BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

DALE WHITMORE, Claimant, v. CABELA'S, Employer, and SENTRY INSURANCE A MUTUAL CO., Surety, and STATE OF IDAHO, INDUSTRIAL SPECIAL INDEMNITY FUND, Defendants.	**IC 2007-033768** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** December 27, 2010

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 Boise on June 9, 2010. Claimant was present and represented by Hugh V. Mossman of Boise. Alan R. Gardner, also of Boise, represented Employer, Cabela's and its surety, Sentry Insurance a Mutual Company ("Defendants"). Kenneth L. Mallea of Meridian represented State of Idaho, Industrial Special Indemnity Fund ("ISIF"). Oral and documentary evidence was presented. The record remained open for the taking of post-hearing deposition. The parties then submitted post-hearing briefs and this matter came under advisement on October 28, 2010. On November 17, 2010, Referee Powers filed a Notice of Recusal. Thereafter, following a telephone conference conducted by Alan Taylor, Chief Referee, on November 23, 2010, the case was reassigned to Referee LaDawn Marsters pursuant to a Notice of Re-Assignment filed on November 30, 2010.

ISSUES

As stipulated by the parties, the issues to be decided are:

1. Whether Claimant's alleged Regional Pain Syndrome ("RSD") and/or Complex Regional Pain Syndrome ("CRPS") was caused by his industrial accident.

2. Whether Claimant is entitled to reasonable and necessary medical care.

3. Whether and to what extent Claimant is entitled to Temporary Partial and/or Temporary Total ("TPD/TTD") benefits.

4. Whether Claimant is entitled to an award of attorney fees.[1]

CONTENTIONS OF THE PARTIES

Claimant contends that he contracted RSD/CRPS, hereinafter referred to as simply CRPS, as the result of a left ankle injury sustained in an accepted industrial accident with Employer. He admitted at his second prehearing deposition that he lied about certain educational and military matters in his first prehearing deposition, to his wife and to physicians, but insists he did so only to impress his wife. Claimant maintains he has never lied about the nature of the injuries he suffered in his industrial accident. He asserts he is entitled to continuing medical and time loss benefits, from the date Surety discontinued payment.

Employer/Surety contends that Claimant's current complaints are unrelated to the relatively minor ligament injury he sustained in his industrial accident. They posit Claimant has failed to prove that he has CRPS. There is ample evidence in the record to show that Claimant's current complaints are related to his history of behaviors related to somatoform disorder and medical problems such as gout and arthritis. Further, Employer/Surety argues that Claimant is not a credible witness. His lies extend beyond embellishments meant to impress his wife to his

[1] Although Claimant's entitlement to attorney fees was discussed as being an issue at hearing, Claimant did not address that issue in his post-hearing briefing and it is deemed abandoned.

medical records, to his sworn statements in these proceedings. Claimant's lack of credibility is extremely important in the diagnosis of CRPS, not only because diagnosing physicians need to rely on accurate medical and psychological histories to reach a medically supportable diagnosis, but also because the primary symptom of CRPS, pain in excess of a known injury, cannot be conclusively and objectively evaluated. Claimant has recovered from the injuries he received in his accident and is entitled to no more benefits.

ISIF joins Employer/Surety in contending Claimant does not have CRPS and, whatever his condition might be, it is not related to the minor ankle sprain he suffered in his industrial accident. Claimant is not credible and evidence of any reports to his physicians or others regarding his subjective signs and symptoms consistent with the diagnosis of CRPS should be afforded no weight.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The Industrial Commission legal file;
2. The pre-hearing deposition testimony of Dale Whitmore, taken November 18, 2008;
3. The pre-hearing deposition testimony of Myung A. Song, D.O. taken November 18, 2008;
4. The pre-hearing deposition testimony of Dale Whitmore, taken January 6, 2010;
5. Claimant's Exhibits 1 through 26 admitted at the hearing;
6. Defendants' Joint Exhibits 1 through 60 admitted at the hearing;
7. The testimony of Claimant, taken at the hearing;
8. The testimony of Myung A. Song, D.O. taken at the hearing;

9. The testimony of Randy Longnecker, taken at the hearing;

10. The testimony of Derrek Bailey, taken at the hearing;

11. The post-hearing deposition testimony of Michael Mann, taken July 12, 2010;

12. The post-hearing deposition testimony of Kevin Krafft, M.D., taken July 19, 2010;

13. The post-hearing deposition testimony of Vic Kadyan, M.D., taken July 26, 2010;

14. The post-hearing deposition testimony of Clinton Mallari, M.D., taken July 29, 2010;

15. The post-hearing deposition testimony of Michael Enright, Ph.D., taken July 30, 2010;

16. The post-hearing deposition testimony of Robert Calhoun, Ph.D., taken August 4, 2010; and

17. The post-hearing deposition testimony of Gerald Moress, M.D., taken August 5, 2010.

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

OBJECTIONS

All objections are overruled, with the exception of the following, which are sustained: Claimant's objection recorded at page 16 of Claimant's first deposition; Defendants' objections recorded on page 28, ll. 6, 25 and p. 29 of the transcript of Dr. Mallari's deposition; Claimant's objections recorded on page 20 of the transcript of Dr. Calhoun's deposition; Claimant's objections recorded at pages 8 and 59, Defendants' objections recorded at pages 36, 38 and 59, and ISIF's objection recorded at pages 36 and 37 of Dr. Krafft's deposition; and Defendants'

objections recorded at pages 29 and 33, and Claimant's objections recorded at pages 47, 48 and 52 of Dr. Moress's deposition.

FINDINGS OF FACT

Claimant's Past History

1. Claimant was 60 years of age at the time of the hearing and residing in Nampa, Idaho. He completed high school, then attended two quarters at Oregon State University in 1968-69, with lower than average or failing grade point averages (1.86 and .36, respectively). Around this time, in 1968, Claimant left a job at a service station due to an injury. In October 1969, Claimant was drafted into the military. He was honorably discharged 2 months later due to a medical condition that Claimant has apparently alternately attributed to an accident and to a gout diagnosis. Defendants' Exh. 6, p. 79; Defendants' Exh. 7, p. 108.

2. Throughout the 1970's, Claimant was a police officer in Arizona. He filed a dozen or so worker's compensation notices of injury, alleging repeated injuries to his right wrist, left hip, cervical spine and lumbar spine, as well as an injury to his left leg. His medical records toward the end of this period establish a general pattern, with a few exceptions, of pain complaints in the absence of objectively identifiable pathology requiring extended periods off work. There is also some evidence of malingering. For example:

a. On July 29, 1976, Thomas E. Bittker, M.D., Chairman of the Arizona Department of Mental Health Services Health Plan, noted that Claimant's slow response to treatment for injuries following an automobile accident was troubling his medical care providers. In his report of psychiatric consultation, Dr. Bittker did not dispute Claimant's diagnosis of cervical radiculitis, but nevertheless opined:

> …there seems to be sufficient evidence to cause us to be concerned regarding this young man's potential dependency. It is certainly

> compatible that he is using his pain syndrome as a way of satisfying dependency needs which he could not otherwise manifest without loss of self-esteem…From behavioral [sic] perspective, the patient's capacity to function as an outgoing, aggressive police officer, has been threatened by this recent injury. Confronted by the prospect of some compromise of his functioning and aware that his dependency needs will only be satisfied as long as his pain persists, the patient will experience inertia in holding onto his symptoms previous to his recovery.

