BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

IZET KRDZALIC, Claimant, v. JAYCO, INC., Employer, and SENTRY INSURANCE, A MUTUAL COMPANY, Surety, Defendants.	**IC 2008-020850** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** **FILED: 22 APRIL 2013**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Rinda Just, who conducted a hearing in Twin Falls, Idaho, on November 15, 2012. Patrick D. Brown of Twin Falls represented Claimant. Susan R. Veltman of Boise represented Defendants. Refik Sadikovic of Boise provided English to Bosnian and Bosnian to English interpretation. The parties submitted oral and documentary evidence, took post-hearing depositions, and submitted post-hearing briefs. The matter came under advisement on February 8, 2013 and is now ready for decision.

ISSUES

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

1. Whether the condition for which Claimant seeks benefits was caused by the industrial accident;

2. Whether Claimant's condition is due in whole or in part to a pre-existing and/or subsequent injury or condition;

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

   A. Medical care;

   B. Temporary partial and/or temporary total disability benefits (TPD/TTD);[1]

   C. Permanent partial impairment (PPI);

   D. Permanent partial disability in excess of impairment; and

4. Whether apportionment for a pre-existing or subsequent condition pursuant to Idaho Code § 72-406 is appropriate.

CONTENTIONS OF THE PARTIES

It is undisputed that Claimant injured his right elbow and permanently aggravated pre-existing degenerative conditions in his cervical spine as the result of a fall at work in June 2008.[2] Claimant's injuries necessitated a right ulnar nerve transposition and a four-level cervical fusion. Surety paid compensation for:

- Claimant's medical care related to his ulnar nerve and cervical injuries as performed or

[1] Claimant did not address the issue of TTDs in his opening or reply brief. As Defendants paid TTDs for periods that Claimant was off work prior to the time he was laid off by Employer, the Referee presumes that the issue of payment of past TTDs has been waived. An award of future TTDs is dependent upon a finding that Claimant needs additional medical care as a result of his injury.

[2] There is some discrepancy in the records as to the exact date of the injury. The discrepancy is immaterial to the resolution of this matter.

referred by treating physicians Douglas Stagg, M.D., David B. Verst, M.D., and Mark Wright, M.D;

- Temporary total disability (TTD) benefits from June 4, 2009 through November 5, 2010; and

- Permanent partial impairment (PPI) benefits based on a rating of 6.25 percent of the whole person.

It is also undisputed that sometime after his cervical fusion, Claimant developed symptoms in his right upper extremity (RUE) that are chronic and intermittent and involve painful spasms or "locking" of his RUE. The gravamen of this dispute is whether the RUE symptoms are relatable to the undisputed industrial injury.

Claimant asserts that the RUE symptoms that developed after his cervical surgery are relatable to his industrial accident; therefore, he is entitled to on-going medical care for his RUE symptoms. Claimant argues that he is also entitled to PPI benefits totaling 25% of the whole person without apportionment for his multiple industrial injuries. Finally, Claimant contends he has sustained permanent partial disability (PPD) of 75% to 90% inclusive of his impairment, all of which is attributable to the industrial accident.

Defendants argue that Claimant has failed to establish that it is more likely than not that his current RUE complaints are the result of his June 2008 industrial accident; therefore, he is not entitled to additional medical care related to the RUE complaints.

Defendants also assert that the Commission, as the ultimate evaluator of impairment should either:

- Strictly apply the *AMA Guides to the Evaluation of Permanent Impairment,* 6th ed. (*AMA Guides*) and rate Claimant's whole person impairment at 11% without apportionment; or

- Defer to Dr. Verst's medical opinions and impairment rating and his apportionment which results in 8.58% whole person impairment attributable to the accident.

Finally, Defendants concede that Claimant has sustained some disability in excess of his impairment, but argue that his disability does not exceed 50% inclusive of impairment. In particular, Defendants contend that Claimant's RUE complaints arose after his treating physicians determined he had reached maximum medical improvement from his industrial injuries, and that they are medically unrelated to his industrial injuries.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant, Anthony Sirucek, D.C., David Duhaime, and Cindy Weigel taken at hearing;

2. Claimant's exhibits (CE) A through BB admitted at hearing;

3. Defendants' exhibits (DE) 1 through 10 admitted at hearing; and

4. Post-hearing depositions of John D. Steffens, M.D., taken November 9, 2012,[3] Douglas Stagg, M.D., taken November 20, 2012, and David B. Verst, M.D., taken December 14, 2012.

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

FINDINGS OF FACT

BACKGROUND

1. Claimant, who is right-hand dominant, was sixty-three years of age at the time of hearing. He was born in Bosnia and completed twelve years of education, receiving a certificate to work as an electrician. Claimant served mandatory military service in Bosnia where he served

[3] Actually taken prior to the hearing, but denominated a post-hearing deposition for ease of reference.

as an electrician. Before immigrating to the US in 1996, he worked for a number of years selling uniforms for a manufacturer. Upon coming to the US, Claimant and his wife Djana settled in Twin Falls.

2. After his arrival in Twin Falls, Claimant worked for Charmac, a trailer manufacturer, for eight and a half years installing electrical systems. He left Charmac because he wanted work that was not so physically demanding.

3. Upon leaving Charmac, Claimant immediately went to work for Employer, also a trailer manufacturer. For the first two years, Claimant worked as an electrician for Employer. Employer then transferred Claimant to a job installing windows and doors. Claimant was installing a window on Employer's production line at the time of his accident in June 2008. At the time of the subject injury, Claimant earned $9.50 per hour plus production bonuses.

4. Claimant does not speak English, but his wife is fluent and sometimes serves as a Bosnian/English interpreter.

PRIOR MEDICAL

5. Claimant was generally healthy and suffered from no significant conditions and had no significant injuries prior to the industrial injury of June 2008.

6 About two years before the subject industrial injury, Claimant saw Dr. Verst over a two-month period for a low back complaint. Dr. Verst ordered physical therapy, and ultimately, a series of epidural steroid injections. Claimant made a complete recovery and had no further low back complaints.

THE ACCIDENT

7. On or about June 18, 2008, Claimant was installing windows in trailers at Employer's production facility. Claimant was climbing a ladder and carrying a framed window

assembly when he lost his balance and fell from the ladder. Claimant landed on his right side, still holding the intact window assembly.

MEDICAL CARE

Dr. Stagg

8. Claimant testified that the day he was injured, Employer took him to the emergency room for a drug test, then to Dr. Stagg's office. There are no ER records among the exhibits, and the first documented visit with Dr. Stagg was June 24, 2008. However, Claimant's testimony about the events of the day he was injured is not in dispute.

9. Claimant's June 24, 2008 visit to Dr. Stagg required the use of a telephonic interpretation service. The chart note is in error regarding the cause of Claimant's injuries.[4] Dr. Stagg's chart note for the visit records "[r]ight neck, shoulder, elbow, wrist, and hand pain, and some numbness." DE 6, p. 143. Claimant reported "radicular-type pain into the small and ring finger on the right, along with paresthesias in the same area." *Id.*, at p. 144. Dr. Stagg diagnosed right neck, shoulder, elbow, hand and wrist strains with right arm radiculopathy, and prescribed a prednisone taper and anti-inflammatories. Dr. Stagg was concerned that Claimant's radicular symptoms could be the result of an injured cervical disc, but did not want to pursue additional imaging until the steroids had an opportunity to work. Dr. Stagg imposed work restrictions that limited Claimant's lifting, pushing, and pulling to ten pounds or less. Claimant returned to work, and Employer made work available to Claimant that complied with his work restrictions.

10. On June 30, 2008, Claimant returned to Dr. Stagg for follow up. The prednisone had not helped with Claimant's complaints and he was still exhibiting hypesthesia in the C8

[4] Apparently, the description of the mechanism of injury was pulled into the current chart note from previous visits when Claimant had been having low back complaints. Dr. Stagg acknowledged the error during his deposition.

distribution on the right side. Dr. Stagg remained concerned about a possible herniated disc, and requested authorization for a cervical MRI.

11. The MRI showed multi-level degenerative disc disease and uncovertebral spurring, severe spinal canal stenosis at C3-4, C4-5, and C5-6, and moderate spinal canal stenosis at C6-7. The report described multiple areas of neuroforaminal narrowing and myelomalacia in the cervical cord at C4 and C5. Dr. Stagg referred Claimant to Dr. Verst for a consultation.

