BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

DEBBRA MORRIS, Claimant, v. U.S. BANK, Employer, and OLD REPUBLIC INSURANCE CO., Surety, Defendants.	**IC 2008-027719** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **Filed May 24, 2012**

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 Coeur d'Alene, Idaho on December 15, 2010. Starr Kelso of Coeur d'Alene represented Claimant. Eric S. Bailey of Boise represented Defendants. The parties submitted oral and documentary evidence and took three post-hearing depositions. Both parties filed post-hearing briefs. The matter came under advisement on December 3, 2011 and is now ready for decision. The undersigned

Commissioners have chosen not to adopt the Referee's recommendation and hereby issue their own findings of fact, conclusions of law, and order.

ISSUES

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

1. Whether Claimant has complied with the notice limitations set forth in Idaho Code §72-448;

2. 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); and

   C. Attorney fees.

After reviewing the record and the briefs of the parties, it appears that this proceeding also poses a predicate issue of compensability. The Commission cannot reach the issue of entitlement to medical care unless and until it determines that Claimant has a compensable occupational disease. See, *Gomez v. Dura Mark, Inc.*, 2012 Opinion No. 44, (March 5, 2012).

CONTENTIONS OF THE PARTIES

Claimant asserts that as a result of her work as a customer service representative at Employer's call center, she acquired an occupational disease involving her wrists, hands, and thumbs. Claimant avers that she notified Employer of her occupational disease the same day that she learned of her diagnosis. She claims entitlement to medical care, which Defendants have denied, TTD benefits for a period of time that she was off work due to restrictions, and attorney fees for unreasonable denial of her claim.

Defendants assert that no physician has diagnosed Claimant with an occupational disease of her wrists, hands, and thumbs on a more-likely-than-not basis. If Claimant does suffer from an occupational disease, it became manifest many years before Claimant went to work for Employer. Claimant received short-term disability benefits while she was off work due to her alleged hand, wrist, and thumb complaints, so she is not entitled to TTD benefits. Because Employer is not liable for Claimant's alleged occupational disease, it cannot be responsible for attorney fees on a properly denied claim.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant, taken at hearing;

2. Claimant's exhibits A through Q, admitted at hearing;

3. Defendants' exhibits 1 through 17, admitted at the hearing, with the following exceptions, which the Referee strikes, *sua sponte*, as being irrelevant in the extreme:[1] The Commission finds no reason to disturb the Referee's evidentiary rulings.

- Exhibit 1: Pages 1 through 36, and 38 through 72;
- Exhibit 2: Pages 77 through 81;
- Exhibit 4: Page 85;
- Exhibit 5: Pages 86 through 89; and
- Exhibit 6: Pages 90 through 91;

Along with the following duplicates within Defendants' records:

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[1] These extraneous medical records were not only irrelevant, but were intensely private in nature, and should never have become a part of the record in this matter. It was inappropriate for Defendants to offer them in evidence, and incomprehensible that Claimant did not object to exhibits that are clearly beyond the pale in this particular case. The Referee also notes that each party submitted a number of duplicate records, including those from Drs. Sturges, Borsheim, and Emry, along with records from providers such as Pinnacle Physical Therapy. Oddly, neither set of Dr. Sturges' records contained in the exhibits was complete; however, the *third* set of Dr. Sturges' records, admitted along with his deposition, was.

- Pages 97 through 99;
- Pages 104 through 106;
- Pages 110 through 113;
- Pages 115 through 120; and
- Pages 128 through 122.

4. Post-hearing depositions of Peter Jones, M.D., taken by Claimant on May 15, 2011; John Sturges, M.D., taken by Claimant on May 13, 2011; and Craig Stevens, M.D., taken by Defendants on June 22, 2011.

During the course of Dr. Stevens' deposition, Defendants asked a number of questions relating to information that Dr. Stevens could only have obtained post-hearing. Claimant interposed objections to such questioning, the first appearing at page 9, on the grounds that J.R.P. 10(E)(4) prohibits expert testimony regarding evidence developed post-hearing. In particular, Defendants sought to obtain Dr. Stevens' opinion concerning the post-hearing depositions of Drs. Sturges and Jones. Claimant's objection to such testimony is sustained.

FINDINGS OF FACT

BACKGROUND

1. At the time of hearing, Claimant was forty-two years of age, unmarried, and resided in Hayden, Idaho, with the youngest of her three daughters.

2. Claimant graduated from high school, and had some training as a medical assistant. Claimant's work history includes experience as a night auditor at a hotel, minting coins for Sunshine Minting, and as a customer service representative for Employer, where she remained employed at the time of hearing.

RELEVANT PRIOR MEDICAL HISTORY

3. In late March 2002, while Claimant was working for Sunshine Minting, she presented at North Idaho Family Physicians, LLC (NIFP), complaining of:

> . . . right hand pain for the past 24 hours. She has had problems with some wrist discomfort on and off for the past 8 years but has not had a problem with this over the last several months until yesterday.

DE 1, p. 73. Claimant attributed the wrist pain to lifting and transferring heavy lots of coins into a sorting bucket in the course of her work at Sunshine Minting. The chart note for the visit states:

> Exam of the right hand reveals no visible swelling or thenar atrophy. There is tenderness over the thenar eminence extending down to the central portion of the volar wrist. Tinel's sign is negative but on Phalen's maneuver there is some tingling in the 3rd digit.

Id. The treating physician diagnosed "mild carpal tunnel *symptoms*," (emphasis added) and prescribed a splint, ice, and stretching exercises. Claimant was advised to avoid repetitive motion activities at work for five days and return for recheck in a week. There are no follow-up notes regarding this complaint.

4. In May 2003, while working at Sunshine Minting, Claimant presented at Kootenai Medical Center complaining of an injury to her left hand that occurred while she was lifting a thirty-pound tub of metal pieces. As she poured the metal pieces, she experienced acute left hand pain over the fifth distal metacarpal and proximal phalanx. Claimant denied blunt trauma, numbness, or tingling. The treating physician observed some swelling and ordered an x-ray, which was negative. He diagnosed a left hand sprain, and advised Claimant to rest the hand for the next three days.

5. In late December 2003, Claimant presented at NIFP complaining of neck pain that had persisted for eight days. She denied numbness or tingling. On exam, Claimant's neck was normal with some diffuse tenderness and spasm in the paracervical muscles. The treating physician diagnosed neck pain secondary to strain. He prescribed medication and recommended follow-up with her primary care physician if her symptoms did not improve within a week.