Defendants' Exh. 6, p. 84

b. On August 17, 1976, when Claimant was discharged after nearly three weeks in the hospital due to acute cervical syndrome from his June 1976 car accident, Dr. Ritsick wrote, "The patient did over-react to his pain syndrome and showed a great deal of dependency and somatoization [sic] on this admission." Defendants' Exh. 6, p. 90.

c. On September 9, 1976, Dr. Retter noted, "…his complaints are not in accord with the signs…and the possibility must be considered that his specific visual complaints are on a strong functional basis." Defendants' Exh. 5, p. 53.

d. On October 12, 1976, Dr. Bittker described his impressions after evaluating Claimant on 6 separate visits over 3 months:

> Mr. Whitmore is suffering from a pain syndrome refractory to medical treatment. A number of issues are complicating the pain syndrome including current family stresses as well as a modest depression secondary to the accident[2]. I am currently following Mr. Whitmore…in an effort to raise his pain threshold.

Defendants' Exh. 5, p. 56.

e. On December 13, 1976, Dr. Bittker advised the worker's compensation claims examiner:

> In response to your question as to whether or not the "primary treatment is related or secondary to the injury", I can respond that I feel that psychiatric intervention in this case has markedly accelerated Mr. Whitmore's recovery and am confident that both his increased functioning and increased pain threshold would not have occurred without this

[2] In June 1976, Claimant was involved in a work-related automobile accident resulting in a neck injury from which Claimant did not recover as anticipated by his physicians.

intervention.

Defendants' Exh. 5, pp. 60-61.

f. On August 18, 1978, Claimant had a neurological consultation for neck pain with onset after he suddenly looked up. The consulting neurologist noted that Claimant presumed surgery would be necessary, but that no surgery was indicated, in part, because his x-rays and other clinical tests were normal. He also noted that Claimant kept his head somewhat forward flexed in his cervical collar, but could assume normal posture with the collar off. Defendants' Exh. 8, pp. 110-111.

g. On September 2, 1980, Claimant had sudden onset of low back pain when bending over and lifting a small box at work. The pain persisted, and he was admitted to Good Samaritan Hospital in Phoenix on September 8, 1980. Although lumbosacral x-rays indicated positive findings, a subsequent myelogram demonstrated that the artifact identified by x-ray was retained Pantopaque from a "normal" August 1976 cervical myelogram. Notwithstanding Claimant's pain complaints following this workplace injury, a lumbar myelogram and EMG nerve conduction test also returned normal results.

h. A letter from the Arizona State Compensation Fund Claims Department to a Dr. Marshall, dated January 9, 1981, inquires about Claimant's 12-day trip down the Colorado River while he was off work due to disability from his lumbar condition described above. Dr. Marshall's response, dated January 13, 1981, states that he learned, after the fact, that Claimant took the river trip. In addition, Dr. Marshall wrote that he was surprised to hear that Claimant had not returned to work, explaining:

> I am still having trouble correlating the patient's symptoms with any significant physical problems. I doubt whether there is any nerve damage or nerve root irritation. I doubt whether there is significant muscle or bone pathology that limits him from doing his job. He did return to work for a

> short period of time in early January and I just evaluated him in my office today after another injury to the back will [sic] sitting at his desk…In summary, I find it difficult to correlate all these physical symptoms with significant organic problems in this patient.

Defendants' Exh. 5, p. 74.

i. On January 26, 1981, Claimant was seen for recurring low back pain radiating into his right lower extremity ("RLE") following primarily an L-5 pattern into the right foot. "The appearance was one objectively primarily of pain complicated by a sympathetic reflex dystrophy involving the right lower extremity." Defendants' Exh. 9, p. 120. Marked coolness in Claimant's RLE was immediately relieved by an epidural corticosteroid block, which both warmed the leg up and relaxed the pain sensation. Claimant still reported pain, and was off work, as of February 10, 1981. A repeat epidural block was administered on April 14, 1981 and on June 9, 1981, the physician reported "…definite hypesthesia [sic] corresponding to the L-4 and 5 dermatome pattern, right lower extremity." He recommended a confirmatory transfemoral ascending venography in light of Claimant's prior "somewhat equivocal" myelograms, EMG's and neurosurgical consultation, as well as a "…neurosurgical refusal for laminectomy which might have been enhanced by the patient…". Defendants' Exh. 9, p. 124.

j. On June 24, 1981, Claimant again presented to Good Samaritan Hospital for treatment of pain symptoms he attributed to the September 2, 1980 lifting incident. Claimant underwent a chest x-ray and a left transfemoral epidural venogram, which were both normal. Then he underwent a diagnostic spinal block in which progressively higher doses of anesthetic were administered, with Claimant confirming greater pain relief with each stepped-up dose. As a result, the treating physician commented, "In summation, there is obviously sensory pain with little or no cerebralization and in the opinion of this

observer, this is strickly [sic] a physical process and not an emotional process." Defendants' Exh. 6, p. 101. The physician's conclusions were based solely upon Claimant's reports of pain relief, not on any objectively measurable change.

k. On July 15, 1981, Claimant underwent a group consultation at the request of the workers compensation carrier. It was noted, similarly to previous and subsequent notes by other physicians, that Claimant heel walked and toe walked somewhat satisfactorily, but (inconsistently) resisted flexing his left foot on examination due to pain. Upon completion of the examination and review of new lumbosacral spine x-rays, the panel found "…no specific abnormal objective findings indicative of any pathology or permanent impairment of function which could reasonably be related to the accident of September 2, 1980." Defendants' Exh. 11, p. 127. It recommended that Claimant be returned to work without restrictions. *Id.*

l. On November 18, 2002[3], Claimant was evaluated for back and lower extremity pain and partial paralysis with onset while he was putting on a sock. The physician assessed "Mechanical motor syndrome with strange motor findings not fitting with any specific nerve root or peripheral nerve." Defendants' Exh. 8, p. 119. Further, "The MR scan is reviewed and he has some minor foraminal stenosis at L3-4 which of course is not in the area of where his pain is located. The rest of it looks pretty much normal for age." *Id.*

m. On September 16, 2003, Claimant was admitted to Flagstaff Medical Center for evaluation of severe lumbar pain, following lumbar fusion surgery on April 3, 2003 and an examination within the previous week in which he did not complain of undue pain.

[3] Claimant left the Phoenix Police Department in approximately 1980, after which he reports being a self-employed hunting and fishing guide for 20 years. No medical records from this period are contained in the record, and Claimant testified that he was healthy during this time. Soon after marrying his third wife in 2001, unverified subjective pain reports again began appearing in his medical records.

Upon examination, after following Claimant for several months, Claimant's surgeon reported that Claimant's pain was "…not related to previous spinal procedures, probable addiction issues, functional overlay…". Defendants' Exh. 17, p. 205.

