gap between the initial injury and

Claimant's complaints of radiculopathy. In particular, Ms. Kennon asked Dr. Montalbano to review the treatment records she had given him at the appointment and clarify the chronology of Claimant's complaints.

44. On February 24, 2009, Dr. Montalbano wrote to Dr. Rogers once more. He advised her that he had reviewed his previous letter and Claimant's medical records, and had changed his opinion on the cause of Claimant's C4-5 pathology. In this letter, he opined that Claimant's symptomatology was the result of a degenerative condition, and that it was *possible*, but not *probable*, that Claimant's symptoms arose as a result of his work accident. In particular, Dr. Montalbano noted that "it is quite clear that [Claimant's] symptomatology involving his right upper extremity began quite some time, approximately nine months, after his work related injury on November 30, 2007." D. Ex. 9, p. 205.

45. In June 2010, TSS/Advantage wrote Dr. Montalbano and provided him with Claimant's treatment records for shoulder and neck injuries dating back to 1996. TSS/Advantage asked Dr. Montalbano to: First, clarify what led him to change his position between February 19 and February 24, 2009, and, second, to review the additional medical records and advise whether the new information would impact his decision or reasoning.

46. In his August 20, 2010 response to TSS/Advantage, Dr. Montalbano acknowledged that he had discussed Claimant's case with Ms. Kennon following the medical visit, because there was some uncertainty about the nine- or ten-month interval between the November 2007 accident and Claimant's first report of radicular symptoms. The change of opinion he expressed in his February 24, 2009 letter to Dr. Rogers was the result of his review of the MRI and the records that he had at the time which showed "a lack of documented cervical complaints for a period of ten months following [Claimant's] initial evaluation after his work

related injury." D. Ex. 7, p. 45.

47. Dr. Montalbano went on to address the significance of the additional medical records he received and reviewed in June 2010. In particular, Dr. Montalbano discussed Claimant's pre-existing cervical disease dating back more than ten years, and for which he received extensive treatment. Dr. Montalbano observed that those records provided further support for his February 24, 2009 causation opinion.

48. In the course of his deposition, Dr. Montalbano had an opportunity to once again address the matter of his causation opinion and further explicate his medical opinions and the circumstances surrounding his evaluation of Claimant's cervical complaints. Dr. Montalbano clarified his statement contained in his February 24, 2009 letter that Claimant's *right upper extremity symptoms* began approximately nine months after his work-related injury:

> When I refer to right upper extremity symptomatology is [*sic*] that is what I would consider consistent with the *cervical radiculopathy*. And he was complaining of right shoulder discomfort, but there was [*sic*] no radicular symptoms and no complaints of actual neck pain after his injury of November 30, 2007, up until, I think, the mid part of '08.

Id., at p. 13 (emphasis added). Dr. Montalbano agreed that Claimant had reported neck pain on his initial medical visit on November 30, 2007, but reiterated that given Claimant's long history of cervical trauma and degenerative disease, if he had suffered a cervical injury in the November 2007 fall, neck pain and radicular symptoms would have appeared well before October 2008.

Additional Care

49. Claimant returned to Dr. Rogers on April 27, 2009, still complaining of burning in his right shoulder and neck. Claimant told Dr. Rogers that his workers' compensation claim was resolved, and that this visit was on his private insurance. On exam, Dr. Rogers noted that Claimant was "tender to palpation in the midcervical spine on the right. He has no progressive

motor deficit in the right upper extremity." Cl. Ex. 14, p. 001. She noted that Claimant had seen Dr. Montalbano, and by Claimant's report, Dr. Montalbano had recommended surgery. Dr. Rogers advised Claimant to follow-up with Dr. Montalbano, but offered to arrange for an ESI if Claimant was not able to get an appointment quickly.

50. On September 30, 2009, Claimant saw Samuel S. Jorgensen, M.D., a spinal surgeon who practiced with both Drs. Verska and Rogers. The purpose of the visit was for a surgical consultation relating to his cervical spine. According to Dr. Jorgensen's chart note, Claimant related that his cervical complaints began "approximately *a year ago* when he fell on some ice at a trade show . . ." D. Ex. 9, p. 206 (emphasis added.) Claimant also reported to Dr. Jorgensen that he had seen Dr. Montalbano, who had recommended surgery, but Advantage had denied the request. Dr. Jorgensen had reports of the imaging studies, but wished to see the films. He advised Claimant to return to the office after he had obtained the films.

