BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

KARRI PENOYER, Claimant, v. GABLES HOLDING LLC, Employer, and WCF NATIONAL INSURANCE COMPANY, Surety, Defendants.	**IC 2018-012160** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** **FILED** **FEBRUARY 16, 2024** **IDAHO INDUSTRIAL COMMISSION**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Sonnet Robinson. A hearing was conducted on April 25 and continued for further testimony on May 5, 2023. Claimant, Karri Penoyer, was represented by Dalon Esplin of Blackfoot. Eric Bailey of Boise represented Defendants. The matter came under advisement on October 24, 2023, and is ready for decision.

ISSUES[1]

1. Whether Claimant is entitled to:
    a. Medical care;
    b. Temporary partial or temporary total disability (TPD/TTD);
    c. Permanent partial impairment (PPI);

[1] Claimant did not argue for retraining in briefing, and it is deemed waived.

d. Attorney's fees;

2. Whether Claimant's suicidal ideation and psychological injuries meet the requirements of Idaho Code § 72-451 such that these conditions are compensable;
3. Whether Claimant is totally and permanently disabled;
4. Whether apportionment is appropriate;
5. If Claimant is not totally and permanently disabled, whether Claimant is entitled to:
    a. Permanent partial disability.

CONTENTIONS OF THE PARTIES

Claimant contends that her April 2018 industrial accident aggravated her pre-existing low back condition and Defendants are liable for all treatment related to that condition. Claimant is limited to sedentary work, and she is totally and permanently disabled via the odd lot method from her physical restrictions alone. She is totally and permanently disabled from the April 2018 accident alone. Defendants are liable for Claimant's treatment for suicidal ideation which was predominantly caused by the industrial accident. Defendants are liable for attorney's fees for their unreasonable denial of a low back MRI and refusal to pay for Claimant's mental health treatment for her suicidal ideation.

Defendants respond Claimant's suicidal ideation was more likely caused by traumas suffered pre-injury, traumas of which her expert psychiatrist was not fully aware of in rendering his opinion. There are no impairment ratings in the record for Claimant's psychiatric conditions, which is a requirement of Idaho Code § 72-451. Claimant's low back pain was minor before and during her inpatient psychiatric stay and did not cause her suicidal ideation. Claimant's own experts believe there is future, curative treatment for Claimant; thus she is not at MMI and determining disability from her low back and psychiatric conditions is premature. If Claimant is at MMI, then her condition should be apportioned for her pre-existing low back issues, and she

has medium duty restrictions, or no restrictions related to the industrial accident. Claimant has somatoform disorder and the records document years of pain complaints with no physical cause. Any disability Claimant does suffer from her low back injury is minimal.

Claimant replies that she is totally and permanently disabled based on the FCE results and apportionment is not appropriate as she had no prior physical impairment, and her psychological impairment was in remission and well controlled. If Claimant's pre-existing psychological impairment is considered, it should be considered as a non-medical factor. The 2009 low back pain record is insufficient to apportion Claimant's low back condition. Claimant is a credible witness. Claimant's pre-existing mental health diagnoses were not caused by the industrial accident, only her suicidal ideation was caused by the industrial accident, and this was due to the loss of her coping mechanism, caretaking, not the pain from the injury. Only Claimant supplied an Idaho licensed psychologist or psychiatrist as required by Idaho Code § 72-451 and Claimant has met her burden to prove the industrial accident was the predominant cause of her suicidal ideation by clear and convincing evidence.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The Industrial Commission legal file;
2. Joint exhibits 1-32 and demonstrative exhibits 33-35;
3. The hearing testimony of Karri Penoyer, Claimant, Jay Ellis, DPT, Alan Poulter, MD, Jake Moss, MD/JD, Daniel Traughber, PhD;
4. The post-hearing deposition of Delyn Porter taken by Claimant;
5. The post-hearing deposition of Robert Friedman, MD, taken by Defendants.

All outstanding objections are OVERRULED.

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.

FINDINGS OF FACT

1. On November 9, 2009, Claimant presented to the Blackfoot Medical Center with reports of left lower back pain. JE 3:15. Claimant reported she had several episodes of back pain, and on this occasion twisted her back while carrying 50 pounds, heard a "pop or snap," and thought she dislocated her hip. *Id.* Claimant's hip X-rays showed no fracture or dislocation, and Claimant was diagnosed with a muscle strain. *Id.* at 15, 17. She was treated with a Toradol injection, prescribed Flexeril, Motrin, and Tylenol/Codeine, and told to avoid heavy lifting for a week. *Id.* at 15.

2. On May 28, 2013, Claimant reported left sided chest pain which radiated into her back and shortness of breath. JE 3:21. Claimant was diagnosed with shortness of breath, chest pain, high blood pressure, anxiety, and costochondritis. *Id.* at 22. Claimant was prescribed lisinopril and Celexa. *Id.* at 23.

3. On April 18, 2014, Claimant reported shortness of breath, palpitations, lightheadedness, fever, fatigue, and anxiety; she rated her symptom severity at 9/10. JE 3:30. Claimant's EKG, CBC, SOB panel, and chemical panel were normal; Claimant was prescribed Valium. *Id.* at 32.

4. On September 12, 2014, Claimant again reported chest pain which radiated into her midback. *Id.* at 43. Claimant was taking weight loss supplements with caffeine; Claimant was given metoprolol and her symptoms resolved within an hour. *Id.* at 45. Two days later, Claimant went to the emergency room for the same symptoms; Claimant's CT scan, X-rays, blood panel, and CBC were normal, and she was diagnosed with "palpitations." JE 5:144-153.

5. On October 23, 2015, Claimant presented to Bingham Memorial Hospital for high blood pressure and depression. JE 5:337. She reported she was very depressed with some anxiety, denied prior suicide attempts, and while not currently suicidal, she had been "mildly suicidal" when she was younger. *Id.* Claimant filled out the PHQ-9 and GAD-7 and her "scores were very high on both forms." *Id.* at 338. Claimant was prescribed Prozac.

6. On November 25, 2016, Claimant presented again with shortness of breath, chest pain, headaches, dizziness, and rapid heart rate which she rated at 4/10 in severity; Claimant's panels were again normal, she was diagnosed with anxiety, and prescribed Zoloft. JE 3:54-56.

7. On March 31, 2017, Claimant presented for anxiety, shortness of breath, and chest pain; Claimant's lisinopril and Zoloft were refilled. JE 3:64-65.

8. Claimant began working at Employers on October 11, 2017. JE 1:1. Prior to this, Claimant had worked as a janitor at an elementary school for four years. Hr. Vol 1, p. 60-63.

9. On April 29, 2018, Claimant was bathing a resident's leg when she "heard her back pop and felt it crack." JE 1:1.

10. On May 1, 2018, Claimant presented to the Blackfoot Medical Center and reported bending over to a wash a resident's legs, hearing a snap, and falling "on [her] butt" it hurt so bad. JE 3:67. Claimant was diagnosed with a back strain and restricted to seated work for seven days. *Id.* at 68.

11. At follow-up on May 8, 2018, Claimant reported the pain had been improving until she rode her lawn mower, which flared her back again; Claimant had yet to start physical therapy. *Id.* at 75. On May 15, Claimant's X-rays showed spondylolisthesis at L5-S1 and bilateral pars defects at L5 and Travis Erickson, DO, recommended an MRI. *Id.* at 80, 82. On May 24, Claimant underwent a lumbar MRI which showed: (1) multilevel degenerative spondylosis; (2) grade two

anterolisthesis of L5 on S1; (3) broad based central disc protrusion at L4-L5 which did not cause significant spinal stenosis. *Id.* at 88. Dr. Erickson reviewed her MRIs and opined she should be evaluated by a spinal surgeon. *Id.* at 92.

12. On June 6, 2018, Claimant began physical therapy. JE 7:391. She reported her pain was a 15/10 and was in tears throughout the exam. *Id.* The physical therapist was unable to perform certain tests due to pain. *Id.*

13. On June 19, 2018, Claimant presented to Jake Poulter, MD. JE 8:424. Claimant reported pain with any type of activity, but that physical therapy seemed to be helping. *Id.* Dr. Poulter prescribed gabapentin and cyclobenzaprine. *Id.* at 428. On June 21, Claimant underwent bilateral L5-S1 ESI shots. *Id.* at 431. Claimant's pain was 10/10 prior to the procedure and 4/10 afterwards. *Id.* On June 25, Claimant reported to her physical therapist that the ESI shots had only made her worse. JE 7:395.

14. On July 8, 2018, Claimant presented to the ER with anxiety, dizziness, and chest pain. JE 4:154. Claimant reported three prior strokes and her chest pain at a 9/10. *Id.* at 155. She reported a history of chronic back pain which ranged from her low back to her mid back. *Id.* She reported smoking 3 cigarettes a day. *Id.* Claimant x-rays and blood panel were normal, and she was diagnosed with costochondritis (chest inflammation) and discharged. *Id.* at 166.

15. On July 10, 2018, Claimant returned to the ER with chest pain and reported her left arm was numb. *Id.* at 167. Claimant's EKG at her primary care physician's office showed atrial fibrillation and she again reported her history of three strokes. *Id.* at 168. Claimant's two repeat EKGs were normal, and she was discharged with a diagnosis of costochondritis and chest pain. *Id.* at 175, 187.