CLAIMANT'S JOB

6. Claimant started working for Employer in June 2005. At all times relevant to this proceeding, she worked in customer service. Claimant's first position was in consumer credit, where she provided customer service to bank patrons regarding their personal credit card accounts. In November 2005, Claimant switched from personal credit card accounts to business credit card accounts, and thereafter served Employer's business customers regarding their business credit accounts.

7. Claimant performed her job at a corner workstation with a CPU, monitor, keyboard, mouse, filing cabinet, and phone. Her monitor was on the desk atop the CPU. Her ergonomic keyboard and a standard mouse (with right and left click functions) sat on the desktop with the mouse and the phone to the right of her keyboard. Claimant's file cabinet was on her left. Claimant used a telephone headset for calls. Claimant's forearms rested on her desk without foam or gel wrist rests.

8. Claimant used all of the digits on both of her hands for general keyboarding, and all of the digits on her right hand when operating the keyboard number pad. Claimant did not do production typing, but she was keyboarding, using the number pad, and using the mouse constantly throughout her eight-hour workday. Claimant handled between ninety and one hundred twenty calls per eight-hour workday. That means each call lasted, on average, three-and-three-quarters minutes to five minutes. During each call, Claimant would be required to use her mouse and keyboard to navigate through a number of different screens, key in account numbers (approximately twenty-one digits, including the account number, expiration date, and security code), and then access or input additional information related to the call, including names, addresses, or social security numbers.

9. In February 2008, Claimant's physical therapist suggested ergonomic changes to Claimant's work station, and provided Claimant a graphic depicting an ergonomically correct workstation. In March 2008, Dr. Sturges wrote a prescription for an ergonomic assessment of Claimant's workstation. In late February 2008, Claimant began working with Carol Jenks, rehabilitation consultant for the Industrial Commission Rehabilitation Division (ICRD). In mid-April 2008, Ms. Jenks visited Claimant's workplace and recommended changes to Claimant's workstation, based on an OSHA checklist. Ms. Jenks' ergonomic assessment was not included in the exhibits. The general nature of the recommendations is gleaned from testimony and other materials that are a part of the record and include lowering the monitor, providing wrist pads and a lumbar support, and installing a keyboard tray. Claimant testified that Employer acted quickly to lower the monitor by relocating the CPU and placing the monitor on the desk. However, other recommended changes were not implemented for nearly a year. Once the recommended changes were in place, there was no further review to make adjustments and assure that all of the recommendations resulted in an ergonomic workstation. Claimant testified that about the time Employer provided all of the recommended ergonomic changes, she changed jobs and moved to a different workstation, but that the necessary ergonomic adjustments did not follow her to the new workstation.

OCCUPATIONAL DISEASE

10. Sometime in August 2007, Claimant began to notice aching in both her wrists that traveled down into her fingers. The symptoms were worse in her right hand. Claimant's symptoms worsened over the ensuing months, and by late in 2007, the pain in her right upper extremity had moved up her arm to the shoulder, under her arm and into her neck. Claimant's symptoms were most noticeable when she was at work and using her hands. Away from work

her symptoms diminished, although some activities, such as vacuuming, aggravated them.

MEDICAL CARE

Dr. Esau

11. On January 11, 2008, Claimant presented at the offices of her primary care provider (PCP) complaining of pain in both hands, mainly in her thumbs, that had been persistent for eight months. She reported to Arlie Esau, M.D., that the pain was worse at the end of her workday. On exam, Dr. Esau noted that both MCP joints were tender and there was tenderness with passive flexion on the right. Dr. Esau diagnosed repetitive strain injury and prescribed an anti-inflammatory and physical therapy. He also suggested that Claimant "request a position where she is not doing the same work with her hands and if necessary, she may need to consider changing jobs." DE 2, p. 37.

Dr. Emry

12. Claimant notified Employer that she had a work-related repetitive strain injury, as diagnosed by Dr. Esau, on January 11, 2008. Employer advised Claimant that she was required to see Employer's occupational medicine provider, which happened to be the after-hours urgent care clinic of NIFP (hereinafter NIFP-OM). On January 22, 2008, Claimant saw Geoffrey T. Emry, M.D., at NIFP-OM. Dr. Emry's chart note states:

> She describes as pain at the base of the left [*sic*] thumb on the right side which is her dominant.[2] The pain even radiates up into the elbow and shoulder. It hurts only when she is at work and not on the weekends. She has been taking Mobic periodically and she isn't sure if it is helping.

DE 7, p. 92. On exam, Dr. Emry described Claimant's left thumb as grossly normal with good range of motion, normal sensation, and normal pulse. Claimant localized the pain to the base of

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[2] Claimant is right-hand dominant.

the thumb. Claimant's right thumb was also grossly normal with good range of motion, sensation, and pulse. The pain in Claimant's right upper extremity radiated up into the shoulder. Dr. Emry diagnosed bilateral thumb strain. He continued Claimant's anti-inflammatories, prescribed physical therapy, and imposed work restrictions.[3]

13. Claimant returned to Dr. Emry for follow-up on February 5, 2008. Claimant advised Dr. Emry that her condition had not improved appreciably since her initial visit. She had not been able to return to work because of the restrictions he imposed; she had been to physical therapy twice, and thought that the therapy and the Mobic might be helping somewhat. On exam, Dr. Emry noted tenderness along the tendons on the volar surface and the base of her left thumb. Dr. Emry diagnosed bilateral wrist strain, continued Claimant's work restrictions, and suggested following up in two weeks. If Claimant was not showing improvement by that time, he suggested imaging might be appropriate, along with a referral to a specialist.

14. Claimant returned for follow-up care on February 19, 2008. She reported that her right hand had improved, but there had been no change in the symptoms in her left. Dr. Emry ordered x-rays of the left wrist, which were normal. He diagnosed bilateral wrist strain and continued Claimant's work restrictions.

15. Claimant next returned to Dr. Emry on March 4, 2008. She reported that her left wrist was unchanged and that her right wrist was still sore, "but maybe is a little bit better." *Id.*, at p. 121. Dr. Emry continued Claimant's work restrictions and referred her to Peter Jones, M.D., a hand specialist, for further evaluation.

