BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

JACK E. WACASTER, Claimant, v. ARLO LOTT TRUCKING, INC., Employer, and LIBERTY NORTHWEST INSURANCE CORPORATION, Surety, Defendants.	)	**IC 2007-028189** **2008-027324** **FINDINGS OF FACT, CONCLUSION OF LAW, AND RECOMMENDATION** Filed: September 14, 2010

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 Boise, Idaho, on November 9, 2009. Darin G. Monroe of Boise represented Claimant. Kimberly A. Doyle of Boise represented Defendants. The parties submitted oral and documentary evidence at hearing, took two post-hearing depositions, and filed post-hearing briefs. The matter came under advisement on July 28, 2010 and is now ready for decision.

ISSUES

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

1. Whether Claimant's low back condition is causally related to the industrial accident of August 13, 2007, or is the result of a pre-existing condition;

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

a. Medical care;

b. Temporary total or temporary partial disability (TTD/TPD);

c. Permanent partial impairment (PPI);

d. Attorney fees; and

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

CONTENTIONS OF THE PARTIES

Claimant asserts that the industrial accident he suffered on August 13, 2007 caused a permanent aggravation of his pre-existing, but not debilitating, low back condition, accelerating his need for a three-level lumbar fusion. Defendants are liable for the cost of medical care relating to the fusion and TTDs during his period of recovery. As a result of his lumbar fusion, Claimant asserts that he has sustained 10% whole person impairment attributable to the August 13, 2007 accident. Finally, Claimant contends that Defendants' denial of his industrially-related surgery was unreasonable, entitling him to attorney fees pursuant to Idaho Code § 72-804.

Defendants assert that the industrial injury, at most, resulted in a temporary exacerbation of Claimant's chronic low back condition which resolved without impairment. Claimant's lumbar fusion was due solely to the natural progression of his long-standing degenerative condition. Defendants are not liable for Claimant's medical care related to his lumbar fusion, TTD benefits, or PPI benefits. Since Claimant's claim was not compensable, Defendants' denial was not unreasonable and Claimant is not entitled to an award of attorney fees.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant, taken at hearing;

2. Joint Exhibits A through CC, admitted at hearing; and

3. Post-hearing depositions of Michael Hajjar, M.D., taken May 5, 2010, and Roy Tyler Frizzell, M.D., taken March 15, 2010.

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

FINDINGS OF FACT

1. Claimant was sixty-nine years of age at the time of hearing and was anticipating his seventieth birthday three days hence. Claimant has lived in Idaho since 1999 and has been married to his current wife for seventeen years.

EMPLOYMENT HISTORY

2. Claimant joined the U.S. Navy at seventeen, and served for over eleven years. Subsequent to his military service, Claimant worked in law enforcement in Wyoming. Since the late 1970s, he has worked as a long-haul trucker. Claimant went to work as a driver for Employer in 2002.

PRIOR MEDICAL HISTORY

3. In 1989, Claimant injured his lumbar spine when he fell from a front-end loader and struck his low back on an unidentified object. He spent two days in the hospital with what he described as severe lumbar pain and extreme low back pain. For two days following the accident, Claimant lost sensation in both lower extremities and was unable to walk.

4. In early June 2001, Manuel Lois, M.D., Claimant's primary care physician, ordered a lumbar MRI. The record does not contain any chart notes leading up to the MRI, but the MRI report states, "[e]valuate low back pain with numbness to the left leg." Ex. E, p. 33.

Relevant findings include:

- At L3-4—disc desiccation together with a bulging disc, and posterior osteophytic ridging, both described as "mild," and degenerative facet disease, severe central canal stenosis and bilateral foraminal narrowing, described as "moderate;"

- At L4-5—minimal grade I anterior spondylolisthesis[1] of L4 on L5 secondary to degenerative facet disease, disc desiccation, mild bulging disc, mild posterior osteophytic ridging, hypertrophic degenerative facet changes, severe central canal stenosis and moderate bilateral foraminal narrowing;

- At L5-S1—hypertrophic degenerative facet changes and mild bilateral foraminal narrowing with no focal disc protrusion or central canal stenosis noted.

5. Claimant began treating with Timothy Johans, M.D., for back pain in July 2001. His presenting complaint was "low back pain slowly progressive over the last two years, with left leg radiating pain down to the calf which is commonly 10/10." Ex. H, p. 121. Dr. Johans reviewed the MRI and was in agreement with all but the finding of the spondylolisthesis of L4 on L5, which he interpreted as:

> severe degenerative facet disease and mild bulging disk, but he has severe and very large degenerative facet joints and ligamentum hypertrophy causing severe central canal stenosis here.

Id., at p. 122. The only option that Dr. Johans could offer Claimant was surgical decompression of L3-4-5.

6. Dr. Johans performed an L3-4-5 decompressive laminectomy on July 10, 2001. There were some complications during the surgery, causing a tear in the dura, which Dr. Johans repaired. Dr. Johans returned Claimant to surgery eight days later to repair two additional tears in the dura that were leaking spinal fluid. Claimant had a normal recovery following the second

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[1] Claimant's spondylolisthesis is variously described as "anterior spondylolisthesis," "anterolisthesis," and "anterior subluxation." The spondylolisthesis is anterior because the L4 disc is in front of the L5 disc. All three terms describe the same condition, and for purposes of brevity and consistency, the condition will be referred to simply as spondylolisthesis.

surgery, and by the end of August, 2001, both Claimant and Dr. Johans were ecstatic with his surgical outcome.[2]

7. In October 2002, just a year after his laminectomy, Claimant was once again having low back pain with radicular symptoms in his left leg. There are no chart notes, but according to the MRI report, dated October 9, 2002, Dr. Lois ordered another lumbar MRI. According to the report, the purpose of the MRI was to "[e]valuate low back pain with numbness to left leg." Ex. E, p. 40. The radiologist compared the results with the images taken in June 2001. Apart from evidence of the laminectomies, the images were substantially consistent with those taken the year before, particularly with regard to the lumbar stenosis at L3-4 and the stenosis and spondylolisthesis of L4 on L5. There is nothing in the record to indicate that Claimant sought further treatment at that time.

