BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

ISMET KOSTJEREVAC, Claimant, vs. OAK EXPRESS-Furniture Row, LLC, Employer, and HARTFORD INSURANCE COMPANY OF THE MIDWEST, Surety, Defendants.	)	**IC 2005-002564** **IC 2007-014622** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** Filed May 16, 2011

Pursuant to Idaho Code § 72-506, the above entitled matter was assigned to Referee LaDawn Marsters, who conducted a hearing on October 15, 2010 in Boise, Idaho. Claimant was present in person and was represented by Jerry J. Goicoechea. Employer and Surety were represented by W. Scott Wigle. Oral and documentary evidence was admitted, and post-hearing depositions were taken. The matter was briefed and came under advisement on March 3, 2011.

ISSUES

The issues to be decided are:

1. Whether and to what extent Claimant's injuries were caused by a preexisting condition;

2. Whether and to what extent Claimant is entitled to worker's compensation benefits, including:

a. Medical care;

b. Permanent partial impairment (PPI); and

c. Permanent partial disability (PPD).

3. Whether apportionment for a preexisting condition pursuant to Idaho Code § 72-406 is appropriate; and

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

CONTENTIONS OF THE PARTIES

This consolidated matter arises out of two accepted claims. The first claim arose on February 15, 2005, when Claimant stumbled backward into a forklift tine while pulling a table off a shelf. The tine struck his right lower back, resulting in a bruise and a strain. The second injury arose on April 23, 2007, when Claimant was hit on the right side of his head by a heavy metal object that fell from above him while he was assembling a bed. Claimant suffered a mild concussion and other related injuries. Although these claims were accepted, the parties hotly dispute whether Claimant suffered any permanent injury as a result of either industrial accident.

Claimant contends that he continues to suffer debilitating back pain as a result of his 2005 injury and recurring headaches, dizziness and jaw pain, as well as other symptoms, as a result of his 2007 injury. He seeks benefits related to his industrial injuries including PPI of 2% of the whole person (1% for each injury) and PPD of 29%. Claimant relies upon the opinions of Richard A. Radnovich, D.O. and Shannon Purvis, vocational consultant, to support his claims.

Defendants counter that Claimant has failed to prove that he has suffered any new PPI or, consequently, any PPD, as a result of either his 2005 or his 2007 industrial injuries. They posit that Claimant's back symptoms are due to his preexisting back condition, for which he underwent multiple level fusion surgery in 1997, treatment for pain in 2000, and treatment for a

precursor industrial injury in 2002. Claimant was issued permanent restrictions following his 2005 back injury; however, they do not exceed his 2003 restrictions so, in any event, he is not entitled to PPD related to the 2005 accident. As for Claimant's other symptoms, Defendants assert that, they are attributable to Claimant's work-related stressors or other causes unrelated to his 2007 injury. With respect to all of Claimant's subjective reports, Defendants argue that they are insufficient to establish his case because Claimant is not a credible witness. Defendants rely upon the opinions of Nancy Greenwald, M.D. and Craig W. Beaver, Ph.D. to defend their case.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The Industrial Commission legal file;
2. Claimant's Exhibits A through W admitted at the hearing;
3. Defendants' Exhibits A through D admitted at the hearing;
4. The testimony of Claimant, Brandon Rogers, Zejna Kostjerevac, Minela Kostjerevac, Carl Eric Peterson and Shannon Purvis taken at the hearing;
5. The post-hearing deposition testimony of Craig Perry Henderson taken October 25, 2010;
6. The post-hearing deposition testimony of Richard A. Radnovich, D.O. taken October 25, 2010;
7. The post-hearing deposition testimony of Nancy Greenwald, M.D. taken November 8, 2010; and
8. The post-hearing deposition testimony of Craig W. Beaver, Ph.D. taken November 12, 2010.

OBJECTIONS

All pending objections are overruled except the following, which are sustained: Claimant's objection at page 18 of the deposition of Dr. Beaver and Defendants' objection at page 46 of the deposition of Dr. Greenwald. Claimant's Exhibit X is admitted for the sole purpose of establishing that Claimant filed a complaint with the Idaho Human Rights Commission following his discharge from Employer's.

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

FINDINGS OF FACT

History.

1. Claimant was 44 years of age and residing in Meridian at the time of the hearing. He was born and raised in Bosnia-Herzegovina ("Bosnia"), where he completed high school plus nearly two years of college studying criminal justice. He worked as a police officer for many years. Claimant is married with two children. He smokes cigarettes, but rarely drinks alcohol.

2. Claimant testified, consistent with many historical notes in his medical records[1], that he retains shrapnel in his body from 1993 in the Bosnian war when a bomb and/or a landmine exploded. He denies that this resulted in a back injury.

3. Nevertheless, in 1997, prior to immigrating to Idaho, Claimant underwent a multiple-level fusion surgery at L4-L5-S1. No medical records from that time are in evidence. According to Claimant, the surgery was apparently performed to relieve back pain related to a degenerative spine condition[2]. No permanent restrictions were issued, and Claimant testified

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[1] Oddly, Dr. Beaver's notes indicate Claimant reported to him that he had never been involved in a war.

[2] Claimant testified that his physician told him, "I cannot tell what the problem, but so many people have problem with lower back and--…so many players – basketball players, soccer players, you know, go to play soccer and, you know, a lot of people have problem with low back…". Tr. P. 19.

that he returned to his job as a police officer after two 3-week sessions at a live-in rehabilitation facility. Claimant's medical care and rehabilitation were provided without charge, as is customary in Bosnia for Bosnian citizens.

4. **Dr. Verska.** Claimant came to the United States in January 2000. In April 2000, Claimant began a round of appointments with Joseph Verska, M.D., an orthopedic surgeon, and others at Intermountain Orthopaedics for evaluation and treatment of right-sided back pain as well as numbness and tingling in his left leg. Among other symptoms, Dr. Verska recorded that Claimant's "low back pain is bothering him when he sits and stands." Claimant's Exh. Q, p. 258. An interpreter assisted Claimant in completing the Patient Questionnaire. One questionnaire response indicates Claimant was seeking treatment primarily for neck and back pain, dizziness and lack of sleep:

> **[Q:] History of Present Illness: (What is the reason for this visit? Describe the onset, quality, location, duration, timing, and severity of symptoms and any treatments tried to date.)**
>
> [A:] *Pain in neck and back and both legs…dizziness and lack of sleep. Ismet has tried physical therapy repeatedly with no change in condition. He has been on pain medication since 1997 following surgery.*

Claimant's Exh. Q, p. 259. Other questionnaire responses indicate Claimant was taking Analgin for pain as well as ibuprofen, "Nezepan" and Tylenol. In addition, they represent that Claimant underwent the 1997 back surgery plus three other surgeries to remove shrapnel, and that he still retains shrapnel in his legs and left arm. *Id.*

5. A lumbar spine MRI on April 25, 2000 demonstrated no obvious right-sided nerve root impingement at L4-L5 or L5-S1. In Dr. Verska's opinion, the MRI did identify a left-sided disc herniation. Claimant's Exh. Q, p. 253. He also reported that Claimant had a prior back surgery in "Boston" which "really did not help him at all." *Id.*

6. On June 13, 2000, Claimant reported to Dr. Verska that he was doing better but still experiencing pain and discomfort. Claimant's lumbar spine is not specifically referenced in this note. However, one week later a physician's assistant at Intermountain Orthopaedics again confirmed that Claimant was still experiencing back pain, leg symptoms and dizziness, without objective findings pinpointing a cause:

> *Ismet and I spoke at length regarding his pain and discomfort. He was involved in Bosnia where he was around an explosion. Since that time he has had this pain and discomfort. He has dizziness, neck pain, no radicular symptoms in his upper extremities. He has had some back pain and leg symptoms. We would like to refer him to Dr. James Herrold for evaluation and treatment since we have done cervical MRIs, lumbar MRIs, EMG studies and tried to evaluate and treat him at this point, but were unable to find any significant pathology.*

Claimant's Exh. Q, p. 249.

7. Claimant was referred for physical therapy in June 2000. However, the therapist's chart notes indicate that Claimant was inconsistent with his home exercises, and inconsistent in attending his physical therapy sessions. In addition, he was "interested primarily in soft tissue work & was reluctant to work on stretching & strengthening ex's." Claimant's Exh. Q, p. 262. Claimant was provided with massage therapist referrals and discharged from physical therapy.

8. An August 8, 2000 physical therapy note indicates Claimant sought further treatment, so the therapist agreed to treat him once per week for two weeks, focusing on exercises. However, "Pt. attended one appointment & then no showed" so, again, Claimant was discharged from physical therapy. Claimant's Exh. Q, p. 261.

9. **Dr. Krafft.** On December 12, 2000, Claimant was evaluated by Kevin R. Krafft, M.D., a physiatrist, for functional capacity evaluation recommendations. He noted Claimant had multiple complaints including "dizziness, frequent pain, anxiety, nightmares, fear, back pain and

circulating pains as he describes it." Claimant's Exh. R, p. 278. Dr. Krafft characterized Claimant's chief complaint as "chronic pain" and documented his medical history in Bosnia, including shrapnel in his heel, calf and left arm from a grenade and a landmine during the war in 1993. He also, erroneously, reported that Dr. Verska had performed Claimant's 1997 back surgery. In addition, Dr. Krafft recorded that Claimant had a history of hay fever and asthma, arthritis, fractures (noting that Claimant previously reported no broken bones), weight loss, shortness of breath, cardiovascular problems, headache, head trauma, multiple neurological problems, gastrointestinal problems, difficulty urinating and loss of bladder control, and psychological issues including depression and anxiety.

10. On exam, Dr. Krafft identified positive Waddell's signs, indicating a nonorganic cause for Claimant's pain. For example, he noted that Claimant was able to walk on his heels and toes without difficulty but, inconsistently, he exhibited a decrease in dorsi and plantar flexion on exam. In addition, Claimant adequately performed the single leg raise test while sitting but, in the prone position, he demonstrated a significant pain reaction in his back while attempting a straight leg raise of less than 45 degrees. Overall, Dr. Krafft found Claimant demonstrated positive Waddell's signs on axial load, rotation, distraction and increased reaction testing.

11. Dr. Krafft diagnosed chronic pain syndrome with "positive Wadell's" and a normal neurological exam. Claimant's Exh. R, p. 279. He recommended a comprehensive chronic pain program including neuropsychology evaluation and treatment. He also recommended follow-up with Claimant's orthopedic surgeon concerning assessment of appropriate restrictions following his 1997 spinal fusion surgery, noting that generally imposed restrictions include a 50-pound occasional lifting limit without bending, twisting or stooping.

