BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

LINDA D. RYAN, Claimant, v. DUCKWALL-ALCO STORES, INC., Employer, and LIBERTY MUTUAL FIRE INSURANCE COMPANY, Surety, Defendants.	**IC 2004-507310** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** Filed September 27, 2011

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Michael E. Powers, who conducted a hearing in Pocatello on January 13, 2011. Claimant was present and represented by Albert Matsuura of Pocatello. Kimberly A. Doyle of Boise represented Employer/Surety. Oral and documentary evidence was presented and the record remained open for the taking of two post-hearing depositions. The parties then submitted post-hearing briefs and this matter came under advisement on June 3, 2011.

ISSUES

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

1. Claimant's entitlement to reimbursement for medical care;
2. Claimant's entitlement to total temporary disability (TTD) benefits; and
3. Claimant's entitlement to permanent partial impairment (PPI) benefits.

CONTENTIONS OF THE PARTIES

Claimant contends that she is entitled to reimbursement for medical care she received after having been declared at maximum medical improvement (MMI) by her treating physician. Claimant injured her left shoulder and low back in a lifting accident. Defendants picked up the claim and provided appropriate care until she was declared at MMI, after which she was required to undergo shoulder and low back surgeries. Based on her medical expert's opinion that the post-MMI surgeries were related to her original compensable injuries, Claimant seeks reimbursement for the costs of that treatment, as well as TTD benefits and PPI benefits for her left shoulder and back.

Defendants contend that Claimant's treating physician[1] was correct when he declared Claimant to be at MMI in January 2005, and any treatment she received after that time was for either pre-existing conditions or subsequent intervening events. The strain/sprain-type injuries for which Dr. Simon was treating Claimant had resolved by the time of her back surgery. The surgery was necessitated by long-standing back problems and an event post-MMI, where Claimant collapsed while standing up from a table in a restaurant causing a shift in sides of her lumbar symptoms. Her left shoulder surgery was needed to correct conditions brought on by normal wear and tear. Prior to her shoulder surgery, her treating physician for that condition released her to return to work without restrictions. Defendants have paid all the benefits owed Claimant.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant presented at the hearing.

[1] Claimant's treating physician, David Simon, M.D., also performed two medical evaluations at Defendants' request after he declared Claimant to be at MMI.

2. Joint Exhibits A-W admitted at the hearing.[2]

3. The post-hearing depositions of: Gary Cook, M.D., taken by Claimant on January 18, 2011, and David Simon, M.D., taken by Defendants on February 8, 2011.

Defendants' objection at page 95 of Dr. Cook's deposition regarding relevancy is sustained.

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

FINDINGS OF FACT

1. Claimant was 57 years of age and resided in Challis at the time of the hearing. Claimant's last name was Ryan at the time of her March 29, 2004 industrial accident, but was changed to Erickson sometime during this litigation. Some medical records refer to her as Ryan, and others as Erickson. Before moving to Challis, Claimant resided in the Montpelier area.

2. In Montpelier, Claimant worked for Employer's department store as soft-lines manager. On March 29, 2004, Claimant was unloading heavy and awkward futons and some lawn furniture from a semi-trailer. The job required lifting, bending, straining, and twisting to remove the items from the trailer. It was during this process that Claimant injured her left lower back and left shoulder, and developed left leg and hip pain. Claimant timely reported her accident.

Summary of Claimant's post–accident medical care

3. Claimant initially presented to N.E. Wolff, M.D., at Bear Lake Family Medicine in Montpelier on March 31, 2004 complaining of low back, left hip, and left leg pain. X-rays of the lumbar spine revealed degenerative changes at L5-S1, but no acute injury. In an April 6

[2] As always, the Commission appreciates counsels' efforts in preparing joint exhibits.

follow-up visit, Dr. Wolff noted that Claimant was still complaining of pain down both legs, especially on the left. An April 13, 2004 MRI of Claimant's lumbar spine revealed minor degenerative disc disease at L4-L5. It did not show any acute injury. Dr. Wolff referred Claimant to William Neal, M.D., a local orthopedic surgeon.

4. Claimant first saw Dr. Neal on April 27, 2004 complaining primarily of low back, right hip,[3] and left shoulder pain. Dr. Neal diagnosed a low back strain and prescribed physical therapy and anti-inflammatories and took Claimant off work. Claimant returned in follow-up on May 3, 2004 and informed Dr. Neal that her low back pain was improving with physical therapy. Her primary complaint was her left shoulder with pain radiating to her left arm and forearm, but not her hand. Dr. Neal injected Claimant's left shoulder. Claimant's low back and left hip continued to improve; her left shoulder did not. An MRI of Claimant's left shoulder on May 11, 2004 did not reveal any labral or rotator cuff tears. Dr. Neal referred Claimant to Mary Neal, M.D., for further evaluation of the left shoulder MRI as well as Claimant's low back. Surety cancelled that referral and instead arranged for Claimant to meet with David Simon, M.D., a physiatrist practicing in Idaho Falls.