Dr. Verst

12. Claimant saw Dr. Verst on July 24, 2008. Following examination and review of the MRI, Dr. Verst diagnosed a herniated nucleus pulposus at C3-C4. However, because of the severe problems throughout Claimant's cervical spine, he could not repair the herniated disc without also fusing additional levels. Recognizing the significance of a four-level fusion, Dr. Verst advised that Claimant's condition was life altering, not life threatening, and that he would not consider surgery without first pursuing all available conservative treatments. Dr. Verst ordered physical therapy. A month later, Claimant's condition was unchanged, and Dr. Verst ordered a series of epidural steroidal injections (ESIs).

13. Dr. Verst saw Claimant again on October 30. The chart note indicates that the translaminar ESIs had been more helpful than the transforaminal injections, and Dr. Verst ordered repeat translaminar ESIs. When Claimant returned for follow up on January 22, 2009, he complained of elbow pain and a loss of muscle strength in his right hand. Dr. Verst observed atrophy of the thenar region of the right hand and a positive Tinel's sign at the right elbow. Dr. Verst ordered a RUE EMG/NCS, which showed severe ulnar nerve compression, but no evidence of cervical radiculopathy or myelopathy. Dr. Verst referred Claimant to Dr. Wright for

consultation on surgical ulnar nerve transposition.

Dr. Wright

14. Dr. Wright saw Claimant for the first time on April 15, 2009. After reviewing the EMG/NCS results and examining Claimant, he diagnosed cubital tunnel syndrome and recommended surgery:

> Given the EMG and nerve conduction results I believe he should undergo a [sic] ulnar nerve transposition. . . I have explained to his wife who has interpreted for her husband that I do not expect full recovery but I am trying to keep the nerve from continuing to be damaged. Hopefully, he will improve after the ulnar nerve transposition but I make no guarantees.

DE 8, p. 203.

15. Dr. Wright performed the ulnar nerve transposition surgery on June 4, 2009. Claimant's recovery from the surgery was uneventful, but Claimant reported no change in the numbness he experienced in his fourth and ring fingers. Objectively, however, Dr. Wright documented incremental improvement in Claimant's FDP (flexor digitorum profundus) tendon. On a follow-up visit on October 5, 2009, Dr. Wright noted that Claimant continued to complain of severe pain and a sensation of cramping in his right hand, noting, "He is overall not happy with the surgery." *Id.,* at p. 224. On exam, however, Dr. Wright noted improved function of the FDP tendon in the ring and small fingers and improvements in strength. Dr. Wright ordered a repeat EMG/NCS. At a follow-up visit on December 23, 2009, Dr. Wright noted that Claimant's EMG/NCS showed significant improvement in Claimant's ulnar nerve function, along with C7 radiculopathy without evidence of denervation. Claimant continued to report the constant pain in his lateral RUE.

16. Claimant returned to Dr. Wright again in January 2010, expressing frustration regarding the outcome of his ulnar nerve transposition surgery. Again, Dr. Wright noted

improvement in the FDP tendon, and improved strength in the right hand. Dr. Wright referred Claimant back to Dr. Verst for reevaluation of his cervical problems, as Dr. Wright had no additional treatment to offer Claimant for his ulnar nerve as the nerve was recovering uneventfully.

17. On September 13, 2010, Dr. Wright opined that Claimant was at maximum medical improvement as regards his ulnar nerve transposition. Dr. Wright calculated a permanent partial impairment rating for Claimant's ulnar nerve injury using the *AMA Guides.* Dr. Wright used Table 15-21 and a diagnosis of cubital tunnel release for ulnar neuropathy. He found a Grade I modifier based on EMG/NCS results, a Grade III modifier for his history, and a Grade III modifier for his functional studies. This resulted in an over-all Grade II modifier and a 5% upper extremity PPI, which converts to a 3% whole person impairment.

18. Claimant last saw Dr. Wright in July 2011. At that time, Claimant complained that he was losing strength in his fingers and he continued to have pain in his RUE. "Overall he is just not satisfied with his results." DE 8, p. 238. Dr. Wright offered to seek authorization from Surety to send Claimant for a second opinion to Dr. Lamey in Boise, whom he described as a well-respected hand surgeon.[5]

19. In late October 2011, Defendants contacted Dr. Wright to clarify whether Claimant needed any additional treatment or medications for his RUE. Dr. Wright responded by letter dated November 17, 2011:

> I am in receipt of your letter dated 25 October 2011, regarding [Claimant]. I am certain that you have reference to my chart notes. However, in terms of further

[5] Surety contacted Dr. Lamey and provided him with Claimant's medical records after which he declined to consult on Claimant's case. Surety attempted to arrange a consultation with Dr. Clawson and provided him with Claimant's medical records. Dr. Clawson also declined to see Claimant.

> surgery, I have nothing else to offer. I thought that I made that clear on his 25 July 2011 visit. The EMG/NCS that was done after the surgery showed significant improvement. He has never really been happy with this situation. It has not really gotten any worse in terms of pain and dysfunction, but it has not gotten to the point that he has been satisfied. He has a significant confounding situation wherein he has undergone neck surgery as well; which always makes these things more difficulty [sic] to tease out exactly what is causing the problem. In my opinion, his ulnar nerve has been released and is as good as it will be at this point.

Id., at p. 244.

Dr. Verst

20. Claimant returned to Dr. Verst on February 11, 2010. Dr. Verst noted the improvement in Claimant's ulnar nerve function following the surgery, but observed Claimant continued to report RUE pain with evidence of cervical radiculopathy. Dr. Verst ordered a cervical MRI. Claimant and Dr. Verst discussed the MRI results during an office visit on February 25, 2010. Dr. Verst described the MRI results as demonstrating a "large central disc rupture at C3 level that is causing spinal cord deformation along with myelomalacia at C4-5 and C5-6 level. In addition, there is also foraminal stenosis at 3-4, also significant narrowing of the central canal at C4-5 and C5-6 with foraminal stenosis." DE 7, p. 181. Dr. Verst recommended C3-6 anterior decompression with fusion and instrumentation.

21. Dr. Verst performed the four-level decompression with fusion and instrumentation on April 27, 2010. Aspiration pneumonia and a neck hematoma complicated Claimant's recovery. By September 2010, Claimant had completed his post-surgical physical therapy. He reported improvement in his neck, but was still complaining of weakness and numbness in his right hand.

22. Dr. Verst declared Claimant at maximum medical improvement on October 14, 2010. Dr. Verst used the *AMA Guides* to calculate a permanent impairment rating for Claimant's

injury. Dr. Verst used Table 17-2 and placed Claimant in class III based on multiple level altered range of motion with medically documented findings of persistent radiculopathy involving his upper extremity. Dr. Verst found the modifier for Claimant's functional history to be 4, his physical findings modifier to be 2 based on weakness and atrophy in his RUE, and his clinical studies grade modifier to be 2. Dr. Verst calculated Claimant's whole person impairment for his cervical complaints at 23%. Dr. Verst combined the cervical impairment of 23% with the ulnar nerve impairment of 3% for a combined value of 25% whole person impairment.

23. Dr. Verst opined that 75% of Claimant's condition related to his pre-existing degenerative disc disease and spinal stenosis, leaving Claimant with 10% whole person impairment related to his industrial accident. Dr. Verst noted that Claimant would require long-term pain management, and offered to provide pain management services to Claimant on a quarterly basis.

24. Dr. Verst imposed the following permanent restrictions:

- Occasionally to frequently: sit, stand, walk, climb, bend/stoop, kneel, crouch/squat, twist, reach above shoulder, and reach below shoulder;
- Continuously: grasp/handle, fine manipulation/fingering, operate foot controls, and push/pull 20 pounds;
- Continuously: lift/carry 0 to 10 pounds;
- Frequently: lift/carry 11 to 20 pounds;
- Occasionally: lift/carry 21-35 pounds;
- Rarely: lift/carry 36 to 100 pounds;

25. In late December 2010, Surety contacted Dr. Verst with some questions regarding his impairment rating. Surety noted that 75% of 25% impairment was actually 18.75%, which

would leave 6.25% whole person impairment related to the industrial accident (25.00 – 18.75 = 6.25). Dr. Verst agreed with Surety's calculation.[6]

Joseph Ippolito, M.D.