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[3] The record did not include documentation of Claimant's work restrictions related to this visit. However, on a subsequent visit, the continued restrictions are noted as: no lifting over five pounds, no hand, wrist/arm work and no fine manipulation.

16. On March 4, 2008, Dr. Emry responded to a February 11, 2008 letter from Surety's third party adjuster (TPA). He referred the TPA to his chart notes, particularly noting:

> [Claimant's] objective findings to support her diagnosis of bilateral thumb strain including pain at the site of tendon insertion, the objective findings to support severe restricted use of her right hand are the nature of chronic overuse type injury and accepted treatment protocol.

DE 7, p. 124. Dr. Emry reiterated that he had performed diagnostic testing and x-rays before reaching his diagnosis. He concluded by opining that Claimant's prognosis was positive with regard to her right hand, but he was more guarded about her left hand as it had been slow to respond to therapy—thus his referral to Dr. Jones.

Dr. Stevens

17. On March 13, 2008, Claimant saw J. Craig Stevens, M.D., for an independent medical evaluation (IME) ordered by Defendants. Dr. Stevens' review of Claimant's medical records was limited to the March 29, 2002 note discussed in paragraph 3, the December 29, 2003 note discussed in paragraph 5, and Dr. Emry's notes. In addition to reviewing the medical records, Dr. Stevens took a patient history and conducted an exam. Claimant provided a history that was consistent with those she provided to Drs. Esau and Emry. Dr. Stevens asked a number of questions about Claimant's work, endeavoring to ascertain whether there was anything unusual about her work that might cause her symptoms.

18. On examination, Dr. Stevens concluded that Claimant's right hand was normal in all respects except for tenderness to palpation over the CMC joint of the thumb. Dr. Stevens noted that percussion over the carpal tunnel produced a complaint of pain, but no electric-type sensations and, thus, was not a positive Tinel's sign. Similarly, Claimant's right wrist and forearm were normal in range of motion, grip strength, and pincer strength. Upper arm reflexes were brisk and symmetric, but sensory exam suggested "global hypesthesia of the proximal

portion of the right arm relative to the left, not confined to a distinct dermatome." DE 9, pages not numbered. Dr. Stevens also found Claimant's left upper extremity normal in all respects.

19. Because of Claimant's complaints of volar wrist pain, Dr. Stevens conducted bilateral median nerve latency testing "to rule out carpal tunnel syndrome as a contribution to her current symptoms." *Id.* Dr. Stevens concluded that Claimant's "latencies are well within normal limits and rule out effective electrodiagnostics criteria of carpal tunnel syndrome." *Id.*

20. Following the exam, Dr. Stevens dictated his impressions of Claimant and her condition and answered questions posed by Surety. Dr. Stevens raised "significant concerns in regard to this Claimant's presentation." *Id.* The first of Dr. Stevens' concerns was that Claimant's pain came on gradually and was not associated with any specific event. Second, Dr. Stevens did not believe that Claimant's description of her work revealed "any unusual use of the thumb sufficient to cause a work-caused condition." *Id.* In particular, he noted that in keyboarding, there is minimal use of the thumb.

21. Dr. Stevens concluded that Claimant's complaints of thumb pain "are of spontaneous onset and may possibly relate to low-grade CMC osteoarthritis based on her description of pain and tenderness over the CMC joint." *Id.* Dr. Stevens concluded by noting that he ordered a right hand x-ray to try and establish a diagnosis for Claimant's pain at the base of her right thumb.

22. Dr. Stevens opined that, given a normal objective examination of both upper extremities and a normal neurologic examination, he could make no diagnosis for Claimant. In short, there was nothing wrong with Claimant that could give rise to a workers' compensation claim. Dr. Stevens opined that Claimant required no further treatment, had no restrictions, and suffered no permanent impairment.

23. Surety, relying on Dr. Stevens' report, denied Claimant further care. It appears that Claimant returned to her time-of-injury position around the end of March 2008.

CONTINUING CARE

24. On March 16, 2008, Claimant presented at NIFP-OM for the x-rays that Dr. Stevens had ordered. Claimant saw Dr. Sturges. Noting that this was the first time he had seen Claimant for her hand and wrist complaints, Dr. Sturges reviewed Claimant's history and examined her hands and wrists. On exam, he appreciated tenderness over the right lateral epicondyle with no tenderness on the left. Claimant described an aching sensation in her forearms and over the thenar eminence of the right thumb, but there was no frank tenderness. Claimant's right thumb was tender along the MCP joint, but she maintained good pinch strength. Dr. Sturges diagnosed repetitive wrist strain, right greater than left, and early CTS. He ordered the x-rays, recommended Claimant see a surgeon, and suggested Claimant tape her hand at night to alleviate the CTS symptoms.

25. Claimant had right wrist and hand x-rays on March 17, 2008. They were read as normal.

26. Claimant saw Mark Borsheim, M.D., one of the physicians at her primary care clinic, on April 24, 2008. The chart note for the visit reviewed her initial visit with Dr. Esau, referral to Dr. Emry and eventually leading to a referral to Dr. Jones. Before Claimant could see Dr. Jones, Dr. Stevens opined that Claimant had no compensable injury and Surety terminated benefits. Claimant was still having the same problems with pain in her hands, so Dr. Borsheim referred her, once again, to Dr. Jones.

27. Claimant saw Dr. Jones, a hand surgeon, on May 9, 2008. Dr. Jones examined Claimant and opined:

> This patient has bilateral upper extremity pain, however I don't think she has a hand surgical problem. I don't think the patient has carpal tunnel syndrome *at this time.* Her symptoms do not localize to an area which would suggest a specific tendinitis.

CE L, p. 65 (emphasis added). Dr. Jones suggested that Claimant consult with a rheumatologist if her symptoms persist and anti-inflammatories do not control her pain. He further noted that should Claimant develop progressive numbness in her hands, then he would recommend nerve conduction studies.

28. Claimant continued to see Dr. Borsheim regarding her hand and wrist complaints in June and August 2008. On October 1, 2008, Claimant saw Linda Sakai, M.D., a rheumatologist, on referral from Dr. Borsheim. Dr. Sakai examined Claimant and ordered x-rays. Neither the exam nor the imaging showed evidence of arthritis in Claimant's hands and wrists.

29. In May 2009, James Lea, M.D., conducted an EMG/nerve conduction study on Claimant's upper extremities. The results were within normal limits.