16. On July 16, 2018, Claimant returned to Dr. Poulter and reported the ESI shots only

improved her pain for two to three days, and neither physical therapy nor gabapentin had helped her pain. JE 8:445. Flexeril made her drowsy and she used it sparingly. *Id.* Claimant had developed occipital neuralgia, with no prior history of headaches, and was treated with occipital nerve blocks which "resolved her headaches for the duration of the local anesthetic only." *Id.* Dr. Poulter scheduled her for a second ESI shot and increased her gabapentin prescription. He also explained that she may be a candidate for medial branch nerve blocks and thermal ablation; her imagery showed no obvious instability, and these modalities could help her avoid surgery. *Id.* at 449. Claimant had her second ESI shot the next day; she reported her pain was 10/10 prior to the shot and 5/10 afterwards. *Id.* at 453. At follow-up on July 23, she again reported that the ESI shots and physical therapy had not helped; the gabapentin and Flexeril made her symptoms "tolerable." *Id.* at 459.

17. On July 31, 2018, Claimant was examined by Lynn Stromberg, MD. JE 9:500. Dr. Stromberg diagnosed spondylolysis, spondylolisthesis at L5-S1, and noted "the patient is quite hyperreactive to the examination." *Id.* at 501. Dr. Stromberg recommended surgery as Claimant had no benefit from injections. *Id.*

18. On August 13, 2018, Claimant underwent posterior lumbar decompression and fusion. JE 9:505.

19. On August 28, 2018, Claimant reported she was getting along fine post-surgery with no medication and Dr. Stromberg observed "this is well advanced from where I thought she would be at this point." *Id.* at 511. Dr. Stromberg gave her a prescription for Tylenol with Codeine just in case she felt she needed something and that they would refer her to physical therapy if she could not continue to be active. *Id.*

20. On September 25, 2018, at follow-up with Dr. Stromberg, Claimant seemed quite

happy and was getting along well; Dr. Stromberg predicted that in six to eight weeks she could return to full duty but was presently limited to sedentary duty. JE 9:513.

21. On October 17, 2018, Claimant presented to F.B. Moser, DO:

> The patient is a 37 year old Caucasian/White female who presented for a depressed mood. The symptoms have been present for 1 years [sic] and are described as severe.
>
> She also reports feelings of worthlessness, suicidal ideation, and social withdrawal. She does have a formed plan to commit suicide. She intends to harm herself with a firearm that is available and taking an overdose of medication that is readily available. She denies feelings of isolation, weight gain, and social withdrawal.
>
> The patient feels she is unable to care for herself or her dependents. Predisposing factors include: She currently lives with her daughter. She has a history of suicide attempts and major depression. She was being treated for these conditions.

JE 3:121. Dr. Moser assessed a severe episode of recurrent major depressive disorder. *Id.* at 123. Claimant was transported voluntarily to Bingham Memorial Hospital for treatment. *Id.*

22. On October 18, 2018, Claimant was transferred to the Portneuf Medical Center's Behavioral Unit. JE 11:604. On admission, Claimant reported low back pain. *Id.* Kathleen Erwin, MD, evaluated Claimant. *Id.* at 606. Dr. Erwin wrote under circumstances leading to admission: "taken to outside ED by police after verbalizing SI in doctor's ofc; this was in context of being off work x4 mos d/t back injury, and no specialty MH care." *Id.* Regarding symptoms and behaviors leading up to admission, Dr. Erwin wrote:

> 37yo F w/ h/o depression and PTSD is adm w/intense SI and plan to OD; she has hoarded a large quantity of pills at home and was very committed to following through w/ this plan. However, she let slip to a friend that she was having these thoughts. friend alerted pt's bishop, who convinced her to come in for care… pt does endorse racing thoughts, decreased need for sleep, impulse behavior. She becomes very tearful when asked about hallucinations; she reveals that she has been having AH and VH for years, but never told anyone. The voices are multiple, unfamiliar, both M and F, sometimes benign but often scary, never command. The VH have been present from childhood, and pt's father had them too. They were scary a few yrs ago, less so now. Pt also endorses frequent nightmares and flashbacks to childhood abuse, as well as the death of 4 relatives in her care over

> the last several yrs. She is now living in the house she inherited where these deaths occurred, and she finds that very difficult. Has frequent PA w/classical physical sx. Describes relationship w/ husband as distant and unsupportive, not really conflictual. Denies drug or EtOH use. Pt states the only time she ever feels at peace is sitting in the cemetery (which she has done since childhood).

JE 11:606. Claimant reported her symptoms began in childhood, she had two hospitalizations as a child, and two prior suicide attempts. *Id.* Claimant also reported severe physical abuse by her mother and sexual abuse by her father. *Id.* at 607. Dr. Erwin diagnosed bipolar 1 disorder with mixed severe psychotic features but could not exclude schizoaffective disorder bipolar type; she also diagnosed PTSD, generalized anxiety disorder, insomnia, and suicidal ideation. *Id.* at 609. Claimant underwent group, individual, and milieu therapy throughout her eight-day stay and medication management. See JE 12.

23. On October 19, 20, 22, 23, 24, 25, and 26 2018, Claimant denied any pain. JE 12:837, 847, 860, 864, 878, 886. On October 21, 2018, Claimant reported low back pain and was given Tylenol. JE 12:853.

24. On October 22, 2018, Claimant reported her auditory and visual hallucinations were worsening; she was still suicidal. JE 12:735. On October 24, 2018, Claimant reported severe PTSD after watching three of her close family members pass away and "having to re-live those moments every day." JE 12:727. Claimant was still suicidal and reported she had had suicidal thoughts since childhood. *Id.* at 727, 932. Claimant's stay did not involve discussion of her work injury, lack of work, or low back pain other than at intake and the October 21, 2018 report of low back. See JE 12; JE 12:931-938.

25. Claimant was discharged on October 26, 2018 after improvement in her symptoms. JE 11:614. Claimant was to follow-up with Brittany Barnes, LCSW, on October 29 for medication management. *Id.* at 622. At discharge, Claimant was prescribed Ziprasidone for auditory

hallucinations and bipolar I disorder, Propranolol for anxiety, Lithium Carbonate, Prazosin for nightmares, and Clonazepam for her sleep disorder. JE 12:913-914.

26. On November 13, 2018, Claimant returned to Dr. Stromberg and reported she was having significant discomfort: she couldn't lift a gallon of milk and twisting and bending were intolerable. Dr. Stromberg noted her CT scan showed the screws were very well fixed, and there was bone formation, but her healing was not "fully matured yet." Dr. Stromberg wrote Claimant's "reported symptoms seem out of proportion to the timing and condition of surgical intervention. She should have made significantly more progress at this point." JE 5:517. Dr. Stromberg returned her to light duty work and prescribed physical therapy. *Id.*

27. On November 19, 2018, Claimant returned to physical therapy and reported since the fusion, she was better; her pain was currently a 1/10, at its worst a 5/10, and at its best a 0/10. JE 7:404. On November 26, 2018, Claimant again reported her pain was about a 1/10, she had a good weekend with no increase in pain. *Id.* at 407. On November 28 and 30, Claimant's pain was the same. *Id.* at 408, 409. On December 3, Claimant had more pain; on December 5, Claimant was a little better. *Id.* at 410, 412. On December 7, Claimant's PT wrote: "Pt states that she is feeling a lot better today and last treatment worked miracles and she has not had pain throughout the weekend. She states she does not have pain throughout the treatment as well." *Id.* at 413.

28. On December 11, 2018, Claimant followed-up with Dr. Stromberg and reported she was having difficulty moving 10-pound items because of pain. JE 9:525. Dr. Stromberg conducted a physical examination and wrote: "her pain complaints are out of proportion to her performance on the exam excepting the signs of symptom magnification." *Id.* He recommended CT of the lumbar spine. *Id.*

29. On December 12, 2018, Claimant reported to her physical therapist that at her

appointment the prior day her physician had told her she would have this pain for the rest of her life, she expressed this was not fair and was emotional; she stated that therapy was helping her. JE 7:415.

30. Claimant's December 14, 2018 lumbar CT scan showed: (1) Postsurgical changes as described without apparent acute hardware complication. (2) There is a new small posterior disc bulge at L2-L3 which may result in mild spinal canal narrowing. (3) Arthritic changes in the SI joints bilaterally with appearance favoring sacroiliitis. This is symmetric, without erosions. Clinical correlation for signs/symptoms of inflammatory back pain/seronegative spondyloarthropathy is suggested. JE 9:527.

31. On December 18, 2018, at her initial interview with the Industrial Commission Rehabilitation consultant, Tiffany Kidd, Claimant reported she was better but not 100%. She also reported she was mostly sedentary; Claimant denied any pre-existing conditions. JE 2:3.

32. On December 20, 2018, Claimant reported her CT scan showed she was not healed all the way and "the bone in the middle is not solid," however, she did feel that PT was helping her. JE 7:419. Her physical therapist wrote:

> patient demonstrates slow, cautious movements throughout exercises today with increased facial grimacing and moaning indicating increased pain today. She has not had this amount of pain since starting therapy indicating that there is a strong correlation with mental and physical health as she continually stated throughout treatment that now it is not healed all the way that that is why she is having so much pain. As compared to previous treatments when she had decreased pain and was motivated to get back to work.

JE 7:419. Claimant no-showed for her next appointment and did not resume physical therapy until April 2023. *Id.* at 422; Hr. Vol 1, p 121; JE 8:498.

33. On February 12, 2019, Dr. Stromberg reviewed the CT scan she had that day and wrote she had a stable fusion and that she could engage in any activity she chose without harm;

Dr. Stromberg released her to regular duty without restriction. JE 9:529. The next day, Dr. Stromberg rated her condition at 7% whole person, with 100% apportionment her pre-existing pars fracture with grade 2 spondylolisthesis. JE 5:533.