12. Notwithstanding this history, Claimant reported to subsequent care providers and testified at the hearing, that his back did not bother him following his 1997 surgery until 2002, discussed infra. He also testified and/or reported to his medical care providers that he had no history of head pain, dizziness, headaches, head trauma or sinus problems, among other things.

Claimant's Experience at Employer's

13. On March 29, 2001 Claimant was hired by Employer, a furniture retailer, as a warehouseman. His job required daily heavy lifting.

14. Following an unrelated industrial injury in September 2001, Claimant was assisted by Shaun Byrne of the Idaho Industrial Commission Rehabilitation Division. That file was closed after Claimant had returned to work for his time-of-injury employer at his prior work status for 30 days.

15. **Dr. Shoemaker.** In December 2002, Claimant suffered an industrial twisting/lifting injury to his low back while moving a heavy table with another employee at Employer's. He was treated conservatively by Howard Shoemaker, M.D. and other caretakers at Primary Health. On January 2, 2003, Dr. Shoemaker acknowledged "definite language barrier issues." Claimant's Exh. S, p. 308. He noted, contrary to information from Claimant's prior medical records, that Claimant had "had 7 years of symptom-free activity" prior to this accident. *Id.* On January 16, 2003, Dr. Shoemaker wrote that he anticipated Claimant's condition would warrant a 50-pound permanent lifting restriction upon his recovery.

16. Dr. Shoemaker consistently reported that Claimant was pain-free after he recovered from his 1997 spinal fusion surgery. Then, on February 3, 2003, he noted Claimant revealed that he had undergone an examination for "welfare" purposes with Dr. Verska in 2000. Claimant's Exh. S, p. 295. Claimant reported Dr. Verska told him he was in good health but

should not do any heavy lifting. Nevertheless, Claimant accepted the position at Employer's because he could not find any other work.

17. On February 11, 2003, after comparing Claimant's recent MRI with the one taken in 2000 and finding no change, Dr. Shoemaker recommended an EMG nerve conduction study to determine whether the S1 nerve root was causing the burning pain Claimant reported in his left lower extremity. If not, Dr. Shoemaker reasoned, then Claimant's 2002 industrial injury did not significantly change his back condition and it would be appropriate to discharge him with permanent lifting restrictions "based on his chronic problem that has existed for a number of years." Claimant's Exh. S, p. 291.

18. After Claimant's February 18, 2003 nerve conduction study demonstrated no evidence of left lumbar radiculopathy, Dr. Shoemaker opined that soft tissue injuries must be the cause of Claimant's symptoms. He recommended a functional capacity evaluation and a work conditioning program and predicted that Claimant should achieve full rehabilitation with no resulting permanent impairment or disability.

19. On March 25, 2003, Dr. Shoemaker opined that Claimant had reached MMI. Although Claimant still reported low back pain and occasional pain radiating into his left leg, it was significantly improved. Dr. Shoemaker acknowledged Claimant's medical restrictions, including lifting restrictions of 50 pounds occasionally and 35 pounds frequently with occasional bending or twisting, based on his 1997 back surgery, noting "These restrictions are related to his chronic back condition. At this point there is no new impairment or disability over that which was present prior to this recent injury." Claimant's Exh. S, p. 284.

20. **Physical therapy.** Claimant's physical therapy records are more critical than Dr. Shoemaker's. They indicate that Claimant presented with significant Waddell's signs,

inconsistencies on evaluation and barriers to recovery, so he was conditionally transitioned from a work conditioning program to a work hardening program at the end of February 2003. Claimant participated for two hours each day in conjunction with working full time, light duty, for Employer.

21. In spite of the guarded initial prognosis for Claimant's success in the work hardening program, he made steady progress and was released to medium duty work as of March 26, 2003.

22. **Return to work.** Upon his return to work, Claimant disregarded his medical restrictions and returned to his regular heavy duty job. He testified that he felt fully recovered from his back injury and was able to lift objects and move his body in excess of his restrictions without pain.

Industrial Back Injury (2005).

23. On February 15, 2005, Claimant was working on an overhead shelf, pulling on a table, when he fell back into a forklift tine. He was wearing a safety harness at the time which prevented him from falling to the ground. However, the impact between Claimant's right lower back and the forklift tine left a visible bruise.

24. **Dr. Gibson.** Claimant was examined at an emergency facility later that day. He was given a morphine shot and prescriptions for oral pain and anxiety/depression medications. The next day, he was examined by Michael P. Gibson, M.D., an occupational medicine practitioner. Dr. Gibson diagnosed a lumbosacral contusion and sprain and treated Claimant on approximately 15 separate visits between February 15, 2005 and June 22, 2005.

25. X-rays taken February 16, 2005 identified mild scoliosis, mild left lateral offset of L4 upon L5, normal alignment through L5 with slight posterior positioning of L5 on S1,

moderate disc space narrowing at L4-5 and moderate to marked narrowing at L5-S1 with large osteophytes at these levels, and facet joint arthritis at L4-5 through L5-S1. In addition, the imaging demonstrated irregular calcific deposits in the left mid abdomen adjacent to L4. The radiologist's report indicated no certain evidence of acute pathology, but recommended a CT scan to further investigate concerning symptoms[3]:

> IMPRESSION:
> SIGNIFICANT DEGENERATIVE CHANGE IN THE LOWER LUMBAR SPINE WITHOUT OBVIOUS ACUTE FRACTURE. HOWEVER, ACUTE INJURY COULD BE SOMEWHAT DIFFICULT TO DETECT. THERE IS A CLUSTER OF CALCIFICATIONS OF UNCERTAIN DURATION AND ETIOLOGY, POTENTIALLY CHRONIC, OVER THE SOFT TISSUES AND BOWEL AT THE L4 LEVEL. FOR ANY SYMPTOMS OF CONCERN, PROCEED TO CT SCANNING.

Claimant's Exh. C, p. 94.

26. On February 23, 2005, Dr. Gibson reported that Claimant's pain had improved. He still had tingling in both legs when sitting. He also had pain in the left lower back with some pain up the thoracic spine and into his neck area. Claimant also reported headaches. By March 2, 2005, Claimant seemed worse. He was now reporting left leg pain and tingling, to some extent, all of the time. Dr. Gibson diagnosed left lumbar radiculitis, suspecting recurrent disc herniation.

27. Claimant continued to have recurrent leg and back pain on the left until March 31, 2005, when he reported primarily right-sided pain. Dr. Gibson diagnosed lumbar radiculitis on the right. By April 14, 2005, Claimant had no pain in the right leg, some numbness in his left leg and an episode of shooting pain in his heel. His primary pain at that time was in his back. Claimant's condition was the same on April 28, when Dr. Gibson became aware that Claimant

[3] Dr. Gibson recommended Claimant follow-up with his PPO physician regarding the calcifications; however, it appears this was not done.

was exceeding his lifting restrictions at work.

28. On May 2, 2005, Claimant underwent a lumbar spine MRI with and without contrast. The interpreting radiologist provided a complicated report of his findings. According to Dr. Gibson, "The findings are basically of previous surgeries with some facet arthropathy and disk space narrowing. No nerve deformities or nerve compressions were identified." Claimant's Exh. C, p. 70.

29. On May 4, 2005, Dr. Gibson noted Employer sent Claimant home for four weeks because he was exceeding his lifting restrictions at work. Dr. Gibson suspected this was a reason Claimant was no longer improving. Although Claimant also continued to report left leg numbness, his MRI showed no nerve impingements on the left which would correlate with his current symptoms. Claimant also continued to report shooting pain in his right leg and back pain. Dr. Gibson continued to prescribe medications and physical therapy.

30. On May 11, Dr. Gibson reported significant improvement due to time off from work.

31. By May 25, 2005, Claimant's left leg numbness was almost completely resolved, though the bottom of his foot still had some mild altered sensation. There is no mention of the right leg. In contrast, Claimant's low back pain was worse. Dr. Gibson referred Claimant to Paul Montalbano, M.D., a neurosurgeon, to rule out surgical problems.

32. **Dr. Montalbano.** Dr. Montalbano examined Claimant on June 6, 2005. Claimant had no right lower extremity symptoms, but he reported low back pain radiating into his left thigh and calf with associated tingling, numbness and weakness. After reviewing Claimant's February 6, 2003 and May 2, 2005 lumbar spine MRIs and other medical records, Dr. Montalbano found no evidence of foraminal stenosis or disc herniation and determined Claimant

was not a surgical candidate. He recommended continued conservative treatment and a consultation with a physiatrist.

33. Claimant saw Dr. Gibson again on June 8, 2005. Dr. Gibson noted Dr. Montalbano's findings and opinion and noted no significant change in Claimant's symptoms, including variable pain on both sides of his back and tingling in his left leg.

34. On June 22, 2005, Claimant reported only back pain, no leg pain, with improvement in his left leg tingling.

35. **Dr. Johnson.** Claimant transferred his care to Tracy Johnson, M.D., a physiatrist, apparently as a result of Dr. Montalbano's recommendation. On June 30, 2005 Dr. Johnson interviewed Claimant and noted facts that disagreed with Dr. Krafft's recorded history for Claimant from 2000. At this time, Claimant denied any medical history except gastritis and his 1997 lumbar surgery.

36. Following examination, Dr. Johnson diagnosed an aggravation of Claimant's previous back pain with a new injury. She noted Claimant's case is complicated by the fact that he was working outside his restrictions following his March 25, 2003 release to back to work. Dr. Johnson recommended physical therapy and a return to his 2003 restrictions.

37. On July 28, 2005, Dr. Johnson noted Claimant demonstrated several Waddell's signs and tight hamstrings. He reported back pain and a burning sensation down his left leg that decreased with treatments from the TENS unit at physical therapy. Claimant asked if he could do some swimming because this helped strengthen his back in the past. Dr. Johnson recommended continued physical therapy, wrote prescriptions for pool therapy, a muscle stimulator unit and medications, and continued Claimant's restrictions.