30. In late July 2009, Dr. Borsheim referred Claimant to James C. Bonvallet, M.D., a thoracic and cardiovascular surgeon, for a consult to see if Claimant's upper extremity pain was the result of thoracic outlet syndrome. Dr. Bonvallet opined that Claimant's hand and arm symptoms were not the result of thoracic outlet syndrome, and recommended a cervical/upper thoracic MRI to identify the etiology of Claimant's symptoms.

31. In late September 2009, Claimant sought to establish a doctor/patient relationship with Dr. Sturges, who had treated her on one previous visit to NIFP-OM. Dr. Sturges had since moved his practice. Dr. Sturges reviewed Claimant's history related to her upper extremity complaints, in particular noting that arthritis and thoracic outlet syndrome had been ruled out. Claimant had obtained a cervical/upper thoracic MRI which was negative for any indication of

thoracic outlet syndrome, but did reveal some degenerative condition in her cervical spine. Dr. Sturges noted that the degenerative cervical condition did not correlate with Claimant's upper extremity complaints. He noted that at one time she complained of pain in both upper extremities, but that symptoms had resolved on the left, leaving her right dominant hand and arm affected. Dr. Sturges diagnosed repetitive strain injury, CTS, and degenerative cervical disc disease. He recommended:

> Trial of carpal tunnel taping. If not improved consider surgery in spite of normal EMG. I suspect [Claimant] would clearly benefit from this. She is now aware that the repetitive strain will follow her and be easily aggravated but provided carpal tunnel taken care of I think will be able to cope with this. After reviewing cervical MRI I do not believe it's responsible for present symptoms and is a side issue but could be responsible for some of her scapular symptoms.

Dr. Sturges deposition exhibit 1 (9/25/09 chart note).

32. In early December 2009, Claimant saw William F. Ganz, M.D., a neurosurgeon, on referral from Dr. Sturges. Dr. Ganz agreed with Dr. Sturges that Claimant's mild degenerative cervical spine was not causing Claimant's neck and arm pain. He did not believe Claimant was a surgical candidate, but he was of the opinion that her neck complaints were treatable with physical therapy directed at strengthening her neck muscles. Dr. Ganz further opined:

> She may also have an early carpal tunnel syndrome which has not become clinically apparent on an EMG. If her symptoms of numbness that wake her at night when she sleeps continue, that study should be repeated at some point in the future by Dr. Lea.

CE B, p. 9.

33. Claimant returned to Dr. Sturges on December 15, 2009, after she had seen Dr. Ganz. Dr. Sturges reiterated Claimant's frustration with the long course of treatment—mostly at her own expense—that had provided her no relief. Dr. Sturges still was of the opinion

that Claimant had two different problems—one that was causing the discomfort in her neck and shoulder, and "fairly classic carpal tunnel symptoms" in a median distribution that was responsible for the symptoms in her hands. Dr. Sturges also noted that some emotional overlay was apparent in Claimant's presentation, mostly related to the financial hardship that ensued following denial of her workers' compensation claim. Dr. Sturges referred Claimant back to Dr. Jones for another consultation.

34. Claimant saw Dr. Jones on December 22, 2009. He noted:

> I last saw [Claimant] in May of 2008. At that time she had some vague signs and symptoms suggestive of carpal tunnel syndrome, but nothing very confirmatory. She has gone on to develop symptoms more suggestive of carpal tunnel syndrome.

CE L, p. 66. In particular, Dr. Jones referenced Claimant's statement that her "hands go to sleep at night, primarily the index, middle, and ring fingers," and that her right hand goes to sleep when she blow-dries her hair. *Id.* Dr. Jones clearly advised Claimant that there was no way he could be *certain* that she had CTS or that surgery would relieve her symptoms.

35. Dr. Jones outlined Claimant's treatment options: 1) continue conservative treatment; or 2) proceed with a CT release on the right, followed by surgery on the left if the first surgery resolves her symptoms. Claimant opted to pursue the surgical option, but was not able to do so at the time because she could not afford the co-pay required by her private health insurance.

36. Claimant returned to Dr. Sturges on March 4, May 10, and August 26, 2010. Her symptoms were getting progressively worse. In May, he considered sending Claimant for a second neuro consult, but there is no record of such a visit. By August, Dr. Sturges once again raised the possibility of thoracic outlet syndrome as one of Claimant's diagnoses. In early September, Dr. Sturges referred Claimant to a pain specialist for her neck pain.

37. Claimant saw Soren Ispirescu, M.D., a pain management specialist, on October 6, 2010. Dr. Ispirescu noted indications of depression and significant social stressors, and referred Claimant to a behavioral therapist in the clinic. He also recommended a course of physical therapy focusing on a particular technique for her neck. He also suggested epidural steroids, which Claimant vehemently declined, as she is extremely averse to needles.

38. Claimant returned to Dr. Sturges for follow-up in November and December 2010. She continued working for Employer and her condition and diagnosis were unchanged. When Claimant saw Dr. Sturges in early April 2011, he expressed concern that Claimant might be developing complex regional pain syndrome (CRPS, also called reflex sympathetic dystrophy, (RSD)) as a result of her untreated overuse injury.

DISCUSSION AND FURTHER FINDINGS

NOTICE

39. The requirements for providing notice of and filing claims for occupational diseases are set out at Idaho Code § 72-448, which provides in pertinent part:

> (1) Unless written notice of the manifestation of an occupational disease is given to the employer within sixty (60) days after its first manifestation, or to the industrial commission if the employer cannot be reasonably located within ninety (90) days after the first manifestation, and unless claim for worker's [*sic*] compensation benefits for an occupational disease is filed with the industrial commission within one (1) year after the first manifestation, all rights of the employee to worker's [*sic*] compensation due to the occupational disease shall be forever barred.

According to Idaho Code § 72-102(18), an occupational disease becomes manifest "when an employee knows that he has an occupational disease, or whenever a qualified physician shall inform the injured worker that he has an occupational disease."