51. Claimant returned to Dr. Jorgensen on December 14, 2009. Claimant provided the MRI image from 2008, along with Dr. Curran's records. Based on the MRI, Dr. Curran's records, and Dr. Rogers' records, Dr. Jorgensen opined, ". . . it is my opinion that [Claimant's] symptoms of cervical radiculopathy are related to an industrial injury." Dr. Jorgensen went on to state:

> [Claimant] has findings of preexisting degenerative spinal stenosis. However, he denies any previous symptoms of neck pain or cervical radiculopathy prior to his industrial injury . . .
>
> * * *
>
> His diagnosis of cervical radiculopathy was delayed as consequence of the overshadowing isolated shoulder symptoms. However, they have been present and seem to be consistent throughout.
>
> It is my opinion medically on a more probable than not basis that his current symptoms of cervical radiculopathy are related to the industrial injury dated 11/30/07.

D. Ex. 9, pp. 208-209.

Dr. Frizzell

52. On June 28, 2010, Claimant saw Dr. Frizzell for an IME. Dr. Frizzell conveyed his report to Claimant by letter dated July 5, 2010. Dr. Frizzell included in his report a listing of the medical records that he reviewed in performing the IME. The list is comprehensive, but not complete. In particular, records from January 26, 1996, June 12, 1996, November and December 1998, and April 1999 are not included in Dr. Frizzell's listing.

53. Based on Claimant's reported history, his review of the medical records, and an examination of Claimant, Dr. Frizzell concluded:

> On a more probable than not basis, [Claimant's] need for cervical spine surgery at C4-5 at this point is *in part related* to his trade show accident November 30, 2007. I would apportion 25% of the need for the surgery on a more probable than not basis to the November 30, 2007, industrial accident.

Id. (emphasis added).

54. When asked to explicate his opinion, Dr. Frizzell cited to two particular factors that led him to his conclusion. The first factor relates to Claimant's symptoms, the second to the radiographic evidence. Dr. Frizzell was of the opinion that many of Claimant's shoulder complaints following the November 2007 accident were caused, in part, by his cervical injuries. In particular, Dr. Frizzell noted that scapular pain, pain at the base of the neck, and pain across the top of the shoulder are often associated with cervical injuries. When asked if shoulder pathologies could cause those same symptoms, Dr. Frizzell demurred, stating that he was not qualified to discuss shoulder injuries.

55. When Dr. Frizzell reviewed Claimant's radiographic imaging, he placed great weight on the myelogram CT that he had ordered in 2000. Dr. Frizzell testified that the myelogram CT was the "gold standard" for bony imaging, and it showed no pathology at C4-5.

CREDIBILITY

56. Claimant is, by his own admission, an unreliable historian. His difficulty remembering dates, conversations, and chronology is evident both in his testimony and in the medical records. Because of Claimant's undependable memory, the medical records provide the most reliable record of Claimant's medical history.

DISCUSSION AND FURTHER FINDINGS

MEDICAL CAUSATION

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

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

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

58. In this proceeding, there is no dispute that Claimant slipped on ice and fell while attending a trade show in Spokane, Washington. There is no dispute that on the day of the accident, Claimant reported injuries to his neck, right shoulder, right elbow, and right hip. TSS/Advantage accepted Claimant's claim, and provided extensive care for Claimant's right shoulder. It is also undisputed that Claimant now needs a C4-5 ACDFI. What *is* at issue in this proceeding is *who is going to pay* for Claimant's cervical surgery. The answer to that question

depends upon whether Claimant can prove that, medically, it is more likely than not that the November 2007 accident caused his present need for surgery.

59. While Claimant's task might appear simple and straightforward, the medical opinions on causation are in conflict. On one hand, Dr. Montalbano is of the opinion that the November 30, 2007 accident is not the reason that Claimant needs cervical surgery. On the other hand, Dr. Frizzell believes that the November 30, 2007 accident is *part* of the reason that Claimant needs cervical surgery.

60. The conflicting opinions of Drs. Montalbano and Frizzell are central to this decision, because they are the only two medical experts who had access to complete or nearly complete records of Claimant's medical history. Each is a neurosurgeon, each is well-qualified and well-respected in his field, and each opinion finds support in the record.