34. On March 12, 2019, Claimant reported to ICRD that she had attempted to return to work with Employer but was in too much pain and needed to find another position. JE 2:10. At hearing, Claimant explained her supervisor told her that "This work isn't for you anymore." Hr. Vol I p. 88. Claimant struggled to dress the residents and it hurt too much to push residents in wheelchairs. *Id.*

35. On May 28, 2019, ICRD contacted Claimant. JE 2:11. Claimant reported she was working 40 hours a week at State Hospital South as an aide and 15 hours a week at the Idaho Potato Museum and had been working there since mid-April. *Id.* Claimant stopped working for the Idaho Potato Museum in late August 2019. Hr. Vol I p. 93.

36. On September 26, 2019, Gary Cook, MD, examined Claimant for an independent medical exam (IME) at her request. JE 13:948. Dr. Cook's resume reveals he primarily worked as an anesthesiologist but had been conducting IMEs since 2009. *Id.* at 978-979. Dr. Cook took a history, reviewed medical records, and conducted a physical examination. *Id.*

37. Dr. Cook recorded Claimant was currently employed as a medication technician by the Fairwinds Retirement Community. *Id.* Dr. Cook recorded Claimant's presenting problems were: (1) persistent, severe, constant disabling low pain back; (2) status post L5-S1 lumbar fusion, with no post-operative improvement despite physical therapy; (3) significant functional losses with regard to activities of daily living; (4) severe mood disorder, with recent 10-day hospitalization, and two prior hospitalizations; (5) post-fusion severe, daily migraine headaches, new onset. *Id.* at 949.

38. Dr. Cook did not feel Claimant was at maximum medical improvement (MMI); she needed a re-evaluation with another spine surgeon, pain management with Dr. Poulter, a consultation with a neurologist for her headaches, and to undergo a sleep assessment. *Id.* at 960. An FCE was also recommended. *Id.* at 973. Claimant could require neuro-ablative blocks and a spinal cord stimulator or morphine pump. *Id.* at 972. Dr. Cook diagnosed: (1) lumbar pain, post-fusion, with residual radiculopathy; (2) post-spinal surgery syndrome; (3) neuropathic pain; (4) chronic pain syndrome; (5) migraine headaches; (6) depression; (7) deconditioning; (8) sleep disorder. JE 13:960-966.

39. Dr. Cook discussed that Dr. Stromberg "may be unfamiliar with neuropathic pain. As an oversight, he may have overlooked the common symptoms of hypersensitization and interpreted the usual symptoms, signs, and complaints as suggest of exaggerated response to stimuli." *Id.* at 961. Dr. Cook opined that Claimant was not malingering and offered that Dr. Stromberg "wisely" used the more clinically accurate term symptom magnification. *Id.* at 962. However, Dr. Cook added "the inference from such remarks might be construed that the claimant is somehow exaggerating symptomatology for purposes of defrauding the examiner and other [sic]. This oversight could rise to a level of serious lapse of objectivity." *Id.* at 975. Dr. Cook conducted Waddell's Signs testing and noted that Claimant had no positive findings. *Id.*

40. Dr. Cook rated Claimant's lumbar spine at 20% WPI and her headaches at 5% WPI, for a total of 24% WPI. Dr. Cook did not apportion her lumbar spine rating as she had no immediate pre-injury symptoms. *Id.* at 969. Dr. Cook did not assign specific restrictions but observed Claimant could not work in a sedentary position and was not capable of sustained, daily employment. *Id.* at 972.

41. On October 28, 2019, Claimant returned to Dr. Poulter. JE 8:466. Claimant reported

that after her fusion, she had some improvement, but had a resurgence in pain about a month ago, is now in extreme pain (10/10) and was close to going to the emergency room. She had no pain medications. *Id.* Claimant was still working full-time at Fairwinds. *Id.* at 467. Dr. Poulter prescribed Percocet, Flexeril, and a Medrol Dosepack. *Id.* at 469. Dr. Poulter was concerned about adjacent level disease, a structural problem in her back, her giveaway weakness on her right side, and the intractable nature of her pain; he wanted x-rays and a lumbar MRI. *Id.* The request for an MRI was not authorized and Claimant was referred back to Dr. Stromberg. *Id.* at 471.

42. On November 26, 2019, Claimant saw Dr. Stromberg. JE 9:534. Dr. Stromberg wrote Claimant was tremulous, whimpering, and quite emotional; she reported Dr. Poulter had prescribed Gabapentin and Oxycodone. Dr. Stromberg performed a physical exam and wrote: "It is evident that Mrs. Penoyer is not in a good place emotionally. I am concerned that she is now taking dependency producing medications without a diagnosis of an origin for pain. Her complaints and pain manifestations are unrealistic and sensory components are not anatomic." He recommended a CT scan "for completeness." *Id.*

43. Claimant's CT scan was completed on November 27, 2019. JE 9:534. Dr. Stromberg reviewed the scan and noted there was no evidence of motion at the fused segment and the fusion was stable. *Id.* at 535. He wrote that Claimant had strong signs of an emotional reaction to examination and her complaints were not anatomic and there was no objective evidence of any pathology that would explain her symptoms or support the use of pain medications. *Id.*

44. Dr. Stromberg had a very strong critique of Dr. Cook's IME, writing: "I simply do not find Dr. Cook to be a legitimate producer of such a report by training, medical practice, or in the quality of previously generated work." He noted Dr. Cook's report was filled with citations from obscure sources and was not reliable. *Id.* Dr. Stromberg further wrote:

> Examples: Dr. Cook reports on page 10 that there is radicular back pain in an L5S1 dermatomal distribution. The claimant reports pain/numbness circumferentially around both legs, but not affecting the feet. Not only is this description not consistent with L5, S1, or both L5 and S1, it is simply not anatomic. Circumferential complaints are notably a strong sign of symptom magnification. Further, in his recorded exam he records circumferential differences in the thighs and calves. The implication of this is that there is radiculopathy, or nerve damage yielding loss of muscle mass. As recorded above this would presumably be at L5 or S1. Were it so, one would see atrophy of the calves, but not of the thighs, and one would undoubtedly detect weakness in the affected muscle group. Suffice it to say that his recorded muscle strengths are not able to be reconciled…
>
> On my own exam the circumferences of the thighs and calves measured (yes, I actually measured them) equally. Motor strengths are symmetric. She strained at toe and heel walking but had normal manual tests and, most importantly, no alteration of gait that would necessarily be present if there was weakness in either of these muscle groups.

JE 9:535. Dr. Stromberg concluded that Claimant was at MMI and her new, progressive, ongoing pain complaints had no objective basis relative to the work incident. *Id.* Dr. Stromberg did revise his impairment rating, noting that the accident exacerbated a pre-existing condition, and that there were no lumbar problems prior to this accident by history; he wrote her impairment should be apportioned 80% to the pre-existing condition and 20% to the industrial condition and therefore her accident produced impairment was 1%. Dr. Stromberg maintained his opinion that no work restrictions were necessary. *Id.* at 536.

45. On January 6, 2020, Dr. Poulter noted that Claimant's CT scan appeared to accomplish its goal of stabilizing her spondylolisthesis, but recommended an MRI to determine whether there was impingement. JE 8:476. Dr. Poulter also discussed failed back syndrome with Claimant: if the MRI did not reveal soft tissue impingement, she would potentially be a candidate for a spinal cord stimulator. Dr. Poulter did not believe Claimant had reached MMI. *Id.* at 477.

46. The MRI Dr. Poulter requested was performed on April 2, 2020 and showed no impingement, improvement in her foraminal narrowing at L5-S1, and a slight increase in the size

of her disc protrusion at L4-L5. JE 8:485. Dr. Poulter wrote her small disc bulges were not severe enough to contribute to her pain. *Id.* at 486. Dr. Poulter discussed with Claimant that 10%-20% of lumbar fusion recipients struggled with intractable pain and a diagnosis of post laminectomy syndrome was the most appropriate for now. *Id.* at 487. Dr. Poulter noted that Claimant's pain "is likely not curative" and that she would need long-term pain management, namely prescriptions and injections, but potentially a spinal cord stimulator. *Id.* at 488.

47. On October 1, 2020, Dr. Poulter had a telephone consultation with Claimant; he refilled her prescriptions and noted she used her pain medication "extremely conservatively" and had stretched 84 pills from July to October. JE 31:1363. Claimant later explained that she was taking methamphetamine at this time.

48. On July 21, 2021, Claimant was examined by Daniel Traughber, Ph.D., at her request for a psychological IME. JE 14:980. This report is discussed *infra*.

49. On October 28, 2021, Claimant established primary care with Brian Hansen, DO. Dr. Hansen evaluated Claimant for hypertension, depression, chronic low back pain, obesity, and constipation. JE 15:1001. Dr. Hansen prescribed lisinopril for her hypertension, referred her to a psychiatrist for her depression, and referred her back to Dr. Poulter for pain management. *Id.*

50. On February 24, 2022, Dr. Ellis called Dr. Hansen regarding Claimant's blood pressure during an FCE; Dr. Ellis noted Claimant was not on medication and her blood pressure was 184/128. Dr. Hansen did not recommend Dr. Ellis continue with the FCE, wrote that Claimant was supposed to follow up with him but had not, and was noncompliant. JE 15:1004. The next day, Claimant reported to Dr. Hansen regarding her blood pressure; Dr. Hansen referred Claimant to the emergency room. *Id.* at 1006. Claimant presented to the ER on February 25, 2022 for her blood pressure. JE 4:292. Claimant's lab work was noncontributory, and her angiogram was

normal; Claimant was instructed to take her blood pressure medication and released. *Id.* at 293. Claimant did not complain of back pain. *Id.*

51. On March 24, 2022 and March 25, 2022, Claimant underwent an FCE with Jay Ellis, DPT at her request. JE 16:1009. This FCE is discussed *infra*.

52. On August 18, 2022, Jacob Moss, MD/JD, examined Claimant for an IME at her request. JE 17:1062. This IME is discussed *infra*.