40. Claimant reported her occupational disease to Employer on January 11, 2008, the same day that Dr. Esau diagnosed her with a work-related repetitive strain injury. Nevertheless,

Defendants assert that Claimant's report to Employer was untimely because a physician diagnosed her with CTS in March 2002. DE 1, p. 73. A careful reading of the referenced chart note does not reveal, however, that Claimant was either possessed of the independent conviction, or given the unambiguous opinion of her physician that the symptoms with which she presented were causally related to the demands of her employment. Without more, that Claimant may have "felt" that her symptoms were related to lifting at work is insufficient to persuade the Commission that she "knew" her condition was work related. *See*, I.C. § 72-102. The Commission finds that Claimant provided timely notice to Employer, pursuant to Idaho Code § 72-448, that she was diagnosed with a potentially compensable occupational disease claim.

COMPENSABLE OCCUPATIONAL DISEASE CLAIM

41. Idaho Code § 72-102(22)(a) defines "occupational disease" in pertinent part as:

> . . . a disease due to the nature of an employment in which the hazards of such disease actually exist, are characteristic of, and peculiar to the trade, occupation, process, or employment . . .

Establishing a compensable occupational disease is a multi-step process. First, a claimant must establish that she has an occupational disease, as defined in Idaho Code § 72-102(22)(a). Idaho Code § 72-439 further limits an employer's liability by requiring a claimant to establish that the disease was actually incurred in the employer's employment and that the worker was exposed to the hazard of such disease for sixty days for the same employer. The sixty-day exposure requirement is not at issue in the instant proceeding.

42. Once a claimant has established that she suffers from an occupational disease, she must next establish, to a reasonable degree of medical probability, a causal connection between her condition and the occupational exposure which she asserts caused her condition. See*, Langley v. State Industrial Special Indemnity Fund,* 126 Idaho 781, 786, 890 P.2d 732, 737

(1995). Medical evidence is necessary to prove a probable causal connection. "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). In the case of medical records, the records relied upon do not have to include magic words such as "medical probability" or "more likely than not." What is required is that the medical evidence plainly and unequivocally conveys the opinion that events are causally related. See, *Jensen v. City of Pocatello,* 135 Idaho 406, 412, 18 P.3d 211, 217 (2000), citing *Paulson v. Idaho Forest Indus., Inc.,* 99 Idaho 896, 901, 591 P.2d 143, 148 (1979). As discussed extensively in *Jensen,* the causation opinion need not be an affirmative finding.

43. Thus, in order for this Claimant to prove a compensable occupational disease claim, she must establish that:

- She is afflicted by a disease;
- The disease was incurred in or arose out of and in the course of her employment;
- The hazards of such disease actually exist and are characteristic of and peculiar to the employment in which she was engaged; and
- She was exposed to the hazards of such nonacute disease for a minimum of sixty days with the same employer.

Disease

44. On and after January 2008, nearly every physician who saw Claimant diagnosed her with some pathology in her hands and wrists—though uncertainty remained regarding the specific pathology.

45. Dr. Esau was Claimant's PCP in late 2007 and early 2008. It was Dr. Esau whom Claimant first consulted regarding her hand and wrist complaints in January 2008. He diagnosed a repetitive strain injury.

46. Dr. Emry, Employer's occupational medicine specialist, saw Claimant several times in the winter and spring of 2008 and diagnosed a repetitive strain injury.

47. Dr. Sturges first saw Claimant when she visited the NIFP-OM clinic in March 2008. At that time, he diagnosed repetitive wrist strain, right greater than left, and early CTS. Subsequently, he became Claimant's PCP and became increasingly certain that Claimant suffered from CTS.

48. Dr. Stevens saw Claimant in March 2008 for an IME at the direction of Surety. He concluded that Claimant's objective findings were entirely normal. He made no differential diagnosis, stating that Claimant had no condition to diagnose.

49. Claimant saw Dr. Jones, a hand surgeon, in May 2008 upon referral from NIFP. Dr. Jones opined that Claimant was not a surgical candidate at that time because he could not "localize her pain or tenderness to an area that suggested that she had a focal problem that would be remedied by hand surgical treatment." Dr. Jones Dep., p. 6. There is nothing in Dr. Jones' note, however, that suggests he questioned that Claimant had a problem with her hands. In fact, he suggested a rheumatology consultation and specifically directed that if Claimant began to experience progressive numbness in her hands, she should seek further testing for CTS.

50. Among the various medical opinions addressing Claimant's diagnosis, the Commission finds the opinions and reasoning of Drs. Jones and Sturges more persuasive than those of Dr. Stevens for the reasons discussed below.

51. Dr. Sturges. Dr. Sturges saw Claimant over the longest period of time, and his notes document the progression of Claimant's hand and wrist complaints. He suspected CTS early on, but continued to consider and rule out other causes for Claimant's complaints. As Claimant's PCP, he was in the best position to evaluate Claimant from a global perspective—taking into consideration her overall health, her work, her family, and her emotional and psychological health. He was aware of the stressors in Claimant's life, including the sense of

frustration and the financial impacts that arose in connection with her claim, and was cognizant of the effects that these stressors might have on Claimant's presentation. The longer that Dr. Sturges treated Claimant, the more adamant he became that she had a classic presentation of CTS, and the longer it went untreated, the more concerned he became about further consequences such as CRPS/RSD.

52. Dr. Jones. Dr. Jones only saw Claimant on two occasions, but it is his specific medical specialty, not the frequency of his interactions with Claimant, that lend persuasive authority to his opinions. First, Dr. Jones is a surgeon. He specializes in surgery of the hand. In this regard, his expertise certainly exceeds that of both Drs. Sturges and Dr. Stevens. Second, Dr. Jones is also something of a skeptic—at least in the realm of suspected CTS without confirming electrical studies.

53. Dr. Jones described that on Claimant's second visit, in December 2009, she reported *symptoms* consistent with CTS, including that her hands went to sleep at night and while she was blow-drying her hair. In addition, she had a positive Tinel's *sign*. Dr. Jones did note that Claimant had a negative Phalen's test, and that her nerve conduction studies continued to be within normal limits. He explained:

> When we get a patient with a negative nerve test, but all the signs and symptoms of carpal tunnel, we sometimes offer them surgery if they have had symptoms for a long enough period of time. But in my experience the success rate for surgery in that group of patients is not great. Maybe 50 percent. Maybe a little more benefit. And it interestingly breaks down in that subgroup of patients. In the workmans' [*sic*] comp population I'm much more reluctant to do the surgery with a negative nerve test. I usually need to be convinced. Either we give them enough time, or the neurologist agrees that she has all the signs and symptoms, etc., etc.