26. Dr. Ippolito, Claimant's primary care physician, treated Claimant following his release by Drs. Wright and Verst in fall 2010. Dr. Ippolito followed Claimant for both his industrial and non-industrial conditions. Claimant sought care from Dr. Ippolito for right arm pain on November 21, 2011. Claimant described "pain down his right arm and particularly weakness. He has weakness of his 1st and 2nd finger. His middle finger has relatively maintained strength but the 4th and 5th fingers of his right hand, he has weakness in flexion and extension of the hand and the arm." CE C, p. 125. Dr. Ippolito prescribed Tramadol and Neurontin and advised that if the medication did not moderate Claimant's pain complaints, it may be appropriate to have another neurological consultation with either Richard Hammond, M.D., or Dr.Steffens. A repeat EMG/NCS performed on December 13, 2012 showed no change from the prior testing ordered by Dr. Wright in late 2009.

27. Claimant returned to Dr. Ippolito in early February 2012 for a comprehensive exam. In the "Assessment" portion of his chart note, Dr. Ippolito noted: "Right arm pain with chronic ulnar neuropathy. He seems to be well controlled currently on Ultracet 1 tab t.i.d. and Neurontin 100 mg q.h.s. low doses, and this seems to be effective. He has a follow up with Dr. Steffens in the near future regarding this." *Id.*, at p. 129.

---

[6] Surety's calculation resulted in an improper apportionment of Claimant's 3% WPI for his ulnar nerve injury, since 25% impairment was a combination of the 3% ulnar nerve and the 23% cervical ratings. Using Dr. Verst's corrected calculation, and properly accounting for the ulnar injury which was not apportionable, Claimant's WPI related to his industrial injury was 5.75% (cervical) combined with 3% (ulnar nerve) for a combined value of 8.58 WPI attributable to the accident. (The formula for combining impairments—A + B(1-A) is set out at *AMA Guides,* p. 604.)

28. On April 25, 2012, Claimant saw Dr. Ippolito to review routine lab studies. Dr. Ippolitio's chart note states: "He continues to complain of intermittent right arm, forearm and hand *cramps*. It will last sometimes for 10 minutes or so. It will happen sometimes several times a day and he finds it quite painful." *Id.*, at p. 136 (emphasis added.) This is the first reference the Referee found that describes Claimant's RUE complaints as a cramp or a spasm that persisted for a period of time. Prior to this time, Claimant consistently reported pain in his arm and either numbness or tingling in his little and ring fingers. Dr. Ippolito suggested a neurological consultation with Dr. Hammond or Dr. Steffens.

Tony J. Sirucek, D.C., N.D, B.C.C.T., D. A. A. M. L. P.

29. On March 13, 2012, Claimant saw Dr. Sirucek, a chiropractor practicing in Twin Falls, for a functional capacity evaluation (FCE). It is not clear how Claimant came to see Dr. Sirucek. Dr. Sirucek performed a number of tests measuring range of motion, grip strength, pinch strength, and other functional measurements and analyzed them using a proprietary software program. Dr. Sirucek also reviewed Claimant's medical history. In the course of the FCE, Claimant experienced one of his RUE spasms that temporarily halted the testing. Testing resumed, and Claimant experienced a second RUE spasm. Dr. Sirucek described the spasm:

> [Claimant's] right arm and fingers developed continuous spasms (prolonged involuntary muscle contraction involving the 1, 2, 3 & thumb and also the 4 distal index finger) Claw like formation. Pain level 10 started sweating hands shaking extremely uncomfortable. Lasted for 20 minutes.

CE BB, p. 1290 (quoted *verbatim* including punctuation and capitalization errors). Dr. Sirucek resumed testing and Claimant experienced a second episode of RUE muscle spasms, so Dr. Sirucek terminated the FCE.

30. In his report, Dr. Sirucek opined, without explanation or citation, that based on the *AMA Guides*, he rated Claimant's whole person impairment to be 25%. Dr. Sirucek also

opined that Claimant had permanent disability of 75% (presumably inclusive of impairment). Dr. Sirucek did not apportion any of the impairment or disability.

Dr. Steffens

31. Claimant saw Dr. Steffens for the first time on May 21, 2012. Dr. Steffens recorded Claimant's relevant history:

> In roughly 2008, he was found to have an ulnar neuropathy on the right. He had an ulnar nerve transposition in 2009. He had a cervical surgery with decompression and fusion from C3 through C6 in April of 2010. *At some point subsequent to this, he began having recurrent sets of symptoms that he is describing.*
>
> He states that he has never had good function of his arms [sic] since the ulnar nerve. He states that he has always had numbness and pain in that area. After his neck surgery, *he is not certain of the interval,* he began having periods of spasming of the right arm. These were always triggered by activity. These became quite painful and his arms [sic] become "nonfunctional." It is because of these symptoms that he is seeking additional information.

DE 10, p. 263 (emphasis added).

32. On exam, Dr. Steffens reported:

> A focused exam reveals normal strength in the proximal musculature of his right arm. When I am doing the testing, he is hesitant to provide full effort and in fact, has give-way weakness, etc., but eventually I can coax him into providing full effort. When he does provide full effort, he has full strength in the shoulder adduction and shoulder abduction, elbow flexion and extension. I began attempting wrist flexion and extension testing and then he develops a spasm but he says it is quite painful. He develops a forcibly closed fist in the right hand, forced flexion of his arm in a hemiparetic posturing with cocontraction of triceps, biceps, a little bit of deltoid as well as his brachial radialis and all of the finger flexors of his hand. Oddly enough, he does not have much wrist flexion tightening. I can work him out of it over the course of about 2 minutes but he becomes a little bit diaphoretic as we go through this and he gradually loosens up. I would note that this event was triggered by my active intervention of testing of his motor strength.
>
> In between the spasm, he has normal reflexes and sensation proximally. Elbow sensation distally was limited to ulnar positioning of his hands. The rest of his neuro exam elsewhere in the body is completely normal.

Id., at p. 265.

33. Dr. Steffens diagnosed Claimant with "acquired focal torsion dystonia, kinesogenic," which he explained as, "for all intents and purposes what he has is a kinesogenic dystonia that is focal in nature and probably related to spinal cord injury related to his preexisting cervical stenosis." *Id.*, at p. 266. He prescribed baclofen and ordered a repeat cervical MRI.

34. Claimant returned to Dr. Steffens for follow up on June 20, 2012. Claimant reported that the baclofen had reduced his spells from "numerous spells per day to 2-3 spells per day." *Id.,* at p. 268. Dr. Steffens noted that half of the time spent with the patient was spent explaining the nature of the disease and various treatments. Dr. Steffens stated:

> Specifically I do not think that the ulnar nerve has anything whatsoever to do with this. I discussed the fact that neck surgery by itself had nothing to do with this. Discussed the fact that no specific injuries appear to have caused this, but this is probably a net result of the injury to his spinal cord from typical degenerative changes that necessitated his cervical surgery, now followed by the impact of age superimposed. This is just an aberrant circuit.

Id.

35. Claimant returned to Dr. Steffens in late August. Dr. Steffens wrote:

> He comes in today accompanied by his spouse who does the interpretation. He is very angry and frustrated with the situation, stating that he has been through many physicians and is upset that "somehow workman's [sic] comp got hold of my clinic notes despite the fact that they refuse to pay for my clinic visits." He goes on at length regarding his frustrations with his pain and allegations regarding its cause and effect. I spent a majority of the 35 minutes that the patient was in the room answering questions, trying to counsel him, and discussing the fact that at this juncture, my job is not so much to render an opinion as to why things are like they are so much as to treat them so that he has better quality of life. After extensive discussion in this regard, he finally relented and agreed to proceed with the treatment.

CE L, p. 35. Dr. Steffens reviewed Claimant's journal, noting that he was experiencing from one to five spells per day while taking 20 mg of baclofen for times per day. The spells lasted from

nine to thirty-five minutes. Dr. Steffens reduced Claimant's baclofen and added Tegretol and told Claimant to follow up in four to six weeks. This is the last chart note from Dr. Steffens.

David Christensen, M.D.