3. Claimant has a history of gout beginning as early as February 25, 1974. Gout is a painful condition marked by the build-up of uric acid crystals in the joints and surrounding tissues. Symptoms include warmth, swelling and color changes over the affected joint(s), intense night pains exacerbated by pressure as slight as the weight of a sheet, limited range of motion in the joint, and painful attacks that ease over a matter of days. On August 12, 2003, Claimant reported to Dr. Weibe, his podiatrist, that he "…keeps getting "the gout"…", and on September 13, 2003, Claimant's wife reported to his spine surgeon that he had a history of gout treated by medication (Allopurinol) and a gout flare-up following his spine surgery.

4. Claimant's medical history is also positive for painful left foot conditions including plantar fasciitis and Morton's neuroma. An early plantar spur in Claimant's left foot was incidentally identified by x-ray on March 13, 1991 when Claimant's left ankle was x-rayed pursuant to an injury examination. By November 24, 1999, he sought treatment for painful plantar lesions in his left foot. On November 22, 2005, Claimant was diagnosed with plantar fasciitis in his left heel and a neuroma with bursitis in the third interspace of his right foot. On February 9, 2006, Claimant was again seen for plantar pain in his left foot. Records indicate treatments for Claimant's plantar symptoms did not permanently relieve his pain; however, Claimant reported to the claims examiner in this case that he no longer has plantar pain. His right foot neuroma was surgically repaired in 2001. Claimant continues to wear orthotics to alleviate the associated pain.

5. Claimant had anterior lumbar spinal fusion surgery on April 4, 2003, after conservative

treatment for degenerative disc disease from L4-S1 and stenosis at L3-L4 had failed. Paul Saiz, M.D., surgeon, performed the surgery (in Arizona) with the caveat that Claimant's back pain would likely not be completely relieved. Claimant's initial pain was relieved by the surgery, but he developed a new pain that was less than pre-surgery, but nevertheless grew intolerable within a few months. Claimant moved to Idaho during this period and immediately sought treatment for his pain. He established care with Clinton Mallari, M.D., physiatrist, who eventually suggested that it may be the hardware placed during surgery that was causing Claimant's pain. Dr. Mallari referred Claimant to Joseph Verska, M.D., orthopedic surgeon, to discuss removing the hardware. Dr. Verska declined to recommend this intervention, in part because no objective findings indicated a problem with the hardware and he believed the procedure only had a 50-50 chance of relieving Claimant's pain. Dr. Mallari then referred Claimant to Howard King, M.D., orthopedic surgeon, who removed the hardware in November 2004. After the hardware was removed, Claimant reported relief from all of his continuous back pain, both pre- and post-2003 surgery.

6. On April 15, 2005, Claimant fell onto his right arm while out on his boat. He presented to Andrew Curran, M.D. on April 19 reporting pain in his right hand, a feeling as if his right hand was swollen and not working properly, and shoulder pain. Dr. Curran noted an abrasion, swelling, tenderness, a positive Tinel's sign and some limitations in range of movement. X-rays on May 10, 2005 showed some degenerative changes and a healed fracture of Claimant's olecranon spur. Claimant's swelling had resolved and the injury site appeared atraumatic; however, he still complained of pain and intermittent numbness along the ulnar distribution. When Claimant's pain did not improve, Dr. Curran diagnosed right ulnar nerve palsy. As a result, Claimant underwent a right ulnar nerve anterior subcutaneous transposition on July 13,

2005 and a right radial nerve decompression on August 31, 2005, both by Tildon Clark Robinson, M.D. Claimant reported that his associated pain resolved after these procedures.

Claimant's History at Employer's and Credibility

7. In July 2006, Claimant returned to the workforce. He was hired by Employer, as an "outfitter", in the optical devices department. Claimant maintained his position until mid-December 2007, when he quit due to the workplace injury that is the subject of these proceedings. During the year and a half or so that he worked at Employer's, Claimant received 4 raises and his employment performance records indicate he was an exceptional employee.

8. Notwithstanding his excellent performance reviews, Claimant had a reputation at work for untruthfulness. This reputation grew out of Claimant's propensity for tall tales, including a claim that he kicked the winning field goal for the Oregon State University ("OSU") football team, thus denying O.J. Simpson's California team a trip to the Rose Bowl. Claimant's co-workers searched for his name on a record of the team roster. When they could not find it, they concluded he had lied.

9. It turns out, Claimant's workplace lies started with his application, cover letter and resume. For example, Claimant wrote that he had a B.S. in biology and "ichthiology [sic-ichthyology]" from OSU and had begun a graduate degree in criminal law at Arizona State, even though he only attended OSU for 2 quarters. Defendants' Exh. 32, p. 337. He also claimed to have owned and operated a hunting and fishing guide business in Alaska and Arizona in which, among other things, he piloted float equipped aircraft for clients. There is no evidence in the record, other than Claimant's statements, to establish that he did or did not own such a business; however, Claimant lied about being a pilot. Claimant also wrote that he was returning to work after a 3-year sabbatical, even though his records indicate he had been off work for medical

reasons since at least 2001.

10. Claimant admitted he lied about his education, being a pilot and other matters in his second deposition in this case in January 2010. His confirmed lies extend well beyond his application materials for his job at Employer's. Claimant lied to his wife about these matters. Claimant also lied in the histories he provided to his medical care providers beginning at least as early as 1999. In addition, he lied with respect to matters pertinent to this case to numerous medical evaluators, the claims examiner, and this tribunal during, at a minimum, his first deposition. Claimant admitted he had been untruthful only after the attorneys in this case uncovered a number of inconsistencies through discovery. Examples of additional untruthful statements in the record by Claimant include, but are not limited to, statements that he:

a. Obtained his pilot's license when he was 16;
b. Attended college on a football scholarship;
c. Tore his Achilles tendon in a game against USC: Question: "…which foot was that?" Response: "The left. I was a kicker. And I had my right foot up when they clipped me. So all my weight was on my left foot." Claimant's First Dep., p. 52;
d. Went to Alaska on a 6-week program and worked with a stream biologist studying salmon while at OSU working on his biology degree;
e. Received his baccalaureate degree from OSU in 1970;
f. Was accepted into medical school at University of Colorado, Boulder;
g. Voluntarily enlisted in the aviation program in the military or, alternatively, that he was drafted out of medical school;
h. Attended Warrant Officer Candidate School at Fort Gordon, Georgia after Basic

Training for 3 ½ months, including aviation training;

i. Was a fixed-wing pilot already, so the Army waived those training requirements;

j. Was stationed at "Baunmiuit [sic-Buon Ma Thuot]" in Vietnam for 7 months;

k. Flew Cobra helicopters in Vietnam on live intelligence missions;

l. Crashed his helicopter in Vietnam;

m. Sustained injuries in multiple helicopter crashes in Vietnam;

n. Sold surplus helicopters (after Vietnam) to third world countries in a training unit for 2 months while on active duty, in Panama City, Panama and Medellin, Columbia or, alternatively, that he was not involved in the sales and disposal of aircraft, but only trained pilots;

o. Was discharged from the military in 1972;

p. Has or had residual shrapnel from Vietnam;

q. Spent years as an instructor pilot, including time spent training pilots in South and Central America;

r. Had an air taxi service and flew fishermen and hunters;

s. Did not fly for the Phoenix Police Department: "I thought I was going to. And they had a federal grant to get the aircraft. And the initial pilots that were assigned, I think was almost zero attrition. I think the whole time I was there, there was never an opening, or might have been one opening. And at that point, I wasn't as current as other people that applied for it." Claimant's First Dep., p. 31;

t. Had annual flight physicals when he was a pilot;

u. Decided to quit flying when he married his (current) wife; and

v. Could work as a pilot for an air taxi service in Alaska if he decides to move back.