Dr. Jones Dep., pp. 9-10. Dr. Jones then went on to state that he found Claimant's history convincing:

> Well, I think her signs and symptoms were fairly convincing. I followed her – had seen her for what, a year before, and she was still symptomatic, or several months before.[4] And she was still symptomatic. Her family physician was fairly sure she had it. And given all those things I said, well, we can try doing one side. And if all your symptoms go away, I will do the other side. But we wait to see if it's a success. *It's basically a diagnostic test as well as therapeutic.* And if it works, we do the other side. If it doesn't, we don't.

Id., at p. 10. Dr. Jones and Claimant's counsel then engaged in the following colloquy:

> Q. Okay. And so based upon your evaluation of [Claimant], and all the things that you take into consideration, do you have an opinion to a reasonable degree of medical probability, which is 51 percent more for than against, whether or not carpal tunnel surgery on the right is reasonably required for [Claimant]?
>
> A. I think it's better than 50 percent, but it's not 90 percent.

Id., at p. 11.

54. Dr. Stevens. Dr. Stevens saw Claimant on one occasion relatively early in the medical history of the instant claim. He had the opportunity to discuss his IME with particularity some years later during his post-hearing deposition. Dr. Stevens testified that he had no independent recollection of Claimant's case, and he based his testimony on his chart notes and information contained in the post-hearing depositions of Drs. Sturges and Jones. As noted, previously, the Commission excluded the portions of Dr. Stevens' testimony relating to information in those post-hearing depositions, pursuant to J.R.P. 10(E)(4).

55. Dr. Stevens evaluated Claimant on March 13, 2008. He had the opportunity to review most medical records generated in connection with Claimant's treatment to that date. As well, he took a history from Claimant concerning the work activities to which she attributed to the onset of her right upper extremity discomfort. He also took a history from Claimant

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[4] Actually one year and nine months.

concerning her avocational activities. Claimant told Dr. Stevens that she crocheted as a hobby, but had given that up in December 2007 because of hand discomfort.

56. Physical examination of Claimant's right hand revealed tenderness to palpation over the CMC joint of the thumb. Percussion over the carpal tunnel also produced complaints of pain, but no electric sensations that would represent a true Tinel sign. Sensory examination was suggestive of a global hypesthesia over the proximal portion of the right arm relative to the left, not confined to a distinct dermatome. Claimant's exam was otherwise negative. However, because of Claimant's complaint of right wrist pain, Dr. Stevens performed electrodiagnostic testing to rule out carpal tunnel syndrome. Claimant's testing was within normal limits, and therefore, failed to support a diagnosis of carpal tunnel syndrome.

57. Dr. Stevens did not denigrate Claimant's complaints of bilateral thumb pain. However, he was not able to establish a diagnosis for Claimant's condition in the absence of any objective abnormalities on testing or exam. He proposed that Claimant might be suffering from low grade CMC osteoarthritis. He did not believe that Claimant's described keyboarding activities could be causative of such a condition. In the end, his evaluation of Claimant left him unable to establish a diagnosis to explain Claimant's subjective pain complaints, much less a connection between Claimant's employment and her pain complaints.

58. Defendants did not ask Dr. Stevens to see Claimant following her second visit to Dr. Jones, in which he opined that carpal tunnel surgery was reasonably necessary, nor did they ask Dr. Stevens to review the medical records that had accumulated over the interval between his exam and Dr. Jones' exam until after the hearing. With regard to Claimant's condition in December 2009, Dr. Jones' medical opinion is unrebutted.

59. The Commission concludes that there is substantial medical evidence to support a finding that when her claim arose in January 2008, Claimant suffered from hand and wrist disease related to repetitive motion. A specific diagnosis would have been helpful in providing care and treatment for Claimant at the outset of her claim. However, there is nothing in statute or case law that requires that an occupational disease be named with specificity or its etiology identified before it becomes a disease. By the time of hearing, substantial medical evidence supports a finding that Claimant, more likely than not, suffered from CTS and required surgical intervention.

Arising Out Of And In The Course Of Employment

60. The Commission has frequently addressed the "arising out of" and "in the course of" language in the statute. *Mahoney v. Silver Wood Good Samaritan Center,* 1986 IIC 0091, 0091.4 (February 10, 1986) provides a concise explication:

> "Course of employment" refers to the course of an activity related to employment which is generally said to be related if it *carries out the employer's purpose or advances his interests.* Thus, an accident is said to arise out of employment if it is within the time and space limitations of employment and is in the course of employment if it is in an activity related to employment. *Larson,* The Law of Workmen's Compensation, Sections 6 and 20.

Again, with the exception of Dr. Stevens, there is little dispute that Claimant's hand symptoms were brought on by her work. Drs. Esau, Emry, and Sturges were all of the opinion that Claimant's hand symptoms were the result of work that required constant use of her wrists and hands. During her first visit to Dr. Esau in January 2008, he suggested that she look for work that did not require constant use of her hands. On her first visit to Dr. Emry, Surety's occupational medicine provider, he imposed restrictions on the use of her hands that took her off work for nearly two months. Dr. Sturges wrote Claimant a prescription for an ergonomic assessment of her workstation. Each of these physicians consistently noted that Claimant's

symptoms were most prominent during her workweek, and that her symptoms improved when she was off work and on weekends.

61. As a hand surgeon, Dr. Jones' primary focus was on the question of whether Claimant was a surgical candidate. He did not offer an opinion on whether Claimant's upper extremity complaints related to her work, specifically noting that he ordinarily deferred such determinations to occupational medicine specialists.

62. Claimant's constant keyboarding, use of the number pad, and use of the mouse unquestionably arose out of and in the course of her work for Employer. The Commission finds that Claimant's occupational disease arose out of and in the course of her employment.

Hazards Of Disease Actually Exist, Are Characteristic Of And Peculiar To The Employment

63. The Idaho Supreme Court has weighed in on how the statutory phrase "characteristic of, and peculiar to" is to be construed.

> In *Bowman v. Twin Falls Const. Co., Inc.,* 99 Idaho 312, 581 P.2d 770 (1978), we adopted the construction given by the Supreme Court of Michigan in holding that: "The phrase, 'peculiar to the occupation,' is not here used in the sense that the disease must be one which originates *exclusively* from the particular kind of employment in which the employee is engaged, but rather in the sense that the conditions of that employment must result in a hazard which distinguishes it in character from the general run of occupations." 99 Idaho at 323, 581 P.2d at 781, *overruled on other grounds, DeMain v. Bruce McLaughlin Logging,* 132 Idaho 782, 979 P.2d 655 (1999) (emphasis in original).

