BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

MURIEL JOHNSON, Claimant, v. ST. JOSEPH REGIONAL MEDICAL CENTER, Self-Insured Employer, Defendant.	**IC 2006-006060** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** Filed May 14, 2010

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Michael E. Powers, who conducted a hearing in Lewiston on July 15, 2009. Claimant was present and represented by Scott M. Chapman of Lewiston. Lora J. Rainey-Breen of Boise represented the self-insured Employer. Oral and documentary evidence was presented and the record remained open for the taking of five post-hearing depositions. The parties then submitted post-hearing briefs and this matter came under advisement on March 3, 2010.

ISSUES

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

1. Whether Claimant is medically stable;

2. Whether Claimant suffered a personal injury arising out of and in the course of her employment;

3. Whether Claimant's injury was the result of an accident arising out of and in the course of her employment;

4. Whether and to what extent Claimant is entitled to medical care pursuant to Idaho Code § 72-432;

5. Whether and to what extent Claimant is entitled to total temporary disability (TTD) benefits;

6. Whether and to what extent Claimant is entitled to permanent partial impairment (PPI) benefits;

7. Whether and to what extent Claimant is entitled to permanent partial disability (PPD) benefits; and

8. Whether Claimant is permanently and totally disabled pursuant to the odd-lot doctrine.

CONTENTIONS OF THE PARTIES

Claimant contends that she is not medically stable from a left shoulder injury resulting in chronic pain/Complex Regional Pain Syndrome (CRPS) in that two physicians have recommended further medical care regarding pain management. In the event the Commission finds that Claimant is not medically stable, then she is entitled to TTD benefits until she becomes medically stable. In the event the Commission finds that Claimant is medically stable, then she should be found to be an odd-lot worker.

While acknowledging some degree of injury to Claimant's left shoulder in her 2006 accident and a subsequent exacerbation, Defendant contends that Claimant's ongoing subjective, "non-anatomic/nonphysiologic" complaints are not related to her industrial accident and injury and, thus, are noncompensable. Claimant is medically stable and has been paid for a 10% whole person PPI rating. Further, Claimant has not looked for work and is "abnormally focused on disability." She is a low-wage earner and could readily replace her time-of-injury income if only she would try. While Claimant may have "little if any" disability above impairment, she is not an odd-lot worker.

Claimant did not file a reply brief.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant and Industrial Commission Rehabilitation Division (ICRD) consultant Wade Beeler.

2. Claimant's Exhibits A-J admitted at the hearing.

3. Defendant's Exhibits 1-31 admitted at the hearing.

4. The pre-hearing deposition of Claimant taken by Defendant on June 5, 2000.

5. The post-hearing deposition of Timothy Flock, M.D., taken by Claimant on September 9, 2009.

6. The post-hearing deposition of Robert Calhoun, M.D., taken by Claimant on September 10, 2009.

7. The post-hearing deposition of Matthew Provencher, M.D., taken by Defendant on October 15, 2009.

8. The post-hearing deposition of Mark Bengston, P.T., taken by Defendant on October 15, 2009.

9. The post-hearing deposition of Michael Enright, Ph.D., taken by Defendant on October 23, 2009.

The objections made during the taking of the above-referenced depositions are overruled.

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

1. Claimant was 58 years of age at the time of the hearing and resided in Lewiston. She was 55 years of age at the time of her May 1, 2006, industrial accident.

2. Claimant worked as a housekeeper/janitor for Employer and had been so employed since 2001. On May 1, 2006, Claimant's left shoulder "popped" when she pulled on a heavy door. She immediately informed Employer and was seen in Employer's emergency department. Claimant was able to finish her shift.

3. Although Claimant testified that she saw Timothy Walker, M.D., the next day, the medical records reveal that Claimant first was treated by Brian Hocum, M.D., on May 7, 2006, at which time she was diagnosed with a left shoulder sprain, but Dr. Hocum could not rule out a rotator cuff tear. There was no evidence of a dislocation. X-rays revealed no fracture, but there was calcific tendinitis and a "suggestion" of some rotator cuff atrophy.

4. On June 7, 2006, Claimant began treating with Timothy Flock, M.D., an orthopedic surgeon. Dr. Flock diagnosed calcific tendinitis versus an acute rotator cuff injury. He took Claimant to surgery on June 22, 2006, and performed an arthroscopic bursectomy, acromioplasty, and distal clavicle excision. No rotator cuff tear was found at surgery and Claimant's glenohumeral joint appeared normal.

5. On July 26, 2006, Dr. Flock noted that Claimant had full range of motion in her left shoulder, was pain free, and was ". . . delighted with the results." He further noted that Claimant wanted to return to work without restrictions, so he wrote a work release in that regard effective a week later.