5. Claimant first saw Dr. Simon on June 28, 2004 complaining of low back, left hip, and left shoulder pain since her accident. Claimant denied any history of back pain or other medical problems. Dr. Simon diagnosed a low back strain with residual inflammation and suggested that oral steroids may help. He referenced a May 27, 2004 lumbar MRI that showed no evidence of a disk herniation or neural impingement. Dr. Simon opined that Claimant was not a surgical candidate and, if the steroids worked, no further treatment would be necessary. He

[3] Right hip pain was listed by Claimant under Current Complaints on her initial evaluation questionnaire. However, Dr. Neal's chart notes indicate Claimant was seen for left leg pain, as well as the other conditions listed.

further opined that even if the steroids did not work, Claimant may still be at MMI in that no further treatment would be helpful since she had not responded to any treatment in any event. Dr. Simon prescribed a Medrol Dose Pac (oral steroids) and released Claimant to full duty with lifting of 35 pounds occasionally and 20 pounds frequently.

6. Claimant returned to Dr. Neal in follow-up on July 27, 2004 at which time she reported that her left hip and left shoulder were "fine," but her back was still the same. Based on Claimant's representation as well as his physical examination of her left shoulder, Dr. Neal released Claimant from his care and returned her to unrestricted work regarding her hip and shoulder.

7. In a September 9, 2004 follow-up visit with Dr. Simon, Claimant reported that her left hip and left shoulder pain had completely resolved after taking the oral steroids, however, her low back pain was still present. Dr. Simon decreased Claimant's physical therapy for her low back. When Claimant's low back pain did not improve, Dr. Simon prescribed oral steroids at a higher dosage than before and for a longer period of time.

8. Claimant returned to Dr. Simon on December 2, 2004 reporting that she had quit physical therapy as it was not helping, and that the steroids prescribed at the last visit provided little relief. Dr. Simon noted, "The cause of her continued symptoms (persistent low back pain) is difficult to determine and is certainly unusual but since her symptoms persist, I would recommend that blood tests be done to rule out a rheumatologic problem. Beyond that, I do not have much else to offer her." Exhibit D, p. 9. Claimant had the blood tests, which were normal.

9. Claimant returned to Dr. Simon on January 3, 2005 reporting continued pain in her left lower back and left hip area. Dr. Simon noted, "I reviewed some of her medical records again and I noted that on 9/19/02 she complained of lower back and left flank pain. It was noted

that she had it for years but was worse the last couple of months. When I asked Ms. Ryan about this today, she does not recall this readily. On 2/28/03 there is a handwritten note indicating that she had back pain and she was taking Naprosyn. Ms. Ryan does not have a recollection of that either." *Id.*, p. 12. Dr. Simon also noted that the cause of Claimant's complaints is difficult to determine. He suspected that ". . . this is simply a continuation of this left lower back/flank pain that she has had for years." *Id*. Dr. Simon declared Claimant at MMI regarding her work injury and indicated that no further treatment was necessary. Surety has denied benefits from this date forward.

Summary of Claimant's post-MMI medical care

Low back:

10. Claimant returned to her primary care physician (Robert Nash, M.D.) on January 20, 2005 complaining of severe pain down her right leg. Dr. Nash's note indicates that, "On Monday of this week she went out to eat with her boyfriend/fiancé when suddenly when she went to get up from the table she had severe right sided sciatica. She had to actually be carried out to the car because of this." Exhibit E, p. 9. At hearing, Claimant confirmed the accuracy of Dr. Nash's notation:

> Q. (By Ms. Doyle): Okay. All right. Now, we talked a little bit earlier about you going to see Dr. Nash in January of 2005 when you had the incident when you and your husband were at lunch. You had a sudden onset of right sciatica, I believe, and then nearly fell to the ground. Do you recall if that's the first time after your industrial accident in this case that you had any right-sided symptoms or complaints?
>
> A. (Claimant) I believe it was when I – when my legs gave out.
>
> Q. Okay. And this would have been nine months after the industrial accident then; is that correct?
>
> A. Correct.

Hearing Transcript, pp. 68-69.