8. On December 26, 2003, Claimant was in his personal vehicle when a service truck ran a stop sign and collided with Claimant's vehicle. The accident totaled Claimant's vehicle. An MRI done in early January 2004 showed no significant change from the October 2002 imaging with regard to the lumbar stenosis at L3-4 and the stenosis and spondylolisthesis of L4 on L5. Nevertheless, Claimant had such severe back pain that he quit his job with Employer and did not return to work for fifteen months.

9. During the time Claimant was off work, he began treating with Douglas Smith, M.D., for his low back pain and occasional radicular symptoms. Dr. Smith recommended conservative care and referred Claimant to physical therapy. By early March 2004, Claimant, Dr. Smith, and the physical therapist were in agreement that therapy was not helping. Flexion

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[2] *See*, Ex. K, p. 183.

and extension x-rays taken March 8 quantified the L4 on L-5 spondylolisthesis as approximately two millimeters. Dr. Smith suggested Claimant try water therapy and ordered an epidural steroid injection (ESI).

10. Claimant obtained some relief from the ESI, and saw Dr. Smith again on April 2, 2004 for a discussion about his treatment options. Dr. Smith followed up the discussion with a letter of even date in which he documented the gist of their discussion on the following points:

- Should Claimant progress to need surgical intervention, the surgery would involve a three-level fusion from L3 through L5;
- Even with the best possible outcome, Claimant would have a fifty-pound lifting restriction post fusion;
- A fifty-pound lifting restriction would preclude Claimant from returning to long-haul trucking because he would not be able to tarp a load or chain up his truck in inclement weather.

11. Claimant chose not to proceed with surgery because he wanted to drive truck until he was seventy. Claimant saw Dr. Smith again in July 2004, reporting that his condition was worsening; he could no longer perform small tasks around the house, and he occasionally needed assistance getting up from a sitting or reclining position.

12. In October 2004, Claimant saw Dr. Barr for a regular checkup and medication refill. Claimant reported:

> He has some problems with chronic back pain. He said that he was actually diagnosed with a compression fracture of the lumbar vertebra just this past Friday by Dr. Lahey.[3] This apparently was diagnosed and attributed to that MVA, although, the MRI that I did on him in January showed no evidence of that. Getting along reasonably well but he still cannot work because of his back . . .

Ex. M, p. 203.

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[3] The Referee was unable to locate any documentation in the record supporting Claimant's assertion.

13. Claimant either saw or called Dr. Smith in early December 2004; a chart note written by Dr. Smith and dated December 9 discusses the January 6, 2004 MRI results and states, "eventual need for discectomies and fusions L2-3-4-5." Ex. L, p. 199. The last documentation in Dr. Smith's file is a hand-written note from the office manager recording a telephone call from Claimant: "[Phone call] from patient 1/5/05 disputing cost estimate for surgery. Revised estimate mailed 1/6/05." *Id.* At hearing, Claimant averred that contrary to the implication in the chart note, he had not considered having the surgery at that time.

14. Claimant returned to work as a long-haul driver for Employer sometime in late April or early May 2005. Claimant testified that in the fifteen months he was off work he did a lot of fishing and purchased a treadmill which he used to rehabilitate his low back.

15. Claimant worked for Employer until October 2005, when he voluntarily quit after a series of incidents in which Employer's equipment sustained damage. From October 2005 until the late summer of 2006, Claimant worked in his woodshop and fished. He testified that he had minimal back pain—"it wasn't anything that I would even take an aspirin for . . ." Tr., p. 46.

16. Claimant returned to work for Employer in the late summer or early fall of 2006.

> I wanted some bigger toys for my wood shop, so I – I called him and said how about let's – going back to work and he said when do you want to go to work and I said I'm ready and they said come to work.

Tr., p. 48.

17. In mid-September 2006, in the course of treatment for gastric reflux, Claimant identified back pain from the 2003 MVA as part of his medical history. Claimant admitted at hearing that he had low back pain in September 2006.

AUGUST 13, 2007 INDUSTRIAL ACCIDENT

18. On August 13, 2007, Claimant was in Utah driving for Employer. While traversing a particularly rough railroad crossing, the pneumatic seat malfunctioned and bottomed out, causing the immediate onset of pain in his low back. Claimant returned to the Treasure Valley and sought medical care the following day at Holy Rosary Medical Center. Claimant described the rough railroad crossing, a "crunch" in his low back, and reported that his back hurt "pretty severely" since that time, and he had some numbness in his left leg. Ex. N, p. 241. AP and lateral lumbar x-rays taken that day identified a grade I spondylolisthesis of L4 on L5 along with lumbar stenosis at L3-4 and L4-5. Claimant refused pain medication because it interfered with his driving. The chart note indicates "specific work limitations" were imposed, but none are extant in the record. Six days later, Claimant returned to Holy Rosary for follow-up. He reported that "he is doing fine and ready to go back to work. He just needs a release." *Id.* at p. 243. On exam, Claimant had full range of motion in his lumbar spine, and no bruising, swelling or tenderness to palpation. He was released from care and returned to full-duty work.