6. Claimant testified at hearing that she "felt great" after her surgery. She returned to work and complained that Employer was not honoring her work restrictions of no lifting, pulling, pushing, or "shoving."[1] As a result, Claimant again injured her left shoulder.

7. Claimant returned to Dr. Flock on November 10, 2006, who noted that she had a full range of motion in her left shoulder. Dr. Flock diagnosed a probable chronic calcific tendinitis. He injected Claimant's left shoulder and planned to see her back in two to three weeks.

8. Dr. Flock recommended a second surgery for Claimant's left shoulder; however, in a "check the box" letter, he indicated that the need for surgery was not related to Claimant's industrial accident. *See*, Defendant's Exhibit 15, p. 253. In any event, Dr. Flock performed an open distal clavicle excision and removal of calcific deposits on January 18, 2007. When a defense-generated IME opined that both surgeries were related to Claimant's industrial accident, Defendant paid for the second surgery.

9. Following the second surgery, Claimant participated in physical therapy beginning January 22, 2007. The physical therapy notes, Defendant's Exhibit 18, generally indicate that Claimant experienced hypersensitivity to the anterior portion of her left shoulder and slow progress in healing. On March 30, 2007, Claimant was discharged short of meeting all the goals of full, pain-free range of motion. She was discharged due to the difficulty in attending ". . . due to personal family issues." Defendant's Exhibit 18, p. 337. Claimant testified at hearing that the physical therapy only lasted two-three weeks - - "And they said that they had

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[1] Claimant's testimony in this regard is interesting in that Dr. Flock released Claimant to return to work without restrictions at Claimant's request. *See*, finding number 5 above.

done everything that they could do for me and just to go home and continue with what I was doing there." Hearing Transcript, pp. 32-33.

10. At the time of the hearing, Claimant rated her pain at 8/10 and described her pain as being "tender to the touch," and was referring to the outside of her skin on her left shoulder. She testified at hearing that she was terminated from her employment because she could not do her work and could not provide Employer with an exact date she would be able to return to work, as Dr. Flock had never released her. She has not worked or looked for work since.

11. On March 26, 2007, Claimant followed up with Dr. Flock who noted that she was getting "whole arm" numbness on and off since her surgery. Dr. Flock found signs of nerve irritation, especially the ulnar nerve at the elbow. Dr. Flock ordered nerve conduction studies[2] and recommended that Claimant continue her physical therapy. On June 5, 2007, Dr. Flock performed an ulnar nerve transposition for Claimant's suspected cubital tunnel syndrome. Dr. Flock again recommended physical therapy post-surgery. Again, Claimant testified that physical therapy ended when she was told there was nothing more they could do for her and she was to continue on her own. The physical therapy notes indicate that although Claimant was making "significant progress" she requested a discharge as she was ". . . having a separate procedure performed." Defendant's Exhibit 21, p. 365. It is not clear what that "separate procedure" was.

12. On January 24, 2008, Objective Medical Assessments Corporation (OMAC) conducted an independent medical evaluation of Claimant at Defendant's request. The panel consisted of Matthew Provencher, M.D., an orthopedic surgeon, and Lewis B. Alvaraz, M.D., a neurologist. At that time, Claimant presented with chief complaints of left shoulder pain, left

[2] The EMG revealed, "Possible left ulnar neuropathy, at or near the elbow." Defendant's Exhibit 15, p. 275.

elbow pain, left arm pain, and continued numbness in the ulnar three-sided digits. Claimant mentioned to the panel that Employer did not honor her return-to-work restrictions imposed by Dr. Flock. *See* finding number 5 above. It was noted that her height was 4 feet 11 inches and her weight was 153 pounds.

13. Regarding the orthopedic portion of the examination, Dr. Provencher noted:

> I asked her to do some range of motion. She is essentially unable to be examined by me today. Her active flexion of her left shoulder is 50 degrees and she stops. Active abduction is neutral. Her right shoulder has full range of motion. Any area of her left upper extremity from the midline including the sternoclavicular joint over, I am unable to touch because of even very light touch, extreme sensitivity. I have stopped the examination because she would not let me do any additional examination or provocative findings. I did try to test her external rotation strength in neutral however this was impossible to obtain a good evaluation.

Defendant's Exhibit 23, p. 394.