Claimant also described the January 2005 incident (hereinafter "the restaurant incident") during direct examination by counsel:

> A. (Claimant) My husband and I were having lunch at a café, and I got up from the booth. My husband always goes and pays the check and then comes back to the table to get me. And I got out of the booth, and I went to take a step and went down. I didn't hit the ground or – he was there, and then he carried me to the truck.
>
> Q. (By Mr. Matsuura) Okay. When you say you went down but didn't, didn't hit the ground, I mean what caused you to go down?
>
> A. My legs just gave out. It was –
> Q. You didn't slip on something –
>
> A. No.
>
> Q. – or trip on anything?
>
> A. I did not.

Hearing Transcript, pp. 28-29

Importantly, at hearing, Claimant confirmed that it was only after the January 2005 restaurant incident that she developed symptomology in her right lower extremity. Dr. Nash's physical examination revealed marked tenderness over the lower lumbar spine in the right paravertebral muscles with palpable spasm. There was equivocal straight leg raising on the right. Because it had been a year since her last lumbar MRI, Dr. Nash recommended another; however, Claimant was unable to afford it since her workers' compensation benefits had been terminated. Dr. Nash suggested that Claimant see a back specialist.

11. A lumbar MRI was eventually accomplished on October 27, 2005. It demonstrated a broad-based central disk protrusion at L5-S1 without significant accompanying spinal stenosis. The left S1 nerve root appeared to be contacted, but not displaced by disk

material. A possible annular tear was identified in the posterior annular fibrosis at L4-5. There was no significant central canal stenosis in Claimant's lumbar spine.

12. Claimant treated for a little over a year beginning in November 2005 with Catherine Linderman, M.D., a pain specialist. Dr. Linderman's notes reflect that Claimant was continuing to complain of right leg pain, numbness, and tingling. Dr. Linderman's treatment regimen consisted of trigger point and steroid injections, lumbar nerve root blocks, lumbar radiofrequency neurolysis, physical therapy, and medications. Claimant testified that she got no relief from Dr. Linderman's treatment.

13. Claimant saw Kenneth Brait, a neurologist, on February 20, 2007 as a referral from Dr. Linderman. Claimant was complaining of right leg pain and numbness and low back pain. Dr. Brait notes that Claimant's symptoms were not those seen with a typical herniated disk. Dr. Brait ordered EMG testing of Claimant's lumbar region and lower extremities, which were normal without any evidence of radiculopathy. In an addendum to his February 20 office note, Dr. Brait wrote, "I failed to mention that her low back pain actually started when she was working in a furniture store and was lifting a number of heavy items. Certainly I suspect that that is the cause of her back pain. Whether or not her other neurological problems are related to that I am not positive about it at this time but certainly would be suspicious of cause and effect." Exhibit G., p. 3. It is unknown which, if any, of Claimant's prior medical records Dr. Brait reviewed. As a result of the negative EMG, Dr. Brait had nothing to offer Claimant by way of treatment other than a short course of steroids.

14. Claimant next began treatment with Grant Walker, M.D., an orthopedic surgeon in April 2007. In addition to Claimant's lumbar issues, Dr. Walker also treated her for a neck condition that resulted in two cervical surgeries. Claimant is not alleging her cervical problems

are related to the subject accident. Regarding Claimant's back, Dr. Walker noted that her chief complaint was radicular right low back pain extending down the right leg, radicular neck pain and "all over weakness." An April 2, 2007 lumbar MRI demonstrated a "[v]ery tiny central disk protrusion at L5-S1, which I doubt would be clinically significant" and "… some mild-to-moderate facet arthropathy bilaterally at L3-4." Exhibit L, p. 8A. Despite these minimal objective findings, Dr. Walker opined that Claimant suffered from a right-sided radiculopathy in an L5 nerve distribution. He recommended right-sided decompression at L4-L5 and L5-S1, along with a transforaminal lumbar interbody fusion at L4-L5 and L5-S1. This surgery was ultimately performed on June 12, 2007.

15. Claimant's lumbar surgery healed appropriately in the beginning, but an August 2007 lumbar MRI revealed early degenerative changes at L3-4, scar formation, but no recurrent disk extrusions. Dr. Walker diagnosed early arachnoiditis and recommended a spinal cord stimulator (SCS) for Claimant's right leg pain. She underwent placement of the SCS in December 2007.

16. Claimant began treating with Stephan Marano, M.D., a neurosurgeon, for neck, back, and right leg pain in March 2009, because Dr. Walker had closed his practice.[4] In June 2009, Dr. Marano repositioned Claimant's spinal cord stimulator and performed a right foraminotomy and decompression at L5-S1, removed hardware and redid the fusion at L4-5 and L5-S1. By August 2009, Claimant's treatment with Dr. Marano was entirely for her unrelated neck problems.

[4] Claimant insisted that she was "kicked out" by Dr. Walker, but the evidence established that Dr. Walker, for whatever reason, closed his practice to all patients.