19. Claimant immediately returned to the same job, driving the same truck, and performing the same duties for Employer.

AUGUST 29, 2007 INCIDENT

20. Claimant alleges he had an industrial accident on August 29, 2007 when he encountered some rough road in Colorado. This alleged accident is the subject of IC 2008-027324, consolidated for hearing with IC 2007-028189 (the August 13 accident). Apart from a passing mention at hearing, Claimant has not pursued the August 29 claim. None of the issues delineated at the outset of the hearing pertain to the August 29, 2007 incident, and the

record contains no evidence of medical treatment related to the August 29 event. Neither is it addressed in Claimant's briefing.[4]

OCTOBER 12, 2007 INJURY

21. On October 12, 2007, almost two months after returning to full-duty work following the August 13 accident, Claimant injured his right shoulder in an industrial accident.[5] The shoulder injury alone took Claimant off work.

FURTHER TREATMENT FOR LOW BACK PAIN

22. When Claimant sought care for his shoulder injury, he once again raised the issue of low back pain, which he attributed to the August 13 accident. The chart note for the October 16, 2007 visit documents:

> This is a follow up to a back injury. Patient stated that on his last visit on 08/20/07, that he was doing better without any pain what so ever [sic] and was released to full duty. However, he reports today that he has been having back pain. Originally he said for two to three days and then changed that to say it was two to three weeks ago. He reports that this pain is new.

Id., at p. 247. Claimant localized his low back pain to the area around L3-4-5. The physician's assistant treating Claimant noted decreased range of motion, but no swelling, bruising, or noticeable muscle spasm in Claimant's back. Lumbar spine x-rays taken that day showed a six-millimeter spondylolisthesis of L4 on L5 but noted, "no adverse change from the lumbar radiographs of 08/14/07." Ex. E, p. 57. The PA prescribed pain meds and muscle relaxers for Claimant's shoulder and noted that these medications would also cover his back pain.

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[4] For purposes of brevity and clarity, the remainder of these findings and conclusions pertain only to the August 13, 2007 accident and injury, which will be denominated as the August 13 accident or injury.

[5] Claimant's right shoulder claim was accepted and is not at issue in this proceeding.

23. Claimant remained off work and continued to treat for his shoulder, including an arthroscopic rotator cuff repair in December 2007, until his surgeon declared his shoulder medically stable on May 15, 2008. Permanent restrictions related to the shoulder included no work above shoulder level and no lifting of more than thirty pounds. These restrictions precluded Claimant from returning to his time-of-injury job as a long-haul trucker.

24. In late April 2008, Claimant saw Paul C. Gering, Jr., M.D., at Ontario Family Medicine to establish a primary care provider relationship. Dr. Gering noted fourteen different diagnoses requiring continuing management. Relevant to this proceeding were presenting complaints of neck pain with left upper extremity radiculopathy, which Claimant attributed to the August 13 industrial accident, and pain in the left hip joint.[6] Dr. Gering ordered MRIs of Claimant's cervical, thoracic and lumbar spine. The lumbar MRI report, Ex. E, p. 65, dated May 9, 2008 included findings of "about 5 mm" of spondylolisthesis of L4 upon L5, and generalized stenosis of the spinal canal and moderate foraminal stenosis at L4-5 and moderate stenosis at L3-4. The report concluded: "*When today's MR study is compared with 1-6-04, very little if any significant interval change has occurred at any of the levels imaged today including L4-5." Id.,* at p. 66 (Emphasis added.)

25. On July 1, 2008, Claimant saw Dr. Frizzell, a neurosurgeon, about his low back pain and left lumbar radiculopathy. Dr. Frizzell ordered another lumbar MRI. The radiologist who read the MRI did not have any of the previous four lumbar MRIs for comparison.[7] Relevant findings in addition to evidence of the 2001 laminectomies include:

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[6] Although the medical history notes the 2001 laminectomies, there is no mention of any lumbar complaints in the chart notes from this visit.

[7] There is a hand-written note in the margin that seems to read "no pronounced change" and "no change," but the remainder of the writing that references which films were compared is not

- At L3-4—moderate bilateral facet joint arthropathy; loss of disc height and hydration with subtle broad-based disc bulge; moderate to severe left and moderate right foraminal stenosis;

- At L4-5—"subtle" spondylolisthesis, and mild to moderate central spinal canal stenosis with moderate bilateral foraminal stenosis.

26. Dr. Frizzell discussed treatment options with Claimant on July 31, 2008. Claimant opted to proceed with a three-level discectomy and fusion at L3-L4-L5. Dr. Frizzell performed the fusion August 27, 2008. Claimant had some refractory leg pain following the surgery, which Dr. Frizzell attributed to post-surgical nerve swelling. The post-operative CT scan also revealed an avascular necrosis of the left femoral head that Dr. Frizzell thought might be contributing to Claimant's leg pain. The CT also showed a fracture of the right L5 pedicle adjacent to the right L5 pedicle screw without evidence that the hardware had moved. Dr. Frizzell referred Claimant to William G. Binegar, M.D., for consultation regarding Claimant's leg pain, and Dr. Binegar performed a series of L4-L5 nerve root blocks.

27. Claimant saw Dr. Frizzell for a surgical follow-up on October 7, 2008. Claimant reported he was doing well, and the L4-L5 nerve root injections had relieved Claimant's post-surgical radicular symptoms. At hearing, Claimant testified that he was quite happy with his fusion. His leg pain was gone, and he rated his low back pain as a fairly constant one out of ten.