Mulder v. Liberty Northwest Ins. Co., 135 Idaho 52, 55, 14 P.3d 372 (2000).

64. The facts surrounding Mr. Mulder's occupational disease claim are similar, if somewhat less compelling, that those in the instant case. Mr. Mulder worked in Boise, but was required to drive frequently to eastern Idaho for his work. During his trips, Mr. Mulder would meet with as many as four clients per day, and his duties required him to write by hand from one-and-a-half to four pages of notes per client. When he was at his office in Boise,

Mr. Mulder's duties included use of a computer keyboard. In 1994, Mr. Mulder began to experience symptoms of CTS. Two years later, he was diagnosed with CTS. The Commission found that Mr. Mulder's CTS was a compensable occupational disease. Defendants appealed on the ground that Mr. Mulder offered no proof that his carpal tunnel syndrome was *peculiar* to his job, or that he distinguished his particular job requirements from the general run of occupations.

65. Defendants argued on appeal that the test set out in *Bowman* was not applicable to cases of CTS, because such claims involve exposure to hazards which are common to the activities of day-to-day living, and are indistinguishable from the vast majority of other occupations. The Court disagreed with Defendants' argument and held that it was proper to apply the test set out in *Bowman* to worker's compensation claims involving carpal tunnel syndrome. Applying the test from *Bowman,* the Commission found the hazards to which Mr. Mulder was exposed during his work *could* be distinguished from the general run of occupations, and that exposure to long periods of repetitive upper extremity motions, including writing, keyboarding, and gripping of a steering wheel are not characteristic of all occupations. The Commission based its factual determination, in part, on medical testimony and upon the description of the job duties peculiar to Mr. Mulder's position, which included driving, handwriting and keyboarding.

66. In the instant case, Claimant's repetitive use of her upper extremities is less varied and more constant than the activities described in *Mulder.* Mr. Mulder drove, wrote, and keyboarded at various times while performing his work. Claimant sat at the same desk, performing the same highly repetitive activity throughout her eight-hour workday in an environment where speed and accuracy were paramount. Claimant's treating physicians, and the Surety's occupational medicine physicians all attributed Claimant's symptoms to the nature of

her work. The Commission finds that, applying the *Bowman* test, the hazards of a repetitive motion injury to the wrists and hands is a hazard that exists and is characteristic of and peculiar to Claimant's work.

Sixty-Day Exposure

67. Claimant had worked for Employer, performing the same type of work, for more than two years prior to Dr. Esau's diagnosis of her bilateral hand condition on January 11, 2008. There is no question but that Claimant has satisfied the statutory requirements of Idaho Code § 72-439.

Summary

68. The Commission finds that there is substantial and persuasive medical evidence to establish that Claimant suffered from a compensable occupational disease.

MEDICAL CARE

69. An employer shall provide for an injured employee such reasonable medical, surgical or other attendance or treatment, nurse and hospital service, medicines, crutches and apparatus, as may be required by the employee's physician or needed immediately after an injury or disability from an occupational disease, and for a reasonable time thereafter. If the employer fails to provide the same, the injured employee may do so at the expense of the employer. Idaho Code § 72-432 (1). It is for the physician, not the Commission, to decide whether the treatment was required. The only review the Commission is entitled to make of the physician's decision is whether the treatment was reasonable. Sprague v. Caldwell Transportation, Inc., 116 Idaho 720, 779 P.2d 395 (1989).

70. Claimant is entitled to such reasonable medical care as is related to her occupational disease beginning January 11, 2008. This includes diagnostic testing, conservative

care (monitoring, physical therapy, occupational health services) and medications, along with workplace modifications that are reasonably medically necessary.

71. *Neel v. Western Construction, Inc.*, 147 Idaho 146, 206 P.3d 852 (2009), has been generally cited for the proposition that where a surety has denied responsibility for medical treatment, surety is responsible for the payment of 100% of the invoiced amount of the bills in question upon the Industrial Commission's subsequent determination that surety is responsible for that care. The underlying premise of *Neel* is that where the workers' compensation surety has denied responsibility for the payment of medical benefits, claimant is in the wilderness: The claimant must go out and strike his/her own bargain with providers, and is potentially liable for 100% of the invoiced amount of bills for services. For this reason, once the Industrial Commission determines that the denied care is the responsibility of surety, surety is obligated to pay claimant 100% of the invoiced amount of the bills in question, this sum representing the injured worker's exposure on the bills he incurred outside the Workers' Compensation system.

72. The Commission is not inclined to perform a forensic accounting of Claimant's medical invoices. Claimant and/or her medical providers are entitled to reimbursement for medical care reasonably related to diagnostics and conservative care and monitoring of her hand and wrist complaints. This includes, but is not limited to, nerve conduction studies, x-rays, rheumatology, neurology, and surgical consults, physical therapy, medications, and appliances. By the time of the hearing in this matter, Claimant was a surgical candidate for a carpal tunnel release on the right with the potential for a second surgery on the left if the first surgery is successful. Defendants are obligated to cover the costs of the surgery or surgeries and related after-care. Recognizing that surgical intervention cannot guarantee the outcome she seeks, the decision whether to proceed with a right carpal tunnel release remains with Claimant.

TTDs

73. Pursuant to Idaho Code § 72-408, a claimant is entitled to income benefits for total and partial disability during a period of recovery. The burden of proof is on the claimant to present expert medical evidence to establish periods of disability in order to recover income benefits. *Sykes v. C.P. Clare & Compan*y, 100 Idaho 761, 763, 605 P.2d 939, 941 (1980). In order to recover TTDs in occupational disease cases, the employee must be "disabled from performing his work in the last occupation in which he was injuriously exposed to the hazards of such disease . . ." Idaho Code § 72-437.

> The Commission has found injured workers to be eligible for TTD/TPDs under an occupational disease theory when they *can no longer perform the job tasks required of their time-of-injury employment*. *See*, *Ewers v. Kit Manufacturing Co.*, 1994 IIC 0627 (emphasis added). "Disability is defined as the state of becoming "actually and totally incapacitated" from further performing the particular tasks which induced such incapacity." *Id.*, *citing* Idaho Code § 72-102(18)(c); *Jones v. Morrison-Knudsen Co.*, 98 Idaho 458, 567 P.2d 3 (1977); *see also*, *Blang v. Basic American Foods*, 94.5 ISCR 241, 125 Idaho 275, 869, P.2d 1370.