38. On August 18, 2005, Dr. Johnson again identified several Waddell's signs and

tight hamstrings. Claimant reported left-sided leg pain. Dr. Johnson again reviewed Claimant's MRI with him, explaining it shows no cause for this pain. Electrodiagnostic medical evaluations were performed, indicating normal left sural and left peroneal nerve responses and no evidence of left lower extremity radiculopathy. Dr. Johnson apparently found Claimant at MMI because she calculated an impairment rating related to his 2005 injury under the *AMA Guides, Fifth Edition*. She assessed 0%. Noting they did not increase with the 2005 injury, Dr. Johnson issued permanent work restrictions including lifting limitations of 50 pounds occasionally and 35 pounds frequently, as well as limited bending, twisting, stooping, prolonged sitting and prolonged standing. In addition, she recommended discontinuing Claimant's physical therapy but reiterated her recommendation for a home muscle stimulator for pain relief.

39. In December 2005, Claimant consulted both Dr. Gibson and Dr. Johnson regarding additional symptoms he attributed to his February 2005 industrial back injury. On December 5, 2005, he reported intermittent calf pain to Dr. Gibson and on December 22, 2005, he reported to Dr. Johnson calf pain as well as pain radiating from his low back up through his neck and upper extremities. Dr. Gibson's exam revealed no radiculopathy findings; he prescribed Mobic, which helped. Dr. Johnson noted several Waddell's signs and confirmed her opinion that Claimant was at MMI from his 2005 industrial injury. She opined that his upper extremity pain is new and unrelated to any workplace accident and reiterated her prior restrictions. As for his calf pain, she recommended continuation of Mobic or over-the-counter anti-inflammatories. She apparently felt this was unrelated to a compensable injury, as well.

40. **Dr. Nicola.** On May 4, 2006, Claimant sought a second opinion from George A. Nicola, M.D., an orthopedic surgeon. Dr. Nicola reviewed Claimant's medical records,

including his May 2, 2005 MRI, which he opined[4] showed no evidence of stenosis or recurrent disc herniation, among other things. On exam, Dr. Nicola identified lumbar stiffness but no evidence of significant neurological changes and no significant weakness. He concurred with Dr. Montalbano's opinion and recommended a walking and swimming program.

41. On July 20, 2006, Claimant sought treatment from Dr. Nicola for worsening back pain with tingling on the bottoms of both feet. Dr. Nicola decided to wait for the results of Claimant's recent nerve conduction study performed in Bosnia:

> *I am going to await the results of that study, but I carefully went over with this patient that I do not feel that a blow to the back with subsequent bruising is the cause of his injury, but more is the natural progression of his prior lumbar disc operation.*

Claimant's Exh. I, p. 156. Apparently, Claimant did not thereafter follow up with Dr. Nicola.

42. Surety still had not approved the muscle stimulator recommended by Dr. Johnson so, on August 1, 2006, Surety's representative telephoned Dr. Nicola regarding his need for the device. Dr. Nicola's chart note of that conversation conveys that he does not believe Claimant's recent pain complaints were due to his industrial accident:

> *We discussed the patient's need for his RS Medical stimulator. It is my feeling at this point that his problem is the result of a natural progression of his prior back injury from ten years ago in Bosnia. He had a forklift injury to the back with a bruise. He complains of some numbness, tingling and burning.*
>
> *The patient had an MRI scan which shows multiple disc protrusions, but no evidence or recurrent disc protrusion and no evidence of entrapped nerves at this point.*
>
> *I feel the need for the RS Medical stimulator unit is the result of his old Bosnian injury and not the more recent injury suffered at Oak Express.*

Claimant's Exh. I, p. 155.

[4] Although it appears from the context of Dr. Nicola's report that he viewed the MRI films, he does not specifically state this.

43. Following his 2005 back injury, Claimant and Employer finally began observing his work restrictions. As a result, a new position was created for him. Instead of doing heavy lifting as a warehouseman, he was now the warehouse supervisor responsible for putting together chairs and other furniture pieces.

44. Claimant had always liked his job at Employer's and was known as a good worker. He got along well with the store and regional managers. However, a new store manager was hired in 2006. Claimant testified that he did not like the new manager. Moreover, he was convinced that this man was looking for the earliest opportunity to fire him because he was making $40,000, which is high pay for a warehouse supervisor whose primary duty is to assemble furniture. Many of Claimant's care providers opined, infra, that Claimant's work stress is the cause of his continuing symptoms.

Industrial Head Injury (2007).

45. On April 23, 2007, Claimant suffered a mild concussion when a 3-4 kilogram[5] object fell approximately 6 feet from atop a headboard onto the right side of his head. No one witnessed the event. Claimant has reported that he lost consciousness for up to a half-minute. He has also reported that he experienced pain and became dizzy but did not lose consciousness. Claimant finished work that day. He did not seek medical treatment until the following day, when he had a left-sided nosebleed. He again consulted Dr. Gibson.

46. **Dr. Gibson.** Dr. Gibson noted pain and swelling over the right temporal area. Claimant reported he had a headache, better than the day before, and continued dizziness. He also complained of vision problems, tenderness on opening his mouth in the temporomandibular

[5] One kilogram equals 2.2 pounds.

joint (TMJ) area and low back complaints since his lumbar surgery by “Dr. Montalbano.” Claimant’s Exh. C, p. 46.

47. On exam, Claimant’s right pupil was slightly larger than the left but both pupils reacted to light equally. He had tenderness over his TMJ but could open his mouth without significant difficulty. Vision testing revealed a normal right eye and good peripheral vision bilaterally. However, Claimant said he could not see the big “E” with his left eye and that this represented a change in his vision. Romberg and tandem walking tests were normal. Dr. Gibson confirmed evidence of a recent nosebleed and ordered a head CT scan, which returned normal results. He diagnosed a concussion without cerebral bleeding.

48. Dr. Gibson consulted Michael L. Henbest, a neurosurgeon. Dr. Henbest could identify no evidence of injury caused by the industrial accident on the CT scan. He recommended an ophthalmologist referral if Claimant’s vision did not improve. Regarding Claimant’s disparate pupils, he recommended a chest x-ray to rule out Horner syndrome and a magnetic resonance angiogram (MRA) to rule out an occult aneurysm as potential causes.

49. On April 25, 2007, Claimant reported his prior symptoms had improved, but he reported new left-sided head pain. Another consultation with Dr. Henbest confirmed no evidence for vision loss on his CT scan. Claimant’s wife told Dr. Gibson she had never noticed Claimant’s pupils were not the same size. Dr. Gibson opined none of Claimant’s history would indicate this anomaly preexisted his head injury.

50. Also on April 25, Claimant was examined by Lawrence D. Anderson, M.D., an ophthalmologist. No medical records from Dr. Anderson are in evidence; however, Dr. Gibson reported, as per Claimant, that Dr. Anderson found a visual field defect that he attributed to a bruise on the brain. On April 30, 2007, Dr. Gibson referred to this as a “questionable” field

defect. Claimant's Exh. C, p. 43. On that same day, Dr. Anderson called to report that Claimant's vision had improved to 20/25 bilaterally and that the difference in Claimant's pupils is probably physiological anisocoria, a benign condition.

51. On April 26, 2007, Claimant reported sharp shooting pains from his left temporal area into his left eye, constant aching and related sleep disturbance. On the other hand, he reported improvement in his jaw pain and dizziness. By April 30, he reported episodic vertigo, primarily when moving quickly in any direction and when flexing and extending his neck. Claimant exhibited very brief rotary nystagmus when moving his head quickly. His right pupil continued to appear larger than the left. Dr. Gibson ordered another head MRI, which returned normal results except for findings consistent with sinusitis. He referred Claimant to STARRS for evaluation of his vertigo symptoms and Epley treatments.

52. On May 3, 2007, Claimant was still having five or six dizzy spells per day lasting about five minutes each. Upon learning his April 27, 2007 MRI results, Claimant reported that he had not had sinusitis symptoms in the past. Dr. Gibson ordered vestibular testing with Stanley D. Harmer, Ph.D. ("Dean"), a hearing and speech specialist. Those results are reported, infra. In summary, Dr. Harmer diagnosed a mild concussion but no hearing or vestibular disorder. He felt Claimant had likely incurred a labyrinthine contusion. He also opined that Claimant had exaggerated his symptoms.

53. On May 10, 2007, Claimant exhibited no nystagmus and his other symptoms had improved. Dr. Gibson diagnosed post-concussion syndrome, slowly improving.

54. On Claimant's last visit, on May 17, 2007, he reported new symptoms including memory problems and sharp migratory pains all over his head. He also reported dizziness and continued sleep problems, including waking up with headaches, in spite of trialing a number of

different medications. Dr. Gibson maintained his diagnosis of post-concussion syndrome and referred Claimant to Boise Physical Medicine and Rehabilitation Clinic (BPMRC).

55. Claimant was off work following his head injury through mid-May. When he returned, he was put to work at a light-duty job at 4 hours per day with lifting restrictions.

56. **Dr. Kadyan.** Vic Kadyan, M.D., a physiatrist with BPMRC, treated Claimant from May 17, 2007 through December 13, 2007. Prior to his initial evaluation, Dr. Kadyan reviewed Claimant's prior medical records and interviewed Claimant.

57. At his initial appointment with Dr. Kadyan, Claimant reported dizziness, headaches, neck pain, memory problems, asymmetric pupils, vertigo particularly with extension of his neck, and waking from sleep the night before with sharp head pain. He had no paresthesias into his hands or legs. He exhibited significant anxiety related to his head injury and concern over his symptoms progressing.

58. On examination, Dr. Kadyan could not elicit nystagmus even with provocative maneuvers. He diagnosed post concussive symptoms with headaches, dizziness and sleep disturbance. Specifically, he opined that Claimant likely sustained a mild traumatic brain injury. Dr. Kadyan prescribed medications for sleep, headache and pain and referred Claimant to a neuropsychologist to investigate his memory issues and a vestibular rehabilitation therapist in regard to his balance problems. He returned Claimant to work with a 15-pound lifting restriction and recommended he not work at unprotected heights.

59. Dr. Kadyan predicted Claimant's recovery would be slow, but that he would reach MMI in 4-6 months and would be able to return to work without restrictions.