Dr. Montalbano

61. Dr. Montalbano saw Claimant, accompanied by Susan Kennon, on one occasion. As discussed previously, Dr. Montalbano initially opined that Claimant's need for cervical surgery did relate to the industrial injury. Several days later, Dr. Montalbano wrote a second letter to Dr. Rogers, wherein he changed his opinion and concluded that Claimant's need for cervical surgery was not the result of the industrial accident. Dr. Montalbano's about-face provided fodder for further inquiry by both parties.

62. One area of further inquiry related to Ms. Kennon's involvement in Claimant's case. Ms. Kennon became involved in the case in early 2009, only after Claimant reported radicular symptoms in his right upper extremity, and shortly before Claimant's February appointment with Dr. Rogers. She accompanied Claimant to his appointments with Dr. Rogers and Dr. Montalbano.

63. Claimant believes that the reason that Dr. Montalbano changed his mind about causation was because Ms. Kennon pressured him to do so. Claimant was quite impressed by Ms. Kennon's relationship with Dr. Montalbano and his staff, noting that they treated her like a queen. He testified that, after Dr. Montalbano had examined him and verbally opined that he did need cervical surgery as a result of the industrial accident, Ms. Kennon and the doctor got into what he described as a heated discussion right in front of him. Claimant did not understand all of the discussion, but he believed the dispute was not about the need for surgery, but rather, why the surgery was necessary.

64. Ms. Kennon did not recall engaging in a heated discussion with Dr. Montalbano. She explained that it was an important part of her business to maintain good relationships with physicians and their office staff. She agreed that assertiveness was a trait that was often necessary in her work, but that it would not be in the best interest of her consulting business to engage in arguments or disputes with physicians.

65. In his post-hearing deposition, Dr. Montalbano testified:

> Well, I never had an argument with Ms. Kennon. We talked about maybe indications. I can't remember what we talked about, was the indication to do surgery in this case or what were the issues? I'm sure at some point in time it was discussed whether the degenerative condition, what caused what. [*sic*] But there was certainly no arguing. I did tell him that he did need surgery.

Dr. Montalbano Depo., p. 18.

66. Dr. Montalbano did not receive the bulk of Claimant's relevant medical records until long after he had offered his causation opinion on February 24, 2009. Nevertheless, the medical records supplied by TSS/Advantage in June 2010 are an important component of this recommendation. Dr. Montalbano based his initial opinion, in part, upon Claimant's subjectively

reported history. Neither Dr. Montalbano nor Ms. Kennon had any reason to doubt Claimant's reported history during his visit with Dr. Montalbano.

67. Ms. Kennon was clearly surprised when she first learned of Claimant's extensive history of cervical trauma and degenerative disease in June 2010. By the time of his deposition, Dr. Montalbano had also seen the substantial medical history related to Claimant's neck and shoulder complaints. As Dr. Montalbano stated in his August 2010 letter to TSS/Advantage, and again during his deposition, Claimant's medical history only bolstered Dr. Montalbano's ultimate causation opinion. The additional medical records underlined Claimant's inability to accurately report his medical history and brought into question any medical opinion based upon his reported history.

Drs. Rogers and Jorgensen

68. Both Dr. Rogers and Dr. Jorgensen offered causation opinions following Dr. Montalbano's IME report. Both opined that Claimant's need for cervical surgery was due to his industrial accident. Neither physician was aware of Claimant's complete medical history, nor Claimant's unreliable reportage at the time they offered their opinions. Because both physicians based their opinions largely on Claimant's inaccurate history, the Referee does not find the opinions persuasive on the issue of causation.

Dr. Frizzell

69. Dr. Frizzell had a longer physician/patient relationship with Claimant than did Dr. Montalbano, having first treated Claimant in 2000 for cervical complaints related to his 1998 MVA. That treatment ended in December 2000. Dr. Frizzell did not provide any treatment to Claimant in the intervening years until he returned in June 2010 for an IME. Dr. Frizzell had a

fairly comprehensive set of records at the time he issued his July 2010 report, and testified that he identified in his report every medical record that he considered in reaching his conclusions.

70. Dr. Frizzell's opinion differed from Dr. Montalbano's in two main respects—how he interpreted Claimant's symptoms and how he interpreted Claimant's imaging. Dr. Montalbano noted Claimant's *lack of radicular complaints* in the ten months following the subject accident. Dr. Frizzell focused on Claimant's *consistent complaints* of burning pain at the base of his neck, pain radiating into his shoulder blades, and pain across the top of his shoulder as evidence of a cervical injury.