36. Claimant self-referred to Dr. Christensen at Intermountain Spine and Orthopaedics. Dr. Christensen saw Claimant on one occasion, July 2, 2012. Claimant's presenting complaint focused on uncontrolled spasms in the right arm and hand that last from five to fifteen minutes. Claimant reported that he had constant pain and weakness in his RUE following his industrial accident, along with numbness in the digits of his right hand, but that it was the spasms that were causing him the most problem. Dr. Christensen took a patient history, reviewed the May 2012 cervical MRI report, and examined Claimant. On examination of Claimant's right shoulder, he reported:

> Patient began experiencing very hard, rigid, almost tetanic contractions of multiple muscles in his shoulder, causing the right upper extremity to be contracted against the patient's chest wall, elbow flexed, and hand gripped tightly.

CE T, p. 1031. Dr. Christensen diagnosed causalgia with pain and spasming of multiple muscle groups in the RUE, reflex sympathetic dystrophy of the RUE, and cervical radiculitis. He suggested a trial of stellate ganglion injections with Clinton L. Dille, M.D. Claimant saw Dr. Dille on July 19, 2012 for evaluation of his neck pain and to consider a stellate ganglion block procedure. Dr. Dille performed the stellate ganglion block on July 24, 2012. Claimant returned to Dr. Dille for follow up on July 31, 2012, reporting minimal change in his neck and RUE pain as a result of the procedure. Dr. Dille recommended Claimant follow up with Dr. Christensen.

37. In late September 2012, Claimant presented at Pain Care Boise for an intake evaluation preparatory to stellate ganglion injections. The records do not indicate that Claimant returned for the procedure(s).

38. In late October, 2012, counsel for Claimant contacted Dr. Sirucek by letter. Counsel provided medical records generated after Dr. Sirucek saw Claimant, and posed a number of questions.[7] The additional records provided to Dr. Sirucek included those of Drs. Steffens, Christensen, and Dille.

39. Dr. Sirucek made a number of points in his November 2, 2012 letter to counsel:

- Prior to his industrial injury, Claimant has pre-existing degenerative disc disease, severe spinal stenosis, myelomalacia, and uncovertebral spurring. While those conditions were not caused by the industrial injury, the conditions "increased the susceptibility of the joint to more damage with less trauma." CE BB, p. 1332;

- From the date of the first MRI in February 2010 until the cervical surgery in late April of that year, medical records document pressure on the spinal canal from a ruptured disc at C3;

- Claimant's present diagnoses include: disc herniation with myelopathy, spasm and spastic hypertonia of right arm induced by trauma, post-cervical surgery syndrome, trauma-induced right arm dystonia, causalgia, and reflex sympathetic dystrophy;

- All of Claimant's current diagnoses are the result of the industrial injury and associated trauma to the nervous system;

- Claimant has permanent functional problems as a result of the industrial injury, and cannot return to the type of work he was doing at the time of the injury. In particular, Claimant has limited use of his right arm and hand; and

- Based on the *AMA Guides*, Claimant "has 25% permanent impairment and a 75% disability with no apportionment."

VOCATIONAL EVIDENCE

40. Following his June 2008 accident, Claimant continued working for Employer. Claimant was off work following his ulnar nerve transposition surgery, and following his cervical fusion. Surety paid TTD benefits during those periods. In early January 2011,

[7] The Referee was unable to locate counsel's letter to Dr. Sirucek in the hearing record. Dr. Sirucek did not restate counsel's questions in his response. Dr. Sirucek's answers will be discussed, but the questions remain a mystery.

Employer notified Claimant that it could not accommodate his permanent work restrictions, and terminated his employment.

41. David Duhaime, rehabilitation consultant for the Industrial Commission Rehabilitation Division (ICRD) offered vocational testimony at hearing, as did Claimant himself. Neither party retained outside vocational experts to provide opinions on Claimant's loss of labor market access and loss of wage earning capacity.

Claimant

42. Defendants deposed Claimant July 25, 2011. During his deposition he testified that in Bosnia he worked as an electrician in the telecommunication field and as a salesman for protective clothing. After coming to Twin Falls, he worked for Charmac, a trailer manufacturer, for eight years. Charmac built primarily metal trailers, and Claimant installed electrical systems. Claimant left Charmac and went to work for Employer because Employer built trailers primarily of wood, and it was easier to do the electrical installations in Jayco trailers. Claimant had no other relevant work experience or skills. Claimant testified that he does not use a computer and he does not speak English. Claimant was able to work in the trailer-manufacturing field because both companies employed other Bosnian workers and because electrical work is basically the same, regardless of the country, so he was able to work effectively without speaking English.

43. After Employer laid Claimant off, he worked briefly delivering newspapers. Claimant testified that the work was difficult because he could not lift heavy items, and that by the time he paid for the gas for his vehicle, he made very little money. Claimant applied for work through a temporary personnel agency, but the only work he got was some electrical work for the personnel agency. Because of the problems with his RUE, the job took him longer than it should have, and the agency did not call him back.

44. At hearing, Claimant's testimony about his vocational history was consonant with the testimony he gave at his deposition. He also testified that he had applied for or inquired about jobs at Charmac, Jayco, and as a school bus driver, all without success. Claimant had not looked for work since September of 2011. He did not believe that he could work because of his work restrictions, the pain in his RUE, and the frequent spasms of his RUE.

David Duhaime

45. Following Claimant's cervical surgery in the spring of 2010, Surety referred Claimant to ICRD for return to work and vocational assistance. Claimant's case was assigned to David Duhaime, an ICRD consultant with many years of experience in assisting injured workers in returning to work. The parties stipulated to Mr. Duhaime's qualifications.

46. Claimant and Mr. Duhaime met July 1, 2010 for an initial interview. Claimant's wife interpreted. Dr. Verst had not yet released Claimant to return to work at the time of their first meeting. Mr. Duhaime contacted Employer and set up a time to perform a job site evaluation and discuss return to work options for Claimant. Following the initial interview, Mr. Duhaime monitored Claimant's medical recovery.

47. Dr. Wright released Claimant *vis a vis* his cubital tunnel surgery on September 1, 2010 without restrictions. Dr. Verst released Claimant to return to work *vis a vis* his cervical surgery effective September 13, 2010, with permanent work restrictions as outlined previously in these findings. Mr. Duhaime provided the release and restrictions to Employer preparatory to discussing Claimant's return to work for Employer. On September 21, 2010, Employer advised Mr. Duhaime that it could not bring Claimant back to work at that time because of a work slowdown and Claimant's work restrictions. Employer advised that if Claimant improved and production increased, it might be possible for Claimant to return to work for Employer in the

future. On October 6, 2010, Surety advised Mr. Duhaime that Employer considered Claimant on a "leave of absence" while it evaluated whether it could accommodate Claimant's restrictions.

48. While awaiting a final answer about returning to work for Employer, Mr. Duhaime assisted Claimant in applying for unemployment benefits. On December 28, 2010, Employer contacted Mr. Duhaime and advised that it would not be able to employ Claimant. Claimant received a layoff letter from Employer in early January 2011.

49. Claimant and Mr. Duhaime remained in regular monthly contact (primarily through Mrs. Krdzalic) following his permanent layoff from Employer in January 2011. Mr. Duhaime and Mrs. Krdzalic discussed his unemployment benefits and Mr. Duhaime suggested that Claimant should look for employment with his wife's help. In mid-March 2011, Mrs. Krdzalic reported that Claimant was working delivering newspapers on a rural delivery route, and his unemployment benefits had terminated when he took the job. By the end of March, Mrs. Krdzalic reported that Claimant had not been able to manage the newspaper delivery work, even with her help, so that work would be ending in a couple of weeks.

50. Claimant, Mrs. Krdzalic, and Mr. Duhaime met in mid-April 2011 to discuss Claimant's vocational future. Mr. Duhaime suggested that Claimant might consider obtaining a commercial driver's license (CDL), possibly with some financial assistance from Surety, which would qualify him to drive vehicles for local care facilities or local transit companies. He also suggested that Claimant contact RV dealers to see if they had work repairing electrical systems on RVs available, as he was skilled at that work. In early May, Mr. Duhaime made inquires at a local truck driving school on Claimant's behalf.