60. Dr. Kadyan addressed Claimant's condition again on 14 additional occasions:

a. On May 24, 2007, he reported that Claimant had called two days previously to

report he was much worse. He was not taking his headache medication. On examination, Claimant had a negative Romberg and no significant ataxia, and his gait was within normal limits, among other measures. Dr. Kadyan's diagnosis and recommendations did not significantly change.

b. On June 4, 2007, he reported that Claimant had phoned in a complaint about conjunctival erythema in his left eye prior to this appointment. The problem resolved without further treatment. On examination, Claimant's gait was normal and his asymmetrical pupils were both reactive to light. Claimant's May 26, 2007 head CT scan revealed no acute intercranial process but did reveal chronic sinus disease. Dr. Kadyan's initial diagnosis did not change. He prescribed medication for sinus disease because this could be causing Claimant's headaches. He recommended continuing physical therapy and neuropsychological treatment and advised Claimant of the importance of follow-through to his recovery. Claimant remained frustrated with his work and his symptoms. Dr. Kadyan released him to work 6 hours per day with a lifting limit of 30 pounds.

c. On June 14, 2007, Claimant reported no new symptoms, but he remained frustrated that he wasn't improving. Dr. Kadyan appreciated no loss of balance and a gait within normal limits. Dr. Kadyan altered Claimant's medication prescriptions, referred him for occupational therapy and maintained his prescriptions.

d. On June 27, 2007, Claimant reported slight improvement in his headache pain and sleep disturbance. He continued to participate in occupational and neuropsychological therapy and had been discharged from physical therapy. Claimant's gait was within normal limits. Dr. Kadyan altered Claimant's medications, continued his restrictions and recommended continuing his supplemental therapies. He had spoken with Robert F. Calhoun, a neuropsychologist, and noted that Claimant's neuropsychological testing was inconsistent with his obvious functional abilities, so he would likely require retesting in the future.

e. On July 13, 2007, Claimant again denied any new complaints. He was happy about continuing to work but somewhat resistive to the idea of increasing his hours. Claimant's gait was within normal limits. Dr. Kadyan noted appropriate conversation and affect with some perseveration and anxiety. Dr. Kadyan again altered Claimant's medications and maintained Claimant's work restrictions and outpatient therapies.

f. On August 3, 2007, Claimant had primary complaints of headache and sleep difficulty. He also expressed dissatisfaction with his progress and significant anxiety related to work. Claimant's gait was within normal limits. Dr. Kadyan altered Claimant's medications and maintained his restrictions and neuropsychological treatment.

g. On August 21, 2007, Claimant reported the TENS unit was helping with his headaches and medications were helping with his sleep difficulties. He noted occasional dizziness with his headaches. He was working 6 ½ hours per day, 5 days per week, and was still unhappy with his work situation, expressing a great deal of frustration. Claimant's gait was within normal limits. He had tenderness in his temporal area but not around his cervical spine. Dr. Kadyan reported Claimant was improving and released him to work 7 hours per day, encouraging home exercise and smoking cessation.

h. On September 14, 2007, Claimant reported improvement in his headaches and sleep disturbance. Now dizziness was his primary problem. Claimant's gait was within normal limits. Dr. Kadyan made plans to begin weaning Claimant off his medications. In addition, Dr. Kadyan reviewed with Claimant a copy of Dr. Greenwald's IME report. He recommended that Claimant continue using the TENS unit and follow Dr. Greenwald's recommendation for balance testing.

i. On September 21, 2007, Dr. Kadyan released Claimant to work 8 hours per day with lifting limited to 40 pounds.

j. On October 5, 2007, Claimant reported increasing headaches, dizziness and neck stiffness. He also reported occasional palpitations and one panic attack. He was very distressed that he was getting worse. Dr. Kadyan determined the source of Claimant's upset could be traced to his work situation:

> *On further conversations and identification, it appears that the patient has significant job dissatisfaction and he did have a long discussion with his employers today. Some of the sources of his symptoms, he reports, are related to that he feels "completely stressed out". He has looked for other employment without any luck at this point.*

Claimant's Exh. L, p. 182. Dr. Kadyan diagnosed post concussive symptoms, headaches, mood disorder and sleep disturbance. "I did inform him that his symptom exacerbation is likely related to somatization." *Id.* He recommended discussing this with Dr. Calhoun. Dr. Kadyan altered Claimant's restrictions to allow him to work just 7 hours on days when he had medical appointments, with a lifting limit of 25 pounds frequently and 50 pounds occasionally.

k. On October 15, 2007, Claimant reported bilateral throbbing headaches and worsening insomnia, as well as paresthesias in his face, difficulty and discomfort with swallowing, and occasional palpitations. Claimant's gait was fluid. He reported problems with his work and that his attorney had counseled him to stay in that position:

> *He has found work to be quite stressful and he reports that every day he is being harassed at work. At this time, he wishes to continue to work in his current setting. He did consult with a lawyer and recommendations have been that the patient not look for other employment. Furthermore, it was recommended that he not leave his position. The patient has had concerns regarding his future outcome. He is concerned that he may not be able to hold down a position in the long run.*

Claimant's Exh. L, p. 180. Dr. Kadyan believes Claimant should not follow this advice: "I strongly disagree with his attorney's advice. The patient's increase in symptoms I think are related more to stress and psychological issues than his brain injury." *Id at 181.* Dr. Kadyan maintained his diagnosis, recommended Claimant follow-up with Dr. Calhoun and opined Claimant was likely medically stable.

l. On November 12, 2007, Dr. Kadyan opined Claimant had reached MMI. He was still reporting symptoms including insomnia, head paresthesias, headaches and chest heaviness. He was still experiencing workplace stress. Claimant had a fluid gait with no loss of balance while walking, but his unipedal stance was mildly impaired. Dr. Kadyan maintained his diagnosis of post concussive symptoms, headaches, mood disorder and sleep disturbance. He anticipated Claimant would be weaned from his medications within 4-6 months. He deferred to Dr. Calhoun with respect to an impairment rating following repeat testing.

m. On November 28, 2007, Claimant reported headaches, memory problems, nightmares, occasional shortness of breath and myalgias in his biceps. Claimant's gait was within normal limits. Dr. Kadyan maintained his diagnosis and continued planning for Claimant's discontinuation of his medications. He updated Claimant's lifting restrictions to 50 pounds occasionally and 35 pounds frequently and recommended he continue using the TENS unit. He declined Claimant's request for another head MRI, finding it medically unnecessary.

n. Dr. Kadyan's last chart note in the record is dated December 13, 2007. On that day, Claimant reported no changes. No gait abnormality was noted. Dr. Kadyan maintained his diagnosis and restrictions and recommended follow-up with Dr. Calhoun which apparently did not happen. He anticipated Claimant would be weaned from his medications in two months.

61. Claimant was laid off by Employer on January 29, 2009. After an arduous job search, he was hired by a school district as a janitor and continued to work at that job at the time of the hearing. Claimant's job duties require frequent bending and stooping, leading to back pain

that makes him worry that he will have to quit.

<u>Testing for Dizziness/Vertigo and Balance Problems.</u>

62. **Dr. Harmer.** On May 7, 2007, Claimant was evaluated by Dr. Harmer for vestibular difficulties in search of an explanation for his dizziness. On his intake questionnaire, Claimant described his initial episode of dizziness as, "[h]eadache, very nauseus [sic], no energy, feelings of vomiting." Defendants' Exh. 14, p. 1. He also indicated the initial occurrence happened while he was standing, 24 hours following his injury. Claimant described his dizziness as episodic, occurring 10 times per day for about 5 minutes apiece. He wrote that he knows he is about to have an episode when he feels a loss of all energy. Further, there is nothing he can do to decrease the severity of the attack and he knows of nothing he does that brings on the episodes. Claimant cited his head injury as the cause. In the space provided for Claimant to list other health problems he is having, he listed "back pain". *Id.*

63. Dr. Harmer, the speech and hearing specialist, supra, administered testing including an electronystagmography (ENG) and motor control tests. He concluded that Claimant was suffering no significant hearing loss or vestibular abnormality. Claimant's Equitest score of 21 indicated poor balance. However, Dr. Harmer determined Claimant was enhancing his symptoms because his composite score reflected a considerably poorer condition than Claimant's observed gait and balance belied. Dr. Harmer found further evidence of symptom enhancement while observing Claimant's excessive voluntary foot movement during the motor control test.

64. Dr. Harmer diagnosed symptom-enhanced post-traumatic vertigo and recommended physical therapy.

65. **Vestibular therapy.** Claimant underwent vestibular and balance therapy testing

at St. Alphonsus Rehabilitation Services on several different occasions between May 2, 2007[6] and November 2, 2007. The treating therapist initially believed Claimant was a good candidate for rehabilitation. However, by October 30, 2007, following another balance test, the same therapist opined that he was a poor candidate:

> *In my clinical opinion, the patient is a poor candidate for vestibular rehabilitation services. The patient demonstrates poor potential for improvement by receiving these services. The patient's Balance Master score of 0/100 appears to be inconsistent with his ability to ambulate and stand during other activities that were done today in the clinic.*

Defendants' Exh. 7, p. 19. On Balance Master testing at his final visit, Claimant achieved a score of 5/100 which, again, was clearly inconsistent with his apparent functional abilities. Among other normal findings, he demonstrated no gait deviations.

Psychological Assessments.

66. **Robert F. Calhoun, Ph.D.** Pursuant to Dr. Kadyan's recommendation following his industrial head injury, Dr. Calhoun, a neuropsychologist, treated Claimant from June 1, 2007 through November 8, 2007. Dr. Calhoun interviewed Claimant, reviewed his medical records and administered a battery of tests[7].

67. On testing, Claimant gave up prematurely on some tests and was generally "distracted by his emotional frustration and need to tell his story" such that "the current neuropsychological evaluation is an underestimate of his true neuropsychological capabilities." Claimant's Exh. N, p. 232. His MCMI-III results were consistent with individuals with somatoform tendencies, severe anxiety and depression that worsens with psychosocial stress.

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[6] On Claimant's initial visit, his Balance Master score of 44/100 greatly underestimated his apparent abilities.

[7] On June 1, 2007, Dr. Calhoun administered the Wechsler Adult Intelligence Scale III, Wechsler Memory Scale-Revised (Logical and Visual Memory portions only), Wide Range Achievement Test III, Rey Auditory Verbal Learning Test, Wisconsin Card Sorting Test, Ruff Figural Fluency Test, Rey complex Figure Test, Mesulam Cancellation Test, Validity Indicatory Profile and the Millon Clinical Multiaxial Inventory III (MCMI-III).