53. On March 26, 2023, Claimant was examined by Robert Friedman, MD, for an IME at Defendants' request. JE 19. This IME is discussed *infra*.

54. On March 27, 2023, Claimant saw Dr. Poulter again. JE 8:491. Claimant reported nothing made her pain better and everything seemed to make it worse, and she was unable to work. *Id.* Claimant had resorted to methamphetamine when she had no insurance, but her daughters intervened, and now she had state insurance, so was back to establish care. *Id.* at 491. Dr. Poulter recommended another MRI, and prescribed Lyrica and tramadol. *Id.* at 494.

55. Claimant underwent an EMG on March 29, 2023, which was abnormal and showed subacute and chronic axonal pathology affecting her lower lumbar nerve roots primarily on her right S1 nerve and: "positive sharp waves and/or polyphasic motor units in the right abductor hallucis, right EHL and upper, mid, and lower lumbar paraspinals. Also, the right tibial H-reflex exhibited a diminished amplitude as compared to the left by > 50%." JE 20:1097.

56. On April 3, 2023, Claimant returned to Dr. Poulter. JE 8:496. Dr. Poulter wrote that her MRI showed her mild adjacent level facet joint hypertrophy was stable from the previous MRI three years ago. *Id.* at 497. Claimant's prescriptions were renewed, she was prescribed physical therapy, and she should return to see if she was a candidate for a spinal cord stimulator. *Id.* at 498. Dr. Poulter wrote her lifting injury in 2018 likely shifted her from asymptomatic to symptomatic

as she had no prior back pain complaints. *Id.*

57. **Expert Medical Opinions.**[2] On July 21, 2021, Claimant was examined by Daniel Traughber, Ph.D., at her request for a psychological IME. JE 14:980. Dr. Traughber is a licensed psychologist and has been in practice since 2008. JE 14:986-990. Dr. Traughber took a history, reviewed records from Claimant's stay at Portneuf, Dr. Stromberg's records, and Dr. Cook's report, administered psychological testing, and met with Claimant once.[3] See JE 14. Dr. Traughber diagnosed Claimant with PTSD, chronic/complex, Major Depressive Disorder, Severe, and Somatoform Disorder, Unspecified. *Id.* at 980. Regarding her Somatoform Disorder, Dr. Traughber explained that Claimant's psychological distress manifested as physical symptoms and that this cluster of symptoms was common for individuals with a traumatic history: "the experience of physical pain is often exacerbated, and the subjective experience of pain can be amplified and debilitating." *Id.* at 981. Dr. Traughber recorded Claimant had a traumatic childhood wherein her parents abused and neglected her; Claimant was taken in by her grandparents and aunt. She took care of them as a way to give back to them and used caregiving as a coping mechanism; eventually caregiving became part of her identity and purpose in life. *Id.* at 982. After her grandparents and aunt passed away, Claimant experienced a noticeable increase in her depression and anxiety but used caring for others as "effective treatment." *Id.*

58. Dr Traughber concluded Claimant's trauma played a necessary role in her current anxiety and depression: "It is clear that Ms. Penoyer would not be experiencing her current level of severity, without her early childhood trauma." However, her current symptoms were related to

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[2] Dr. Cook's opinion is not included herein as he did not testify and for clarity.

[3] Dr. Traughber clarified at hearing that the additional dates listed in his report were not dates he met with Claimant, but dates he worked on the report. He confirmed he only met with Claimant once in preparing his report.

the accident because she had developed an effective coping mechanism through her role as a caregiver. Dr. Traughber concluded:

> Rather than inflicting direct trauma, it appears that her injury, instead, stripped her of her ability [to] maintain her sense of self-worth and value (as well as the serious psychological strain of chronic pain). Another way of expressing this is that, despite her pre-existing trauma history, she had become fairly stable and functional, which would have likely continued if she had been able to maintain her employment and ability to care for others. In other words, while her accident/injury was not the originating cause of her childhood trauma, it did result in the loss of her ability to manage her psychological stability (which she has gradually learned to maintain during her adult life). Therefore, in my clinical opinion, her accident on April 29th, 2018, is the predominant cause of her inpatient hospitalization at Portneuf Behavioral Health in October of 2018 and her current need for mental health treatment (which began soon after the accident).

JE 14:984. He recommended individual psychotherapy for 48 months, including EMDR, before her symptoms "would resolve." He also recommended psychotropic medication for 48 months.

59. Dr. Traughber testified at hearing on May 5. Hr. Vol II, p. 368. Dr. Traughber explained that he was just made aware of Claimant's methamphetamine use, and it did not change any of the opinions in his report. *Id.* at 379. Dr. Traughber had also reviewed additional records since his original report from Blackfoot Medical Center and Claimant's 2009 report of low back pain. *Id.* at 377-378. Dr. Traughber reiterated his diagnoses from his report and noted that these diagnoses (PTSD, depression, and somatoform disorder) were related to her need for treatment for suicidal ideation. *Id.* 384-385. Dr. Traughber defined somatoform disorder as when an individual has an "unusually powerful connection" between their brain and body and experience psychological distress as physical problems; it can exacerbate, intensify, or prolong pre-existing medical problems. *Id.* at 386-387. Dr. Traughber testified he did believe Claimant experienced amplification of her pain due to somatoform disorder:

> It's very common for people with chronic pain to experience overlapping mental health issues related to pain. Chronic-pain individuals tend to suffer from very severe anxiety…they tend to have a lot of anxiety regarding the pain itself…the

> chronic pain is such a long-term strain, it tends to trigger increasing kind of anxiety and depression…there's sort of a cyclical effect to them. They kind of feed off each other.

Hr. Vol II, p. 387-388. Dr. Traughber explained that Claimant's psychological profile was complex, partially because her childhood was so extremely traumatic. *Id.* at 388. Claimant had coped with her trauma by finding her calling in life which was taking care of others; it helped manage her emotional stress. *Id.* at 390. In other words, when she had people to take care of, she was stable. *Id.* The accident took away the stabilizing, coping mechanism of care for others and was the predominant cause of her suicidal ideation. *Id.* at 392-393. When asked whether it was the "greater cause" than all the things that happened in her past, Dr. Traughber testified it was the "greater immediate cause. So she comes with all of this trauma, she's established a period of stability using kind of her natural abilities and resources, and then the accident causes a situation where she no longer has the ability to regulate her mental health." *Id.* at 393.

60. Regarding future treatment, Dr. Traughber did believe Claimant would function better psychologically with medications and therapy. *Id.* at 394. Dr. Traughber recommended EMDR to treat Claimant's trauma. *Id.* at 395. Claimant had complex, chronic PTSD and somatoform disorder, which were especially difficult to treat, so she would require about 48 months of once-a-week therapy and medications for treatment to be effective and for Claimant to improve. *Id.* at 396-397. Dr. Traughber explained that although the treatment would be to address Claimant's childhood trauma, the predominant cause for the need for treatment was that Claimant's natural coping mechanism, caring for others, was stripped away. *Id.* at 397-398. Regarding Claimant's pre-existing presentations for anxiety, Dr. Traughber opined that her anxiety was in the low-hanging range as she did not have chronic suicidal ideation, which she now has post-accident. *Id.* at 401-402.

61. On cross-examination, Dr. Traughber opined that Claimant's mental status was not at MMI; she could benefit "a lot" from treatment. *Id.* at 406-407. Dr. Traughber did agree that Claimant met the diagnostic criteria for depression and anxiety prior to the accident, but he would not have classified either as "severe." *Id.* at 407-408. Dr. Traughber did agree Claimant suffered from somatoform disorder before the accident as well; Claimant's presentation with chest pain and shortness of breath supported that diagnosis:

> Somatoform tends to be a really long thing to develop. So it tends to connect to -- it tends to connect a lot of individuals who only feel safe having psychological problems kind of that are more medical based. And it starts fairly young. And what it does is it develops over time, and the more severe it becomes, the more often a person might have just almost, like, the pure physical symptoms without even being aware that there's a psychological side to it. So that is a long-term development process.

Id. at 409. Dr. Traughber reiterated his conclusion that even with all of Claimant's pre-existing trauma, he still thought the predominant cause of Claimant's need for treatment was the removal of her natural coping mechanism, caretaking. *Id.* at 413-414.

62. On March 24, 2022 and March 25, 2022, Claimant underwent an FCE with Jay Ellis, DPT. JE 16:1009. Dr. Ellis is a Doctor of Physical Therapy, licensed physical therapist, and has been practicing since 1978. JE 16:1058-1059. Dr. Ellis recorded Claimant gave maximum effort and was cooperative throughout testing. *Id.* at 1010. Dr. Ellis observed Claimant's performance decreased the second day, which meant it was more reflective of what she was capable of on a day-to-day basis. *Id.* Claimant's limitations were "partly" due to pain and discomfort, and Claimant had moderate issues with deconditioning, weakness, and fatigue. *Id.* Dr. Ellis recorded Claimant's abilities as follows: never waist to floor carry, occasional waist to crown lifting of no more than eight pounds, occasional front carry of more than seven pounds for 30 feet, occasional short carry of no more than seven pounds for five feet, occasional long right/left

carry of no more than five pounds for 30 feet, rarely bending forward while standing for more than one minute, occasional standing work no more than 15 minutes, never crouching, rarely kneeling, occasional stairs no more than 25 at a time, walking limited to 250 yards, sitting no more than 10 minutes, occasional pushing/pulling of no more than 35 pounds. JE 16:1012-1013. Every limitation listed above was due to "pain and weakness in the low back and legs" or "constant pain in the low back and legs." *Id.*

63. Dr. Ellis testified at hearing. Hr. Vol I p. 153. Dr. Ellis explained that there were many ways to tell whether someone was making an honest effort, including repeating the same test, monitoring heartrate, observing them dressing; Claimant was very consistent in her presentation during the FCE. *Id.* at 162-163. Dr. Ellis reiterated the findings in his report. *Id.* at 164-178, 180-190. Claimant's upper body, her shoulders, elbow, forearm, and wrists were functional with level 5 strength. Claimant's lower body was weaker because she was out of shape. *Id.* at 178-179. Dr. Ellis explained that multiple tests he administered showed Claimant perceived herself to be very disabled. *Id.* at 192-194. On cross-examination, Dr. Ellis agreed psychological status was important and added information but did not "reduce the results of the test - - the physical aspect of the test; it just enhances the correlation for me." *Id.* at 201.