11. In addition, when the questioning into a subject area of Claimant's lies got difficult, Claimant posited that CRPS was to blame for his faulty "memory":

> Q. Where were you stationed in Vietnam?
> A. Buon Ma Thuot.
> Q. Spell that for her, if you would
> A. T-U-E-T was tuet, and B-A-U-N-M-I-U-I-T (sic).
> Q. And how long were you stationed at that particular location, approximately?
> A. I'm sorry it's just –
> Q. Approximately.
> A. Trying to remember.
> Q. Are you on any medication?
> A. Just my normal medication.
> Q. And what is that?
> A. Oxycontin for pain, Colchicine. Somewhere I have a list of them. If I can refer to that, that would be better.
> Q. So you're on several medications today?
> A. Quite a few, yeah. But it's the complex regional pain syndrome, one of the effects of that is memory problems.

Claimant's First Dep., pp. 12-13.

12. In light of Claimant's above-referenced, confirmed prevarications, the Referee is unpersuaded of the veracity of other far-fetched uncorroborated statements by Claimant, such as those claiming he:

a. Sustained injuries in helicopter crashes in Mexico or South America;

b. Worked as a secret anti-terrorist sniper for the U.S. government;

c. Went on missions as a member of the President's tactical drug task force while maintaining his position as a police officer in Arizona as a "cover"; and

d. Worked as a private contractor for the U.S. government selling surplus Vietnam helicopters to the Colombian government.

13. Claimant testified at the hearing that his lies had been weighing on him so he decided to come clean. This testimony is unpersuasive given the breadth and longevity of Claimant's

deceits, and his demonstrated willingness to lie, even while under oath, in these proceedings. Likewise, his explanations that he only lied because he was intimidated by his physician-wife's accomplishments, do not limit or blunt the effects of his dishonesty. If anything, Claimant's maintenance of untruths about his background and character for years, throughout his most intimate relationship, demonstrates a heightened comfort level with lying.

14. Claimant explained that even though he has lied, he has not lied about his symptoms in relation to this case. However, the record establishes that this is untrue. During Claimant's first deposition, as noted above, he attributed his inability to "remember" a detail about his service in Vietnam to CRPS when he knew CRPS had nothing to do with his inability to respond to the question because he knew he was lying.

15. Dr. Calhoun, a neuropsychologist who later discovered that Claimant lied to him about his military background, reported that Claimant was very comfortable with his lies, betraying no obvious signs of dishonesty. As a result, Dr. Calhoun predicted that Claimant could approach his pain in the same way. The above example confirms Dr. Calhoun's suspicion.

16. Claimant's lies are pervasive and, when he's telling them, they are indistinguishable from his truths. He has voluntarily lied to his wife, to his employer, in these proceedings while under oath, to his medical providers, and to others, verbally and in writing. Under these circumstances, the Referee finds Claimant is not a credible witness.

17. Moreover, Claimant's lies, most overtly on his job application for Employer, and in these proceedings, indicate clear motivations for secondary gain (obtaining employment and succeeding on this claim) both prior to and after his industrial injury. As a result, the Referee declines to allocate any weight to statements made by Claimant, to medical providers or others, that are not otherwise supported by sufficient objective evidence in the record.

September 27, 2007 Left Ankle Injury

18. Claimant sustained either a sprain or closed fracture to his left ankle when he tripped at work on September 27, 2007. Employer accepted the claim and sent Claimant for medical treatment.

19. **Scott Lossman, M.D.** Claimant was treated by Scott D. Lossman, M.D., from September 28, 2007 until December 6, 2007. By November 5, 2007, Claimant's ankle was within normal limits in all respects, with expected weakness. Dr. Lossman referred Claimant to physical therapy with Cathy Dufur, P.T., at Claimant's and his wife's request.

20. On November 26, 2007, however, Claimant reported swelling and foot numbness. By December 6, 2007, Claimant's pain and swelling had not dissipated, and he was losing range of motion in his foot and ankle, with weakness on dorsiflexion of his left great toe that affected his gait. Dr. Lossman referred Claimant to Ronald Kristensen, M.D., an orthopedic surgeon, for follow-up. None of Dr. Lossman's notes indicate Claimant's history of gout.

21. Around this timeframe, Clinton Mallari, M.D., physiatrist and pain specialist, stopped by Employer's and saw Claimant at work. They had a discussion in which Dr. Mallari warned Claimant of the possibility for developing CRPS. Shortly thereafter, his physicians began investigating whether Claimant had this condition.

DISCUSSION AND FURTHER FINDINGS

The provisions of the Workers' Compensation Law are to be liberally construed in favor of the employee. *Haldiman v. American Fine Foods,* 117 Idaho 955, 956, 793 P.2d 187, 188 (1990). The humane purposes which it serves leave no room for narrow, technical construction. *Ogden v. Thompson*, 128 Idaho 87, 88, 910 P.2d 759, 760 (1996). Facts, however, need not be

construed liberally in favor of the worker when evidence is conflicting. *Aldrich v. Lamb-Weston, Inc*., 122 Idaho 361, 363, 834 P.2d 878, 880 (1992).

Causation

The Idaho Workers' Compensation Act places an emphasis on the element of causation in determining whether a worker is entitled to compensation. In order to obtain workers' compensation benefits, a claimant's disability must result from an injury, which was caused by an accident arising out of and in the course of employment. *Green v. Columbia Foods, Inc.*, 104 Idaho 204, 657 P.2d 1072 (1983); *Tipton v. Jannson*, 91 Idaho 904, 435 P.2d 244 (1967). The claimant has the burden of proving the condition for which compensation is sought is causally related to an industrial accident. *Callantine v.Blue Ribbon Supply*, 103 Idaho 734, 653 P.2d 455 (1982). Further, there must be medical testimony supporting the claim for compensation to a reasonable degree of medical probability. A claimant is required to establish a probable, not merely a possible, connection between cause and effect to support his or her contention. *Dean v. Drapo Corporation*, 95 Idaho 958, 560-61, 511 P.2d 1334, 1336-37 (1973). See also *Callantine*, *Id*.

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

When the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury likewise arises out of employment, unless it

is the result of an independent intervening cause attributable to claimant's own intentional conduct. *Larsons, The Law of Worker's Compensation,* § 13.

22. **CRPS.** CRPS is a difficult condition to diagnose. It can be triggered by a relatively minor injury, such as an ankle sprain, and there are reports in the literature of the condition spreading from the affected limb to other parts of the body. However, CRPS is more often the result of a neurological injury than a soft tissue or peripheral injury, and it is quite rare for the condition to spread to other parts of the body. After reviewing the literature, Dr. Moress testified at his deposition that only 7% of CRPS cases involve symptoms that extend beyond the injured limb. Diagnostic criteria are set forth in the *AMA Guides*, *6th Ed.* and they are identified elsewhere as the "Budapest" criteria.