Noting Claimant's medical findings of a mild closed head injury with postconcussive syndrome accompanied by normal MRI and CT scans, Dr. Calhoun opined:

> *At this time, it is very difficult to truly assess whether or not Mr. Kostjerevac is having valid ongoing neurocognitive impairment secondary to his head trauma and mild closed head injury. As stated previously, his neuropsychological test performance was strongly influenced by variable motivation, head pain, and need to communicate his symptoms over the course of testing. It is possible that he has some efficiency [sic] in visual short-term memory. Otherwise, he appears to be at baseline neurocognitively and is capable of continuing to function as a furniture assembler.*
>
> *Affectively, Mr. Kostjerevac is depressed, anxious, and angry. Structured personality testing paired with clinical observation and past history indicates that Mr. Kostjerevac is at high risk for somatizing stress. Thus, it is likely his ongoing head pain, dizziness, and reported neurocognitive inefficiency are strongly influenced by psychological factors. He expresses significant anger toward his employer as well as job dissatisfaction since there has been a change in management. Mr. Kostjerevac also expresses anger toward his attending physicians, feeling as though "nobody is understanding my side." His ongoing head pain and sleep disturbance certainly could contribute to his subjective experience of neurocognitive inefficiency.*

Claimant's Exh. N, p. 234. Dr. Calhoun recommended a work schedule that allows for Claimant's medical appointments, an anti-depressive medication, and 8-10 sessions of neuropsychological counseling to address his depression, somatization tendencies, strong pain focus, anger, sleep disturbance and short frustration tolerance. He found no neuropsychological reason why Claimant should not continue working for Employer as a furniture assembler.

68. Dr. Calhoun treated Claimant on approximately eight subsequent occasions. Claimant's complaints varied somewhat from visit to visit, and Dr. Calhoun responded each time by encouraging Claimant to employ cognitive retraining techniques:

a. On June 11, 2007, Claimant complained of headache, short-term memory difficulties, sleep disturbance and short frustration tolerance. Dr. Calhoun explained how short frustration tolerance can exacerbate headaches and sleep problems.

b. On June 25, 2007, Claimant complained of memory impairment, sleep disturbance, sweating and severe anxiety prior to falling asleep at night, right-sided head pain and facial tingling. Dr. Calhoun explained to Claimant that his symptoms should continue to improve and that his anger and job dissatisfaction can contribute to his ongoing symptoms. He reviewed relaxation techniques with Claimant.

c. On July 12, 2007, Claimant complained of sleep difficulties and headache. Dr. Calhoun discussed how anxiety and physical tension can exacerbate his headache condition as well as his sleep problems. "I strongly emphasize the importance of Ismet learning to control the cognitive and behavioral factors which are impacting his inability to sleep which affects everything else including his headache, short-term memory, etc.". Claimant's Exh. N, p. 226.

d. On July 27, 2007, Claimant reported that he had head pain and dizziness, that his symptoms were getting worse and that he was frightened because he was not improving. Dr. Calhoun explained how anxiety and stress can exacerbate Claimant's pain and dizziness and reviewed cognitive restructuring techniques to help with Claimant's short frustration tolerance and physical tension. He also encouraged Claimant to be more assertive at work as opposed to retaining anger about what is going on there. He also discussed the possibility of prescribing a beta blocker with Dr. Kadyan.

e. On August 7, 2007, Claimant reported improvement, at times, in his pain. He also reported diffuse head pain and numbness, describing it as a "tight band feeling around his head." Claimant's Exh. N, p. 224. Again, Dr. Calhoun explained how panic and fear can exacerbate Claimant's symptoms and delay his healing. He also reviewed relaxation exercises with Claimant.

f. On August 27, 2007, Claimant reported improvements in his head pain and dizziness, but remained focused upon dysesthetic-type sensations in his right parietal occipital region. Claimant also described a confrontation with his boss that brought on an immediate headache and dizziness. Dr. Calhoun again explained cognitive restructuring techniques to help reduce Claimant's anxiety and panic when he experiences his physical symptoms. He also reassured Claimant about the recovery timeline for his head injury.

g. On October 9, 2007, Claimant complained of increased head and neck pain as well as sleep disturbances. He also reported increased stress at his job, feeling discriminated against, being unfairly reprimanded and being told that he is being paid too much. Claimant was tearful, anxious and tense. Dr. Calhoun reviewed with Claimant ways to be less physically responsive to his work stress.

h. On October 22, 2007, Dr. Calhoun penned an open letter recommending Claimant take a leave of absence from work because his head pain, neck pain, dizziness,

anxiety and depression had increased over the prior two weeks. Dr. Calhoun attributed Claimant's worsening to his workplace stress. He evidently derived his opinion from his meetings with Claimant because no additional medical or psychological testing appears in the record.

i. On November 8, 2007, apparently Dr. Calhoun's last treatment with Claimant, he reported significant workplace stress and feeling harassed. He presented as tense, anxious and highly fearful of losing his job. In addition, Claimant reported ongoing headaches, shakiness and dizziness, with improvements in the tingling in the back of his head and the pain on the side of his head. Dr. Calhoun reviewed body awareness techniques and encouraged Claimant not to personalize his employer's purported attacks.

69. There is no evidence in the record of follow-up testing or an impairment evaluation by Dr. Calhoun as prefaced by Dr. Kadyan in his December 13, 2007 chart note.

70. **Craig Beaver, Ph.D.** On September 10 and 14, 2010, Dr. Beaver performed an independent psychological evaluation (IPE) of Claimant at Defendants' request. Specifically, Defendants sought an evaluation of Claimant's current functioning, the nature of his difficulties, what (if any) further care is indicated, and what (if any) impairment rating should be assessed with respect to the psychological consequences of Claimant's 2005 and 2007 industrial injuries.

71. At their first meeting, Dr. Beaver interviewed Claimant. A translator was present, but was only needed occasionally because Claimant was able to express himself in English, for the most part. On both days, Dr. Beaver administered psychological tests[8]. Prior to rendering his opinion, Dr. Beaver reviewed Claimant's medical records ranging from Dr. Krafft's February 28, 2003 chart notes through the date of his evaluation. He noted Claimant denied any history of mental health pathology. Interestingly, Dr. Beaver reported that Claimant also denied having any exposure to war in Bosnia.

[8] Dr. Beaver administered the SIMS, SOPA, Connors Continuous Performance Test II, Non-Verbal Validity Indicator Profile, P-3 Pain Patient Profile, Grooved Pegboard Test, Rey Complex Figure Test, Color Trail Making Test, Test of Memory and Malingering, Wechsler Adult Intelligence Scale IV (selected subtests), Wechsler Memory Scale-III (abbreviated form), Wisconsin Card Sorting Test, C-TONI, Green's Word Memory Test and Victoria Symptom Validity Test.

72. Dr. Beaver attempted to utilize tests that are culturally neutral and do not require significant mastery of English. Along those lines, the Green's Word Memory Test was administered in Bosnian, the C-TONI is a culturally unbiased measure of general intelligence designed to withstand language barriers, and the Color Trail Making Test is considered neutral, both culturally and with respect to language. On the other hand, the SOPA, SIMS and P-3 Pain Patient Profile, all of which evaluate emotional and psychological issues, were administered with the assistance of an interpreter.

73. At the hearing, Claimant testified that the interpreter was rude and of little assistance because she was preoccupied with her homework while he was taking his tests. He became very angry with her when she was uncooperative after he caught and apparently tore his shirt, a birthday gift. Claimant believes these are reasons why he did poorly on the testing. He did not report the assistant's behavior or seek additional assistance.

74. Dr. Beaver described Claimant as generally engaging, alert, attentive, though somewhat guarded and initially mildly irritable, frequently expressing frustration about having to undergo testing. Claimant was oriented to person, place and time and complained of pain difficulties during the course of the evaluation.

75. Dr. Beaver evaluated Claimant's performance on his individual tests, noting many concerns with Claimant's level of effort and scores so low they were inconsistent with Claimant's ability to function and work as his interview and history suggested he could. Deeming Claimant's testing invalid, Dr. Beaver wrote:

> *Overall, his performance, which in many cases was worse than change [sic – chance], indicates not only poor effort in the neurocognitive testing but also likely reflects some actual orchestrated effort to perform poorly. Therefore, his test results clearly are invalid and greatly underestimate his abilities.*

Defendants' Exh. 15, p. 13. Nevertheless, Dr. Beaver attempted to evaluate Claimant's abilities based upon the information available to him. He concluded:

> *Of primary concern…is his poor performance on both internal and external measures of motivation and effort. This patient consistently performed below change [sic – chance] on those measures, indicating not only poor motivation in the neurocognitive testing, but actually using some effort to perform poorly. His level of performance…was substantially below the level that would be expected given his presentation and current employment…he was essentially unable to do any of the visual spatial tasks, yet, has worked doing picture framing, furniture building, etc., post accident…he also presented as having almost no ability to learn and retain new information. Yet, he was able to offer relatively detailed discussions about the various care and treatment that he has received since his injuries and what jobs he has had, and provided good detail of his current job situation. Again, his poor performance on neuropsychometric measures was suspect.*

Defendants' Exh., p. 16. With respect to Claimant's pain presentation, Dr. Beaver opined:

> *Mr. Kostjerevac is very focused on pain issues. He shows a strong tendency for symptom magnification, as noted on the SIMS. He also showed significant somatization on the P-3 Pain Patient Profile. On the SOPA, he presented as being highly convinced that he is disabled and is harming himself by continuing to work.*

Id.

76. Based upon Claimant's medical course indicating a mild concussive event and subsequent history, as well as his poor effort and attempts to exaggerate his difficulties on cognitive testing, Dr. Beaver opined that Claimant has not suffered any residual neurological defects from his 2007 head injury. In addition, Dr. Beaver opined that Claimant does show signs of chronic pain, noting that these were identified before his 2005 industrial injury. Dr. Beaver opined that Claimant's emotional distress and his cultural background are both likely factors contributing to his pain and cognitive complaints:

> *…it is clear that he does have some ongoing emotional distress that likely contributes to his level of pain and cognitive complaints. I strongly suspect there are some cultural issues at play here as well. For example, when he was in*

> *Bosnia and had a back problem and subsequent surgery, he was hospitalized for a long period of time and given an extended period of time to convalesce. He has expectations that in the United States, there must be something else that can be done to resolve his pain, that he should not be working and should be cared for. This contributes, I believe to some of his frustration and anger.*

Id.

77. Dr. Beaver opined that Claimant has been at MPI regarding his traumatic brain injury and post concussive syndrome "for some time." Defendants' Exh. 15, p. 17. He does not believe Claimant has suffered any permanent partial impairment or that he requires further care or treatment in regard to his head injury. Dr. Beaver assessed no permanent restrictions because he believed any symptoms related to Claimant's mild concussion had already resolved. He deferred to Claimant's physicians with respect opinions concerning his 2005 back injury.