64. On August 18, 2022, Jacob Moss, MD/JD, examined Claimant for an IME at her request. JE 17:1062. Dr. Moss has worked primarily in providing medical/legal consulting services and primary care and has been in practice since 2013. JE 17:1073-1074. Dr. Moss took a history, reviewed medical records, and conducted a physical examination. JE 17. Claimant reported that her pain was unresponsive to physical therapy and other interventions and her pain ranged from a 6-7/10 to a 20+/10. Claimant also reported headaches which were 9-10/10 several times a week. JE 17:1068. Dr. Moss diagnosed spondylosis at L5 and spondylolisthesis at L5-S1. *Id.* at 1069.

Dr. Moss rated her at 7% whole person impairment based on the AMA Guides: "I was unable to reliably verify the presence of objective radicular complaints at the clinically appropriate level. I also did not use any modifiers since claimant's imaging was used to determine the initial class, and there were some inconsistencies in her physical exam and subjective complaints." *Id.* Dr. Moss did not apportion that rating as she had no prior back complaints in his review of the records or difficulty performing her job duties. *Id.* at 1070. Dr. Moss did not rate her headaches as she was not at MMI for that condition. *Id.* at 1069.

65. Dr. Moss did agree with Dr. Stromberg's rating but disagreed with his apportionment. Dr. Moss disagreed with Dr. Cook's ratings for both the low back and headaches. JE 17:1070. Dr. Moss also agreed with Dr. Ellis's restrictions as found in the FCE. *Id.* at 1071. Dr. Moss found that Claimant's ability to lift above chest level, stand, squat, bend, walk, twist, and sit was significantly limited; however, after appropriate treatment for her physical and mental ailments, Claimant would be capable of sedentary work. *Id.* at 1071. Dr. Moss concluded: "My prognosis for Karri is guarded – I say this because improvement of her back pain and other associated complaints could remain unchanged or become worse just as easily as they could improve with strict adherence to physical therapy, individual psychotherapy, and psychotropic medication recommendations." JE 17:1071.

66. Dr. Moss testified at hearing on May 5. Hr. Vol II. Regarding the 2009 report of low back pain, Dr. Moss opined it did not change the opinions in his report. Hr. Vol II, p. 312. Dr. Moss recalled that during the examination Claimant was otherwise stoic, but when discussing her physical limitations and quality of life she became tearful and emotional. *Id.* at 317. Dr. Moss did believe Claimant was at MMI; his care recommendations were palliative, not corrective, and he noted this was a unique case as Claimant's mental health was probably contributing to her

perception of pain. *Id.* at 320. Care such as injections and ablations would provide some relief but were ultimately temporary and would wear off over time. *Id.* at 321. Dr. Moss opined no revision surgery was necessary in his opinion. *Id.* Dr. Moss agreed with Dr. Poulter that Claimant suffered from failed back syndrome; the surgeon did nothing wrong, but the patient still has the same or similar pain post-surgery. *Id.* at 323. The March 2023 EMG showing radiculopathy did not change Dr. Moss's opinion regarding Claimant's impairment because he only found one physical sign of radiculopathy during his physical exam, a positive straight leg raise. *Id.* at 325-327. Dr. Moss disagreed with Dr. Cook's rating for migraines and disagreed with Dr. Stromberg's apportionment. *Id.* at 327-328. Dr. Stromberg's impairment rating of 7%, which 6% pre-existing and 1% accident caused seemed incorrect when Claimant had no pre-existing complaints, although he did agree her pars defect likely pre-existed the injury. *Id.* at 330-331. Dr. Moss's criticism of Dr. Friedman's impairment rating was similar. *Id.* Dr. Moss reiterated that Claimant could resume sedentary work, within the physical restrictions outlined by Dr. Ellis' FCE. *Id.* at 334. Dr. Moss's ultimate prognosis was "guarded… there are several factors that are contributing to the complaints, whether that's mental health, physical limitations…outcomes are variable." *Id.* at 334.

67. On cross-examination, Dr. Moss testified he was aware that impairment ratings could be appropriately apportioned for pre-existing, asymptomatic conditions. *Id.* at 338-339. Dr. Moss did agree there were pre-existing issues which became more significant and accounted for Claimant's later physical ailments. *Id.* at 346. Dr. Moss did recall seeing some records of Claimant's pre-existing episodes of chest pain which were related to anxiety and depression. *Id.* at 340-342. Regarding the Portneuf records wherein Claimant did not report pain when asked every day, multiple times a day, Dr. Moss did recall the records reflected she did not report or discuss pain very often and that she had demonstrated a past ability to "describe pain when prodded." *Id.*

at 347-348. Dr. Moss reiterated his disagreement with Dr. Poulter that ablations or pain pumps would cure Claimant, that nine times out of 10, the complaint will resurface, but he also acknowledged that Dr. Poulter was a pain management specialist, whereas he was not. *Id.* at 352.

68. On March 26, 2023, Claimant was examined by Robert Friedman, MD, for an IME at Defendants' request. JE 19. Dr. Friedman is board certified[4] in physical medicine and rehabilitation, electrodiagnostic medicine, and by the quality assurance and utilization review physicians, by the National Board of Medical Examiners, and the American Board of Medical Examiners; he has been in practice since 1982. JE 19:1094-1095. Dr. Friedman took a history, reviewed records, and conducted a physical examination. JE 19.

69. Dr. Friedman recorded that Claimant admitted to using methamphetamine from the fall of 2019 through the spring of 2021. *Id.* at 1089. Claimant reported PTSD from her childhood, and depression and anxiety from her childhood and adulthood: "she has suicidal thoughts all the time." *Id.* She reported treatment for depression since the 1st grade and treatment for anxiety prior to the industrial injury. *Id.* Claimant reported her headaches began with the injury and were daily. *Id.*

70. Dr. Friedman diagnosed: (1) chronic low back pain which pre-existed the industrial injury; (2) low back fusion, not related to the industrial injury; (3) chronic persistent myofascial back pain; (4) pre-existing depression with suicidal ideation with exacerbation post-surgery requiring hospitalization; (5) pre-existing hypertension; (6) pre-existing obesity; (7) history of methamphetamine use; (8) pre-existing and ongoing psychosocial stressors including "lack of finance" and lack of stable living situation. *Id.* at 1090-1091.

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[4] At deposition, Dr. Friedman clarified he is no longer board certified by the American Board of Quality Assurance and Utilization Review Physicians as listed in his resume. Friedman Depo., 5:5-12.

71. Dr. Friedman opined that the fusion surgery was unrelated to the industrial accident, but she did suffer a permanent aggravation of her pre-existing myofascial pain as a result of the injury. However, he also wrote that her clinical examination was nonphysiologic. *Id.* He did agree with Dr. Stromberg's impairment rating of 7%, with apportionment of 6% to her pre-existing conditions and 1% related to her injury, namely her myofascial pain. *Id.*

72. Regarding her psychological conditions, Dr. Friedman wrote that her industrial injury did not exacerbate her depression or anxiety or cause her need to be hospitalized; he criticized Dr. Traughber's report because it did not include her methamphetamine use or her divorce or her economic straits. *Id.* Further, her somatoform disorder was nonindustrial. Her psychological condition was temporarily exacerbated but had returned to baseline. *Id.* at 1093. Dr. Friedman rated her anxiety, PTSD, and depression with ongoing suicidal ideation at 15% of the whole person; she required ongoing appropriate counseling for her suicidal ideation. *Id.* at 1092. He also rated her hypertension at 2%. Dr. Friedman did not issue any restrictions for her physical conditions and could not opine on restrictions for her psychological conditions; he wrote:

> It is my medical opinion that there are no restrictions for her to return to employment. She has, in fact, been employed at the potato museum for over 3 months and has had subsequent employment. She reports she has terminated those employments because of pain or has been terminated due to attendance issues. This would be inconsistent with her diagnoses as a result of her industrial injury.

JE 19:1093.

73. Dr. Friedman was deposed on July 10, 2023. Friedman Depo. Dr. Friedman explained he was familiar with psychological conditions and concerns due to his experience in private practice, practice at the VA, and experience running the chronic pain program at the Elks Hospital; he was not comfortable discussing "DSM categorizations" for psychological issues but was comfortable discussing impairment ratings for psychological conditions under the AMA

Guides. *Id.* at 7:3-8:12. Dr. Friedman reiterated his opinion that Claimant's fusion was appropriate treatment; her current pain complaints were due to myofascial pain, a musculoskeletal problem. *Id.* at 12:14-13:6. The treatment for that pain would be icing and stretching, which would either resolve her pain after 18 months or she would have to continue with stretching and icing for the rest of her life. *Id.* at 18:15-19:3. Dr. Friedman opined her myofascial pain was related to the industrial injury and her pre-existing spondylolisthesis. *Id.* at 24:2-17.