23. The *sine qua non* of CRPS is pain in excess of what would be expected based upon physical findings. The *AMA Guides, 6th Ed.*, acknowledges some unique difficulties in diagnosing CRPS:

> Since a subjective complaint of pain is the hallmark of this diagnosis, and since all of the associated physical signs and radiologic findings can be the result of disuse, an extensive differential diagnostic process is necessary. Differential diagnoses that must be ruled out include disuse atrophy, unrecognized general medical problems, somatoform disorders, factitious disorder, and malingering. A diagnosis of CRPS may be excluded in the presence of any of these conditions, or any other conditions which could account for the presentation. This exclusion is necessary due to the general lack of scientific validity for the concept of CRPS, and due to the reported extreme rarity of CRPS (any of the differentials would be far more probable).

Id., at p. 451.

24. In addition to disproportionate pain, Claimant must establish three of four categories of CRPS "symptoms" to meet the diagnostic criteria, as well as two of four categories of CRPS "signs". CRPS symptoms include subjective patient experiences that cannot be objectively verified. Evidence of CRPS symptoms include patient reports of hyperesthesia and/or allodynia;

temperature asymmetry, skin color changes and/or skin color asymmetry; and decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin). Evidence of two CRPS signs must be observed by the evaluator at the examination. CRPS signs include hyperalgesia (to pinprick) and/or allodynia; temperature asymmetry and/or skin color changes and/or asymmetry; edema and/or sweating changes and/or sweating asymmetry; decreased range of motion and/or motor dysfunction and/or trophic changes. Finally, CRPS is a diagnosis of exclusion, meaning that all other diagnoses that better explain the signs and symptoms must be ruled out.

25. According to Dr. Kadyan, one of Claimant's physicians, "…credibility is important in any patient. But credibility carries a much higher weight for [CRPS]. Because the hallmark is pain that is out of proportion to the level of injury." Kadyan Dep., p. 24. More generally, Dr. Calhoun, Claimant's treating neuropsychologist, opined that it is "…critical to evaluate a patient's credibility in all areas of his life when evaluating his pain complaints." Calhoun Dep., p. 53. He added that, in Claimant's case given his willingness to lie in other contexts, "…it would just be very difficult to trust what it is he is telling you about his physical symptoms…". Calhoun Dep., p. 56.

26. Claimant has been determined not credible, and there is no means of objectively verifying his pain or other subjective symptoms. Therefore, from a legal evidentiary standpoint, he cannot establish the presence of any CRPS symptoms in these proceedings, let alone three out of four, on a more probable than not basis. Without establishing these symptoms, Claimant cannot prove he suffers from CRPS. There is also ample medical and psychological evidence in the record to prevent Claimant from proving that his residual pain complaints are related to his 2007 industrial injury.

The Weight of Medical and Psychological Opinions Fails to Establish CRPS

27. **Thomas E. Bittker, M.D.** As noted in greater detail, above, in 1976 Dr. Bittker**,** Chairman of the Arizona Department of Mental Health Services Health Plan, noted that Claimant's slow response to treatment for injuries following an automobile accident was troubling his medical care providers. In his report of psychiatric consultation, Dr. Bittker did not dispute Claimant's diagnosis of cervical radiculitis, but nevertheless opined:

> …there seems to be sufficient evidence to cause us to be concerned regarding this young man's potential dependency. It is certainly compatible that he is using his pain syndrome as a way of satisfying dependency needs which he could not otherwise manifest without loss of self-esteem…From behavioral perspective, the patient's capacity to function as an outgoing, aggressive police officer, has been threatened by this recent injury. Confronted by the prospect of some compromise of his functioning and aware that his dependency needs will only be satisfied as long as his pain persists, the patient will experience inertia in holding onto his symptoms previous to his recovery.

Defendants' Exh. 6, p. 84. Dr. Bittker's opinion was supported in Claimant's subsequent medical records through approximately 1981, demonstrating numerous instances in which physicians noted Claimant reported pain that could not be objectively verified by his physicians and one instance in which Claimant took a 12-day river boat trip during a period of disability. The Referee finds Dr. Bittker's opinions as to Claimant's psychological state support the conclusion that he suffered from a somatization disorder, and possibly engaged in malingering, long before his 2007 industrial injury.

28. **Ronald Kristensen, M.D.** Claimant was referred to Dr. Kristensen, an orthopedic surgeon, by Dr. Lossman. A December 13, 2007 patient questionnaire, possibly completed by Claimant's wife, lists preexisting conditions including gout, a multilevel lumbosacral fusion, a Morton's neuroma and plantar fasciitis in Claimant's left foot, spinal stenosis and Achilles tendon

rupture. On that same day, Dr. Kristensen noted the possibility of CRPS[4]. By December 21, 2007, Dr. Kristensen had diagnosed CRPS, although there is no indication in his records as to how he arrived at that diagnosis or whether he had ruled out gout, somatization disorder, malingering, or anything else. He also diagnosed a soft tissue lesion over Claimant's Achilles tendon. Dr. Kristensen next examined Claimant on September 16, 2008, noting that he was still struggling with CRPS and that there was nothing to be done orthopedically. Dr. Kristensen's chart notes are inadequate to establish a diagnosis of CRPS.

29. **Peggy Ann Rupp, M.D.** Dr. Rupp, a rheumatologist, evaluated Claimant on December 28, 2007, when he was admitted to Saint Alphonsus Regional Medical Center ("SARMC") for pain management. She did not believe he was having a gout flare, but renewed his prescriptions for colchicine and Allopurinol at the request of Claimant's wife. Dr. Rupp again saw Claimant in consultation at SARMC on March 19, 2008. She ordered arthrocentesis of his right knee, which proved positive for uric acid crystals. A diagnosis of gout was established, and Claimant was started on Allopurinol and colchicine. His symptoms dissipated. Claimant followed up with Dr. Rupp occasionally through March 2009.

30. Dr. Rupp's gout diagnosis is significant on its own because it shares symptoms with CRPS and, therefore, must be included in any differential diagnosis for CRPS. In addition, in a June 27, 2008 letter to the claims examiner, Dr. Rupp expressed that she did not observe signs consistent with CRPS, that she believed claimant likely has polyarticular disease and osteoarthritis, and that she did not feel his condition(s) were in any way related to the industrial injury. Dr. Rupp's chart notes concurrent with Claimant's two office visits following this letter show no evidence of a change in opinion.

[4] The note actually references Reflex Sympathetic Dystrophy ("RSD"); however, medical evidence in the record establishes that RSD and CRPS are the same, so the condition is referred to herein only as CRPS, for convenience.

31. **Michael Weiss, M.D.** Dr. Weiss, a physiatrist, treated Claimant from January 2, 2008 through February 27, 2008. He initially agreed that Claimant had elements of CRPS and, by the end of his treatment, opined that Claimant had CRPS meeting the "Budapest" criteria. However, by August 20, 2008, after he had more information and the opinions of Dr. Greenwald, Dr. Krafft, Dr. Kadyan, Dr. Calhoun and Dr. Rupp, he retreated from his diagnosis, writing to the claims examiner, "…he only has some elements of the diagnosis but I do not feel it can be ruled in or out." Claimant's Exh. 5, p. 254. Further, he deferred to Dr. Greenwald's opinions as set forth in her March 10, 2008 report. Dr. Weiss's opinion is equivocal and, as such, is not sufficient to establish CRPS by a preponderance of the evidence.