Expert Medical Opinions.

78. **Dr. Greenwald.** On September 6, 2007, Dr. Greenwald, a physiatrist, performed an IME at the behest of Defendants. She conducted follow-up evaluations on December 6, 2007 and September 28, 2010. She only addressed Claimant's symptoms potentially related to his 2007 industrial head injury in her reports of her first two evaluations. In her 2010 report, Dr. Greenwald also addressed Claimant's symptoms potentially related to his 2005 industrial back injury.

79. Based upon Dr. Greenwald's physical examination and interview of Claimant, a telephone conversation with Robert Calhoun, Ph.D. and a medical records review, she assessed 0% PPI in relation to either his 2005 or his 2007 industrial injury. In both of her reports, Dr. Greenwald addressed Claimant's post-concussive syndrome, dizziness, memory loss, headaches, right-sided head parasthesias, sleep difficulties, vision problems, anxiety, chronic sinusitis and whiplash.

80. **Dr. O'Brien.** Michael O'Brien, M.D., a neurologist, evaluated Claimant at Claimant's request on September 1, 2009. Dr. O'Brien reviewed Claimant's medical records, Surety's letter terminating benefits and other documents. He also interviewed and examined Claimant. Dr. O'Brien addressed Claimant's head injury and was aware of, but did not address, Claimant's low back complaints.

81. Claimant reported continuing difficulties with balance, memory loss, pain and tingling and headaches in the eye area, severe pain going into the eye region and shooting pains in his legs. On examination, Dr. O'Brien found Claimant had an intact memory and intelligence slightly above average. Claimant's balance and coordination testing were normal except for a positive Romberg's test. He found, without explanation, that Claimant's TMJ was unstable. When reaching for his toes, Claimant exhibited a pain response within one foot off the ground. His low back was tight. He had difficulty keeping balance in standing, doing Romberg and walking, particularly heel-to-toe walking.

82. Dr. O'Brien drew conclusions and made referrals. In reaching his conclusions he did not address Claimant's prior history of symptom magnification and he assumed Claimant's head problems were "always on the right". Claimant's Exh. P. 11, p. 243. He admitted it is a difficult case due to the comorbidities of depression and anxiety and other unidentified conditions, yet he did not explain how or if he considered them with respect to Claimant's pain presentation. He did not address causation issues, except to note that Claimant's complaints are consistent with the mechanism of injury.

83. Dr. O'Brien referred Claimant for further evaluation of his TMJ and balance issues, noting that the mechanism of injury is consistent with these types of injuries:

I certainly feel that the injury he now has is quite consistent with his complaints

> *[sic] The area that was struck in the right temporal region involves the temporalis muscle which feeds into the temporomandibular joint. The area struck is in the direct vicinity of the internal ear so his [sic] reasonable to assume that internal ear structure was disrupted by the blow to that region…I think it highly improbable that this patient is going to be able to carry on meaningful work when he is constantly battling recurrent vertigo…".*

Claimant's Exh. P. 11, p. 244. He apparently was unaware of Claimant's significant workup for vestibular problems in 2007 and the ultimate conclusions drawn by Dr. Harmer and the rehabilitation therapist at St. Alphonsus that Claimant was exaggerating his symptoms.

84. Dr. O'Brien followed up with a letter to Claimant's attorney on September 14, 2009. Assuming without opining that Claimant had reached MMI, Dr. O'Brien relied upon the *AMA Guides, Fifth Edition* to assess Claimant's PPI. There is no evidence that he had gathered any additional information about Claimant's condition following his September 9 examination or that Claimant had followed up on his referrals.

85. Dr. O'Brien rated Claimant's vertigo, TMJ instability and head pain. With respect to vertigo, he referenced page 253 to assign a Class II rating of 6% of the whole person. He ruled out a Class I rating on the basis that Claimant did not respond to the Epley Maneuver by repositioning the theoretical debris in his ear canal. In support of his rating, Dr. O'Brien explained that the location of Claimant's injury is consistent with his report of balance problems: "The site of his injury is adjacent to the skull area that contains the inner ear apparatus, so his history would be quite consistent with the symptoms that would follow an injury of the type he has had." Claimant's Exh. P. 12, p. 245.

86. Concerning Claimant's TMJ issue, Dr. O'Brien acknowledged the *Fifth Edition* provides no specific guidance, so he cited page 11, which advises physicians to "use clinical judgment comparing measurable impairments resulting from the unlisted condition to

measurable impairment resulting from similar conditions with similar impairment of function in performing activities of daily living." Claimant's Exh. P. 12, p. 245. Notwithstanding this guideline, Dr. O'Brien opined, "Since the patient has a TMJ which indicates an unstable joint and is a source for pain in the temporal region, an impairment of 5% of the whole person would be appropriate for that." *Id.*

87. With respect to Claimant's head pain, Dr. O'Brien was similarly vague. He acknowledged, then rejected, the guidelines on page 574 for rating pain. Instead, he again cited page 11 and assigned 5% of the whole person because, "That rating reflects more that the pain is a result of an injury rather than simply pain as an added factor." Claimant's Exh. P. 12, pp. 245-246.

88. Using the combined values chart, Dr. O'Brien assessed a whole person PPI of 15% with respect to Claimant's head symptoms. He opined that Claimant's vertigo attacks are the most concerning of his symptoms with respect to being able to work.

89. On May 11, 2010, Claimant sought treatment for a number of conditions from Dr. O'Brien. His primary concerns were insomnia and depression. He also reported worsening memory loss, daily headaches, sharp pain in his eyes and 8/10 (average) back pain radiating into his legs. A one-word note suggests a syncope diagnosis, but there is no explanation or history to support it. In addition to his symptoms, Claimant reported he was still unable to find work. Dr. O'Brien treated Claimant with massage and the TENS unit and prescribed medications for depression and insomnia, commenting that Claimant's is a "[v]ery complex problem!" Claimant's Exh. P. 13, p. 247.

90. **Dr. Radnovich.** On March 3, 2010, Dr. Radnovich, a family medicine physician specializing in sports medicine and pain management, interviewed and examined Claimant and

prepared an IME report at his request. Dr. Radnovich was aware of Claimant's prior injuries from the history he took and medical records he reviewed and operated under the assumption that Claimant completely recovered from both his 1997 spinal fusion and his 2002 industrial back injury. He addressed Claimant's symptoms potentially related to both his 2005 and 2007 industrial accidents.

91. Claimant reported that, as a result of his 2005 back injury, he has lower back pain (worse on the right) in addition to numbness, tingling, cramping and sharp, burning, stabbing pain in his left foot that also causes a persistent dull ache. Claimant rated his low back symptoms as typically 8/10 on the pain scale.

92. As a result of his 2007 head injury, Claimant reported to Dr. Radnovich that he continues to have right-sided head and face pain, pain on the top of his head and burning pain between the lower part of his neck down through the middle of his back almost to his sacrum.

93. Utilizing the *AMA Guides, 6th Edition,* Dr. Radnovich opined that Claimant has suffered PPI of 2% of the whole person due to his 2005 and 2007 industrial injuries. He assessed 1% to the 2007 head injury and 7% to Claimant's back symptoms, apportioning 6% to "underlying medical problems" and 1% to the 2005 industrial injury.

94. **Dr. Peck.** Claimant's lumbar MRI report of May 2, 2005 does not indicate that Claimant had any previous images for comparison; however, Claimant did have a prior study taken on February 6, 2003. Reports of both MRIs are long, complex and identify a number of conditions. In order to identify what, if any, changes occurred in the time between those reports, Claimant requested a comparison opinion from Dallas Peck, M.D., a radiologist.

95. Dr. Peck found progression of "acute and chronic appearing reactive marrow changes adjacent to the endplates at L4-5 which have progressed since the previous study…there

are more chronic appearing reactive marrow changes adjacent to the endplates at L5-S1…". Claimant's Exh. K. 7, p. 173. His conclusion did not specifically tie any of these changes to Claimant's 2005 industrial back injury:

<u>*CONCLUSION:*</u> *Progressive degenerative disk disease at L4-5 with progressive reactive marrow change in the endplate regions and slightly more prominent extreme right lateral disk protrusion with disk material abutting but not deviating the exiting right L4 nerve root. Stable left lateral recess stenosis at L5-S1 without definite mass effect on the traversing left S1 nerve root.*

Claimant's Exh. K. 7, p. 174. In his deposition, Dr. Radnovich opined that the finding of acute reactive bone marrow change indicates an exacerbation of Claimant's lumbar spine condition attributable to the 2005 industrial accident. Dr. Greenwald countered that acute reactive bone marrow change can also occur as a result of degenerative conditions.

<u>Video Surveillance.</u>

96. Brandon Rogers, a private investigator hired by Surety, followed Claimant on 5 separate days between approximately August 20, 2010 and September 4, 2010. He also prepared a report and took videotape footage of Claimant. Mr. Rogers's report states that he observed Claimant walk to his mailbox and go to the bank and Fred Meyer. The videotape footage, consisting of only a few minutes on two different days, chronicles these activities. Claimant did not exhibit any pain behaviors that Mr. Rogers noticed, but he admitted that Claimant may have, nevertheless, been in pain. He testified that he did not delete any video footage before providing Surety with his recording.

97. Of note, the videotape depicts Claimant chewing gum in each of three segments taken on August 31, 2010. Collectively, these segments only show a few minutes of activity because when Claimant goes out of the frame, for instance to enter an establishment, the recording stops. All three segments were shot between approximately 10:40 a.m. and 11:07 a.m.

98. The third of those segments also shows Claimant leaving Fred Meyer and loading groceries into the trunk of his car. He twists and bends as he lifts a gallon of milk together with a 12-pack of soda out of the cart and into the trunk, then repeats the motion, this time grabbing what appears to be two grocery bags in each hand.

99. Throughout the very short length of footage, Claimant enters and exits his car without hesitation. He walks into and out of establishments standing upright with a smooth, energetic-appearing gait, as if he is in a good mood and having a good day.

100. Claimant testified that he took a pain pill that day and wondered aloud where the camera was when he was stooped and holding his back. He was extremely upset that he had been followed, saying the surveillance is driving him crazy.

Vocational Consultant Opinion.