Simmons v. Winco Foods, Inc., 2009 IIC 0435, 0435.36 (filed 09/08/2009).

74. In January 2008, Dr. Emry imposed restrictions that took Claimant off work for approximately seven weeks. During that period of time, Claimant was actually and totally incapacitated from performing her work. It is undisputed that Surety did not pay TTD benefits to which Claimant was entitled while she was off work pursuant to Dr. Emry's restrictions. She returned to work in March following Dr. Stevens' report and the termination of her medical benefits. However, Claimant returned to work not because her condition had stabilized, or because Dr. Emry changed her restrictions, but because Surety denied her claim. In effect, Claimant was forced to return to her time-of-injury position despite still being in a period of recovery and, pursuant to her restrictions, actually and totally incapacitated from performing her

job tasks. Her condition has not yet stabilized; indeed, it has worsened. Claimant has therefore established that she has been in a period of recovery since January 22, 2008 and is entitled to TTD benefits from that date until such date as she is deemed medically stable. Defendants are entitled to an offset for wages paid to Claimant during this period.

ATTORNEY FEES

75. Attorney fees are not granted to a claimant as a matter of right under the Idaho Workers' Compensation Law, but may be recovered only under the circumstances set forth in Idaho Code § 72-804, which provides:

> Attorney's fees - Punitive costs in certain cases. - If the commission or any court before whom any proceedings are brought under this law determines that the employer or his surety contested a claim for compensation made by an injured employee or dependent of a deceased employee without reasonable ground, *or that an employer or his surety neglected or refused within a reasonable time after receipt of a written claim for compensation to pay to the injured employee or his dependents the compensation provided by law,* or without reasonable grounds discontinued payment of compensation as provided by law justly due and owing to the employee or his dependents, the employer shall pay reasonable attorney fees in addition to the compensation provided by this law. In all such cases the fees of attorneys employed by injured employees or their dependents shall be fixed by the commission. (Emphasis added.)

The decision that grounds exist for awarding a claimant attorney's fees is a factual determination that rests with the Commission. *Troutner v. Traffic Control Company*, 97 Idaho 525, 528, 547 P.2d 1130, 1133 (1976).

76. Although the question is a close one, the Commission finds that the facts of this case are insufficient to support an award of attorney fees pursuant to Idaho Code § 72-804. With the benefit of hindsight, it is fairly easy to conclude that Claimant was suffering from an occupational disease at the time she first sought medical treatment. However, at the time of her initial treatment, the etiology of her complaints was not clear, and she did not have symptoms that could be definitively diagnosed as carpal tunnel syndrome. At that time, and with

conflicting medical opinions, it was not unreasonable for Surety to rely on Dr. Stevens' opinion, though his report had some obvious flaws.

77. While it is clear that Dr. Jones became more convinced in December of 2009 that Claimant's signs and symptoms were suggestive of carpal tunnel syndrome, even he was cautious enough about that diagnosis to suggest that the CTS surgery he proposed was offered as much for diagnostic purposes as it was to treat Claimant's complaints. He acknowledged that other explanations for Claimant's symptoms continued to be in the differential diagnosis. He noted that the lack of positive electrodiagnostic findings would make one cautious about a diagnosis of CTS, and he pointed out that recent studies have tended to rule out keyboarding activities as a cause of CTS. While it is arguable that Dr. Jones' December 2009 record that Claimant symptoms were becoming more suggestive of CTS should have alerted Defendants to the fact that the lay of the land was changing, such that they should revisit Dr. Stevens' conclusions with an updated exam, the Commission cannot say it was unreasonable for Defendants to continue to rely on Dr. Stevens' March 2008 report, when concerns similar to the ones expressed by Dr. Stevens were voiced by Dr. Jones in his deposition.

78. Further, the timeline of events does not indicate that Surety was neglectful in reassessing the claim. After the 2008 IME opinion of Dr. Stevens the Surety would not have been aware of the continued treatment Claimant was receiving. Even at the time the Complaint was filed on August 29, 2008, Claimant was acting *pro se* and there is no indication that discovery was flowing between the parties. Once the Claimant retained counsel the case proceeded quickly to hearing. Mr. Kelso appeared on Claimant's behalf on April 14, 2010 and the hearing was held on December 15, 2010.

79. For the reasons set out above, the Commission concludes that an award of attorney fees is not warranted under these facts.

CONCLUSIONS OF LAW

1. Having established a compensable claim of occupational disease, Claimant is entitled to medical care for her bilateral hand and wrist complaints. Defendants shall reimburse Claimant for past denied medical care in accordance with *Neel v. Western Construction, Inc.*, 147 Idaho 146, 206 P.3d 852 (2009).

2. Claimant is entitled to TTD benefits from January 22, 2008 until such time as she is found to be medically stable. Defendants are entitled to an offset for wages paid to Claimant during her period of recovery.

3. Claimant is not entitled to an award of attorney fees.

ORDER

Based upon the foregoing, the Commission hereby ORDERS the following:

1. Having established a compensable claim of occupational disease, Claimant is entitled to medical care for her bilateral hand and wrist complaints. Defendants shall reimburse Claimant for past denied medical care in accordance with *Neel v. Western Construction, Inc.*, 147 Idaho 146, 206 P.3d 852 (2009).

2. Claimant is entitled to TTD benefits from January 22, 2008 until such time as she is found to be medically stable. Defendants are entitled to an offset for wages paid to Claimant during her period of recovery.

3. Claimant is not entitled to an award of attorney fees.

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

IT IS SO ORDERED.

DATED this _24th_____ day of __May_____, 2012.

INDUSTRIAL COMMISSION

_/s/_____
Thomas E. Limbaugh, Chairman

_/s/_____
Thomas P. Baskin, Commissioner

_Participated but did not sign_____
R. D. Maynard, Commissioner

ATTEST:

_/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the _24th__ day of ____May_____, 2012, 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:

STARR KELSO
PO BOX 1312
COEUR D'ALENE ID 83816-1312

ERIC S BAILEY
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cs-m/mw ___/s/_____