Left shoulder:

17. Claimant received treatment for her left shoulder injury coincidently with the treatment being rendered for her low back condition. An October 27, 2005 left shoulder MRI revealed "[f]indings consistent with calcific tendinitis of the infraspinatus tendon with possible shallow bursal surface tear or fraying of the distal infraspinatus tendon, but no full thickness or articular partial thickness tears of the rotator cuff seen. Acromioclavicular joint degenerative disease. Small SLAP lesion." Exhibit E, p. 12. A prior left shoulder MRI dated May 11, 2004 revealed no evidence of rotator cuff tear or labral abnormalities. Claimant's last left shoulder MRI, dated June 14, 2006, revealed calcific tendinitis as well as an incomplete, nonarticular surface tear of the posterior supraspinatus tendon. No complete tear of the rotator cuff was identified, nor were any labral tears.

18. Claimant came under the care of John Andary, M.D., an orthopedic surgeon in June 2006. He diagnosed Claimant with left shoulder calcific tendinitis and partial rotator cuff tear. Dr. Andary brought Claimant to arthroscopic surgery on July 13, 2006,where he repaired her partial rotator cuff tear, debrided her calcific deposit, performed a subacromial decompression and acromioplasty, and debrided her Type 1 SLAP lesion. Dr. Andary released Claimant from his care on October 6, 2006 and recommended a home exercise program in lieu of continued physical therapy.

The Expert Medical Opinions

Dr. Simon – 1:

19. Dr. Simon is a board-certified physiatrist who has practiced in Idaho Falls for the past 16 years. He is a past medical director of the rehabilitation unit at Eastern Idaho Regional Medical Center and currently owns his own practice. He has been conducting IMEs since

around 1997. Dr. Simon was Claimant's treating physician for her low back condition until he released her as being at MMI on January 3, 2005. Subsequently, in 2009 and 2010, he evaluated Claimant's condition at Defendant's request.

20. Dr. Simon conducted his first post-treatment evaluation of Claimant on May 18, 2009. Dr. Simon performed a musculoskeletal and neurologic examination of Claimant and reviewed extensive medical records dating back to 1998. He also reviewed the deposition testimony and report of Claimant's IME physician, Dr. Cook. Dr. Simon then prepared a report (Exhibit N), and was deposed. Claimant complained of frequent pain in her low back, and constant pain in her right leg. She informed Dr. Simon that her right leg pain began in 2006. She also reported occasional pain in her left shoulder. Claimant exhibited no significant pain behavior or symptom magnification, but Dr. Simon noted that her sensory deficits were in a non-physiologic pattern.

21. Dr. Simon concluded:

> Work related lifting injury on 3/29/04. Following that, she complained of low back, left hip and left shoulder pain. These complaints were likely related to mild soft tissue strain injuries. An MRI of the lumbar spine following the injury showed no disc herniation. Her left hip and left shoulder pain resolved after treatment with oral steroids. Although she had some persistent left low back pain, this was a pre-existing problem. Her problems related to the industrial injury resolved by 1/3/05 at which time she was at MMI status.

Exhibit N, p. 9.

22. Dr. Simon noted that Claimant's low back and right leg pain started in January 2005, and is in no way related to her industrial accident.

23. Dr. Simon did not assign any PPI rating, imposed no physical restrictions, and indicated that no further medical treatment was required for any accident-related condition(s).

Dr. Cook:

24. Claimant saw Gary L. Cook, M.D., at her attorney's request for the assignment of PPI ratings/independent medical evaluation. According to his deposition testimony, Dr. Cook retired from his anesthesiologist and pain management practice of 20 years after being diagnosed with post-traumatic stress disorder following a scuba diving accident, following a cardiac arrest, a divorce, and a ruptured appendix. He then began doing IMEs part-time in January 2009. Dr. Cook testified that he had never performed an IME for a surety.

25. Claimant saw Dr. Cook on April 26, 2010, at which time she was examined. Dr. Cook reviewed some medical records and diagnostic studies (although none pre-existing Claimant's accident), and generated a 30-page report. (Exhibit Q). Dr. Cook arrived at 16 separate diagnoses and assigned an unapportioned 44% whole person PPI rating (although he reduced this rating at his deposition when he learned for which conditions Claimant was seeking benefits).

Dr. Simon – 2:

26. Dr. Simon conducted his second IME of Claimant on November 3, 2010. At that time, Dr. Simon had reviewed Dr. Cook's IME report, as well as medical records developed after his first IME. Dr. Simon again examined Claimant, who was complaining of ongoing pain in her neck, low back, right leg, and left hip. Dr. Simon again noted that Claimant's motor deficits were non-physiologic in their character and distribution. Further, on her strength testing, Claimant did not meet the validity requirements contained within the *AMA Guides to the Evaluation of Permanent Impairment*. Despite the medical treatment received by Claimant after Dr. Simon declared her at MMI on January 3, 2005, he continued to adhere to his opinion that

she was indeed at MMI on that date for conditions related to her industrial accident, and had no PPI or work restrictions.