51. In mid-May 2011, Mr. Duhaime prepared a labor market summary for Claimant. Mr. Duhaime considered the labor market to include Twin Falls and surrounding towns within

eighteen miles. Unemployment rates in the towns within the labor market ranged from a low of 8% to a high of 8.9%. Considering Claimant's transferrable skills, his restrictions, his lack of fluency in English, and his lack of office skills, Mr. Duhaime still found that suitable work was available in Claimant's labor market. Mr. Duhaime opined that Claimant's restrictions would limit him to part-time work unless he found a job that was sedentary or close to sedentary. Mr. Duhaime identified the following jobs that were available in Claimant's labor market, within his restrictions, and within his skill or learning ability: Motor vehicle operator (public transport), retail sales, demonstrator (food), amusement attendant, janitor or cleaner, and food prep (fast food).

52. After notifying Claimant's counsel of his intent, Mr. Duhaime closed the ICRD file on Claimant's case in mid-July 2011 for the reason that, "claimant is no longer benefiting from the services provided by the Industrial Commission Rehabilitation Division." CE B, p. 50.

53. Defendants called Mr. Duhaime as a witness at hearing. Under questioning by Defendants, Mr. Duhaime reaffirmed the information and conclusions contained in his case-file. He maintained that most of the jobs he had identified as suitable for Claimant in 2010 and 2011 remained suitable and available and within Claimant's restrictions, particularly if he worked part-time. At the close of questioning, counsel posed the following hypothetical to Mr. Duhaime:

> Q. [Ms. Veltman] If you assume, as a hypothetical, that somebody has the restrictions that Dr. Verst has placed on Mr. Krdzalic, but that they have a condition that involves a spasm of the arm and kind of puts them out of Commission [sic] for 20 minutes, 30 minutes at a time, as far as use of that extremity, knowing that or if you assume that's the case, which of these jobs would still be an option?
>
> A. I'd say none.

TR p. 126.

DISCUSSION AND FURTHER FINDINGS

CAUSATION

54. The Idaho Workers' Compensation Act places an emphasis on the element of causation in determining whether a worker is entitled to compensation.

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

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

55. The issue of causation lies at the very heart of this proceeding. Not only does it answer the question of whether Claimant is entitled to additional medical care, it also impacts the calculation of his impairment and disability. Once the issue of causation is decided, everything else falls into place.

56. It is important to recognize that Claimant had two separate and distinct problems with his RUE. Immediately following the industrial injury, and continuing to the time of the hearing, Claimant complained of generalized pain down the right side of his neck, across his right shoulder, and down the outside of his right arm. Claimant also complained of loss of strength (as evidenced by muscle atrophy observed on examination) and paresthesias in his fourth and fifth fingers of the right hand. All of these symptoms were *constant* and persisted

following both the ulnar surgery and the cervical fusion. Defendants do not dispute that these complaints relate to the industrial injury. For ease of reference, these symptoms are denominated as the *initial* symptoms or complaints. The condition that is the focus of this proceeding arose, according to Claimant's testimony, sometime *after* the cervical fusion. The symptoms were intermittent and involved his entire RUE locking up for a relatively short period of time (ten to twenty minutes). Dr. Steffens diagnosed the intermittent spasms as dystonia, and for ease of reference, that is how the symptoms at issue in the proceeding are denominated throughout the remainder of this discussion.

Onset and Diagnosis

57. Claimant was unable to identify with any precision when the dystonia began, though he consistently testified at hearing and in his deposition, and reported to physicians that the symptoms began *after* the cervical surgery. In his briefing, counsel for Claimant conflates the initial symptoms and the dystonia, citing to numerous chart notes where Claimant complained of the initial symptoms to support the proposition that the dystonia was present from the time of the industrial injury. That implication is not borne out by the record. A careful review of the medical records reveals that the first medical documentation of dystonia occurred during the FCE conducted by Dr. Sirucek on March 13, 2012, two years after Claimant's cervical surgery. A month later, on April 25, 2012, Dr. Ippolito reported the on-going dystonia complaints in his chart note.[8]

58. The Referee finds that Claimant's dystonia began in late winter or early spring of 2012 as documented in the medical records of Dr. Sirucek in March 2012.

---

[8] Although the chart note suggests Claimant made such complaints to Dr. Ippolito on prior visits, there is no mention of them in Dr. Ippolito's chart notes.

59. Dr. Steffens, a neurologist, was the only treating physician who focused solely on diagnosing and treating Claimant's dystonia. Drs. Verst and Wright had stopped treating Claimant for his herniated disc and his ulnar nerve respectively long before he began having the dystonia symptoms. Claimant saw Dr. Sirucek on one occasion for an FCE, not a diagnostic opinion, and self-referred to Dr. Christensen for a single documented visit in July 2012.

60. In his deposition, Dr. Steffens was careful to distinguish Claimant's initial symptoms from the new symptoms that started in early 2012. Those persistent initial symptoms he attributed to the ulnar nerve and cervical injuries that resulted from the industrial injury.

61. Dr. Steffens explicated his diagnosis: "So, basically, a dystonia is simply a condition where the muscles have abnormal tone. Okay? That's all that term means." Dr. Steffens' Depo., p. 6.[9] Dr. Steffens explained that dystonia can be primary or secondary—it is primary when dystonia is the problem, and secondary when dystonia is a symptom of another problem. He described Claimant's dystonia as secondary. DE 10, at pp. 21-22. Dr. Steffens went on to explain:

> It means that something has happened to him to make him have this. That's the acquired part of this. Okay? Focal means involves one limb or isn't a generalized dystonia. So it applies to the right arm. Okay? Kinesogenic applies to often triggered by movement.

Id., p. 32.

62. No other medical professional has provided any other supportable diagnosis of Claimant's RUE spasms. Dr. Christensen diagnosed RSD (reflex sympathetic dystrophy), also referred to in modern parlance as CRPS (complex regional pain syndrome). However, as discussed by Dr. Steffens in his deposition and Dr. Sirucek in his testimony, Dr. Christensen did

---

[9] At hearing, Dr. Sirucek agreed that dystonia is described in the medical literature as "a disorder that causes muscles in the body to contract and spasm involuntarily . . ." Tr., p. 93.

not document the existence of the signs or symptoms that are necessary for a diagnosis of CRPS, and both disagreed with Dr. Christensen on that diagnosis. Since Dr. Christensen is an orthopedist, saw Claimant on only one occasion, and did not support his diagnosis with objective medical findings, the Referee gives no weight to Dr. Christensen's diagnosis. Dr. Verst testified that he could neither confirm nor deny Dr. Steffens' diagnosis. Dr. Wright played no role in diagnosing or treating Claimant's dystonia. His chart notes make no reference to Claimant's dystonia-like symptoms, and he last saw Claimant in July 2011, some months before the dystonia symptoms manifested.

Cause of Claimant's Dystonia

63. And thus we arrive at the crucial question: What caused Claimant's RUE dystonia? Theories abound.

- Claimant asserts that the specific cause of his dystonia was compression of his spinal cord that occurred as a result of his industrial accident and evidenced in part by his myelomalacia;

- Dr. Steffens first opined that Claimant's dystonia was the result of his pre-existing degenerative cervical spine condition, and not related to the ulnar nerve injury or to the cervical surgery, and was not associated with a specific injury or event;

- Dr. Steffens later opined that "the abnormal circuitry that's necessary for somebody to develop dystonia is easily explained by a fall and subsequent [spinal] cord injury;" Steffens Depo., p. 14.;

- Dr. Steffens also testified that there were any number of possible causes for dystonia in general and Claimant's dystonia in particular, including the fall from the ladder, the myelomalacia, the degenerative condition of Claimant's cervical spine, normal wear and tear, stenosis, medications, and underlying disease processes that had not yet manifested, such as Parkinson's. *Id.*, p. 27;

- Dr. Verst testified that spinal cord trauma and compression are not known causes of dystonia, that true focal dystonia is very rare (Verst Depo., pp.18-19), and during the course of his treatment Claimant showed no clear signs of spinal cord compression; and

- Even Dr. Sirucek, the chiropractor retained to perform an FCE, threw in a causation opinion of sorts: " . . . it is my opinion that the injury dated June 18, 2008, at Jayco, was

the causation of his injury." CE BB, p. 1318.