14. Regarding the neurologic portion of the examination, Dr. Almaraz noted in pertinent part:

> When I walked into the room, it should be pointed out I am with a female chaperone, the claimant had her left arm folded against her upper body, her right arm was across her left arm, she was touching her left arm with her right hand and arm, and she states she will not allow anyone to touch her arm, that she cannot have anything touch her left upper extremity because of the extreme sensitivity yet the arm is touching her own body across her chest and her right arm is on her left arm, which is a total contradiction to what she has just stated.
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> At this point I asked if I could do reflexes and motor and sensory examinations of the left upper extremity and she declined, stating again that she cannot have anyone touch her arm. I had her hold her arms out in front of me. They are symmetrical in appearance. There are absolutely no trophic changes, grossly noted between either upper extremity. There was no arm drift. She could move her fingers equally in both upper extremities.
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> That was the limit of the neurologic examination since she will not allow us to touch her. I see no obvious evidence here for complex regional pain syndrome and there appears to be a significant psychogenetic factor here playing a roll [sic] in this case.

Defendant's Exhibit 23, p. 394.

15. Regarding Claimant's course of treatment, the panel opined:

> Her main issues are nonanatomic, nonphysiologic entire left upper extremity pain that starts with the sternoclavicular joint and radiates down to her fingertips. This is nonanatomic, nonphysiologic. This is confirmed by two independent examinations today and the panel examination agrees that no additional treatment is necessary in regards to the specifics of her work-related injury of May 1, 2006. This has been treated appropriately, including the shoulder injuries by Dr. Flock and the treatment to date at least of the shoulder has been reasonable and medically necessary and related to the industrial injury in question.

Id., P. 396.

16. Although found to be at MMI, due to "nonphysiologic and nonanatomic" issues, the panel was unable assign Claimant a PPI rating.

17. On April 16, 2008, Dr. Flock authored a letter to Claimant's counsel wherein he indicated that he had reviewed the OMAC evaluation and agreed with many findings of the panel. He opined Claimant had developed chronic pain syndrome with a nerve component in her left arm. Further, "I do not know the right term to describe this, and I would call it a chronic pain syndrome versus nonanatomical or nonphysiologic. I do not think she would have these problems if she had not had an injury or surgery; however, I do not think this is a (complication) of surgery." Defendant's Exhibit 15, p. 269.

18. Claimant returned to Dr. Flock in follow-up on June 16, 2008. At that time she was complaining of numbness in the dorsolateral aspect of her left arm and medial-side forearm pain. Dr. Flock found no temperature differences between her left and right arms, no atrophy of the left hand, and no left-sided root impingement per MRI. Dr. Flock found Claimant's symptoms to be nonanatomic and referred her to a pain clinic for possible RSD/CRPS consideration and treatment.

19. On June 18, 2008, Robert Colburn, M.D., an orthopedic surgeon, saw Claimant at her attorney's request. Dr. Colburn is in the same practice as Dr. Flock. Claimant presented complaining of aching over her left shoulder down to the elbow, pins and needles and pressure-sensitive ulnar nerve, and a weak left hand. Dr. Colburn noted that Claimant held her left upper extremity protectively against her side with the elbow flexed 90 degrees. She was markedly hypersensitive to light touch over her entire left shoulder and especially over her ulnar elbow scar. Dr. Colburn diagnosed, among other things, left upper extremity chronic regional pain syndrome or reflex sympathetic dystrophy. Regarding that diagnosis, Dr. Colburn observed, "Chronic upper extremity or regional pain is and always has been controversial with varying opinions as to its existence, causation, and relationship to injury." Claimant's Exhibit A. In spite of the foregoing comment and the lack of significant objective findings, Dr. Colburn diagnosed Claimant as ". . . a rather classical case of chronic upper extremity or CRPS pain." *Id.*

20. Dr. Colburn found Claimant's shoulder condition to be medically stable, but not her CRPS, which he related to Claimant's industrial accident. Dr. Colburn indicated that pain management and perhaps a spinal cord stimulator should be considered. He assigned restrictions of no continuous use of the left upper extremity for gripping, handling, or reaching. Dr. Colburn noted, "She did not seem to be too distressed by not being able to return to work . . ." *Id.*

21. Defendants arranged for Claimant to be seen in Lewiston by Michael F. Enright, PhD., on July 25, 2008. Dr. Enright is a board-certified clinical psychologist practicing in Jackson, Wyoming. Claimant told Dr. Enright that Dr. Flock returned her to light-duty work following her accident and that Employer would not accommodate her in that regard. Claimant indicated that she cannot raise her left arm all the way and does not have full range of motion.

She has no strength in her left hand and "not a whole lot" of grip. Claimant stated that the pain in her left arm and shoulder has gone into her neck and back and, "It is all caused from nerves." Defendants' Exhibit 25, p. 407. Even so, Claimant told Dr. Enright that she thought she was improving. Dr. Enright could find no evidence of moderate or marked symptoms of depression.

22. Dr. Enright noted: "She kept her left arm close to her body (as if she was continuing to wear a sling) or in her lap through out [sic] the interview. She stroked her arm frequently but otherwise demonstrated no pain behavior." *Id.*, p. 413. Further, "Her current presentation is marked by rather dramatic, exaggerated claims of intense pain (i.e. a ten on a scale of one to ten initially although the claimant continued to work with this level of pain) . . ." *Id.*, p. 415.