28. On August 18, 2009, Dr. Frizzell saw Claimant for impairment rating and assessment of permanent restrictions related to the August 13 accident. Dr. Frizzell found Claimant was medically stable. Permanent restrictions were:

- Lifting limited to thirty-five pounds occasionally and fifteen pounds frequently;

- Avoid prolonged low-frequency vibration; and

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legible. Dr. Frizzell did not discuss his interpretation of the MRI in the chart note documenting Claimant's post-MRI visit.

- Avoid constant bending and twisting.

Dr. Frizzell used the *AMA Guides to the Evaluation of Permanent Impairment,* 5th ed. (*AMA Guides* 5th) to calculate Claimant's permanent partial impairment related to the August 13, industrial accident. Applying the range of motion method and Table 15-7 of the *AMA Guides* 5th, Dr. Frizzell found that Claimant was a category IV C and E, resulting in 10% whole person impairment. Dr. Frizzell mistakenly states that Claimant had *two* prior discectomy surgeries, but his award of an additional 2% whole person impairment for a second surgery was correct, according to Table 15-7(E)(1), for a total of 12% whole person PPI. Dr. Frizzell then measured Claimant's range-of-motion and found him to have 45 degrees of flexion and 26 degrees of extension. Using Table 15-8, the loss of range of flexion and extension adds 2% whole person impairment, for a total of 14% whole person PPI. Finally, Dr. Frizzell measured Claimant's lateral bending (29 degrees right, 18 degrees left) and used Table 15-9 to award an additional 1% PPI for a whole person impairment of 15%. Dr. Frizzell apportioned 5% of the 15% to Claimant's pre-existing conditions, leaving 10% PPI related to the August 13 accident.

IMEs AND RECORD REVIEWS

Dr. Cox

29. On March 28, 2008, Rodde D. Cox, M.D., conducted an independent medical exam (IME) of Claimant at the request of Defendants. Defendants asked Dr. Cox to evaluate Claimant with regard to the August 13 work injury. At the IME, Claimant provided a medical history to Dr. Cox, mentioning the industrial back injury in 1989, a knee injury dating back to 1972, the MVA in 2003, and the August 13 injury. With regard to the 2003 MVA, Claimant advised Dr. Cox that he had been off work for *eight months* as a result of the accident. There is no mention of Claimant's 2001 back surgery in the subjective history. With regard to the August

13 accident, Claimant told Dr. Cox that he hurt his *neck and mid back*. Claimant's chief presenting complaint was neck and upper back pain.

30. Dr. Cox examined Claimant, reviewed medical records related to the August 13 accident, and administered a number of pain status inventories. He concluded that:

- Claimant initially presented with low back pain as a result of the August 13 accident;
- The pain resolved within a week, but resurfaced following the October 16 shoulder injury;
- The injury of record is low back pain and there is nothing in the records to suggest that Claimant sustained injury to his cervical, thoracic, or upper lumbar spine as a result of the August 13 accident;
- "Based upon the available information, to a reasonable degree of medical certainty, there is no causal relationship between the examinee's complaints of neck pain and lower thoracic and upper lumbar pain and the reported injury." Ex. Q, p. 276; and
- Claimant was medically stable with no impairment attributable to the accident.

Dr. Cox offered no opinion as to any causal relationship between the August 13 accident and Claimant's low back complaints.

Dr. Giles

31. In November 2008, Defendants asked David Giles, M.D., a radiologist, to review certain of Claimant's MRI films. In particular, Defendants asked if there were differences between three particular MRIs, and if so, what those differences were. Dr. Giles looked at images from October 9, 2002, January 6, 2004, and May 9, 2008. He concluded:

> There is no significant change when the 2004 examination is compared to the 2002 examination, and when the 2008 examination is compared to both the 2004 and 2002 examinations. This patient has diffuse degenerative changes in the lumbar spine, as detailed, and is status post decompressive L3-S1 laminectomy. There is no focal significant thecal sac or nerve rootlet compressive lesion identified, and, therefore, no evidence of a compressive etiology for lumbar radiculopathy.

Ex. V, p. 324.

Dr. Hajjar

32. On April 3, 2009, Dr. Hajjar, a neurosurgeon, conducted a second IME at Defendants' request. Dr. Hajjar reviewed Claimant's medical records dating back to, and including his 2001 back surgery, as well as the numerous radiographic studies. On exam, Dr. Hajjar observed Claimant to be uncomfortable, with an antalgic gait favoring his right leg. Upper and lower extremity strength and reflexes were symmetric bilaterally.

33. Dr. Hajjar concluded that Claimant sustained a lumbar strain as a result of the August 13 accident, but that it was Claimant's pre-existing lumbar degenerative changes that necessitated the three-level discectomy and fusion in 2008. Dr. Hajjar noted that the course of Claimant's degenerative lumbar pathology was well-documented by a number of radiographic reports beginning prior to his first lumbar surgery and extending to post-operative scans following the 2008 fusion. Dr. Hajjar also observed that the purpose of the 2008 fusion was to fix degenerative problems and all of Dr. Frizzell's surgical findings were consistent with degenerative processes.