27. Dr. Simon disagreed with Dr. Cook's PPI ratings:

> I reviewed Dr. Cook's independent medical evaluation and the impairment rating that he assigned. The main reason I disagree with his impairment rating is that her problems relating to the industrial injury had resolved and that her ongoing problems are either related to pre-existing problems or newer, subsequent problems. Other reasons to disagree with his impairment ratings are that they do not make sense from a medical/anatomic standpoint or they were assigned for problems that were not even permanent. I will address these impairments individually.

Exhibit N, p. 28.

DISCUSSION AND FURTHER FINDINGS

Medical care:

Idaho Code § 72-432(1) obligates an employer to provide an injured employee reasonable medical care as may be required by his or her physician immediately following an injury and for a reasonable time thereafter. It is for the physician, not the Commission, to decide whether the treatment is required. The only review the Commission is entitled to make is whether the treatment was reasonable. *See, Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989). A claimant must provide medical testimony that supports a claim for compensation to a reasonable degree of medical probability. *Langley v. State, Industrial Special Indemnity Fund*, 126 Idaho 781, 890 P.2d 732 (1995). "Probable" is defined as "having more evidence for than against." *Fisher v. Bunker Hill Company*, 96 Idaho 341, 344, 528 P.2d 903, 906 (1974). No "magic" words are necessary where a physician plainly and unequivocally conveys his or her conviction that events are causally related. *Paulson v. Idaho Forest Industries, Inc*, 99 Idaho 896, 901, 591 P.2d 143, 148 (1979). A physician's oral testimony is not

required in every case, but his or her medical records may be utilized to provide "medical testimony." *Jones v. Emmett Manor*, 134 Idaho 160, 997 P.2d 621 (2000).

An employer is not responsible for medical treatment that is not related to a compensable industrial injury. *Williamson v. Whitman Corp./Pet, Inc.*, 130 Idaho 602, 944 P.2d 1365 (1997).

Low back:

28. Dr. Cook relates Claimant's lumber fusion, spinal cord stimulator implant, and the fusion re-do to her industrial accident.[5] He relies primarily on post-accident lumbar MRIs. The first was accomplished on April 13, 2004 and, according to the radiologist, showed no disk herniation and minor degenerative changes at L4-5. *See,* Exhibit A, p. 5. The second MRI Dr. Cook relied upon was taken on May 27, 2004. The attending radiologist reported no evidence of disk herniation or neural impingement. *See,* Exhibit E, p. 6. A third MRI, taken on October 27, 2005 (after the restaurant incident), was read by the radiologist as showing a broad-based central disk protrusion at L5-S1 without significant accompanying spinal stenosis. The left S1 nerve root was contacted but not displaced by disk material. There was also some suggestion of an annular tear in the posterior annular fibrosis at L4-5. No significant central canal stenosis was identified. *See,* Exhibit E. pp. 14-15.

29. Dr. Cook's reliance on the post-accident MRIs to establish causation is not persuasive. The only post-accident MRI to show a disk herniation (actually, protrusion) is the MRI taken after the restaurant incident when Claimant stood from a seated position and collapsed in January 2005. Claimant testified that at that time, her symptoms shifted from her left side to her right side. Dr. Cook explained that the 2004 and 2005 lumbar MRIs did not show a disk herniation because different radiologists, institutions, and MRI technologies can all

[5] Claimant's back surgeon did not offer a causation opinion.

combine to arrive at different interpretations of the studies. However, there is no indication that Dr. Cook reviewed the actual films or that he has any peculiar expertise in interpreting MRI studies, and it is apparent that he is grasping at straws to find support for his causation opinion.