23. Dr. Enright found numerous psychological and behavior factors impacting Claimant's reports of pain, including somatization tendencies, histrionic and dependent personality traits, residual anger at her employer, and associated avoidance behaviors,[3] which serve as ongoing reinforcement for her perceived pain and disability. Dr. Enright does not believe Claimant is consciously malingering, but presents with exaggerated pain with obvious secondary gain issues. He concludes:

> Although Ms. Johnson has suffered from mild psychological distress it is highly unlikely that the events that led her to her alleged pain and numbness in her left arm, shoulder, neck, back and fingers consequent to the event of May 1, 2006 is the predominate factor above all other factors combined that contribute to her psychological condition and result in her alleged pain and debilitation.

Id., p. 416.

24. On December 3, 2008, Dr. Flock responded to a letter from Claimant's attorney regarding further medical treatment as follows:

[3] Claimant was angry at and resentful to Employer for not honoring a non-existent light-duty work release, according to Dr. Enright.

> I do think a Pain Clinic referral to consider an epidural steroid injection in the neck is reasonable for Muriel Johnson as I stated in my note on 5/19/08. This would be to treat any component of her pain which could be from a reflex sympathetic dystrophy, even a very subtle form of this.

Defendant's Exhibit 26, p. 418.

25. On August 23, 2009, OMAC conducted another IME at Defendant's request to obtain an impairment rating. This time the panel consisted of Matthew Provencher, M.D., the orthopedic surgeon who participated in the first IME, and Eugene Wong, M.D., a neurologist. The panel was unable to reach a diagnosis of reflex sympathetic dystrophy or complex regional pain syndrome; therefore, no treatment in that regard was recommended. Dr. Provencher noted, "It is very difficult to examine her left shoulder in terms of range of motion or strength due to multiple give-way episodes and subjective pain complaints. This is overall a very poor effort." Defendant's Exhibit 27, p. 435. Nonetheless, the panel gave its "best estimate" that Claimant incurred PPI of 10% of the left upper extremity. They were unable to give any additional PPI for loss of range of motion. According to the panel, Claimant's ulnar nerve problem is not related to her industrial accident.

26. On April 21, 2009, Dr. Provencher responded to Defendant's attorney's letter regarding permanent restrictions as follows:

> As you are aware, this was a very difficult evaluation to get verifiable and documented clinical/objective evidence. I feel that I am unable to comment based on my objective evaluation of her given the difficulty in examination, demonstrated pain behaviors, and lack of good effort of whether she can safely return to this job as environmental services technician. What I would recommend if you want to answer this question further is for a physical capacities evaluation, mostly to assess for validity, followed by a safe work profile for this job of environmental services technician. If the physical capacities evaluation is valid, then I would use these as the final and permanent restrictions for her specifically in regard to the shoulder. If there were invalid criteria with poor effort on the physical capacities evaluation, then I would state that her limitations would be subjective in nature and not related to the injury in question.

Defendant's Exhibit 27, p. 438.

Dr. Provencher does not believe Claimant's ulnar nerve problem is related to her accident and assigns no permanent restrictions in relation thereto.

27. The physical capacities evaluation recommended by Dr. Provencher was conducted on June 15 and 16, 2009, by Mark Bengston, MPT. Mr. Bengston summarized Claimant's performance as follows: "Client gave maximal effort on 10 of 25 (40%) test items. Client did not demonstrate maximal effort on any items that included the use of her L UE. The overall findings of the FCE indicate invalid effort and inconsistent effort." Defendant's Exhibit 28, p. 441. Mr. Bengston was unable to determine an actual job match due to Claimant's limited/inconsistent effort.

28. When Claimant's testimony is compared to medical and other records and evidence admitted in this matter, it becomes apparent that Claimant is not entirely credible regarding the nature and extent of her injuries.

DISCUSSION AND FURTHER FINDINGS

Medical stability:

Idaho Code § 72-408 provides for income benefits for total and partial disability during an injured worker's period of recovery. "In workmen's [sic] compensation cases, the burden is on the claimant to present expert medical opinion evidence of the extent and duration of the disability in order to recover income benefits for such disability." *Sykes v. C.P. Clare and Company*, 100 Idaho 761, 763, 605 P.2d 939, 941 (1980); *Malueg v. Pierson Enterprises*, 111 Idaho 789, 791, 727 P.2d 1217, 1220 (1986). Once a claimant is medically stable, he or she is no longer in the period of recovery, and total temporary disability benefits cease. *Jarvis v. Rexburg Nursing Center*, 136 Idaho 579, 586, 38 P.3d 617, 624 (2001) (citations omitted).