34. With regard to Claimant's L4-L5 spondylolisthesis, Dr. Hajjar agreed with Dr. Frizzell that it was the change in the degree of Claimant's spondylolisthesis that led to the 2008 fusion, but disagreed as to the cause of the change:

> Q. [by Ms. Doyle] On that issue, the issue of spondylolisthesis, one of the things that Dr. Frizzell testified to in his deposition is that, in his position, he believes that the change from two millimeters to six millimeters spondylolisthesis is what caused the need for [Claimant's] surgery in this case.
>
> Do you have any comment on that?
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> A. I agree with that statement. I think the question is whether or not the progression of two millimeters to six millimeters of anterolisthesis is the anticipated progression of the degenerative change present in the back, or if this finding was acutely caused by the traumatic injury.

> My opinion on that is that *it is far more likely than not, that the ongoing degenerative changes led to the progression of the anterolisthesis*; therefore, the need for surgery.

Deposition of Michael J. Hajjar, M.D., p. 11 (Emphasis added.)

35. Dr. Hajjar opined that Claimant was medically stable with regard to his 2007 injury, but that he may require further back care as a result of continuing degenerative processes. In particular, Dr. Hajjar noted post-operative degenerative findings below the level of the previous surgeries. Dr. Hajjar recommended permanent restrictions to include, ". . . no frequent bending, twisting, stooping, standing or heavy lifting greater then [sic] forty pounds as well as avoiding vibrations and high impact activities." Ex. W, p. 327. Using the *AMA Guides,* 6th ed., Dr. Hajjar opined that Claimant had a pre-existing whole person impairment of 8% as a result of the 2001 surgery. The 2007 lumbar strain did not add any impairment, but Claimant's condition at the time of the IME, together with the 2008 fusion, would add another 10% whole person impairment to the pre-existing 8%, for a total of 18%--all of which is attributable to degenerative changes, and none to work-related findings.

CREDIBILITY

36. Claimant admits that he is not a good historian. A cursory review and comparison of the medical records, Claimant's subjective reports, and his testimony, confirm his assessment. Without suggesting that Claimant sought to deceive, his statements in the medical records and at hearing contain numerous inconsistencies that cannot be explained away. One obvious example pertains to Claimant's statements and actions following the December 2003 MVA and his statements and actions following the August 13 accident. Claimant testified that he could not work for fifteen months when he reported pain at four out of ten, but he continued to work when he reported pain at "ten plus" out of ten. The Referee finds Claimant's subjective reports of his

condition, both at hearing and in the medical records, as too unreliable to rely upon as support for Claimant's position.

DISCUSSION AND FURTHER FINDINGS

CAUSATION

37. The burden of proof in an industrial accident case is on the claimant.

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

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

38. Medical causation is at the very core of this proceeding. If Claimant's August 13 industrial accident made the 2008 fusion necessary, then Defendants are liable for Claimant's medical care related to the surgery, together with other indemnity benefits. If Claimant's 2008 fusion was necessary because of the natural progression of his documented degenerative conditions, then it is not a compensable claim under the Idaho workers' compensation statutes.

39. For the reasons discussed below, the Referee finds that Claimant has failed to establish that it is more likely than not that the August 13 industrial accident caused his need for the 2008 fusion.

History of Degenerative Joint Disease

40. Claimant's twenty-year history of progressive degenerative conditions is well-documented in the hearing record. His degenerative conditions are not limited to his lumbar spine—they occur throughout Claimant's spine, and in his hips, knees, shoulders, hands, and wrists.

41. Dr. Smith advised Claimant as early as 2004 that he was eventually going to require a discectomy and fusion at L3-4-5 because of the *natural progression* of his degenerative joint disease. When asked how he interpreted his practice partner's statement, Dr. Frizzell agreed that, in 2004, when Dr. Smith wrote about Claimant's "eventual need for surgery for his lumbar spine," Dr. Smith meant that given Claimant's degenerative spine, a fusion was going to become necessary—the question was not if, but when. Deposition of Dr. Frizzell, p. 35.

Claimant's Inconsistent Statements and Actions

42. Claimant's statements and actions following the 2003 MVA and the August 13 accident are irreconcilable. Following the 2003 MVA, undoubtedly a very serious accident, Claimant reported constant pain of four out of ten, treated for six months, could not work for fifteen months, and testified that he considered surgical intervention to be optional. Following the relatively minor August 13 accident, Claimant reported constant severe pain of ten "plus" out of ten, treated for one week, continued to work full-time at a strenuous job, reported no low back symptomology for seven months, and testified that he had no choice but to have surgery.

43. Claimant testified that he declined a lumbar fusion in 2004, because he wanted to drive truck for six more years, until he was seventy. Claimant did return to work for Employer in the spring of 2005, fifteen months after his MVA, but worked for only five months before he *voluntarily* quit in early October. Claimant testified that, over the next year, he did a lot of

fishing and played in his woodshop. In fact, Claimant stated that the reason he asked to return to work for Employer in the fall of 2006 was because he "wanted some bigger toys" for his woodshop (Tr., p. 48.) Claimant was only sixty-six at that time, and his testimony about his activities and his reasons for returning to work suggest that Claimant viewed his long-haul driving less an economic imperative and more a matter of choice. It was only after Claimant reached medical stability from his shoulder injury, and long-haul trucking was no longer a choice, that his need for a lumbar fusion moved from the "optional" column to the "no choice" column.

Medical Opinions

44. Understanding Claimant's medical history, statements, and activities helps put the medical evidence in context, but it is ultimately the medical opinions regarding causation that are dispositive of this claim. Drs. Frizzell and Hajjar agree that Claimant's lumbar fusion was necessary; they differ in their opinions as to *why* it was necessary. That difference of opinion makes all the difference.