30. When questioned about the January 2005 restaurant incident, Dr. Cook testified:

> Q. (By Ms. Doyle): All right. Another question about her right leg. You talked about this chart note earlier, but the first medical record that I see in the entire record where Ms. Erickson (Claimant) had problems with her right leg was when she was out to eat with her fiancé and she got up and had the severe onset of right-sided sciatica?
>
> A. Right.
>
> Q. So my question to you, Doctor, is that the first time Ms. Erickson reported to any of her doctors, or any of her chart notes includes anything about right-sided leg complaints, is nine months after the industrial accident?
>
> A. Yeah.
>
> Q. How can you relate the right-sided complaints to that accident?
>
> A. I'm not sure with reasonable medical certainty that I can relate that, other than the fact that that was the first reported incident. I made an error on one of my prior entries of that. Or my laptop did, I'm not sure, but I'll take the blame.
>
> Yeah, you know, I'm not sure. She was seen by Dr. Nash and had the right-sided sciatica. She had an equivocal straight leg raising. But he thought that the reason to redo the MRI because she - - it had been a year since her prior MRI. That's why the October 2005 MRI was done and did show some disk disease and broad-based disk bulges. But I can't definitely give a causal relationship of her onset of right-sided sciatica pain to the industrial accident. I think that was established fairly early in the deposition, I think. I said the right side symptoms were not being challenged at this point. Isn't that correct?
>
> * * *
>
> I made mention of her right-sided sciatica pain, but I can't attribute a causal relationship to that radicular pain on the right side to the industrial accident.

Dr. Cook Deposition, pp. 77-79.

31. Dr. Cook's testimony is equivocal at best regarding the causal relationship between Claimant's low back condition requiring treatment after she was declared at MMI by

Dr. Simon in January 2005.[6] Dr. Simon, on the other hand, convincingly and unequivocally opined and testified that there was no such causal connection. He disagrees with Dr. Cook regarding what the two lumbar MRIs in 2004 demonstrate; that is, no acute injury or herniated disk. Dr. Simon credibly testified that it would be impossible for Claimant to have suffered a herniated disk or acute low back injury in March 2004, without radiographic evidence of a disk protrusion until October 2005, when Claimant's herniation was first detected on her lumbar MRI.

32. As noted, the evidence most strongly supports the proposition that although Claimant has experienced low back pain to one degree or another since the March 29, 2004 accident, she did not experience any right lower extremity symptomology until after the restaurant incident of January 2005. The lumbar MRI of October 27, 2005 suggested that the January 2005 restaurant incident caused new acute injuries to Claimant's lumbar spine. Although these findings were not confirmed by the April 2, 2007 MRI, it was nevertheless for Claimant's right lower extremity symptomology that Dr. Walker performed the right-sided decompression and fusion surgery on June 12, 2007. Assuming that the January 2005 restaurant incident did cause further injury to Claimant's lumbar spine resulting in the need for the June 2007 decompression surgery, the initial question presented by the occurrence of the restaurant incident is whether the injuries caused by that incident flow naturally and foreseeably from the original March 29, 2004, accident.

33. In this regard, the instant case bears some similarities to the facts before the Commission in *Mick v. Home Depot*, 2008 IIC 1007 (2008). In *Mick*, the claimant suffered a

[6] Another problem with Dr. Cook's analysis is that in his deposition, he initially testified that he agreed with Dr. Simon that Claimant was at MMI as of January 3, 2005. Then, later on in his deposition, he placed the date of MMI at April 26, 2010, the date of his IME.

compensable low back injury in 2005. After undergoing surgical treatment, the claimant was declared to be at MMI by his treating physician on or about June 5, 2006. To the claimant's treating physician, this simply meant that the claimant did not require further surgical treatment or further diagnostic testing.

34. On or about July 17, 2006, the claimant was assisting a friend in lifting a 25-30 pound glass table top, when he experienced the sudden onset of severe low back pain. A subsequent MRI evaluation demonstrated a need for additional surgical therapy. The Commission found that the claimant had reached a point of medical stability prior to the table top lifting incident, and recognized that the table top lifting incident caused additional damage to the claimant's lumbar spine. The principal question before the Industrial Commission was whether the July 2006 table top lifting incident was a compensable consequence of the original 2005 accident.

In *Mick*, the Commission found that the July 2006 incident constituted a superseding/intervening cause not connected to the original work accident. Important to this determination was the fact that the claimant had been declared medically stable by his treating physician a little less than a month prior to the table top lifting incident. The Commission also specifically recognized that the table top lifting incident was unconnected to the original 2005 accident, and was sufficient to constitute a separate "intervening" event, independently responsible for causing additional injury to the claimant's lumbar spine.

The facts of the instant matter are similar to *Mick* in that Claimant had been declared medically stable by Dr. Simon prior to the occurrence of the restaurant incident. However, the circumstances of the intervening events at issue in *Mick*, and the instant matter, differ significantly. In *Mick*, the intervening event was a discrete lifting incident which produced

immediate symptoms in the claimant, and which was thought to have caused additional injury to the claimant's lumbar spine. Here, Claimant was not lifting but was simply arising from a seated position when she felt the sudden onset of significant and different symptomology.