101. **Shannon Purvis, M.A.** Ms. Purvis evaluated Claimant in Spring and Fall 2010 and prepared a vocational assessment at Claimant's request. She based her assessment upon the assumption that Claimant's ability to engage in gainful employment was not hampered by any preexisting medical conditions at the time of his initial industrial accident in 2005. Based upon loss of access to his pre-injury labor market and loss of earning capacity related to his industrial accidents, Ms. Purvis opined that Claimant has suffered permanent partial disability of 60%.

Family and Coworker Testimony.

102. A coworker at Employer's testified that Claimant did daily heavy lifting at work and did not appear to be in pain either before his 2002 back injury or following his recovery from that accident through the time of his own departure from the company in 2004.

103. Another coworker testified that Claimant did heavy lifting at work prior to his 2005 injury without complaint but, afterward, he was no longer able do heavy lifting. He also

attested to Claimant's strong work ethic.

104. Claimant's wife and daughter each testified that Claimant is much worse off after his industrial injuries. They have each witnessed his worsening mood and depression, as well as behaviors exhibiting ongoing pain and discomfort, which he did not demonstrate before his 2005 back injury.

DISCUSSION AND FURTHER FINDINGS

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

105. **Claimant's credibility and pain limitations.** A claimant's credibility is generally at issue in a workers' compensation proceeding. Here, the scrutiny is heightened because Claimant is reporting significant pain in the absence of objective medical findings supporting a definite cause. In addition, there is evidence that Claimant may be intentionally exaggerating his pain and/or that a concurrent psychological process may be magnifying his symptoms, thereby affecting his ability to function and maintain gainful employment.

106. Neither Claimant's medical providers nor Defendants dispute that Claimant may indeed experience back pain, head pain or other symptoms. Further, Claimant's presentation at the hearing appeared sincere. The Referee does not doubt that Claimant has some very real concerns about his physical well-being, the level of care he received following his industrial accidents and his ability to work and provide for his family. Nevertheless, the evidence in the

record establishes that Claimant is not a credible witness. His medical records dating back to April 2000 with Drs. Verska and Krafft, to 2003 with Dr. Shoemaker and physical therapy, to Dr. Johnson in 2005, to Dr. Harmer and vestibular therapy in 2007, as well as his psychological therapy and testing by Dr. Calhoun and Dr. Beaver in 2007 and 2010, all indicate Claimant failed to provide adequate effort on testing and/or that he intentionally manipulated his responses to appear worse off than he was.

107. Claimant argues that the language barrier and his anger with the rude interpreter at Dr. Beaver's office are the reasons for his poor performance on testing. The evidence establishes, however, that the suspect results are not isolated to a particular time or confined to any certain type of test. A wide variety of test results over many years show Claimant exerted poor effort or intentionally exaggerated his difficulties.

108. In addition, Dr. Beaver explained he was confident Claimant had exaggerated his responses in many instances because even random guessing would have produced higher scores than Claimant achieved. Claimant's intentionally poor performance leading to his abysmal scores on balance testing was similarly obvious. The balance test administrator on one test noted Claimant could not have walked into the testing facility if his score that day had accurately reflected his abilities.

109. Claimant has also demonstrated psychological conditions which may intensify his pain experience without his knowledge. Dr. Calhoun identified somatization tendencies and correlations between Claimant's pain spikes and his workplace stress. By October 2007 Claimant's condition had deteriorated, as a result of his stress, to the point where Dr. Calhoun recommended a leave of absence from work. Three years later, Dr. Beaver also diagnosed strong somatization traits, along with pain disorder associated with both psychological factors

and a medical condition.

110. The *AMA Guides, Sixth Ed.* cautions against being automatically dismissive when evaluating the impact of aberrant pain behaviors, noting:

> *The appearance of symptom exaggeration can be created by fear or by having learned that certain actions or positions provoke pain…Excessive or exaggerated pain behaviors can be a response to feeling discounted or mistrusted, so that one must emphasize symptoms to persuade the physician of their reality. Anyone might dramatize a problem in an effort to have it taken seriously. Thus, symptom magnification can be an iatrogenic phenomenon that occurs when patients feel mistrusted or poorly cared for.*

AMA Guides, 6th Ed., p. 39. Claimant's medical records demonstrate many occasions on which he felt poorly cared for. However, this is inadequate to fully explain the depth and breadth of his inconsistent responses on testing and when reporting his symptoms. As a result, the Referee finds Claimant's reasons inadequate to fully explain Claimant's pattern of exaggerating his deficits.

111. Even assuming an "honest" explanation, the record nevertheless establishes that Claimant's subjective condition cannot accurately be ascertained from any given self report.

112. Claimant has failed to prove that either his behaviors or his self reports are reliable indicators of his subjective somatic experiences. The Referee finds Claimant is not a credible witness. As a result, the Referee declines to allocate any weight to statements made by Claimant about his symptoms, to medical providers or others, that are not otherwise supported by substantial objective evidence in the record.

Causation of Permanent Partial Impairment.

The Idaho Workers' Compensation Act places an emphasis on the element of causation in determining whether a worker is entitled to compensation. In order to obtain workers' compensation benefits, a claimant's disability must result from an injury, which was caused by

an accident arising out of and in the course of employment. *Green v. Columbia Foods, Inc.*, 104 Idaho 204, 657 P.2d 1072 (1983); *Tipton v. Jannson*, 91 Idaho 904, 435 P.2d 244 (1967).

The claimant has the burden of proving the condition for which compensation is sought is causally related to an industrial accident. *Callantine v.Blue Ribbon Supply*, 103 Idaho 734, 653 P.2d 455 (1982). Further, there must be medical testimony supporting the claim for compensation to a reasonable degree of medical probability. A claimant is required to establish a probable, not merely a possible, connection between cause and effect to support his or her contention. *Dean v. Drapo Corporation*, 95 Idaho 958, 560-61, 511 P.2d 1334, 1336-37 (1973). See also *Callantine*, *Id*..

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

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

"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 on specialized activities of bodily members. Idaho Code § 72-424. When determining impairment, the opinions of physicians are advisory only. The Commission is the ultimate evaluator of impairment. *Urry v. Walker & Fox Masonry Contractors*, 115 Idaho 750, 755, 769 P.2d 1122, 1127 (1989).

113. Claimant has reported a number of symptoms that he believes are permanent, debilitating and were caused by the subject industrial accidents. Defendants counter that he has suffered no permanent impairment as a result of either event. There are medical opinions in the record to support Claimant's contentions with respect to his back pain, headaches, dizziness/vertigo and TMJ pain/instability. Each symptom is addressed, in turn, below.

Back Pain.

114. Claimant's medical restrictions assessed in consideration of his lumbar spine condition did not change after his 2005 industrial injury. Nevertheless, Claimant argues that he continues to experience new, debilitating pain as a result of that event. In support of his position, Dr. Radnovich assessed a PPI rating of 1% of the whole person. Claimant's treating and second opinion physicians, however, believe Claimant did not sustain any permanent impairment due to his 2005 back injury:

a. After treating Claimant's left leg and back pain for a month and a half, Dr. Johnson found no objective reason from his May 2, 2005 MRI or electrodiagnostic studies for his pain. In addition, she noted tight hamstrings and consistent evidence that Claimant was exaggerating his symptoms. She assessed a PPI rating of 0%, ceased his physical therapy and recommended a home muscle stimulator for pain relief.

b. In his second opinion analysis, Dr. Nicola also opined Claimant's May 2, 2005 MRI showed no reason for his pain. In addition, he identified no significant weakness, among other things. When Claimant sought treatment a couple of months later, Dr. Nicola explained to him that he did not feel a blow to his back

> with subsequent bruising was causing his pain and that it was more likely a natural result of his surgery. He reiterated this opinion to Surety, further opining that Claimant's need for a muscle stimulator is due to his preexisting injury.

115. According to Dr. Radnovich and Dr. Peck, acute changes are demonstrated on Claimant's May 2, 2005 lumbar spine MRI as compared with his February 6, 2003 images. Specifically, Dr. Radnovich opined that an acute event led to acute bone marrow changes at L4-L5. He also identified likely aggravation of underlying arachnoidosis. This is the objective evidence he relies upon to establish that Claimant's 2005 back injury is related to his current pain complaints.

116. Dr. Greenwald is the only other physician to address the results of Dr. Peck's comparison report. She does not argue that the findings are not accurate, but she countered that they do not establish an acute injury because degenerative changes can produce the same process. Claimant argues that Dr. Greenwald's opinion is not credible because her practice partner, Dr. Johnson, treated Claimant. The Referee finds inadequate evidence to establish that Dr. Greenwald is biased against Claimant. In fact, it appeared that she went out of her way in her deposition to avoid opining that he had been untruthful. Dr. Greenwald's opinions will be given full weight to the extent they are otherwise credible and authoritative.

117. The evidence as to whether Claimant's May 2, 2005 MRI evidences anatomical changes due to an acute injury in addition to degenerative changes is in equipoise. In addition, even if the results of an acute injury are depicted, there is inadequate evidence to explain how these findings account for Claimant's symptoms, which have varied across both legs and both sides of his low back since the 2005 injury.

118. In addition, there is the added problem that Claimant worked outside his restrictions, thereby placing himself at heightened risk for reinjury, during the two years or so

between the dates the lumbar MRIs Dr. Peck reviewed were performed. Without sufficient evidence linking Claimant's symptoms to the operative findings it cannot be determined on a more probable than not basis that they resulted from Claimant's February 15, 2005 industrial accident and not some other event, at work or elsewhere.

119. The Referee finds inadequate objective evidence to establish that Claimant sustained a permanent back injury due to his 2005 industrial accident.

120. Even without objective evidence of injury, a claimant's permanent impairment due to pain is compensable. Accordingly, Claimant could still establish his right to PPI benefits if he could adduce substantial competent evidence that his back pain permanently worsened as a result of his 2005 injury.

121. In order to prevail on his claim for PPI benefits for back pain, Claimant must, at a minimum, establish that he recovered from his 2002 industrial back injury without the residual pain he now experiences. Toward that end, Claimant testified that he fully recovered. He offered as proof the facts that he was able to do heavy duty work without complaint, as corroborated by coworker and family member testimony.

122. The problem in this case is that Claimant's testimony as to his subjective experiences is unreliable. Specifically with respect to his back pain, he testified that he had no significant back issues following his 1997 surgery. Similarly, following his 2002 industrial injury, he told Dr. Shoemaker he had been symptom-free since his surgery and, when he finally disclosed that he had obtained medical attention for his back, he said it was for welfare purposes. Contradicting those assertions is Claimant's recorded history of post-surgical back and leg pain complaints. In 2000 he told Dr. Verska that he had pain in his back and both legs and that he has been on pain medication since his 1997 surgery. Also in 2000, he told Dr. Krafft that he had

back pain and circulating pains. He was treated for these conditions in 2000 on several different occasions. As discussed, supra, Claimant's language barriers are inadequate to fully explain his inconsistent reports.