45. In his deposition, Dr. Frizzell testified that Claimant's fusion was necessary because of stenosis at L3-4 and L4-5 and spondylolisthesis at L4-5. Dr. Frizzell admitted that the stenosis was a pre-existing degenerative change and not related to the August 13 accident. Dr. Frizzell also agreed that Claimant's spondylolisthesis pre-existed the August 13 accident and would likely have become symptomatic at some point in the future. Dr. Frizzell focused on the change in the *degree* of the spondylolisthesis—which change Dr. Frizzell attributed to the

August 13 accident—to explain the need for the surgery.[8] Dr. Hajjar is of the opinion that Claimant's degenerative condition just continued to degenerate until the accumulation tipped his symptoms across the line from tolerable to intolerable.

46. The Referee finds Dr. Frizzell's causation opinion troubling in two respects: First, Dr. Frizzell's opinion that the increase in the degree of spondylolisthesis was acute and not progressive is conclusory, not explanatory and is based in large part on Claimant's subjective reporting. Secondly, and perhaps corollary to the first concern, is that the medical evidence provides little support for Dr. Frizzell's conclusions.

Acute v. Natural Progression

47. Dr. Frizzell testified that Claimant had stenosis at L3-4 and L4-5, and a spondylolisthesis at L4-5 before the August 13 accident. Comparing the flexion and extension x-rays from March 2004 (after the MVA but before the August 13 accident) and October 2007 (after the August 13 accident, but before 2008 fusion), he observed a four-millimeter increase in the degree of Claimant's spondylolisthesis. Dr. Frizzell attributed the change in the degree of spondylolisthesis to the August 13 accident. The change in the severity of Claimant's spondylolisthesis was the *only* condition that Dr. Frizzell attributed to the August 13 accident.

48. Dr. Frizzell provided the following testimony when asked to explain *why* Claimant's symptoms were consistent with an acute change in his spondylolisthesis:

> [Claimant] likely had what's called a degenerative spondylolisthesis, which means that an arthritic condition had set up between the L4 and L5; conditioned

[8] It is important to distinguish that Dr. Frizzell made his judgment about the *necessity* of surgery based only on the July 2008 MRI, the bone scan, and Claimant's reported symptoms. At the time of the surgery, he had not seen Claimant's prior medical history, and had no information that would lead to a conclusion that there was any change in Claimant's spondylolisthesis. Dr. Frizzell's opinion about causation—what caused the fusion to become necessary—was made, like Dr. Hajjar's, only after the fusion had been done.

> with certain traumatic circumstances, that can lead to an increase in the disruption between the number L4 and the number L5.

Deposition of Dr. Frizzell, p. 16. This may be spot-on as to how Claimant's spondylolisthesis set him up for an eventual fusion. It does nothing to explain why Dr. Frizzell thinks that the changes were acute or caused by the events of August 13.

49. In his deposition, Dr. Hajjar noted his agreement with Dr. Frizzell on Claimant's need for a fusion in 2008, but for entirely different reasons. Dr. Hajjar provided this explanation of how he came to his causation opinion:

> My opinion about the issues that were affecting [Claimant] throughout the last decade was that he had an ongoing degenerative problem that affected his lumbar spine, that was noted and diagnosed as early as 2001.
>
> He had a series of films that were done over time, including 2004. He suffered a relatively minor injury in 2007. He had findings on further radiographic tests that were similar to his preexisting finding. Then he underwent surgery to address the problem. The problem anatomically was fully a degenerative issue. There were no traumatic findings noted on his film.
>
> ***
>
> In this case, the radiographic findings are clearly all degenerative in nature, none traumatic in injury. The patient's final onset of symptoms that led to surgery was the work-related event. But the patient has clear progression of symptoms over the course of the decade that pre-existed his injury.
>
> And based on that progression, my opinion is that the preexisting condition already was symptomatic. And therefore, the need for surgery is related to a preexisting, and not work-related condition.
>
> If [Claimant] had these findings, but he never had any real symptomatology from these problems, and that his pain truly started at the time of the injury, then I would likely state that the surgery is causally related to the work-related accident. But this, indeed, was not the case.

Deposition of Dr. Hajjar, pp. 6-8. Dr. Hajjar's last comment is particularly pertinent—Claimant was not asymptomatic prior to the August 13 accident. And though he reported an immediate onset of severe low back pain on August 13, he nevertheless:

- Continued his strenuous work as a long-haul trucker;
- Continued to drive the same flatbed with the same balky seat; and
- Continued to lift the same heavy, bulky tarpaulins every time he picked up or delivered a load.

Claimant continued this work, without complaint and without seeking medical care, for two more months until he injured his shoulder. But for the October 2007 shoulder injury, Claimant might still be driving that same truck and lifting those same tarpaulins today. In this case, Claimant's actions following the August 13 accident really do speak louder than his words.

Radiographic Evidence of Changes

50. Claimant's twenty-year history of radiographic images of his lumbar spine gave a number of medical experts ample opportunities to compare Claimant's images and look for clinically significant changes. Without exception, when there were images available for comparison, no radiologist noted any significant changes. Even the radiologist who compared the x-rays showing the progression from two millimeters to six millimeters stated that the changes were insignificant. Dr. Giles, the radiologist asked to review MRIs taken in 2002 (after the first lumbar surgery and before the MVA), 2004 (after the MVA, but before the August 13 accident), and 2008 (after the August 13 accident, but before the lumbar fusion), found no significant change.