It is easier to conclude that the table lifting incident in *Mick* is an event which breaks the chain of causation between the original accident and Mr. Mick's injuries, than it is to imagine that Claimant's simple act of standing up from a seated position should constitute an event breaking the chain of causation between the March 29, 2004, accident and her current condition. Ordinarily, normal activities of daily living would not be considered to be significant enough to constitute a superseding/intervening event breaking the chain of causation between a work accident and an injured worker's injuries. Even so, it is Claimant who bears the burden of proving that the right lower extremity symptomology she developed following the restaurant incident is causally related to the March 29, 2004, accident. For the reasons set forth below, the Referee finds that the evidence in the instant matter fails to make this connection to the requisite degree of medical probability.

35. First, there is no evidence that Claimant collapsed as a result of anything connected to the original March 29, 2004, accident. Rather, the testimony and medical records are to the effect that Claimant collapsed because she developed the sudden onset of right lower extremity sciatica after she arose from her seated position at the restaurant. Claimant's testimony does not establish for example, that <u>because</u> of the back pain she experienced after the March 29, 2004 accident, she collapsed at the restaurant and, as a result, suffered additional injuries to her back. Second, there is no medical testimony establishing that the low back condition Claimant developed following the March 29, 2004 accident did anything to contribute to the additional injuries Claimant allegedly suffered as a result of the restaurant incident. Based

on the medical evidence of record that the Referee finds persuasive, the injury occurring to Claimant's lumbar spine as the result of the restaurant incident is just as likely to have occurred entirely independent of the March 29, 2004 accident. Dr. Cook's testimony that the March 29, 2004 accident made it "unavoidable" that Claimant would subsequently develop right-sided symptoms in January 2005 is entirely unpersuasive. (Dr. Cook Deposition, pp. 95-96).

36. Though the facts of this case differ in character from those at issue in *Mick v. Home Depot, supra*, Claimant has similarly failed to establish that whatever injuries she may have suffered as a consequence of the restaurant incident flowed naturally and foreseeably from the original accident of March 29, 2004.

37. The Referee finds that Claimant has failed to prove her need for medical treatment for her back condition or lower extremity problems after January 3, 2005 is causally related to her industrial accident.

Left shoulder:

38. Dr. Cook posits that treatment Claimant received for her left shoulder after January 2005 is causally related to her industrial accident; Dr. Simon disagrees.[7] As with the issues regarding Claimant's back and MRIs, her left shoulder MRIs play a large role in the resolution of the issues surrounding that shoulder. To recap, Claimant's first left shoulder MRI was taken in May 2004 and showed a possible mild rotator cuff tendinitis and no other abnormalities. The next left shoulder MRI was accomplished on October 27, 2005 and revealed tendinitis of the infraspinatus tendon, acromioclavicular degenerative joint disease, and a small SLAP lesion. Claimant's last left shoulder MRI was taken on June 14, 2006, and revealed

[7] Claimant's left shoulder surgeon did not offer a causation opinion.

calcific tendinitis of the supraspinatus tendon with incomplete tear, an incomplete tearing of the rotator cuff, and no labral tears.

39. Dr. Cook testified as follows regarding his opinion that Claimant's left shoulder injury and consequent loss of motion is related to her industrial accident:

> She was followed by several practitioners. Initially it was thought that she had just sustained a left shoulder strain. When an MRI was finally obtained it was found that she had injuries consistent with the initial workplace injury. She had internal derangement, she had a SLAP lesion, which was small and might have been missed on the initial MRI.[8] And then she had some supraspinatus tendonopathy. I'd have to verify that. But it was sufficient to warrant exploration and surgery. She had the surgery with repair of those injuries and then subsequently developed the progressive motor deficits.

Dr. Cook Deposition, pp. 31-32.

40. Regarding the left shoulder conditions prompting surgical intervention by Dr. Andary, Dr. Cook testified:

> Okay. Finding Dr. Andary's note and chart, he had an assessment of left shoulder calcific tendonitis and partial rotator cuff tear. And on operative examination he found that she did have impingement and she did have a rotator cuff tear and what they term a SLAP lesion.
>
> Q. (By Ms. Doyle): So everything you just read, those conditions, are all of those related to the industrial accident in your opinion, just some of them, none of them?
>
> A. That's a good question. I think the calcific tendonitis could in part represent a degenerative condition, but if there is injury to the supraspinatus tendon at the time of the initial accident that creates an injury that causes further degenerative processes to take place in that particular tendon.
>
> I think the rotator cuff tear that wasn't seen on the preoperative imaging studies and was found on the actual arthroscopic surgery, I think that was definitely caused by the lifting injury because that usually implies that there's some trauma and hyperextension, or at least severe stress on the shoulder joint.
>
> The SLAP lesion, again, I think that's also attributable to the lifting injury.

Id., pp. 81-82.

[8] Dr. Cook must be referring to the May 2004 MRI taken shortly after Claimant's accident.