32. **Sandra Thompson, M.D.** Dr. Thompson, a pain specialist, treated Claimant from January 22, 2008 through June 11, 2008 in referral from Dr. Weiss. In a letter to the claims examiner dated July 23, 2008, Ms. Thompson noted Claimant's history in her care, including her understanding that Claimant had declined an offer of sedentary work by Employer without negotiation. Her opinion also fails to establish CRPS:

> After reviewing all of the medical records provided to me and the impression of the care provider as seen by this patient, it is clear that he does have a diagnosis of gout, and the diagnosis of [CRPS] is not supported by objective data and is only supported by subjective patient complaints…but I also am not able to deny that this patient does have pain. Since the diagnosis of [CRPS] is not conclusive, one has to conclude that his current pain complaints are unlikely to be due to his work-related accident.

Claimant's Exh. 7, p. 296.

33. **Michael H. McClay, Ph.D.** Dr. McClay, a psychologist, evaluated Claimant at the behest of Surety on March 4, 2008. He interviewed Claimant and administered tests (including the MMPI-2, the results of which Dr. Calhoun later relied upon). He concluded that Claimant had a history of chronic pain problems and elements of a chronic pain syndrome, including

heightened sensitivity to pain and somatic complaint, with a secondary sleep disorder. Claimant's psychological profile suggested conversion tendencies, strong symptom magnification syndrome and secondary gain. In addition, Dr. McClay opined that Claimant was highly dependent on pain killers and other psychoactive medication. Dr. McClay's conclusions fail to support a CRPS diagnosis.

34. **Nancy Greenwald, M.D.** Dr. Greenwald, a physiatrist, evaluated Claimant on March 10, 2008 in response to Dr. Weiss's request for a second opinion. Dr. Greenwald conducted a thorough examination and reviewed Claimant's relevant medical records, with the exception of Dr. McClay's psychological evaluation. Her findings and recommendations were equally thorough, addressing a number of conditions. Most relevantly, she diagnosed gout and recommended treatment for 3 months, after which time it would be under control. She also concurred with Dr. Weiss that Claimant's left ankle presentation could be related to CRPS, but then discussed at length Claimant's history of left foot plantar fasciitis and neuroma, opining that this pain could likely be the result of chronic radiculopathy. Dr. Greenwald's findings and opinions are equivocal with respect to whether or not Claimant has CRPS.

35. **Vic Kadyan, M.D.** Dr. Kadyan, a physiatrist, treated Claimant from March 19, 2008, when he consulted on Claimant's case while he was at SARMC, until June 27, 2008. As a general proposition, Dr. Kadyan confirmed that the Budapest criteria are the same as the *AMA Guides* criteria for CRPS. He has treated more than 50 CRPS patients, with 15-20 of those patients experiencing onset attributed to a soft tissue or peripheral injury[5]. He opined that Claimant's gout and arthritis account for all of his potential CRPS signs and symptoms, except the reports of observed hair loss, because they all went away after he was treated for gout. As to

[5] The *AMA Guides, 6th Ed.* identifies CRPS with onset due to a soft tissue or peripheral injury as "CRPS-1". CRPS-1 is referred to herein simply as CRPS.

hair pattern changes, Dr. Kadyan explained that a practitioner could err in that assessment. In addition, Dr. Kadyan observed inconsistencies on Claimant's examinations, including inconsistencies in dorsiflexion, hyperesthesias and strength tests. He stated in his deposition that these "…raised a big red flag that there is clearly a discrepancy between what he wants or portrays that his strength is versus what he's actually able to do." Kadyan Dep., p. 19. Even after reading Dr. Mallari's deposition, Dr. Kadyan opined that Claimant does not meet the criteria for a CRPS diagnosis.

36. **Kevin Krafft, M.D.** Dr. Krafft is a physiatrist in practice with Dr. Kadyan. On June 2, 2008, he recommended a team conference to assess Claimant for a work hardening program, to include a physical therapy and neuropsychology evaluation in addition to the physiatry examination. Upon conclusion of the team evaluation, Dr. Krafft informed the claims examiner, on June 20, 2008, that the team had declined to recommend Claimant as a candidate. The group based its decision on a number of factors, including inconsistencies in Claimant's musculoskeletal evaluation, bone scan findings consistent with polyarticular arthritis (as opposed to CRPS), and a general lack of evidence to support a CRPS diagnosis. Further, Claimant "…does not appear to have significant findings related to his injury of record, and therefore there is no impairment or specific restrictions in relationship to [that injury]." Claimant's Exh. 9, p. 335.

37. **Robert Calhoun, Ph.D.** Dr. Calhoun, a clinical neuropsychologist, was a member of Dr. Krafft's team evaluating Claimant for the work hardening program in June 2008. He also continued to treat Claimant for several subsequent visits. By way of history, Dr. Calhoun mentioned that Claimant seemed disgruntled because no one from Employer's had called to see how he was doing. Dr. Calhoun was unaware that Claimant was lying when he reported having

been in military intelligence in Vietnam for 2 years of a total of 12 years in the military. Following a review of Dr. Bittker's findings from the mid-1970s and Dr. McClay's MMPI-2 results, Dr. Calhoun believed Claimant had somatization disorder with histrionic, dependent and narcissistic personality trends that resulted in pain flare-ups marked by his diffuse experience of pain.

38. With respect to narcissistic tendencies, Dr. Calhoun candidly expressed that he thought Claimant's case was sad, explaining:

> …there can be all kinds of different personality disorders that fit with chronic pain syndrome or malingering, but narcissistic is certainly one, because when these individuals can't meet these grandiose expectations, then oftentimes they'll fold their tent. They'll retreat into illness or some way to withdraw, some way to be taken care of, then it turns into a more dependent matter where they become dependent on others.

Calhoun Dep., pp. 26-27.

39. Concerning his diagnosis of somatoform disorder, Dr. Calhoun explained that the affected patient is unaware of it:

> …there can be an objective medical finding, but…the person's presentation and their level of debilitation and reaction to that pain is out of proportion to the medical finding.

Calhoun Dep., p. 34.

40. Even after Dr. Calhoun was informed that Claimant had lied to him about his background, Dr. Calhoun was wary of labeling Claimant as a malingerer, noting the difficulties that label carries for a patient seeking any kind of treatment and explaining that he had not had an opportunity to evaluate Claimant after finding out. However, he did allow that "…with the additional testimony [that Claimant admitted lying], he certainly has that propensity." Calhoun Dep., p. 38.

41. As set forth above, Dr. Calhoun concurred in the work hardening team's assessment that

Claimant's alleged pain condition is not CRPS and is not related to his industrial injury.