Quantification of Changes

51. Most of the experts who read Claimant's radiographic imaging, including radiologists, treating physicians, and surgeons, noted no significant changes in Claimant's back pathology over time, yet Dr. Frizzell's opinion requires both *identifying* and *quantifying* the changes. In order to understand the significance of changes in Claimant's spondylolisthesis over time, it is useful to have some notion as to what is considered significant. In his deposition, Dr. Frizzell opined that a "minimal" spondylolisthesis would "probably be in the range of two millimeters." Deposition of Dr. Frizzell, p. 44. Dr. Frizzell went on to state that it would be unusual for a radiologist in Idaho to call a six-millimeter spondylolisthesis "minimal." Asked if

there was a consensus as to what constituted a minimal spondylolisthesis, he replied, "[t]here is no consensus, but it's my experience that once it's five millimeters or greater, it would not be termed a minimal anterolisthesis." *Id.*

52. *AMA Guides* 5th also includes benchmarks for evaluating the significance of interval changes in the degree of a patient's spondylolisthesis for purposes of rating impairment:

- Grade I—1% to 25% slippage;
- Grade II—26% to 50% slippage;
- Grade III—51% to 75% slippage; or
- Grade IV—76% to 100% slippage.

Table 15-7, p. 404.

53. Beginning in 2001 and until his 2008 fusion, Claimant's L4 on L5 spondylolisthesis is consistently described in radiology reports as "minimal" grade I, or grade I. The first images quantifying the degree of the spondylolisthesis were AP and lateral x-rays taken in March 2004, approximately three months after Claimant's MVA. Claimant had AP and lateral x-rays the day following his August 13 accident, but that radiology report did not quantify the degree of spondylolisthesis. The next set of x-ray images, taken after Claimant's shoulder injury in October 2007, reports a six-millimeter spondylolisthesis. In May 2008, just three months before his lumbar fusion, the MRI report identifies a five-millimeter spondylolisthesis. That report includes a notation that there are no significant changes when the images are compared with the radiographs from 2004. In July 2008, just a month before his fusion, the MRI report describes the spondylolisthesis as "subtle."

54. Dr. Frizzell testified that, in his opinion, x-rays were a better technique than MRI for visualizing degrees of spondylolisthesis, because x-rays are usually taken in the standing position while the patient is supine for an MRI. Dr. Frizzell stated:

> My opinion is that in the supine position, when [Claimant is] laying [sic] down for the MRI, his spondylolisthesis reduces from six back to two millimeters during the most recent study. And in the previous studies, he had a two-millimeter spondylolisthesis, which he continued to have when he extended.

Id., at p. 43. This explanation fails to account for the MRI report from May 2008 that notes a five-millimeter spondylolisthesis at L4 on L5. It is evident from the various reports, some quite close in time, that quantifying the degree, or changes in the degree, of Claimant's spondylolisthesis is a rough art at best, whether relying on MRI or x-ray images. Measuring such subtle differences as exist in the bottom quarter of the bottom quartile of the grade I category provides little certitude regarding the progression of Claimant's spondylolisthesis.

55. Dr. Frizzell testified that he based his opinion about the quantitative significance in the change of Claimant's spondylolisthesis on a comparison of the March 2004 and October 2007 x-rays. Dr. Frizzell did not discuss either the report or the images from the AP and lateral x-rays taken August 14, 2007. He testified that he had those images in his possession. The report for August 14 is not markedly different than all of the reports that preceded it. If Claimant sustained an acute injury on August 13, 2007 that significantly increased the degree of his spondylolisthesis, and there is no mention of significant findings, then the August 14, 2007 images themselves should merit review and comparison. Instead, Dr. Frizzell compares Claimant's pre-accident x-rays (March 2004) with x-rays taken several months after the subject accident (October 2007).

56. Although Dr. Frizzell considers the x-rays more probative than the MRIs, he admits that the particular x-rays upon which he relied in reaching his opinions were difficult to compare. Dr. Frizzell testified:

> . . . I do recall, when I looked at them initially, some were of poor quality, given the age of the x-rays; and some are of different sizes, which makes it difficult to compare the two side by side.

Deposition of Dr. Frizzell, p. 16. If the March 2004 and October 2007 x-rays were difficult to compare, then the August 14, 2007 x-rays become even more relevant.

Summary

57. The Referee finds Dr. Hajjar's opinion on causation to be more persuasive than that of Dr. Frizzell. Dr. Frizzell's opinion is based on his conclusion that Claimant suffered an interval change in the degree of his anterolisthesis between 2004 and August 14, 2007. As important, Dr. Frizzell relates this interval change to the subject accident. Explaining his belief that the subject accident is, in part, responsible for causing the interval change in Claimant's anterolisthesis Dr. Frizzell stated that Claimant had no to minimal symptomatology in the years immediately preceding the subject accident, and intractable pain thereafter.

Notwithstanding that there is some uncertainty as to the degree to which a Claimant's anterolisthesis actually did progress between 2004 and 2007, Dr. Hajjar conceded, for the purposes of discussion, that a review of the radiological studies would confirm such a progression over time. However, Dr. Hajjar concluded that the subject accident did not contribute to the development of Claimant's anterolisthesis. In reaching this conclusion, Dr. Hajjar, too, relied on Claimant's history of pre-injury and post-injury symptomatology to inform his opinion:

> "The question that we are frequently asked, and indeed, I'm asked in this case, is to discern whether or not the causative pathology, the need for surgery is related more to the ongoing preexisting condition, or whether it is caused by the work-related issue or injury.
>
> In Idaho, my opinion on these cases is governed by Idaho law. And Idaho law in a nutshell, in my interpretation, states that the cause for surgery is based on the onset of symptomatology, not the radiographic findings.
>
> In this case, the radiographic findings are clearly all degenerative in nature, none traumatic in injury. The patient's final onset of symptoms that led to surgery was the work-related event. But the patient has clear progression of symptoms over the course of the decade that pre-existed his injury.