74. Dr. Friedman agreed with Drs. Poulter and Moss that Claimant's spondylolisthesis was pre-existing; where his opinion differed was that her need for a fusion was not caused by the accident because she was symptomatic before the industrial accident and required treatment. *Id.* at 17:2-18:10. Dr. Friedman explained that apportionment was appropriate because Claimant had been symptomatic prior to her industrial injury; it was his opinion that a condition did not need to be symptomatic immediately prior to the accident, just previously symptomatic and treated. The time frame did not matter. *Id.* at 23:2-17; 27:2-12. If Claimant had never been symptomatic prior to her injury, Dr. Friedman would not have apportioned her impairment rating. *Id.* at 26:1-27:1. Dr. Friedman agreed with Dr. Moss that Claimant's headaches did not meet the requirements for an impairment rating. *Id.* at 27:13-28:3. Dr. Friedman would not issue restrictions related to the industrial accident, but for the fusion and to prevent next segment degeneration, Dr. Friedman would issue medium duty restrictions of no lifting more than 50 pounds occasionally, 25 pounds repetitively, and no twisting or torquing her back. *Id.* at 41:1-10.

75. Dr. Friedman opined that Dr. Poulter's proposed treatments, injections, nerve ablation, and an implanted stimulator were not curative; injections would not cure the cause of her pain, ablation would temporarily stop the pain, but nerves would grow back, and an implant would block the pain, not cure the cause of the pain. *Id.* at 19:4-20:10. Dr. Friedman was particularly

against an implanted device as it required frequent follow-up and she had demonstrated she was not a reliable patient. *Id.* at 20:11-23; 21:21-22:1. Further, Claimant's somatoform disorder would mean that psychological stressors would present as physical symptoms, which a stimulator would not help. *Id.* at 21:6-16. Her depression would also aggravate her pain and her prior drug use was a contraindication for a stimulator. *Id.* at 21:16-22:3. Claimant's somatoform disorder was pre-existing and supported by her many pre-injury visits for chest pain and shortness of breath which revealed no physical cause: "this would be a perfect example of somatoform." *Id.* at 29:1-30:9. Attempting suicide and self-harm are not "diagnosis" the same way that bipolar, depression, or PTSD are a diagnosis. *Id.* at 32:1-16. Dr. Friedman agreed with Drs. Moss and Traughber that Claimant's PTSD, depression, and somatoform disorder pre-existed the accident and were not caused by the accident. *Id.* at 33:2-10. Dr. Friedman added he did not think any of these conditions were permanently aggravated by the industrial accident, just temporary exacerbations. *Id.* at 33:11-21.

76. On cross-examination, Dr. Friedman explained that the prior instances of back pain he relied on in forming his opinion included the 2009 record, but also a 2013 and 2014 record which either mentioned back pain or identified body parts (pelvis and abdomen) which were "inclusive" of the back. *Id.* at 49:9-50:19. Dr. Friedman opined that the normal course of spondylolisthesis was one of waxing and waning symptoms: "the fact that we don't have any medical records of her seeking medical care, does not mean she didn't have symptoms." *Id.* at 51:3-20. The hip X-ray in 2009 may or may not have shown L5-S1, and it is "very difficult" to see spondylolisthesis on a frontal view. *Id.* at 63:9-16. Regarding the EMG which showed right-sided radiculopathy in 2023, Dr. Friedman explained that finding did not change his opinion or impairment rating as she did not have findings of radiculopathy when he examined her and the

radiculopathy could be the result of what happened between her surgery and the EMG, not the industrial injury. *Id.* at 66:6-67:1. Regarding the results of Dr. Ellis' FCE, Dr. Friedman did not have an opportunity to review those results but opined that FCEs were a measure of "motivation and performance," not restrictions; restrictions were to prevent injury. *Id.* at 72:1-73:1.

77. Dr. Poulter testified at hearing. Dr. Poulter graduated with his medical degree in 2004 and did a fellowship in anesthesiology in critical care in 2008 and in pain management in 2009; he has practiced medicine in Idaho since 2009 and has been in private practice for 10 years. Hr. Vol I p 238-239. Dr. Poulter explained a pars defect is when there is slippage between the L5 and S1 joints which causes pressure on the nerve roots exiting; it can be congenital or caused by an accident and is a very common source of back pain. *Id.* at 245-246. Dr. Poulter testified that the imaging he took in 2023 showed a stable fusion: "what we're looking for was if any adjacent segments or additional degeneration has happened, and it appears as though it's been pretty stable over the past five years." *Id.* at 254. Dr. Poulter did think Claimant's L4-L5 could be the source of her pain, but that spine disorders were complex and there were multiple entities which could be causing her pain. *Id.* at 257. However, Dr. Poulter did not think there was compelling evidence to operate at the L4-L5 level at the time of Claimant's surgery in 2018. *Id.* at 259.

78. Dr. Poulter believed Claimant has failed back syndrome, which is essentially "lingering symptoms" post-surgery. *Id.* at 272. Dr. Poulter explained that the diagnosis is a misnomer because it does not mean the surgeon did anything wrong, but more so that it failed in the goal of accomplishing pain relief. *Id.* at 273. Dr. Poulter thought that Claimant would need pain management for the rest of her life, she would likely never be pain free; however, he did not believe they had fully explored the options that could help her pain and there was a "great likelihood" that they could improve Claimant's condition. *Id.* at 274-275. Specifically, he noted

injections, ablations, and a possible implant could offer pain relief. *Id.* Dr. Poulter did agree the pars defect was likely pre-existing and aggravated by the accident. *Id.* at 275.

79. Regarding the 2009 record of back pain, Dr. Poulter opined "most adults are going to have these episodes of intermittent back pain," but "it must have been a short-lived thing because isn't until nine years later that the first formal imaging is done on Karri's back." *Id.* at 279. Dr. Poulter did not believe Claimant could return to work as a janitor or CNA; he opined that her accident at Employers was the cause of Claimant's back pain. *Id.* at 283.

80. On cross-examination, Dr. Poulter testified he was not a mental health expert, but he did understand that depression and anxiety makes pain worse. *Id.* at 284. Dr. Poulter did agree that future care could include surgery. *Id.* at 288-289. However, it was not indicated at this time; Claimant's recent MRI looked "about the same" as it had after surgery. *Id.* at 289. Regarding whether Claimant was at MMI, Dr. Poulter opined that he was reasonably optimistic they could improve her pain: "I want Karri to have some hope." *Id.* at 290. Dr. Poulter did not believe the care he would provide would be palliative: "palliative would imply you're just trying to limp them along and provide comfort measures and I'm interested in increasing function and increasing quality of life." *Id.* at 291. Dr. Poulter believed with pain management and retraining, Claimant could potentially be employable. *Id.* at 295-296. Dr. Poulter explained that the recent EMG did show right sided radiculopathy at the level she had surgery. *Id.* at 297-298.

81. **Vocational History.** Prior to her accident, Claimant worked as a housekeeper for Best Western, as a janitor for elementary schools, and for Ridley's Supermarket behind the meat counter very briefly. See JE 24, 29, 30. After her accident, Claimant worked for State Hospital from April 5 until at least May 28 and at the Idaho Potato Museum from about April 16, 2019 to late August 2019. JE 2:11, JE 23:1124-1125, Hr. Vol I, p. 93. Claimant then worked at Fairwinds

for about two months in 2019, which was lighter duty caretaking than the Gables. JE 23:1125; JE 25:1213; Hr. Vol I, p. 96. While at Fairwinds, they attempted to promote her to med tech, but this involved too much rushing, which aggravated Claimant's back, and she quit shortly thereafter. *Id.* at 97-98. Claimant did not apply or search for work again until January 2022; Claimant applied for three jobs in January and then did not apply for work again until October 2022. JE 23:1125. Claimant worked as a hostess for two days in October 2022, but then they wanted to train her as a server, which she could not do, specifically cleaning off the tables hurt too much. JE 23:1125, Hr. Vol I, p. 99. Claimant worked in the winter of 2022-2023 as a DoorDasher until she lost her car. *Id.*

82. Delyn Porter, MA, CRC, CIWCS, issued a vocational report on November 3, 2022. JE 29. Mr. Porter interviewed Claimant and reviewed medical records. *Id.* Claimant does not possess a high school degree and only has basic computer skills. JE 29:1337. Claimant was unable to provide a work history prior to 2017, but the work history she did provide consisted of being a janitor, caretaker, salesclerk, and working in restaurants. *Id.* at 1338. Mr. Porter recorded Dr. Stromberg's, Dr. Cook's, and Dr. Moss's restrictions. Based on Dr. Stromberg's restrictions, Claimant had no disability in excess of impairment; based on Dr. Cook's restrictions, was not capable of work; based on Dr. Moss's restrictions, Claimant was totally and permanently disabled via the odd lot method, and she was not capable of sedentary work due to the positional restriction of sitting for no more than 10 minutes at a time. *Id.* at 1349-1351.

83. Mr. Porter went on to observe that Claimant's pre-injury access to jobs was around 8,203, which was reduced to 29 jobs with Dr. Moss's sedentary restrictions resulting in labor market access loss of 96.5%; Claimant had no wage loss because she was already a low wage earner at the time of the injury. Adding in Claimant's positional sitting restriction, Claimant's labor

market loss went up to 99%. *Id.* at 1354.

84. Mr. Porter was deposed on May 12, 2023. Porter Depo. Mr. Porter had reviewed additional medical records, expert reports, and was appraised of Claimant's methamphetamine use; none of this information changed the opinions stated in his report. Porter Depo. p. 8:1-12:12. Porter testified that Claimant's work for Employer was heavy, janitorial work was medium, and Claimant's past salesclerk experience was light duty. *Id.* at 21:10-22:2. Per Dr. Ellis' restrictions, Claimant's capacity for work was at "low sedentary." *Id.* at 26:14-21. Mr. Porter did not think there was a job Claimant could be retrained to perform. *Id.* at 37:5-19. On cross-examination, Mr. Porter agreed that if treatment could increase Claimant's functionality, it would change her disability rating and her disability should be reevaluated after treatment. *Id.* at 43:12-44:15; 47:1-11.