71. When it came to the imaging, Dr. Frizzell placed great weight on the myelogram CT that he had ordered in 2000, two years after Claimant's MVA. That imaging showed no notable pathology at C4-5. Dr. Frizzell dismissed the results of the November 1999 MRI as being of poor quality, and downplayed other imaging as inferior to the myelogram CT. When he compared the 2000 myelogram CT to the post-injury MRI, he noted significant pathology that had not been there before, and concluded that the industrial accident was a factor in Claimant's present need for cervical surgery.

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72. As noted elsewhere in this recommendation, this is a close case. Either outcome could find substantial support in the evidentiary record. But, after reviewing the entire record, the Referee concludes that Dr. Montalbano's reasoning is the most persuasive. The Referee relies on the following points in reaching her conclusion.

Symptoms

73. In the ten months following the November 2007 accident, Claimant frequently reported shoulder pain. However, he never reported symptoms of neck pain or radiculopathy.

Dr. Frizzell equates Claimant's reports of shoulder pain with proof of cervical injury, but his testimony does not indicate any significance in the onset of right side upper extremity radiculopathy in August or September 2007. Claimant had an extensive history of shoulder complaints and cervical complaints, which occurred separately and together over many years. Claimant had experienced radicular symptoms in the right upper extremity in the past, as well as intermittent but chronic right shoulder pain. The Referee recognizes that the 2000 CT scan ordered by Dr. Frizzell, was, per Dr. Frizzell, negative for any surgical lesions. However, when considering the significance of Claimant's past radiological studies it is important to recall that the medical record is clear that Claimant had well-documented radicular complaints in the years predating the November 30, 2007, accident, notwithstanding that some of the radiological studies, in particular, the 2000 CT, were read as not clearly demonstrating the existence of a lesion that might explain Claimant's radicular complaints. The record clearly demonstrates that Claimant suffered from cervical radiculopathy on a pre-injury basis, even though the 2000 CT did not demonstrate a good explanation for these complaints. Likewise, the medical record demonstrates that Claimant complained of similar radicular complaints following the industrial accident, although by this time, radiological studies appear to provide some objective validation for these subjective complaints. However, these facts do not lend particular support to the proposition that Claimant's current complaints of radiculopathy are causally related to the subject accident. First, there is no clear agreement between the various radiological studies that had been performed over the years as to whether Claimant did or did not have objective evidence of a C4-5 lesion on a pre-injury basis. It is notable that the 2003 films, which were evidently not reviewed by Dr. Frizzell, did reveal some potentially significant changes at C3-4 and C4-5. There is no persuasive evidence that Claimant's cervical spine condition is anything but the

progression of a long standing degenerative process, as has been acknowledged by Dr. Frizzell (Frizzell Depo. p. 27).

74. More important is the fact that following November 30, 2007, the medical record makes no reference whatsoever to complaints of cervical spine pain or radiculopathy until September 30, 2008, even though Claimant was seen frequently for complaints of right shoulder pain during this approximate ten-month time frame. This fact is significant to Dr. Montalbano in forming his opinion that Claimant's cervical spine radiculopathy is a new condition which emerged approximately ten months following the industrial accident, and independent of that accident. Dr. Montalbano has testified that if the industrial accident did cause an injury to Claimant's cervical spine sufficient to result in a cervical radiculopathy, one would expect to see the emergence of those radicular complaints no later than three months following the accident. The fact that Claimant's radicular complaints first emerged no earlier than ten months following the subject accident, makes it unlikely, in Dr. Montalbano's view, that the accident is responsible for causing an injury to Claimant's cervical spine.