And based on that progression, my opinion is that the preexisting condition already was symptomatic. And therefore, the need for surgery is related to a preexisting, and not work-related condition.

If Mr. Wacaster had these findings, but he never had any real symptomatology from these problems, and that his pain truly started at the time of the injury, then I would likely state that the surgery is causally related to the work-related accident. But this, indeed, was not the case."

. . .

"Q. You testified earlier that if the industrial accident precipitated an increase in symptoms that led to the surgery, that you would think that it was related to the industrial accident. Was that your testimony?

A. Yes.

Q. And Mr. Wacaster did, in fact, have an industrial accident that increased his symptoms, and to the point where they became unbearable, which led to the surgery. Based on that fact, does that change your opinion in any way?

A. No. Would it be okay if I elaborate on that?

Q. Yes.

A. The reason I state that, that largely is reflected in the 8-14, 2007 note from the original treating practitioner, who evaluated Mr. Wacaster at the time of his injury. The first line states that the patient has a long history of chronic low back pain.

And this type of symptomatology is very typical. We reflected by that statement, a long history of chronic low back pain. Things like Mr. Wacaster's injury, which was not an overtly traumatic episode. It was noted to be driving over a bumpy road. It can exacerbate some symptomatology.

But if the findings that are present on radiographic images don't reflect new traumatic pathology, then the need for surgery is likely simply related to the ongoing degenerative condition."

. . .

"A. No, I don't think so. Mr. Monroe brings up a very important question, which is simply, when did the symptoms arise, and how much did the motor vehicle event contribute to the ongoing pathology, and the need for surgery.

Clearly, something happened that caused Mr. Wacaster to require medical attention. And after that episode of medical attention, he ended up having surgery.

Therefore, the question from my standpoint, and the reason that you both are asking me questions, is whether or not I think that that one event led to the surgery, versus the ongoing constellation of findings.

My opinion needs to synthesize all the medical facts, as well as what is present in the Idaho law as I best understand it as a non-attorney. And my opinions in these cases, which are very common, always relate primarily to symptomatology. In this case, it is clear to me that the patient had significant

> ongoing symptomatology prior to the work-related event. And therefore, that's why I will stand by my opinions stated in the previous notes.
>
> In other cases, regardless of what the x-rays show, patients sometimes have no complaints and no pathology. In those cases, then further treatment is on the accident. And therefore, there is a bit of a balancing act that we all have to perform first and foremost to do what's best for the patient and their interest, but also do what's right and correct by Idaho Industrial law. And therefore, I stand by my opinion."

From the foregoing, it is clear that both Dr. Hajjar and Dr. Frizzell recognize the importance of correlating Claimant's reported symptomatology with objective findings in order to ascertain whether the subject accident contributed to the progression of Claimant's L4-5 anterolisthesis, and need for surgery. Dr. Frizzell has concluded that the subject accident is significant, since, per his assumption, Claimant had no to minimal symptomatology on a pre-injury basis. As noted, *infra*, a review of the medical record demonstrates that Dr. Hajjar has a better understanding of Claimant's pre-injury and post-injury symptomatology. Claimant clearly did have significant symptomatology in the years immediately preceding the subject accident. Moreover, the subject accident did not cause immediate debilitating pain/discomfort, as Claimant has suggested. Rather, the symptoms which eventually led Claimant to his low back surgery were first noted approximately two months subsequent to the subject accident. Between the date of the subject accident, and Claimant's subsequent shoulder injury, he appears to have performed his usual and customary job tasks without the need for accommodation or assistance. All of these factors tend to support the conclusion that Claimant has a long history of low back discomfort, which progressively worsened to the point that he eventually required the surgery performed by Dr. Frizzell. However, Claimant's history of pre-injury and post-injury symptomatology does <u>not</u> support the conclusion that the subject accident is responsible for contributing to the development of Claimant's symptoms and the need for surgery. For these reasons, the Commission adopts the opinion of Dr. Hajjar as being more reliable.

REMAINING ISSUES

58. Because the Referee finds that Claimant's lumbar fusion was necessitated by the natural progression of his degenerative condition, the remaining issues are moot.

CONCLUSION OF LAW

1. Claimant has failed to carry his burden of proving that it is more likely than not that his need for a lumbar fusion was caused by an industrial accident on August 13, 2007.

RECOMMENDATION

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

DATED this 14 day of September, 2010.

INDUSTRIAL COMMISSION

/s/_____
Rinda Just, Referee

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

JACK E. WACASTER, Claimant, v. ARLO LOTT TRUCKING, INC., Employer, and LIBERTY NORTHWEST INSURANCE CORPORATION, Surety, Defendants.	)	**IC 2007-028189** **2008-027324** **ORDER** Filed: September 14, 2010

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

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

1. Claimant has failed to carry his burden of proving that it is more likely than not that his need for a lumbar fusion was caused by an industrial accident on August 13, 2007.

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 14 day of September, 2010.

INDUSTRIAL COMMISSION

/s/_____
R.D. Maynard, Chairman

/s/_____
Thomas E. Limbaugh, Commissioner

/s/_____
Thomas P. Baskin, Commissioner

ATTEST:

/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 14 day of September, 2010, a true and correct copy of the foregoing **FINDINGS, CONCLUSION,** and **ORDER** were served by regular United States Mail upon each of the following persons:

DARIN G MONROE
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KIMBERLY DOYLE
PO BOX 6358
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djb /s/_____