85. **Claimant's Testimony.** On December 22, 2022, Claimant was deposed. Claimant reported she was on Medicaid and living in her car; she had sold her interest in her house to her husband for about $50,000, but had spent about $9,000 on a car for herself, $10,000 on a car for her daughter, and the rest on "baby stuff" for her daughter who was expecting. JE 30.

86. Claimant had not taken her high blood pressure medication since the FCE with Dr. Ellis because she didn't like taking medication and it had run out. *Id.* Claimant did not recall when she had been diagnosed with high blood pressure, but thought it was maybe a couple years. *Id.*

87. Claimant did not like Dr. Hansen because he said no pill could cure what was going on in her head and she disagreed with that; Claimant reported she had not seen anyone for counseling in the past couple of years. *Id.* Claimant did recall seeing Dr. Traughber, but recalled she only saw him once or twice. *Id.* Claimant recalled she was hospitalized at the Behavioral Health

Center at least twice as a child for multiple overdoses on acid reflux pills, but only one of those stays was for a suicide attempt. *Id.* Claimant reported she had seen counselors her whole life. *Id.* Claimant recalled she told Dr. Moser she had enough pills to take down an elephant, he interpreted that as a suicide threat; she disagreed with the characterization that she was hoarding pills. *Id.* However, she then agreed that she was struggling with depression and suicidal ideation and insisted she had been hospitalized for 14 days, but then clarified that maybe it only felt like 14 days. *Id.* She denied she had auditory or visual hallucinations at the time; however, she had good guy/bad guy voices on her shoulder advising her of what to do and had heard those voices since childhood. *Id.* She did have flashbacks to her grandparents and aunt dying and still struggled emotionally with their deaths. *Id.* Claimant never followed up with Britney Barnes as she was instructed on discharge from her Portneuf hospitalization. *Id.*

88. Claimant did recall her multiple episodes of shortness of breath in the 2013–2018 time frame and recalled she was informed her tests were normal and that it could be anxiety. *Id.* Claimant recalled working as a janitor for five years, then with Employer. *Id.* She recalled working for the Potato Museum but kept missing work; she did recall working at State Hospital but testified she only worked there for a week. *Id.* She worked at Fairwinds, an assisted living center, doing the same style of work she had done at the Gables, but it was too much for her. *Id.* She had also worked as a hostess for two days but self-terminated because it was again too much for her. *Id.*

89. At hearing, Claimant admitted to a number of mistakes and not being truthful at her prior deposition. See Hr. Vol I, p. 18-20. Claimant recalled she had seen Britney Barnes whereas previously she had denied seeing her at deposition. Hr. Vol I, p. 19. Claimant also recalled she had actually received 90,000 from the sale of her house to her husband, not 50,000 as she reported in deposition. *Id.* Claimant recalled she had started to use methamphetamine around the time she got

hurt; her attorney reminded her that she had told him it was when she tried to work two jobs, at the Potato Museum and South State Hospital, and she agreed with that time frame. *Id.* at 25-26. She stopped in July of 2021 when her daughter told her she would not be allowed around her grandchild if she continued using meth. *Id.*

90. Claimant did not recall her 2009 episode of low back pain or the reported several episodes of low back she reported at that time. *Id.* at 30. Claimant was able to hunt, fish, ride motorcycles, and take care of her grandparents and aunt without back problems. *Id.* at 53-57. Claimant had no problems with her back performing janitorial work or caretaking work. *Id.* at 59, 61, 63, 67. The work at Employer was not very heavy; they had a hoist to help with transfers. *Id.* at 68.

91. Claimant recounted childhood sexual abuse by her father and that it was witnessed and not stopped by her mother. *Id.* at 34-35. Her mother would frequently tell her life would be better if she (Claimant) would just die. *Id.* Claimant moved a lot, and never graduated high school due to her pregnancy. *Id.* at 35-36, 38. Claimant had tried to get her GED three times but always failed the math portion. *Id.* at 38. Claimant testified she was admitted overnight to the hospital 147 times during her first pregnancy. *Id.* at 38-40. Claimant's grandmother passed in 2010. In 2014, Claimant took care of her father when he had cancer, until he passed away; the day he passed away, Claimant came home to find her husband in bed with her best friend. *Id.* at 45-46, 74. Claimant's Aunt Myrna passed in 2017. *Id.* at 47-50.

92. Claimant remembered she was admitted to the Behavioral Health Center as a child for taking too much Prilosec, and then admitted a second time because she was sent by her mother to prevent her from committing suicide. Hr. Vol. 1 43-45. Claimant did not attempt to commit suicide again after that timeframe because she "was needed" by her three children, her aunt, and

her grandparents. *Id.* at 47. Claimant recalled going to Blackfoot Medical Center in 2013, 2014, 2016, and 2017 for anxiety/panic attacks which manifested as chest pains and "heart skipping," but she was not suicidal. *Id.* at 57-58. Claimant did not attempt suicide while she did janitorial work at schools or caretaking at Employers because she felt self-worth from helping people. *Id.* at 67-68.

93. Claimant is friends with her attorney's wife, Lisa. She would frequently go on walks with her and on October 16, 2018 she told Lisa that she was contemplating "not being here." *Id.* at 81. Dr. Poulter, who at this time was Claimant's treater, LDS bishop, and LDS home teacher, came to her home and got her the appointment with Dr. Moser the following day. *Id.* at 52, 82. This is when she told Dr. Moser she had enough pills to take down an elephant, which he interpreted as suicidal, and had her transported to Bingham Memorial by ambulance. *Id.* Claimant recalled being admitted for suicidal ideation in October 2018 and discharged because she didn't have a plan to end her life. *Id.* at 83-84. She admitted to still thinking about suicide and testified she had not attempted suicide for the last month and half, i.e., the six weeks she had been living with her attorney since losing her car, which she had been living in previously. *Id.* at 17, 84.

94. Claimant recalled that Dr. Erwin, her psychiatrist during her stay at Portneuf Behavioral Health, wanted to focus on her childhood. *Id.* at 111-112. Regarding Dr. Traughber, Claimant recalled her attorney's secretary had helped her fill out the forms for that appointment. *Id.* at 112.

95. Claimant had bills for her stay at Portneuf Behavioral Health, but not for her ambulance ride because the LDS church had paid for that. *Id.* at 85-86. Claimant's attorney had paid for her 2020 MRI and the church had also paid for her pain medications from Dr. Poulter. *Id.* at 108-109. After Claimant got Medicaid, it paid for her medications. *Id.* at 110.

96. Claimant recalled Dr. Stromberg told her she would have no pain three months after surgery, but that she continued to struggle with pain. *Id.* at 80. Claimant recalled she had not had very bad headaches since Dr. Poulter "injected something" after hours on October 28, 2019.[5]

97. On cross-examination, Claimant testified she told Dr. Traughber about her sexual abuse and prior suicidal ideation. Hr. Vol I p. 127. She testified she was physically abused by her brothers and sisters, which she discussed with Dr. Traughber. *Id.* at 128. She did not tell Dr. Erwin she was sexually abused by her father. *Id.* Claimant testified she did not tell the treaters at Portneuf she was in pain but then testified she did tell them. *Id.* at 131-132. Claimant was asked about her report to Dr. Moser that she had been contemplating suicide for a year in October 2018, five months after the accident:

> Q: [By Eric Bailey] So you disagree with the part where it says you've been thinking about that for a year? Is that a "yes" or a "no"?
>
> A: No. I always think about it but I had distractions. I didn't think about it because I had my kids. I had -- I took care of people. It wasn't on my mind.
>
> Q: Well, it says it was -- it says it was on your mind long before you had this accident.
>
> A: No.
>
> Q: So you disagree with that?
>
> A: Yes.
>
> Q: So as far as you're sitting here today, all your suicidal-ideation issues in your mind stem from the accident? Is that your position?
>
> A: Since I got hurt, I can't take care of anybody anymore like I used to.

[5] Dr. Poulter's office notes do show an appointment with Claimant that day, but do not show Claimant had an injection on that date. JE 8:466-470. On July 16, 2018, Claimant had occipital nerve blocks which she reported were ineffective. *Id.* at 445. When Dr. Poulter summarized his notes from that day at hearing, he did not mention an injection. Hr. Vol I 266-267.

Q: That's not what I asked you. I asked you if your suicide thoughts -- if you think they all stem from this accident and nothing else, because that's what I'm hearing from you.

A: Yeah.

Hr. Vol I, p. 138-139. Claimant agreed she had been in counseling since age 12, but could not recall all her counselors names. *Id.* at 148-149. Claimant admitting to hearing voices and seeing visions since childhood. *Id.* at 150-151. Claimant did not tell Dr. Traughber she heard voices or saw visions. *Id.* at 152. She did not tell Dr. Traughber about finding her husband with her best friend the day her dad passed away. *Id.* at 218. Claimant reported she had been in pain since the accident, and it never went away and never got better. *Id.* at 221.

98. On re-direct, Claimant reported she was calm when she was talking with Dr. Moser but could have made an error in talking about how long she had been depressed. *Id.* at 227. Claimant clarified that when she said she had counseling all her life, she did not mean from 15 to 37. *Id.* at 230. Claimant revealed further abuse by her mother for the first time at hearing, in the context of explaining that it was difficult to discuss her abuse openly and be honest with her psychological providers. *Id.* at 233.