75. Of course, Dr. Frizzell reviewed the same (or nearly the same) medical records that were considered by Dr. Montalbano. According to Dr. Frizzell, the fact that Claimant had demonstrated persistent complaints of right shoulder discomfort at all times following the November 30, 2007 accident, <u>is</u> evidence that Claimant's cervical spine condition is causally related to that accident. Dr. Frizzell opined that Claimant's right shoulder complaints subsequent to November 30, 2007 are less representative of an orthopedic injury involving the right shoulder, and more representative of symptoms of a cervical radiculopathy. Following this line of reasoning, the fact that Claimant has had persistent complaints of right shoulder discomfort since the subject accident actually supports the proposition that his cervical spine condition is

causally related to the accident. The problem with this argument is that Claimant also has a long-standing history of right shoulder complaints that pre-date the subject accident. If Dr. Frizzell's theory is correct, then evidence of pre-injury right shoulder complaints ought to also lend support to the existence of pre-injury cervical radiculopathy. Claimant's necessary response to this argument is that there is a qualitative difference between the nature of Claimant's pre-injury right shoulder complaints and his post-injury right shoulder complaints. Therefore, the argument goes, while Claimant's pre-injury right shoulder complaints were clearly related to an injury to the structure of Claimant's right shoulder, Claimant's post-injury right shoulder complaints are clearly related to cervical radiculopathy. A review of the medical record leads the Referee to reject this argument. First, although the 2006 right shoulder MRI did not reveal evidence of rotator cuff tearing, it did demonstrate evidence of tendinopathy in the supraspinatus tendon. The 2008 right shoulder MRI demonstrated some worsening of the supraspinatus tendon defect. On both a pre-injury and post-injury basis, Claimant was thought to exhibit signs and symptoms consistent with right shoulder impingement. On both a pre-injury and post-injury basis, Claimant underwent epidural AC joint injections to treat his symptomatology. Although there are subtle differences between the pre-injury and post-injury records, by and large, Claimant's symptoms, and findings on right shoulder exam, are very similar on both a pre-injury and post-injury basis. The Referee finds that there is no important difference between Claimant's pre-injury and post-injury right shoulder complaints, and that these complaints are most consistent with an orthopedic injury to the right shoulder, at least until true radicular complaints are noted approximately ten months following the subject accident. In the final analysis, the medical record fails to establish that Claimant's post-injury right shoulder symptoms and findings are different enough from those with which he presented on a pre-injury

basis to invite serious consideration of the theory proposed by Claimant. For these reasons, the Referee adopts the views expressed by Dr. Montalbano, and finds that Claimant has failed to demonstrate, on a more probable-than-not basis, that his cervical radiculopathy, first noted in September 2008, is causally related to the subject accident. The Referee is cognizant that Claimant's testimony is to the effect that he continuously experienced both neck and shoulder pain following the subject accident. However, the medical records referenced above are a more accurate representation of Claimant's symptoms following the November 30, 2007 accident than is Claimant's testimony at hearing

ATTORNEY FEES

76. Because Claimant has failed to establish that the November 2007 industrial accident caused his need for cervical surgery, the issue of attorney fees is moot.

CONCLUSIONS OF LAW

1. Claimant has failed to prove that his present undisputed need for cervical surgery is more likely than not caused by the November 2007 industrial injury.

2. All other issues are moot.

RECOMMENDATION

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

DATED this 15 day of June, 2011.

INDUSTRIAL COMMISSION

/s/_____
Rinda Just, Referee

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

ELOYD HARRIS,	)	
	)	
Claimant,	)	**IC 2002-523145**
	)	**2004-507837**
v.	)	**2004-527260**
	)	**2005-522772**
SCALES UNLIMITED, INC., Employer, and **STATE INSURANCE FUND,** Surety,	)	**2007-004663**
	)	**2007-042051**
	)	
and	)	**ORDER**
	)	
TOTAL SCALE SERVICE, Employer, and **ADVANTAGE WORKERS' COMPENSATION INSURANCE CO.,** Surety,	)	Final: July 14, 2011
	)	
Defendants.	)	
	)	

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

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

1. Claimant has failed to prove that his present undisputed need for cervical surgery is more likely than not caused by the November 2007 industrial injury.

2. All other issues are moot.

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

DATED this 14 day of July, 2011.

INDUSTRIAL COMMISSION

/s/_____
Thomas E. Limbaugh, Chairman

/s/_____
Thomas P. Baskin, Commissioner

___Participated but did not sign___
R.D. Maynard, Commissioner

ATTEST:

/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 14 day of July, 2011, a true and correct copy of the foregoing **FINDINGS, CONCLUSIONS,** and **ORDER** were served by regular United States Mail upon each of the following persons:

RICHARD S OWEN
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NAMPA ID 83653-0278

SUSAN R VELTMAN
PO BOX 2528
BOISE ID 83701-2528

djb /s/_____