123. In addition, Dr. Shoemaker concluded in 2003 that Claimant had a chronic back problem that has existed for a number of years. On discharge, Claimant was still reporting low back pain radiating into his left leg. Dr. Beaver also identified chronic pain markers preceding his 2005 injury.

124. The Referee finds Claimant was untruthful when he inaccurately reported he had no preexisting lumbar pain to Dr. Shoemaker in 2003. As a result, his testimony that he fully recovered from his 2002 back injury is unreliable and carries no weight.

125. Even so, the evidence establishes that Claimant did, indeed, do daily heavy lifting without significant complaint following recovery from his 2002 injury. Further, given his somatization, depression and anxiety issues, it is difficult to believe he was intentionally concealing pain symptoms during this time. The Referee finds Claimant did not have limiting pain after he recovered from his 2002 back injury through the time of his 2005 back injury. This does not necessarily mean, however, that Claimant was pain free or that he was no longer subject to medical restrictions.

126. Claimant's psychologists both identified symptom magnification, somatization issues, and workplace stressors as significant contributors to his pain presentation. In addition, Dr. Beaver posited that Claimant's cultural expectations about medical care, inapposite in the United States, could play a role.

127. Claimant did not seek additional treatment for his back pain until after he was laid off from Employer's, where he struggled for years with depression, anxiety and somatization

responses to his work place stress. Claimant's back pain may very well have intensified after his 2005 industrial injury. However, Claimant has failed to prove that his workplace accident is the cause.

128. In addition to Dr. Peck's report, Dr. Radnovich relies upon Claimant's assertion that he fully recovered from his 2002 back injury in formulating his PPI rating. Because Dr. Radnovich relied upon objective evidence that failed to establish a link between Claimant's symptoms and his MRI findings and subjective evidence that has been found to be not credible, his PPI rating is not authoritative. Further, there is insufficient evidence to establish that Claimant's back pain is related to his 2007 industrial head injury.

129. The Referee finds Claimant has failed to prove that his residual back pain is related to either his 2005 or 2007 industrial injuries.

Headaches.

130. As with his back pain, Claimant's headaches are not supported by objective evidence, so his subjective reports are the key to the compensability of his claim. With respect to his headaches, he testified that they began after his 2007 head injury. However, his prior medical records with Dr. Verska indicate a history of neck pain, and those of Dr. Krafft disclose a history of hay fever, asthma, headache, head trauma and multiple neurological problems. In addition, Claimant's head MRIs consistently identified chronic sinusitis, a known cause of headaches.

131. Dr. Beaver concluded that Claimant's headaches are not related to his 2007 mild concussion, and Dr. Calhoun's records indicate they are a result of his inability to effectively deal with his workplace stress.

132. Dr. Radnovich assessed a 1% whole person PPI rating to Claimant's headaches,

however, and Dr. O'Brien assessed 5%. Dr. Greenwald assessed 0%.

133. Claimant does not argue that Dr. O'Brien's assessment should be adopted. The Referee agrees that it should not because his findings assume Claimant is accurately reporting his current symptoms. The Referee declines to adopt Dr. Radnovich's PPI rating for the same reason.

134. The Referee finds Claimant has failed to prove his head pains are related to his 2007 industrial accident.

Dizziness/Vertigo.

135. Claimant has a history of dizziness as reported by Drs. Verska and Krafft. In addition, he intentionally manipulated the results of his Balance Master testing, on four occasions, rendering those results meaningless inasfar as a dizziness or vertigo diagnosis is concerned.

136. Dr. Beaver does not believe Claimant has dizziness or vertigo as a result of his 2007 head injury; neither does Dr. Greenwald.

137. Dr. O'Brien assessed 6% whole person PPI to Claimant's dizziness symptom, opining it to be the most concerning of those he evaluated. There is no evidence that he reviewed Claimant's vestibular treatment records prior to rendering his opinion. As discussed above, because Dr. O'Brien's opinion relies solely upon accurate reporting from Claimant to establish his dizziness, it is not authoritative.

138. The Referee finds Claimant has failed to prove he has residual dizziness/vertigo as a result of his 2007 industrial accident.

TMJ Pain.

139. At his first visit to a physician following his 2007 head injury, Claimant reported

TMJ tenderness adjacent to the area impacted by the falling object. It apparently resolved because the condition is not prominently addressed, if at all, in Claimant's subsequent treatment records.

140. Dr. Greenwald did not evaluate Claimant's TMJ pain in her highly detailed IME report of September 6, 2007, apparently because this was not an issue at the time. On September 14, 2009, however, Dr. O'Brien noted without further explanation that he detected jaw instability on exam and assessed 5% whole person PPI. Dr. Greenwald detected no jaw instability on September 28, 2010, explaining "…the patient had excellent glide and there is no subluxation or lateral slide and he can open his mouth without any difficulty and speak without any difficulty. Therefore I do not feel there is any permanent impairment in regards to his jaw or TMJ complaints at this point." Defendants' Exh. 16, p. 7. She further confirmed Claimant's CT scan was negative for fractures.

141. Dr. O'Brien fails to provide enough information about his finding of TMJ instability to rebut Dr. Greenwald's findings of mechanical and functional stability.

142. Although the surveillance video provides only a very brief window on Claimant's appearance during a very isolated period, it does establish by a preponderance that he was chewing gum for about a half hour during a period in which Claimant testified he had TMJ pain and trouble eating. Though insufficient on its own to establish the absence of such a condition, this evidence does tend to support that conclusion.

143. Claimant has failed to prove that his TMJ pain is related to his 2007 industrial accident.

144. Claimant may very well suffer the pains and difficulties to which he testified at the hearing. However, he has failed to prove that he has suffered any permanent partial

impairment as a result of either his 2005 or 2007 industrial accident.

Permanent partial disability.

The test for determining whether a claimant has suffered a permanent disability greater than permanent impairment is "whether the physical impairment, taken in conjunction with nonmedical factors, has reduced the claimant's capacity for gainful employment." *Graybill v. Swift & Company*, 115 Idaho 293, 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).

145. Because Claimant failed to prove he sustained any PPI as a result of his industrial accidents, a prerequisite to proving he suffered PPD, he has also failed to prove that he suffered any PPD.

146. However, the finding that Claimant has no ratable disability would abide even had it been determined that Claimant suffered some minor ratable impairment as a consequence of the subject accidents. There is no evidence that either the 2005 or 2007 accidents resulted in any limitations/restrictions in addition to those previously given to Claimant. The Referee appreciates that Claimant was evidently capable of working at a job that exceeded the limitations imposed by his treating doctors prior to the 2005 accident. However, such limitations are not intended to be a measure of what Claimant is physically capable of doing. Rather, they are prophylactic in nature, imposed to protect Claimant from future injury. That Claimant exceeded these limitations in his daily work does not therefore diminish their significance. The evidence establishes that Claimant's limitations following the 2005 accident are not significantly different than those he carried on a pre-injury basis. There is no credible evidence supporting the imposition of additional limitations following the 2007 accident. Therefore, the evidence does

not support an award of additional disability even if it were shown that Claimant had minimal impairments from the 2005 and 2007 accidents.

Medical Care.

Idaho Code § 72-432(1) obligates an employer to provide an injured employee reasonable medical care as may be required by his or her physician immediately following an injury and for a reasonable time thereafter. It is for the physician, not the Commission, to decide whether the treatment is required. The only review the Commission is entitled to make is whether the treatment was reasonable. *See, Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989). 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, 890 P.2d 732 (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).

147. Claimant raised this as an issue at hearing and tangentially mentioned it in his briefing. However, he has not presented any specific legal arguments to support his position. Further, there is inadequate evidence in the record to establish that Claimant requires further medical treatment as a result of either his 2005 or 2007 industrial injury.

148. All other issues are moot.

CONCLUSIONS OF LAW

1. Claimant has failed to prove that he is entitled to PPI benefits as a result of either his 2005 or 2007 industrial injury.

2. Claimant has failed to prove that he is entitled to PPD benefits as a result of either his 2005 or 2007 industrial injury.

3. Claimant has failed to prove that he is entitled to additional medical care as a result of either his 2005 or 2007 industrial injuries.

All other issues are moot.

RECOMMENDATION

Based upon the foregoing findings of fact and conclusions of law, the Referee recommends that the Commission adopt such findings and conclusions as its own and issue an appropriate final order.

DATED this __29th___ day of ___April____, 2011.

INDUSTRIAL COMMISSION

___/s/______________________________
LaDawn Marsters, Referee

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

ISMET KOSTJEREVAC, Claimant, v. OAK EXPRESS-Furniture Row, LLC, Employer, HARTFORD INSURANCE COMPANY OF THE MIDWEST, Surety, Defendants.	)	**IC 2005-002564** **IC 2007-014622** **ORDER** Filed May 16, 2011

Pursuant to Idaho Code § 72-717, Referee LaDawn Marsters 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 recommendations of the Referee. The Commission concurs with these recommendations. Therefore, the Commission approves, confirms, and adopts the Referee's proposed findings of fact and conclusions of law as its own.

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

1. Claimant has failed to prove that he is entitled to PPI benefits as a result of either his 2005 or 2007 industrial injury.

2. Claimant has failed to prove that he is entitled to PPD benefits as a result of either his 2005 or 2007 industrial injury.

3. Claimant has failed to prove that he is entitled to additional medical care as a result of either his 2005 or 2007 industrial injuries.

4. All other issues are moot.

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

DATED this _16th__ day of ___May____, 2011.

INDUSTRIAL COMMISSION

__/s/___________________________________
Thomas E. Limbaugh, Chairman

__/s/___________________________________
Thomas P. Baskin, Commissioner

__/s/___________________________________
R.D. Maynard, Commissioner

ATTEST:

___/s/______________________________
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __16th___ day of __May___, 2011, a true and correct copy of the foregoing **Order** was served by regular United States Mail upon each of the following persons:

JERRY J GOICOECHEA
P O BOX 6190
BOISE ID 83707-6190

W SCOTT WIGLE
P O BOX 1007
BOISE ID 83701

jkc __/s/_____________________________________