29. Defendants paid time loss benefits to Claimant until OMAC's January 2008 report finding Claimant to be medically stable. Claimant's treating physician, Dr. Flock, also found Claimant to be medically stable regarding her left shoulder, but recommended a pain clinic referral for possible CRPS. Dr. Colburn found Claimant's left shoulder medically stable but recommended pain management and consideration of a spinal cord stimulator for her potential CRPS. The OMAC panel found Claimant's left shoulder to be medically stable and her ulnar nerve problems unrelated. Regarding medical stability, the Referee agrees with the January 2008 OMAC panel and finds Claimant to be medically stable. Further, she has been rated (and paid) at 10% PPI of the left upper extremity.

Accident/injury:

An accident is defined as an unexpected, undesigned, and unlooked for mishap, or untoward event, connected with the industry in which it occurs, and which can be reasonably located as to time when and place where it occurred, causing an injury. Idaho Code § 72-102(17)(b). An injury is defined as a personal injury caused by an accident arising out of and in the course of employment. An injury is construed to include only an injury caused by an accident, which results in violence to the physical structure of the body. Idaho Code § 72-102(17)(a). A claimant must prove not only that he or she was injured, but also that the injury was the result of an accident arising out of and in the course of employment. *Seamans v. Maaco Auto Painting*, 128 Idaho 747, 751, 918 P.2d 1192, 1196 (1996). Proof of a possible link is not sufficient to satisfy this burden. *Beardsley v. Idaho Forest Industries*, 127 Idaho 404, 406, 901 P.2d 511, 513 (1995). A claimant must provide medical testimony that supports a claim for compensation to a reasonable degree of medical probability. *Langley v. State, Industrial Special Indemnity Fund*, 126 Idaho 781, 785, 890 P.2d 732, 736 (1995). "Probable" is defined as having "more evidence for than against." *Fisher v. Bunker Hill Company*, 96 Idaho 341, 344, 528 P.2d 903,906 (1974).

30. Defendant does not dispute that Claimant injured her left shoulder to some extent on May 1, 2006, and has provided appropriate care for that injury. Further, based on Dr. Flock's causation opinion, Defendant paid for Claimant's ulnar transposition surgery and follow-up care. The dispute centers on the relation of Claimant's whole arm numbness, chronic pain, and "nonanotomic/nonphysiologic" issues post-surgery to her May 1 accident.

31. The January 2008 OMAC panel addressed Claimant's ulnar nerve problem as follows:

> The ulnar nerve findings are equivocal at best on the electromyogram. When I asked the Claimant she had no nonoperative treatment for ulnar nerve issues. She also has persistent entire left upper extremity pain and vague paresthesias on the left. She does predominately point to her left ulnar three digits. From reading the operative report Dr. Flock did an extensive ulnar nerve release and no question or doubt that this is not released and not transposed. This panel does not feel that her ulnar nerve issues are related to the industrial injury of question. We also feel that the ulnar nerve surgery is not related to the industrial injury under question. Thus the panel does not recommend any additional course of treatment.

Defendant's Exhibit 23, p. 396.

32. Dr. Flock ordered EMG/nerve conduction studies of Claimant's carpal and cubital tunnels that revealed, "Possible left ulnar neuropathy, at or near the elbow." Defendant's Exhibit 15, p. 275. Dr. Flock responded to a letter from the third party administrator relating the ulnar problems to Claimant's accident by stating they "could be from swelling, sling, and stretching of

nerve with home and physical therapy." *Id*., p. 261. Dr. Colburn, Dr. Flock's partner, also relates Claimant's ulnar nerve difficulties to her accident. *See* finding number 19 above.

<u>1990 workers' compensation claim</u>:

33. Defendant directs the Commission to a prior workers' compensation claim filed by Claimant wherein she sustained a work-related left knee injury in 1990. Although Claimant complained of pain all around her knee, x-rays showed her knee to be normal with no fractures or other bony or soft tissue pathology. In answering a letter from ICRD regarding return to work issues, Claimant's treating physician hand-wrote this:

> NOTE!!
>
> It seems incredible to me that Muriel is not 100% recovered. She continues to limp around and won't give up her crutches – she says if she stands for more than ½ hour her knee buckles and she falls – it is hard to believe that the mechanism of injury was sufficient to cause all of her problems – I would recommend a state directed physician evaluate her.

Defendant's Exhibit 1B, p. 4.