Since Claimant carries the burden of proving a causal connection between the industrial injury and the subsequent onset of dystonia, this analysis begins with Claimant's theory of causation.

Cord Compression—Dr. Verst

64. Some definitions provide a starting point for this discussion. Dr. Verst explained that *myelomalacia* is:

> . . . the demyelinization of the spinal cord, and what that means is that the spinal cord has a sheath that surrounds it, and the name of that sheath is myelin. Myelin is an insulator for the spinal cord. It allows for transmission and electrical impulses to be sent throughout the spinal cord . . .
>
> If there's any disruption of the myelin, again, the outer sheath of the spinal cord, then it will slow down impulses that are being elicited by the brain to perform whatever function that's desired.

Verst Depo, p. 10. Dr. Verst further explained that myelomalacia is not typically caused by an acute event, but is progressive and often associated with spinal stenosis. Myelomalacia can be asymptomatic, as in Claimant's case. There is no treatment, but patients with myelomalacia are followed closely with regular radiographic scans. *Id.,* pp. 11-12.[10]

65. Dr. Verst explained that spinal *stenosis* is a narrowing of the spinal canal, but that stenosis is not synonymous with spinal cord compression and neurological deficits. "There are lots and lots and lots of people that walk around every day with spinal stenosis, absent neurological impairment." *Id.*, at p. 11.

66. Dr. Verst also discussed the terms myelopathy and radiculopathy: "So there are two terms that are floated around, particularly in the neurological spine world. One is

---

[10] No medical professional has suggested that Claimant's industrial accident caused his myelomalacia. It was present on the first MRI performed shortly after Claimant's accident and identified as pre-existing by Drs. Verst, Steffens, and Sirucek.

radiculopathy, which is a nerve that's pinched. The other is myelopathy, is [sic] when the spinal cord is compressed." *Id.*, at p. 9.

67. While Dr. Verst had released Claimant from care long before his dystonia symptoms manifested, he did treat Claimant's cervical injuries for a number of years, and performed Claimant's four-level fusion. As a board certified orthopedic spine surgeon who treated Claimant over a period of time, Dr. Verst is in an excellent position to discuss, explain, and opine regarding Claimant's cervical conditions both before and after his surgery. In his deposition, Dr. Verst testified clearly and persuasively on the following points:

- Because of the nature of Claimant's injury, and the evidence of pre-existing myelomalacia, Dr. Verst was concerned about the possibility of myelopathy or spinal cord compression;
- During the time Claimant was under Dr. Verst's care prior to his ulnar nerve surgery, he exhibited no evidence of myelopathy;
- Following the ulnar nerve surgery, Claimant exhibited only one sign or symptom that could be evidence of myelopathy, a positive Hoffman's sign, which was not sufficient to clearly identify a myelopathy*;*
- Prior to Claimant's ulnar nerve surgery, his symptoms were very specific for ulnar nerve entrapment. Following the transposition surgery Claimant continued to have symptoms that Dr. Verst "considered *radiculopathy* in its clearest sense." *Id.*, at p. 41.
- Claimant's radicular symptoms following his ulnar nerve transposition were consistent with those that would be associated with a herniation at C-3—the location of his herniated cervical disc.

68. The EMG/NCS testing performed in February 2009 and November 2009, support Dr. Verst's conclusions that Claimant did not have myelopathy or spinal cord compression over this period. The first test confirmed ulnar nerve neuropathy at the elbow, but no other muscle group. The second EMG/NCS, done after the cubital tunnel surgery, documented improvement in the ulnar nerve conduction but showed that a cervical radiculopathy without evidence of denervation had developed. The final study, done in December 2011 after the cervical surgery, showed Claimant continued to have ulnar nerve deficits, but confirmed that the cervical radiculopathy had resolved with the cervical fusion.

Cord Compression—Dr. Steffens

69. Dr. Steffens' initial causation opinion was that Claimant's dystonia resulted from his degenerative cervical conditions, and not the result of a traumatic injury or event. During his deposition he clarified that at the time he issued that opinion, he was not aware of Claimant's industrial accident. Thereafter, he stated that "dystonia is easily explained by a fall and subsequent cord injury." Steffens Depo., p. 14. Dr. Steffens also testified that the MRIs done in 2008 and 2010 were evidence of spinal cord compression during that interval.

70. It would not be accurate, however, to conclude that Dr. Steffens offered a causation opinion on a medically more likely than not basis in this case. In addition to his statement that Claimant's dystonia could easily have been caused by a fall, Dr. Steffens listed a number of other possible causes of dystonia that had nothing to do with Claimant's industrial injury—myelomalacia, the pre-existing degenerative condition of Claimant's cervical spine, normal wear and tear, stenosis, medications, and underlying disease processes not yet manifest.

71. Most importantly, Dr. Steffens clearly stated that he could not offer an opinion as to whether Claimant's dystonia was the result of trauma. If he could not state with any level of certainty that Claimant's dystonia was traumatically induced, then how is it possible to opine that the trauma of the industrial injury was more likely than not the cause of the dystonia? To state that dystonia could easily be caused by a fall is not the same as saying that the fall more likely than not caused the dystonia.

72. It is well settled in the workers' compensation arena that a medical causation opinion need not contain magic words or a particular verbal formula, so long as it "plainly and unequivocally conveys [the doctor's] conviction that events are causally related." *Paulson v. Idaho Forest Indus*., Inc., 99 Idaho 896, 901, 591 P.2d 143, 148 (1979), overruled on other

grounds by *Jones v. Emmett Manor*, 134 Idaho 160, 165, 997 P.2d 621, 625 (2000). Unfortunately for Claimant in this case, Dr. Steffens' opinion in no way conveys an unequivocal conviction that the industrial accident caused Claimant's dystonia.

73. After a careful reading of Dr. Steffens' chart notes and deposition testimony, the Referee finds that Dr. Steffens did not change his opinion about what caused Claimant's dystonia so much as he added to it. Initially unaware that any accident or acute trauma was involved, he assigned causation to Claimant's pre-existing degenerative cervical condition, including the stenosis and myelomalacia. After he learned of the industrial accident, he included the accident as one of many possible causes, but he never expressed an unequivocal belief that the accident was more likely than not the cause of the dystonia. Dr. Steffens could not state that Claimant's dystonia was the result of a trauma; it follows, then, that causation cannot be assigned to the industrial accident with any kind of reasonable medical probability.

74. Dr. Steffens' deposition was particularly useful in helping the Referee to understand Claimant's dystonia or dystonia-like symptoms, and he proved knowledgeable about the condition and its many causes. Dr. Steffens did not have the opportunity to see Claimant during the interval between his injury and his cervical surgery, so he is not in the best position to draw conclusions regarding Claimant's neurological condition during that interval, as is Dr. Verst. For these reasons, the Referee finds Dr. Verst's causation opinions more persuasive than Dr. Steffens'.

Cord Compression—Dr. Sirucek

75. Dr. Sirucek was not one of Claimant's treating physicians. His involvement in the case, apparently, was limited to developing evidence regarding Claimant's impairment and disability. In the course of his rambling and disjointed testimony, Dr. Sirucek touched on

matters of causation, but it is difficult to sift out a coherent analysis. There is a lot of chaff and not much wheat in Dr. Sirucek's testimony. After repeated readings, the Referee gleaned the following points relevant to the issue of causation:

- Dr. Sirucek explained that, from his perspective, dystonia was more of a description of symptoms than a diagnosis, so he preferred the term "dystonia-like symptoms" (Tr., p. 94);
- Prolonged pressure on the spinal cord or peripheral nerves can cause neurogenic damage (*Id.*, at p. 63);
- Dr. Sirucek believed Claimant suffered neurogenic damage to either his spinal cord or his peripheral nervous system that accounted for some of his symptoms (*Id.*, at p. 64);
- Dr. Sirucek could not be sure what was causing Claimant's dystonia (*Id.*, at p. 94);
- In his report, and in his narrative supplement, Dr. Sirucek did not parse Claimant's initial symptoms from his dystonia symptoms and concluded simply that Claimant's fall caused his symptoms.

76. The Referee finds that Dr. Sirucek did not offer an opinion as to the cause of Claimant's dystonia symptoms that was more persuasive than that offered by Dr. Verst. Based upon the medical opinions, the medical records, and the late onset of the dystonia symptoms, the Referee cannot find the requisite causal connection between Claimant's dystonia symptoms and his industrial injury. Claimant has failed to carry his burden of establishing medical causation.