42. **Clinton Mallari, M.D.** Dr. Mallari, a physiatrist and pain specialist, treated Claimant for his symptoms following his industrial accident, beginning August 20, 2008 through approximately 2 weeks before his deposition on June 29, 2010. He has seen less than a dozen CRPS patients in his 20 years of medical practice, yet he does believe Claimant has CRPS. Dr. Mallari's opinion lacks credibility because he did not apply either the Budapest or *AMA Guides* criteria in reaching his diagnosis. He elaborated on his "no criteria" approach, explaining "I think it comes from just having a high level of suspicion as a clinician." Mallari Dep., p. 47. Instead, he took a "longitudinal" approach, assessing CRPS because Claimant had sufficient signs and symptoms collectively over a long period, even though he did not demonstrate them concurrently. In addition, Dr. Mallari did not include gout in his differential diagnosis, and he did not take into account Claimant's somatization and potential malingering when that information became available to him. Further, Dr. Mallari agreed that he would accept a treating physician's opinion that Claimant was magnifying his symptoms "…if they were of the mindset that he was a malingerer." Mallari Dep., p. 60. Yet, Dr. Mallari intentionally rejected evidence that Claimant was, indeed, malingering because he had already arrived at his diagnosis by the time this information came to light.

43. **Raymond Bedell, M.D.** Dr. Bedell is a pain specialist who perfunctorily evaluated Claimant for a spinal cord stimulator on September 19, 2008. There is no indication that he ever again saw Claimant, or that he evaluated Claimant for CPRS. Therefore, his findings and opinions carry less weight than those of the numerous other physicians who conducted evaluations.

44. **Phillip Getson, D.O.** Claimant's wife, Claimant and Dr. Bedell, a pain specialist,

devised a “plan” to consult with Dr. Getson for Ketamine treatment. Song Dep., pp. 44-45. Dr. Getson is a New Jersey chronic pain physician who saw Claimant once, on October 2, 2008. Dr. Getson reviewed some of Claimant's relevant medical records, took a history from Claimant, as augmented by Claimant's wife, and performed a thorough examination. Dr. Getson concluded, on a more probable than not basis, that Claimant has CRPS as a result of his workplace injury.

45. In arriving at his diagnosis, Dr. Getson did not rule out somatization disorder or malingering, and there is no evidence that he was aware of Claimant's propensity for untruthfulness. He also did not indicate that he had applied any differential diagnosis, specifically noting that he would not address the "myriad other diagnoses as detailed by Dr. Greenwald" because he was asked solely to comment on CRPS. Claimant's Exh. 15, p. 419. Given these deficiencies, Dr. Getson's opinions carry less weight than those of the numerous other physicians who offered clear evidence of an appropriate differential diagnosis to support their opinions.

46. **Michael Hajjar, M.D.** Dr. Hajjar is a neurosurgeon who treated Claimant for implantation of two spinal cord stimulators, one in his lumbar region and the other in his cervical region, between November 20, 2008 and July 17, 2009. Dr. Hajjar did no independent evaluation of Claimant's CRPS during this time. He sidestepped this issue in his letter responding to Surety's request for his opinion, claiming that he was not a specialist in CRPS and noting Claimant's very complicated course. Therefore, Dr. Hajjar's findings and opinions carry less weight than those of the other physicians who evaluated Claimant and whose experience and credentials were equal to the task of drawing a causation opinion.

47. **Beth Rogers, M.D.** Dr. Rogers, an orthopedist, conducted an IME at the request of Surety on February 23, 2009. Following intake interview and review of Claimant's past medical

records, Dr. Rogers conducted an examination in which she had difficulty assessing sensation and passive range of motion due to Claimant's complaints of extreme sensitivity. She noted some very slight hair pattern inconsistencies, but no swelling, and no nail or skin color changes. In addition, Dr. Rogers noted that Claimant demonstrated no evidence of shrapnel wounds, apparently referencing Claimant's statement to her that he had multiple shrapnel wounds after a helicopter crash in Vietnam. She opined that CRPS was possible, but not likely. "It is my opinion that Dale's upper extremity and right lower extremity pain are better explained by gout than CRPS. Psychological evaluation provided a second possible cause for Dale's symptoms, the possibility of somatoform tendencies or disorder." Defendants' Exh. 50, p. 691.

48. On January 15, 2010, Dr. Rogers chaired an independent medical panel consisting of herself, Gerald Moress, M.D., and Michael Enright, Ph.D., retained by Surety to evaluate Claimant with respect to several specific issues. Following an intake history, record review and clinical examinations, the panel relevantly opined:

a. Claimant's left ankle fracture/sprain had resolved by the time of his left ankle MRI on December 19, 2007;

b. Stand-alone pain complaints are insufficient, under the *AMA Guides, 6th Ed.*, to establish a CRPS diagnosis;

c. Gout, somatoform disorder and malingering (supported by Dr. Moress and Dr. Enright) are all possible unifying diagnoses explaining Claimant's multiple joint complaints; and

d. Claimant is currently being treated with hand splints even though he has no impediment to passive range of motion in his hands, and Claimant's severe disability depicted on the January 6, 2010 surveillance video, as compared

with the January 15, 2010 video depicting Claimant washing his truck window while grasping the window washer without difficulty, demonstrates too broad of a swing in pain and related symptomatology to support a CRPS diagnosis.

49. **Gerald Moress, M.D.** Elaborating on the January 15, 2010 panel findings, Dr. Moress testified at his deposition that Claimant demonstrated multiple inconsistencies; for example, Claimant would react as if to extreme sensitivity when he knew he was being evaluated for allodynia but would not react at all when similarly touched while distracted. Dr. Moress observed no signs of CRPS and posited that Claimant could be intentionally manipulating signs. He drew the conclusion that Claimant is malingering.

50. **Michael Enright, Ph.D.** After administering and evaluating a number of psychological tests, interviewing Claimant and reviewing the medical records available to the panel, Dr. Enright concurred with Dr. Moress's opinion that Claimant is malingering. Dr. Enright cited Claimant's lack of credibility, expressing incredulity at Claimant's adherence to the South America mission story after admitting he lied about Vietnam, his inconsistent responses to pain stimuli (which he observed during the examination), and his test results which indicate hypochondriasis that usually includes secondary gain, functionally based physical complaints under stress that are often used manipulatively, obsessive worrying, and a tendency to overreact to minor problems.

51. Dr. Enright set forth his conclusion that Claimant is malingering with the sharpness of a closing argument. He left no stone unturned, going as far as to lament the plights of the victims of what he described as Claimant's elaborate fraud. In his deposition, Dr. Enright explained that Claimant is:

> …quite facile in taking information that is dramatic and gets the attention of the person who's listening, and when he's confronted with facts that contradict the

> information, once again, he's quite facile in shifting his focus to another circumstance where the person who's questioning the veracity of his statements may not have information at hand to put the new story also into question.

Enright Dep., p. 15. With respect to causation, Dr. Enright opined that, for Claimant, an injury is an opportunity for malingering, not a cause of it.

52. **Joshua P. Prager, M.D., M.S.** Dr. Prager is a pain specialist practicing in California. He evaluated Claimant on March 31, 2010, at Claimant's request, for Ketamine infusion therapy, an off-label treatment for CRPS. Dr. Prager diagnosed Claimant with chronic pain syndrome which, in his mind, justified going forward with the Ketamine treatment. He verbally wrestled with the possibility of a CRPS diagnosis, noting a number of relevant factors including the possibility that Claimant's spinal cord stimulators could be masking some CRPS indicators. In the end, however, he declined to diagnose CRPS because Claimant augmented his sensory examination so much that Dr. Prager could not rely upon the positive aspects of Claimant's sensory examination to fulfill the diagnostic criteria. A follow-up note indicated that Claimant had a good response to the Ketamine treatment; however, the implication that this supports a diagnosis of CRPS is of little consequence, since Ketamine is an experimental treatment and a patient's favorable response to it has not been recognized to have any bearing on a CRPS diagnosis. The evidence of Dr. Prager's findings and opinions do not support a diagnosis of CRPS.