34. The evaluation recommended above revealed that Claimant's knee was normal. No further treatment was forthcoming. Even though Claimant testified that she was on crutches on and off for a year, she further testified that her left knee was fine as of the time of the hearing. Defendant's point is that in spite of debilitating subjective problems, Claimant's knee (left shoulder here) got better even though she was not being actively treated. Defendant argues that when Claimant's complaints are no longer the focus of attention, she improves. Here, Claimant testified that her shoulder was improving in spite of not being actively treated since the 2009 OMAC evaluation. Therefore, no further medical treatment is warranted.

35. Defendant also references the medical records in support of its position that no further treatment for any left shoulder, arm, or elbow conditions is reasonable. Defendant argues

that the medical opinions of Drs. Flock and Colburn are "ambiguous, equivocal, lacking in foundation and/or are simply incorrect." Defendant's Responsive Brief, p. 18.

Dr. Flock:

36. Dr. Flock testified in his deposition that he believed Claimant's "nerve problems" were related to the treatment she received for her shoulder injury and surgery,[4] rather than the initial injury itself. When Claimant still had difficulties following her ulnar nerve transposition procedure, Dr. Flock suspected CRPS or RSD and referred her to a pain clinic.[5] Dr. Flock noted an inconsistency in Claimant's complaints of incision tenderness from the ulnar nerve transposition procedure when the scar looked entirely normal. Dr. Flock was unaware that Claimant had terminated physical therapy after her ulnar nerve transposition. Dr. Flock had not reviewed the FCE evaluation and was, therefore, unaware of the inconsistencies in testing noted by the examiner.

Dr. Colburn:

37. Dr. Colburn, Dr. Flock's partner, saw Claimant for an evaluation at her attorney's request. He was deposed on September 10, 2009. Dr. Colburn has been a board-certified orthopedic surgeon for 45 years. His practice is currently limited to performing independent medical evaluations. Dr. Colburn opines that, as of his June 19, 2008, report, Claimant was not yet medically stable from the chronic pain in her left arm and shoulder. He further opines that Claimant may benefit from a pain clinic consultation and an evaluation for a spinal cord stimulator. Dr. Colburn's review of the FCE and the March 23, 2009, OMAC evaluation did not

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[4] Dr. Flock later testified that the RSD was not a complication of surgery, but rather a "sequelae" consisting of unexplained post-surgery pain for unclear reasons. *See* Dr. Flock Deposition, pp. 24 and 36.

[5] There is nothing in the record indicating that Claimant ever made it to the pain clinic, as Defendant was no longer paying benefits.

change his opinion. He did not review Dr. Enright's psychological evaluation. Dr. Colburn was unaware of the specific criteria for a diagnosis of CRPS contained within the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition.

Dr. Provencher:

38. Dr. Provencher is the orthopedic surgeon who participated in the OMAC evaluations. Defendant took his deposition on October 15, 2009. Dr. Provencher is "subspecialty certified" in shoulder, knee, and sports surgery. At his practice in San Diego, Dr. Provencher performs more than 500 surgeries a year and conducts several thousand outpatient visits a year. He is also heavily involved in academics and the training of residents at The Naval Medical Center San Diego. Dr. Provencher participates in IMEs for OMAC one or two days a month. Dr. Provencher, as an OMAC panel member, evaluated Claimant on January 23, 2008, and March 23, 2009. Based on an EMG study, Dr. Provencher concluded that Claimant's ulnar nerve was not an issue in his March 23 report. Similarly, Dr. Provencher and neurologist Dr. Almaraz disagreed with Drs. Flock and Colburn regarding Claimant's alleged CRPS:

> The conclusions [regarding CRPS in their January 24, 2008, report] were based on the neurologic examination, as well as my examination, which was a panel evaluation, Dr. Almaraz, who is a neurologist. When inspecting the arms, and also with palpation, they were symmetrical. There were no trophic, T-R-O-P-H-I-C, changes, which means skin or other discoloration issues. There was no arm drift, and she was able to move her arms. And based on that, as well as my objective findings, the conclusion was there was no evidence of Complex Regional Pain Syndrome.

Dr. Provencher Deposition, pp. 13-14.

39. Regarding Dr. Provencher's review of the FCE he recommended, he testified that the FCE was consistent with his findings on examination:

> Inconsistency in performance. Uhm, let's see. Self - - a lot of self-limiting behaviors. This person here, [Mr. Bengston]who I don't know at all, included cogwheeling, giving way during strength testing of the entire left upper extremity not related to the shoulder or elbow, had consistent limitations inconsistently and several other anatomic, nonphysiologic give way and cogwheeling in summary and recommendations. She became emotionally labile, L-A-B-I-L-E, with the slightest palpation of the elbow. Theatrical displays were noted. Poor and invalid grip and pinch efforts were noted, and invalid left shoulder and left elbow examination was present. Significant pain-focused behavior and embellishment of pain was a predominate display. Nonanatomic and nonphysiologic left upper extremity pain.