MEDICAL CARE/TTDs

77. Having failed to establish a causal relationship between his dystonia and his industrial injury, the issues of medical care for the dystonia and TTD benefits during the related period of recovery are moot.

IMPAIRMENT

78. "Permanent impairment" is any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved and which abnormality or loss, medically, is considered stable or non-progressive at the time of the evaluation. Idaho Code § 72-422. "Evaluation (rating) of permanent impairment" is a medical appraisal of the nature and extent of

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

Ulnar Nerve

79. Dr. Wright awarded Claimant 3% whole person impairment for the ulnar nerve injury he sustained as a result of his industrial accident. This rating is undisputed, and apportionment is not an issue as Claimant had no pre-existing cubital tunnel condition. Claimant is entitled to whole person PPI of 3% related to the ulnar nerve injury.

Cervical Spine

80. Drs. Verst and Sirucek rated Claimant's cervical spine impairment. Both used the *AMA Guides*. Both doctors arrived at similar basic ratings, though each applied the *AMA Guides* differently. Where their final impairment ratings diverged, the differences were attributable to apportionment. First, a brief review of how each physician calculated impairment.

81. **Dr. Verst.** Dr. Verst placed Claimant in Class 3 of the cervical spine regional grid (*AMA Guides*, pp. 564-565). Rating using the *AMA Guides* begins with a diagnosis. Dr. Verst did not specify which diagnosis-based category he used, and two are potentially applicable. The *AMA Guides* require that the diagnosis mostly closely related to a claimant's condition be used. In this case, the diagnosis of disc herniation with alteration of motion segment integrity (AOMSI) more closely follows Claimant's diagnosis than the alternative diagnosis of stenosis. Class 3 ranges from 15% to 23% impairment. Dr. Verst applied grade modifiers and determined

that Claimant's whole person impairment for his cervical spine was 23%. Dr. Verst then combined the 3% ulnar nerve impairment with the cervical impairment for a combined whole person impairment of 25%.

82. Dr. Verst apportioned 75% of Claimant's impairment to his pre-existing cervical problems—stenosis, myelomalacia, and his degenerative condition. He explained that Claimant's only accident-related cervical injury was the C3 disc herniation. However, because of Claimant's pre-existing degenerative conditions, it was not possible to operate on C3 without also fusing the additional levels down to C7. Dr. Verst explained:

> C-4, C-5, C-6 were significantly degenerative in nature, and because of the profound—at these three levels, with myelomalacia slash scoliosis, spinal cord stenosis, facet joint arthropathy, degenerative disk disease, neuroforaminal stenosis, were all there prior to the injury, and as a result of these three levels of disease, I felt that the injury had nothing to do with this, and thus the 75 percent apportionment. So if you look, there's four levels. I fixed No. 3. The 4, 5 and 6, which were the other three levels, were already worn out. That's where the 25 percent of the acute injury comes from, C-3. The remaining three elements all preexisted, and therefore the 75 percent.

Verst Depo., pp. 15-16. As discussed previously, Dr. Verst should only have apportioned the cervical rating (23%) and not the 25% combined rating. Using his methodology, but correcting the math, results in 5.75% for cervical impairment combined with 3% relating to his ulnar nerve for a combined value of 8.58 WPI attributable to the accident.

83. **Dr. Sirucek.** Dr. Sirucek did not explain in his report how he calculated Claimant's impairment, though he did use the *AMA Guides*: "It is my opinion based on the 6th edition of the *AMA Guides* that [Claimant] has 25% permanent impairment . . ." CE BB, p. 1318. Dr. Sirucek did not discuss which, if any, grade modifiers he used in reaching his final impairment figure. Dr. Sirucek did not discuss Claimant's ulnar nerve impairment rating, so presumably his 25% PPI rating relates strictly to Claimant's cervical injury. During his

deposition, Dr. Sirucek stated that he had placed Claimant in Class 4 of the cervical spine regional grid, but was unable to provide to further explicate his rating process. He did testify that he considered Claimant's dystonia symptoms to be a sign of RUE radiculopathy.

84. Defendants disagree with both impairment ratings, arguing that the *AMA Guides* require documented signs of residual radiculopathy at a clinically appropriate level or levels at the time of examination in order to exceed a Class 1 designation. The *AMA Guides* define radiculopathy as:

> Any pathological condition of a spinal nerve root, most commonly compression with or without inflammation, or less frequently another disorder such as traction, tumor, or infection. Radicular symptoms may include pain, numbness, tingling, and/or weakness in distribution of the nerve root, usually involving an upper or lower extremity. Physical findings are weakness of the involved myotome (muscles innervated by the nerve root), diminution in or loss of the corresponding muscle stretch reflex (if any), diminished sensation in the appropriate dermatome (are of skin supplied by the nerve root), and/or positive root tension signs. As commonly used, and for purposes of the *Guides*, radiculopathy requires the presence of radicular physical findings, not just symptoms.

AMA Guides, pp. 613-614. The *AMA Guides* further explains:

> The diagnosis [of radiculopathy] requires clinical findings including specific dermatomal distribution of pain, numbness, and/or paresthesias. Subjective reports of sensory changes are more difficult to assess; therefore, these complaints should be consistent and supported by other findings of radiculopathy.
>
> * * *
>
> The identification of a condition that may be associated with radiculopathy (such as a herniated disk) on an imaging study is not sufficient to make a diagnosis of radiculopathy; clinical findings must correlate with the radiographic findings in order to be considered.

Id., at p. 576.

85. As discussed elsewhere in these findings, Claimant had no documented *cervical* radicular complaints after his cervical surgery. EMG/NCS testing done in December 2011 confirmed that Claimant's pre-surgical C7 radiculopathy resolved following the surgery, leaving claimant with RUE complaints that were related to his *ulnar nerve*.

86. A careful reading of Table 17-2 as it appears in pp. 36 and 37 of Clarifications and Corrections (http://www.ama-assn.org/resources/doc/bookstore/no-index/guides-sixth-clarifications.pdf) of the *AMA Guides*, makes it is clear that both practitioners erred in determining the appropriate class for evaluating Claimant's impairment. In order to qualify as Class 3 or 4, a claimant must have documented signs of residual radiculopathy at one (Class 3) or more (Class 4) levels. At the time of examination, Claimant did not have documented residual cervical radiculopathy.

87. Defendants assert that Claimant's condition places him in Class 1, with an impairment range from 1% to 8%. Using the diagnosis of herniation/AOMSI, the portion of the grid for Class 1 requires herniation or AOMSI at multiple levels *and* ". . . with documented *resolved* radiculopathy or *non-verifiable radicular complaints* at the clinically appropriate levels present at the time of examination." *Id.* The *AMA Guides* define non-verifiable radicular complaints as follows:

> Nonverifiable radicular complaints are defined as chronic persisting limb pain or numbness, which is consistently and repetitively recognized in medical records, in the distribution of a single nerve root that the examiner can name and with the following characteristics: preserved sharp vs. full sensation and preserved muscle strength in the muscles it innervates, is not significantly compressed on imaging, and is not affected on electrodiagnostics studies (if performed). Although there are subjective complaints of a specific radicular nature, there are inadequate or no objective findings to support the diagnosis of radiculopathy.

AMA Guides at p. 576. This definition accurately captures Claimant's medical condition—he had documented C7 radiculopathy before his surgery, but electrodiagnostics studies performed after the surgery were negative for cervical radiculopathy. Claimant's dystonia arose from conditions unrelated to his industrial accident, and though his initial subjective complaints persist, there are not adequate objective findings to support a diagnosis of cervical radiculopathy.

88. The Referee finds that Claimant's cervical impairment is 8% whole person, which is the top of the range for Class 1 impairments. Using the Combined Values Chart (*AMA Guides*, p. 604.) Claimant's combined whole person impairment resulting from the industrial accident is 11%.