53. **Marilyn S. Jacobs, Ph.D.** Dr. Jacobs is a clinical psychologist and psychoanalyst practicing in California. She evaluated Claimant on March 31, 2010, in referral by Dr. Prager with respect to pain management medical decision-making (specifically, to identify any psychological reasons not to go forward with the Ketamine treatment). Dr. Jacobs's evaluation included an interview notable for Claimant's report that he felt beat up by Dr. Enright, who

called him a malingerer, and his admissions of past lies about his education and military experience. Claimant complicated his admission by explaining that he was discharged to go to South America to work confidential drug enforcement missions, rather than going to Vietnam. Dr. Jacobs did not have records to verify the latter claim; however, the record indicates that Claimant was discharged from the military in December 1969, that he worked as a police officer in Arizona by at least August 8, 1973, and that he told the claims examiner that he was in Columbia selling Vietnam surplus helicopters in the early 1970s. The Referee is unpersuaded that Claimant came entirely clean with Dr. Jacobs.

54. In any event, Dr. Jacobs's findings were similar to prior findings by psychologists in Claimant's case, including compulsive personality traits, depression, anxiety and cognitive dysfunction. Claimant demonstrated limited resources to admit or solve psychological problems and is thus vulnerable to somatic reactivity in stressful situations. In addition, he has dependent personality traits.

55. Dr. Jacobs expressed concern about Claimant's falsification of his past history, attributing this tendency to low self-esteem and insecurity rather than an overt desire to manipulate others for secondary gain. Thus, his "…motivation for augmentation and exaggeration is likely due to unconscious factors related to immaturity, dependency needs which are unresolved and poor ability to cope with stressful situations and to take responsibility for himself." Claimant's Exh. 18, p. 452. Dr. Jacobs consequently cleared Claimant for Ketamine therapy.

56. Dr. Jacobs's findings do not establish that Claimant has CRPS, nor rule out a propensity for intentional deceit.

57. The medical and psychological evidence is insufficient to establish that Claimant has CRPS, or that Claimant's symptoms that he began reporting sometime after his “normal” follow-

up with Dr. Lossman on November 5, 2007 were caused by or in connection with his industrial ankle fracture/sprain. Further, the record establishes that Claimant suffered from a somatoform disorder, gout, arthritis and other conditions that could account for the symptoms he attributes to CRPS before he was injured at work on September 27, 2007. Since CRPS is a diagnosis of exclusion, and since there are a number of non-work related differential diagnoses that might explain Claimant's complaints, the Referee concludes that Claimant has not met his burden of proving work-related CRPS.

Reasonable 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).

58. The parties agree that Claimant is entitled to the medical care benefits paid for treatment of Claimant's left ankle injury. As of November 5, 2010, at 6 weeks post-injury, Claimant's ankle was healing normally but it was weak, so Dr. Lossman prescribed physical therapy. Subsequently, Claimant developed additional symptoms and Dr. Lossman referred him to Dr. Kristensen, an orthopedic surgeon. Dr. Kristensen investigated Claimant's complaints and

assessed his left ankle after obtaining an MRI on December 19, 2007. The MRI identified a soft tissue mass on his Achilles tendon, but was otherwise normal. On December 21, 2007, Dr. Kristensen released Claimant, stating he did not require further orthopedic treatment. He restricted Claimant to 6 hours of light duty work per day, strictly based upon Claimant's residual pain complaints, which have been determined to be unrelated to his industrial accident.

59. The Referee finds Claimant's industrial left ankle injury reached maximum medical improvement ("MMI") as of December 21, 2007. Claimant is entitled to reasonable medical care for his injury through that date.

60. Claimant has failed to prove that he suffered any additional compensable medical or psychological injury, including but not limited to CRPS or somatization disorder, as a result of his September 27, 2007 industrial injury.

Temporary Total Disability

61. Idaho Code §§ 72-408 and 409 provide time loss benefits to an injured worker who is temporarily totally disabled. Here, Surety paid time loss benefits from September 27, 2007 until after Claimant's left ankle injury reached MMI on December 21, 2007.

62. Claimant has proven that he is entitled to time loss benefits related to his industrial accident from September 27, 2007 until December 21, 2007.

Attorney Fees

63. Idaho Code § 72-804 provides that if the Commission determines that the employer contests a claim for compensation made by an injured employee without reasonable ground or the employer neglected or refused within a reasonable time after receipt of a written claim for compensation to pay to the injured employee the compensation provided by law or without

reasonable ground discontinued compensation as provided by law, the employer shall pay reasonable attorney fees in addition to the compensation provided by law.

64. Claimant did not argue this issue. Therefore, the issue is deemed abandoned.

65. All other issues are moot.

CONCLUSIONS OF LAW

1. Claimant has failed to prove that he has CRPS or any other compensable condition caused by the industrial accident of September 27, 2007.

2. Claimant has proven his entitlement to reasonable medical care for his left ankle injury incurred on September 27, 2007.

3. Claimant has proven his entitlement to temporary total and temporary partial disablement benefits from September 27, 2007 through December 21, 2007.

4. Claimant abandoned his claim for attorney fees pursuant to Idaho Code § 72-804.

5. 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 __14____ day of December, 2010.

INDUSTRIAL COMMISSION

_/s/_____

LaDawn Marsters, Referee

CERTIFICATE OF SERVICE

I hereby certify that on the _27____ day of ___December_____, 2010, 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:

HUGH MOSSMAN
611 W HAYS ST
BOISE ID 83702

ALAN GARDNER
P O BOX 2528
BOISE ID 83701-2528

KENNETH L MALLEA
P O BOX 857
MERIDIAN ID 83680

jkc _/s/_____

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

DALE WHITMORE, Claimant, v. CABELA'S, Employer, SENTRY INSURANCE A MUTUAL COMPANY, Surety, and STATE OF IDAHO, INDUSTRIAL SPECIAL INDEMNITY FUND, Defendants.	)	**IC 2007-033768** **ORDER** December 27, 2010

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

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

1. Claimant has failed to prove that he has CRPS or any other compensable condition caused by the industrial accident of September 27, 2007.

2. Claimant has proven his entitlement to reasonable medical care for his left ankle injury incurred on September 27, 2007.

3. Claimant has proven his entitlement to temporary total and temporary partial disablement benefits from September 27, 2007 through December 21, 2007.

4. Claimant abandoned his claim for attorney fees pursuant to Idaho Code § 72-804.

5. All other issues are moot.

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

DATED this __27___ day of ___December_____, 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 __27___ day of __December_____, 2010, a true and correct copy of the foregoing **Order** was served by regular United States Mail upon each of the following persons:

HUGH MOSSMAN
611 W HAYS ST
BOISE ID 83702

ALAN GARDNER
P O BOX 2528
BOISE ID 83701-2528

KENNETH L MALLEA
P O BOX 857
MERIDIAN ID 83680

jkc _/s/_____