Id., pp.19-20.

40. The Referee finds that Claimant's ulnar nerve problems and RSD/CRPS, if those problems indeed exist, are not related to her industrial accident. Further, the Referee adopts the opinions expressed by Drs. Provencher, Wong, and Almaraz over those of Drs. Flock and Coburn. The panel physicians demonstrated a far better understanding of the factors to be considered in reaching the diagnosis of CRPS. The panel had <u>all</u> of Claimant's medical records unlike Drs. Flock and Colburn. Drs. Flock and Colburn were equivocal in their opinions regarding whether Claimant's ulnar nerve problems and CRPS even existed, let alone related to Claimant's initial accident and left shoulder injury. Claimant herself did not help the situation by limiting the ability of physicians to examine and evaluate her. She was not credible in conveying to them her subjective complaints that could not be objectively verified. Claimant's performance on the FCE was not valid. Her previous workers' compensation claim bore uncanny resemblances to the present claim in terms of Claimant's unrealistic focus on her perceived disabilities. Dr. Enright's psychological evaluation revealed histrionic and secondary gain issues. In sum, the record as a whole provides overwhelming evidence that Claimant's ulnar nerve problems and CRPS, if extant, are unrelated to her industrial accident and no further benefits are due and owing therefor.

TTD benefits:

Idaho Code § 72-408 provides for income benefits for total and partial disability during an injured worker's period of recovery. "In workmen's [sic] compensation cases, the burden is on the claimant to present expert medical opinion evidence of the extent and duration of the disability in order to recover income benefits for such disability." *Sykes v. C.P. Clare and Company*, 100 Idaho 761, 763, 605 P.2d 939, 941 (1980); *Malueg v. Pierson Enterprises*, 111 Idaho 789, 791, 727 P.2d 1217, 1220 (1986). Once a claimant is medically stable, he or she is no longer in the period of recovery, and total temporary disability benefits cease. *Jarvis v. Rexburg Nursing Center*, 136 Idaho 579, 586, 38 P.3d 617, 624 (2001) (citations omitted).

41. Drs. Provencher, Almaraz, and Colburn have found Claimant to be medically stable from her left shoulder injury and Claimant's income benefits were stopped based thereon. Claimant has failed to prove her entitlement to further TTD benefits. Claimant has only requested TTD benefits if Claimant is found not to be at MMI and further medical treatment was ordered. Such is not the case and no further TTD payments are awarded.

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 the evaluation. Idaho Code § 72-422. "Evaluation (rating) of permanent impairment" is a medical appraisal of the nature and extent of the injury or disease as it affects an injured worker's personal efficiency in the activities of daily living, such as self-care, communication, normal living postures, ambulation, elevation, traveling, and nonspecialized activities of bodily members. Idaho Code § 72-424. When determining impairment, the opinions of physicians are advisory only. The Commission is the ultimate evaluator of impairment. *Urry v. Walker Fox Masonry Contractors*, 115 Idaho 750, 755, 769 P.2d 1122, 1127 (1989).

42. Claimant has been paid for a 10% upper extremity PPI rating. Claimant has not proffered any other PPI rating, and has, therefore, failed to prove her entitlement to any further PPI benefits.

PPD/Odd-lot:

"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 impairment and by pertinent non-medical factors provided in Idaho Code §72-430. Idaho Code § 72-425. 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 disfigurement if of a kind likely to handicap the employee in procuring or holding employment, the cumulative effect of multiple injuries, the occupation of the employee, and his or her age at the time of the accident causing the injury, or manifestation of the occupational disease, consideration being given to the diminished ability of the affected employee to compete in an open labor market within a reasonable geographical area considering all the personal and economic circumstances of the employee, and other factors as the Commission may deem relevant, provided that when a scheduled or unscheduled income benefit is paid or payable for the permanent partial or total loss or loss of use of a member or organ of the body no additional benefit shall be payable for disfigurement.

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 non-medical factors, has reduced the claimant's capacity for gainful employment." *Graybill v. Swift & Company*, 115 Idaho 293, 294, 766 P.2d 763, 764 (1988). In sum, 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).

43. Based on the present record, a determination of Claimant's disability above impairment, if any, is difficult at best. With the exception of ICRD consultant Wade Beeler, no vocational expert(s) have weighed in on this issue. While recognizing that no expert testimony is required in establishing disability, it is, nonetheless, Claimant's burden to prove such disability. Mr. Beeler testified that he first met with Claimant on July 23, 2007, on a referral from Employer's TPA. Mr. Beeler noted Claimant's work history to be airport security, ironer and folder at a local linen company, assistant head housekeeper at a local motel, long-haul truck driver for 19 years, riveter, and decorator and hand packer of candy. By the time Claimant met with Mr. Beeler, her job with Employer had been terminated.