APPORTIONMENT

89. Defendants acknowledge that Dr. Verst based his opinions on impairment and apportionment on his medical judgment which finds support in the medical evidence. Defendants concede that Dr. Verst's apportionment analysis does not comport with the elements set forth in the *AMA Guides*. Defendants urge the Commission, as the ultimate evaluator of impairment, to either accept Dr. Verst's rating and apportionment (8.58%), or to apply the *AMA Guides* in respect to both the rating and apportionment (11%). The Referee finds that applying the *AMA Guides* to determine both impairment and apportionment is the best approach for determining impairment—it is based on objective medical findings and promotes consistency in rating. Further, it provides the most favorable result for Claimant. It is a fundamental tenet of the *AMA Guides* that when more than one approach is available, the one that benefits the claimant the most is the one that should be used. Claimant's whole person PPI is 11% with none of it apportionable to Claimant's pre-existing conditions.

DISABILITY

90. The Idaho worker's compensation law defines a "disability" as "a decrease in wage-earning capacity due to injury or occupational disease, as such capacity is affected by the medical factor of physical impairment, and by pertinent nonmedical factors." Idaho Code § 72-102(11). A claimant's permanent disability rating is determined by appraising the combined effect of those medical and nonmedical factors on the "injured employee's present and probable

future ability to engage in gainful activity." Idaho Code § 72-425.

91. Defendants concede that Claimant likely has some permanent disability in excess of his impairment, but assert that it does not exceed 50% inclusive of impairment. Claimant argues that his disability inclusive of impairment is at least 75% but that 90% more accurately accounts for his decrease in wage earning capacity.

92. Dr. Sirucek is the only medical professional to rate Claimant's disability, which he determined was 75%. There are a number of factors that diminish the value of Dr. Sirucek's disability rating, including:

- His credentials and experience regarding the evaluation of disability are not of record;
- His knowledge of the Twin Falls labor market is not of record;
- He conceded that he was not familiar with Claimant's background, training, or education;
- His rating included Claimant's dystonia symptoms, which have been found not to be related to his industrial accident; and
- Claimant's subjective complaints regarding both his initial symptoms and his dystonia were a significant basis for Dr. Sirucek's opinion.

Dr. Sirucek offered no foundation for his disability rating either in his report or in his testimony at hearing. For these reasons, the Referee affords little weight to Dr. Sirucek's opinion as to Claimant's disability.

93. The only other expert providing testimony regarding Claimant's disability was Mr. Duhaime. Mr. Duhaime began working with Claimant in June 2010, after his cervical surgery, and before the onset of his dystonia. Although Claimant's age and limited English skills affected his employability, he had a strong employment history both before and after he came to the US. Mr. Duhaime reviewed the permanent restrictions imposed by Dr. Verst, and determined that Claimant could do sedentary work with respect to his standing/walking abilities and light work up to rare medium work with respect to his strength. Because Dr. Verst limited some of Claimant's activities to "occasionally-frequently," Claimant might be limited to part-time work.

94. Mr. Duhaime testified that, taking all of the relevant factors into account, he believed that Claimant had the physical ability to work and that there were a variety of jobs available to him within the area. Mr. Duhaime encouraged Claimant to obtain a commercial drivers' license, which would qualify him for jobs paying from $7.43 to $9.92 per hour. Although Surety offered to provide financial assistance for Claimant to obtain a CDL, Claimant took no action in that regard. Mr. Duhaime closed Claimant's ICRD file in July 2011 for the reason that ICRD services were not benefitting Claimant—he was not actively seeking work and applying for jobs.

95. Claimant's testimony about his work search was inconsistent, and showed an overall lack of effort to seek work even before the onset of his dystonia. His attempt at delivering newspapers was half-hearted, and his reasons for quitting were vague. Claimant testified that when he looked for work no one would hire him because of his disability, but affirmed that he told prospective employers (erroneously) that his lifting restriction was ten pounds (it was actually 10 pounds continuously, 20 pounds frequently, 35 pounds occasionally, and up to 100 pounds rarely).

96. The Referee finds that following his cervical surgery, there were jobs available to Claimant within the restrictions imposed by Dr. Verst. If Claimant worked full time at minimum wage, ($7.25/hour) his loss of wage earning capacity was 24% [(7.25-9.50) ÷ 9.50 = 24%]. If he could only work part-time, his loss of wage earning capacity was 62%. There is no evidence in the record regarding Claimant's loss of access to the labor market. The Referee concludes that Claimant sustained disability of 43% inclusive of impairment, as a result of his industrial injury and the resulting work restrictions imposed by Dr. Verst. This figure is the average of his wage loss for full-time work and half-time work.

APPORTIONMENT

97. Idaho Code § 72-406 provides for apportionment of disability less than total in cases where the degree or duration of a claimant's disability is increased or prolonged because of pre-existing conditions. In such circumstances, the employer is only liable for the additional disability caused by the industrial injury or occupational disease. The Commission has also determined that apportionment is appropriate where a subsequent condition or injury worsened Claimant's condition. See, *Mcintyre v. Walgreens,* 2010 IIC 0372. Idaho Code § 72-406, taken together with the Commission's interpretation clearly establishes a basic tenet of workers' compensation law: employers are only liable for that portion of disability that is attributable to the industrial accident; they are not liable for Claimant's pre-existing disability nor are they liable for additional disability that occurs subsequent to and is unrelated to an industrial injury.

98. Any additional disability that is attributable to Claimant's dystonia arose after he had been determined to be medically stable following the industrial accident. The medical evidence upon which the Referee's recommendations regarding causation and PPI rest do not include the dystonia symptoms. Therefore, there is no need for the Commission to calculate Claimant's total disability arising from both the industrial injury and the subsequent onset of dystonia and then apportion that disability between the two events. Thus, Claimant's disability is 43% inclusive of his impairment.

CONCLUSIONS OF LAW

1. Claimant has failed to carry his burden of proving that the industrial accident caused his dystonia;

2. Because Claimant has failed to establish a causal connection between his industrial accident and his dystonia, he is not entitled to additional medical or time-loss benefits.

3. Claimant's whole person impairment related to his industrial accident is 11%, which includes 3% for his ulnar nerve injury, combined with 8% for his cervical injury.

4. Claimant has sustained disability inclusive of his impairment of 43% related to his industrial accident.

5. There was no need to calculate whether Claimant's dystonia resulted in additional disability because the subsequent onset of symptoms was unrelated to his industrial injury. The 43% disability inclusive of impairment represents the total amount of disability attributable to the industrial injury without need for apportionment.

RECOMMENDATION

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

DATED this 10 day of April, 2013.

INDUSTRIAL COMMISSION

/s/_____
Rinda Just, Referee

ATTEST:

/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 22 day of April, 2013, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSION OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

PATRICK BROWN
335 BLUE LAKES BLVD N
TWIN FALLS ID 83301

SUSAN R VELTMAN
1703 W HILL RD
BOISE ID 83702

kh /s/_____

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

IZET KRDZALIC, Claimant, v. JAYCO, INC., Employer, and SENTRY INSURANCE, A MUTUAL COMPANY, Surety, Defendants.	**IC 2008-020850** **ORDER** Filed April 22, 2013

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

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

1. Claimant has failed to carry his burden of proving that the industrial accident caused his dystonia;

2. Because Claimant has failed to establish a causal connection between his industrial accident and his dystonia, he is not entitled to additional medical or time-loss benefits.

3. Claimant's whole person impairment related to his industrial accident is 11%, which includes 3% for his ulnar nerve injury, combined with 8% for his cervical injury.

4. Claimant has sustained disability inclusive of his impairment of 43% related to his industrial accident.

5. There was no need to calculate whether Claimant's dystonia resulted in additional disability because the subsequent onset of symptoms was unrelated to his industrial injury. The 43% disability inclusive of impairment represents the total amount of disability attributable to the industrial injury without need for apportionment.

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

DATED this _22nd_____ day of ___April_____, 2013.

INDUSTRIAL COMMISSION

/s/_____
Thomas P. Baskin, Chairman

/s/_____
R.D. Maynard, Commissioner

/s/_____
Thomas E. Limbaugh, Commissioner

ATTEST:

/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 22nd___ day of ___April_____, 2013, a true and correct copy of the foregoing **FINDINGS, CONCLUSIONS,** and **ORDER** were served by regular United States Mail upon each of the following persons:

PATRICK BROWN
335 BLUE LAKES BLVD N
TWIN FALLS ID 83301

SUSAN R VELTMAN
1703 W HILL RD
BOISE ID 83702

kh /s/_____