41. Dr. Simon testified that, based on the May 2004 left shoulder MRI that showed no pathology and his clinical observations, Claimant had no torn rotator cuff at the time of her accident:

> Q. (By Ms. Doyle): All right. So do you have an opinion then, doctor, on whether that pathology[9] in her shoulder was caused by the industrial accident or not?
>
> A. It's my opinion that it wasn't, and that's - - do you want to know my reasons for that or - -
>
> Q. Yes. No, please go ahead, Doctor. I was going to ask some questions about the MRIs, but please go ahead.
>
> A. Well, I mean, there's a couple of reasons here. Number one - - and, again, I was her treating physician; so I have firsthand knowledge of this - - you know, her shoulder symptoms that she had following the industrial injury, you know, improved and resolved with treatment. That's one issue.
>
> The second issue is that the initial MRI of the shoulder done after the industrial injury did not show a rotator cuff tear, and it was a subsequent one that did.
>
> And so, you know, the most likely scenario is, yes, she had some shoulder pains, and this is all likely due to what's called impingement syndrome. And when she had the injury, she had an exacerbation of that and some, you know, pain and inflammation related to the injury. That was treated; it resolved and went back to its baseline state.
>
> And then, you know, with time the impingement problem worsened, and, like I said, due to these repetitive activities; you know, anything from hanging your clothes up on the - - you know, in your closet, to, you know, putting the dishes away.
>
> Every time you lift your arm, you know, up above the shoulder, the impingement kind of pinches and irritates that rotator cuff and, most specifically the supraspinatus tendon, which is the one she tore. It pinches it and it kind of gets frayed like a rope, and then ultimately it just tears, not from - - you know, it doesn't even have to be any sort of significant injury to that; it just finally gets frayed and frayed and frayed and then it tears.
>
> So that's the most likely thing that happened in her case.
>
> * * *
>
> But, you know, I guess the other thing, I would also note that clinically, you know, she responded - - she didn't respond clinically like a rotator cuff tear,

[9] Counsel is referring to what Dr. Andary found at surgery, that is, suprapinatus rotator cuff tear, impingement, and a SLAP lesion.

> and, again, I know this because I was her treating doctor. She got better with, you know, some anti-inflammatory medications, some steroids. I mean, that decreases inflammation, it doesn't fix a rotator cuff tear. So, you know, that's more consistent with it not being torn initially.

Dr. Simon Deposition, pp. 37-38, 42.

42. The Referee finds Dr. Simon's opinion and testimony more persuasive than that of Dr. Cook regarding the causation of Claimant's January 2005 post-MMI left shoulder condition. The three left shoulder MRIs are telling. The first showed no rotator cuff tear or SLAP lesion. The second one, taken a little over a year from the first, showed some degenerative joint disease and a small SLAP lesion. The third, over two years from the first, showed some partial tearing of the rotator cuff. Dr. Cook apparently ignored the first MRI, the one closest in time to Claimant's industrial injury, by testifying without explanation that the partial rotator cuff tear and SLAP lesion could have gone undetected. Dr. Simon, on the other hand, credibly explained how Claimant's shoulder condition progressed from baseline in January 2005 to what Dr. Andary found at surgery a year-and-a-half later. Dr. Simon expressed his opinions unequivocally, whereas Dr. Cook often seemed uncertain and chose to ignore or attempted to explain away objective evidence not supportive of his opinions.

43. The Referee finds that Claimant has failed to prove any treatment Claimant received for her left shoulder after January 3, 2005 is compensable.

CONCLUSIONS OF LAW

1. Claimant has failed to prove that the treatment she received for her low back and left shoulder after January 3, 2005 is compensable.

2. All other issues are moot.

RECOMMENDATION

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

DATED this _6th_ day of September, 2011.

INDUSTRIAL COMMISSION

__/s/_____
Michael E. Powers, Referee

CERTIFICATE OF SERVICE

I hereby certify that on the ___27th____ day of __September____, 2011, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

ALBERT MATSUURA
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ge _Gina Espinosa_

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

LINDA D. RYAN, Claimant, v. DUCKWALL-ALCO STORES, INC., Employer, and LIBERTY MUTUAL FIRE INSURANCE COMPANY, Surety, Defendants.	**IC 2004-507310** **ORDER** Filed September 27, 2011

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

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

1. Claimant has failed to prove that the treatment she received for her low back and left shoulder after January 3, 2005 is compensable.

2. All other issues are moot.

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

DATED this __27th___ day of __September__, 2011.

INDUSTRIAL COMMISSION

__/s/_____
Thomas E. Limbaugh, Chairman

__/s/_____
Thomas P. Baskin, Commissioner

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

ATTEST:

_/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __27th____ day of __September__ 2011, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

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