44. Mr. Beeler testified that: "Her focus during our involvement was always on the medical end. She wasn't at a point to where she could consider any type of employment. There was always another step pending for treatment of her condition." Hearing Transcript, p. 103. Although he had a positive relationship with Claimant, in May 2008, Mr. Beeler closed Claimant's file as it appeared to him that her case "wasn't going anywhere." *Id.*, p. 105. Claimant informed Mr. Beeler that she did not feel capable of pursuing <u>any</u> type of employment and she had not been released to return to work by Dr. Flock. Therefore, Mr. Beeler and Claimant took no steps to actually find employment.

45. After he closed Claimant's case, Mr. Beeler was provided with a copy of Claimant's FCE. Based on the results thereof (even though not showing Claimant's best efforts),[6] Mr. Beeler opined that Claimant could perform work in the sedentary work category such as surveillance system monitor, time keeper, teacher's aide, companion care, demonstrator, travel clerk, telephone solicitor, reservations agent, customer service representative, dispatch service, security guard, and escort vehicle driver. Mr. Beeler acknowledged that the above examples are merely DOT job titles, not actual jobs. However, he did search for current openings and found a number of actual sedentary jobs he believed Claimant could perform in the Lewiston-Clarkston, Moscow-Pullman area.

46. Of concern to this Referee is Claimant's motivation to return to the work force. It is clear from Claimant's testimony in deposition and at hearing and from the record as a whole that, for whatever reason, Claimant has become quite centered on her "nonphysiologic-nonatanomic" pain situation to the exclusion of any real effort at finding work. She herself has made it difficult to near impossible to accurately gauge the extent of the physical limitations she may have regarding her left shoulder and those she may have attributable to "nerve" condition that has been found to be unrelated to her accident. The Referee has reached the conclusion that Claimant is not particularly anxious to return to work in any capacity until she "improves" as she did following her previous work injury discussed above. Mr. Beeler testified that Claimant never expressed any frustration or urgency about being out of work and without her old job to return to.

47. Claimant was earning between $8.67 and $8.84 an hour at the time of her injury. The minimum wage in Idaho is $7.25 an hour and $8.55 an hour in Washington. Most of the

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[6] Mr. Beeler testified that it did not really matter to him that the FCE was deemed invalid in that he was only considering the sedentary labor market in any event and the FCE showed that Claimant has the capacity to perform at the sedentary level.

actual jobs identified by Mr. Beeler exceed Claimant's wage at the time of her injury and could easily replace any loss of earning capacity she may have suffered.

48. When considering Claimant's age, education, work history, labor market, transferrable skills and the factors enumerated in Idaho Code §§72-425 and 430, the Referee finds that, on this record, Claimant has failed to prove she is entitled to any disability above her impairment.

49. The issue of whether Claimant is an odd-lot worker is moot.

CONCLUSIONS OF LAW

1. Claimant is not entitled to further medical care.
2. Claimant is not entitled to additional TTD benefits.
3. Claimant is not entitled to additional PPI benefits beyond those already paid.
4. Claimant is not entitled to PPD above her PPI.
5. Whether Claimant is an odd-lot worker is 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 __6th __ day of May, 2010.

INDUSTRIAL COMMISSION

__/s/______________________
Michael E. Powers, Referee

ATTEST:

__/s/__________________________
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the ___14th___ day of __May__, 2010, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

SCOTT CHAPMAN
PO BOX 446
LEWISTON ID 83501

LORA RAINEY BREEN
PO BOX 2528
BOISE ID 83701

ge Gina Espinosa

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

MURIEL JOHNSON, Claimant, v. ST. JOSEPH REGIONAL MEDICAL CENTER, Self-Insured Employer, Defendants.	)	**IC 2006-006060** **ORDER** Filed May 14, 2010

Pursuant to Idaho Code § 72-717, Referee Michael E. Powers submitted the record in the above-entitled matter, together with his 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 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 is not entitled to further medical care.

2. Claimant is not entitled to additional total temporary disability benefits.

3. Claimant is not entitled to additional permanent partial impairment benefits beyond those already paid.

4. Claimant is not entitled to permanent partial disability above her permanent partial impairment.

5. Whether Claimant is an odd-lot worker is moot.

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

DATED this __14th___ day of ___May___, 2010.

INDUSTRIAL COMMISSION

Unavailable for signature
R.D. Maynard, Chairman

__/s/________________________________
Thomas E. Limbaugh, Commissioner

__/s/________________________________
Thomas P. Baskin, Commissioner

ATTEST:
_/s/____________________________
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __14th__ day of __May___ 2010, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

SCOTT CHAPMAN
PO BOX 446
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ge Gina Espinosa