99. **Credibility.** Claimant's later recollections are very frequently contradicted by contemporaneous medical records or her prior deposition. Claimant's memory is poor, and she had to be reminded frequently at hearing of what she had previously said or what was in the records. Her diagnosed somatoform disorder makes certain representations less credible, as discussed *infra*. Where her later recollections contradict prior medical records, her records will be relied upon.

100. **Condition at Hearing.** At the time of hearing, Claimant was very emotional and frequently tearful. Claimant was currently attending physical therapy, but had only attended two sessions, and was on two blood pressure medications, two pain medications, two anxiety

medications, and one medication to treat insomnia. Hr. Vol I 120-121. Claimant reported that while on medication her pain was at about a 6-7, but it was "off the charts" when she was not on medication; her legs would still go numb down the front and back and she had trouble walking. *Id.* at 120-124. She still struggled with feelings of self-worth and suicidal ideation. *Id.* at 84, 124.

DISCUSSION

101. A worker's compensation claimant has the burden of proving, by a preponderance of the evidence, all the facts essential to recovery. *Evans v. Hara's, Inc.*, 123 Idaho 473, 849 P.2d 934 (1993). Claimant must adduce medical proof in support of his claim, and he must prove his claim to a reasonable degree of medical probability. *Dean v. Dravo Corporation*, 95 Idaho 558, 511 P.2d 1334 (1973).

102. The Industrial Commission, as the fact finder, is free to determine the weight to be given to the testimony of a medical expert. *Rivas v. K.C. Loggin*g, 134 Idaho 603, 608, 7 P.3d 212, 217 (2000). "When deciding the weight to be given an expert opinion, the Commission can certainly consider whether the expert's reasoning and methodology has been sufficiently disclosed and whether or not the opinion takes into consideration all relevant facts." *Eacret v. Clearwater Forest Industries*, 136 Idaho 733, 737, 40 P.3d 91, 95 (2002).

103. **Medical Care.** Idaho Code § 72–432(1) requires an employer to provide an injured employee such reasonable medical, surgical or other attendance or treatment, nurse and hospital service, medicines, crutches and apparatus, as may be reasonably required by the employee's physician or needed immediately after an injury or manifestation of an occupational disease, and for a reasonable time thereafter. Aggravation, exacerbation, or acceleration of a pre-existing condition caused by a compensable accident is compensable in Idaho Worker's Compensation Law. *Nelson v. Ponsness-Warren Idgas Enterprises*, 126 Idaho 129, 879 P.2d 592 (1994).

104. Psychological injuries, disorders, or conditions are not compensated under workers compensation unless the elements of Idaho Code § 72-451 are met. Idaho Code § 72-451 provides:

> (1) Psychological injuries, disorders or conditions shall not be compensated under this title, unless the following conditions are met:
> (a) Such injuries of any kind or nature emanating from the workplace shall be compensated only if caused by accident and physical injury as defined in section 72-102(17)(a) through (17)(c), Idaho Code, or only if accompanying an occupational disease with resultant physical injury, except that a psychological mishap or event may constitute an accident where:
> (i) It results in resultant physical injury as long as the psychological mishap or event meets the other criteria of this section;
> (ii) It is readily recognized and identifiable as having occurred in the workplace; and
> (iii) It must be the product of a sudden and extraordinary event;
> (b) No compensation shall be paid for such injuries arising from conditions generally inherent in every working situation or from a personnel-related action including, but not limited to, disciplinary action, changes in duty, job evaluation or employment termination;
> (c) Such accident and injury **must be the predominant cause as compared to all other causes** combined of any consequence for which benefits are claimed under this section;
> (d) Where psychological causes or injuries are recognized by this section, such causes or injuries must exist in a real and objective sense;
> (e) Any permanent impairment or permanent disability for psychological injury recognizable under the Idaho worker's compensation law must be based on a condition sufficient to constitute a diagnosis **using the terminology and criteria of the American psychiatric association's diagnostic and statistical manual of mental disorders, third edition revised, or any successor manual** promulgated by the American psychiatric association, and **must be made by a psychologist or psychiatrist** duly licensed to practice in the jurisdiction in which treatment is rendered; and
> (f) **Clear and convincing evidence that the psychological injuries arose out of and in the course of the employment** from an accident or occupational disease as contemplated in this section is required. (emphasis supplied).

105. **Headaches.** Claimant testified at hearing that she no longer had very bad headaches due to treatment with Dr. Poulter. Claimant did not argue for treatment for her headaches in briefing.

106. **Failed Back Syndrome/Somatoform Disorder.** Claimant asserts she has failed back syndrome which is the cause of her pain complaints and ongoing physical disability.

Essentially, although Dr. Stromberg's fusion surgery was objectively a success by MRI imaging, Claimant was one of the unlucky few who did not experience any pain relief. Claimant asserts she is entitled to ongoing pain management in the form of medications and possibly injections, ablations, or an implanted device which may provide some pain relief.

107. There are at least two problems with this argument. The first problem is Claimant was significantly improved after her fusion surgery for a number of months. The second problem is Claimant's diagnosed somatoform disorder.

108. Claimant underwent her fusion surgery on August 13, 2018. At her next appointment on August 28 with Dr. Stromberg she reported, "she is getting along fine and is taking no medication… she is getting out and about and has been walking around stores." JE 9:511. On September 25, she was "quite happy," "getting along well," and "doing fine." *Id.* at 513. During her October stay at Portneuf, she reported back pain on intake and only reported back pain one day during her eight day stay even though she was asked daily regarding her pain levels.

109. On November 13, 2018, she reported to Dr. Stromberg she could not tolerate lifting a gallon of milk with one hand and twisting and bending were intolerable. However, on November 19, 2018, she reported to her physical therapist that since the fusion, she was better; her pain was a 1/10, at its worst a 5/10, and at its best a 0/10. JE 7:404. On November 26, 2018, Claimant again reported her pain was about a 1/10, she had a good weekend with no increase in pain. *Id.* at 407. On December 7, Claimant's PT wrote: "Pt states that she is feeling a lot better today and last treatment worked miracles and she has not had pain throughout the weekend. She states she does not have pain throughout the treatment as well." *Id.* at 413. On December 11, she reported to Dr. Stromberg she could not even lift 10 pounds without pain. Claimant was reporting extreme levels of pain and dysfunction to Dr. Stromberg, which contradicted her reports to her physical

therapist at the same time. Claimant's pain complaints are rendered less credible by these contradictions.

110. Claimant also had a successful return to work after her fusion surgery. She worked for State Hospital South full-time for two months, from April 5 until at least May 28 of 2019 per her report to ICRD, possibly longer. She also worked for four months part-time at the Idaho Potato Museum from April 16 until late August of 2019. She worked both jobs for at least 55 hours a week for six weeks.[6] She then worked another two months at Fairwinds in a lighter duty, but similar job to her position with Employer.

111. Claimant's FCE results are the only true contrary piece of evidence that Claimant suffers from low back dysfunction. However, the FCE took place three and a half years after her surgery and two a half years after Claimant had last worked. Dr. Cook's observations in September 2019 contrast with most limitations identified by the FCE. Claimant could lift up to 10 pounds with either hand in 2019 vs. five or seven pounds depending on carrying method in 2022, stand for two hours in 2019 vs. 15 minutes in 2022, walk for a mile in 2019 vs. 250 yards in 2022, driving/sitting for an hour and half in 2019 vs. 10 minutes in 2022. JE 13:957-958.

112. Further, as explained by Dr. Ellis and documented in his report, the limitations he identified were due to Claimant's pain complaints while trying to perform the tested activities, almost every task that Claimant could not complete was due to "pain." Dr. Ellis recorded that Claimant was generally deconditioned ("out of shape") due to her pain. Hr. Vol I, p. 174; see JE 16. The FCE does not demonstrate Claimant's physical limitations due to the accident or fusion,

[6] Claimant's testimony that she was on methamphetamine while working at State Hospital South and the Idaho Potato Museum was prompted by her attorney reminding her that that's what she told him and is contradicted by other reports in the record that she abused methamphetamine from the fall of 2019 until the summer of 2021.

but Claimant's limitations due to her pain and being generally deconditioned. Claimant's pain complaints are exacerbated by her somatoform disorder per Dr. Traughber and discussed *infra*.

113. Claimant's physical capacity for more than a year after surgery far exceeded her performance in her March 2022 FCE, which was conducted two and a half years after she had last worked, three and a half years post-surgery, and four years post-accident. Claimant's experts were not asked and offered no opinion on the records that showed low or no pain post-fusion or on Claimant's successful return to work.[7] Dr. Cook's opinion that she was not capable of sedentary work occurred when she was working for Fairwinds and is not credible. Claimant's experts' lack of explanation for four months of low to no pain back pain post-surgery and lack of explanation for her successful return to work in 2019 is fatal to establishing causation on a more probable than not basis that her later back complaints are related to the industrial accident or fusion surgery.

114. The second problem with Claimant's assertion she suffers from failed back syndrome is Claimant's diagnosed somatoform disorder. Dr. Traughber diagnosed Claimant with "somatoform disorder, unspecified" in his original report and described it as "characterized by **increased physical pain and other physical symptoms** when under stress." (emphasis supplied) JE 14:980. Dr. Traughber wrote:

> During this evaluation, it was observed that there was a significant psychological factor complicating her pain, and **her subjective pain experience is beyond what her medical evaluations can explain... she demonstrates marked somatic symptoms.** For example, she has experienced several physical reactions to psychological distress including chest pain, shortness of breath, **and exacerbation of her chronic pain.** Importantly, this cluster of symptoms is common with certain individuals who have serious trauma history. When an individual experiences somatic/psychological problem, **the experience of physical pain is often exacerbated, and the subjective experience of pain can be amplified and debilitating.** Further, this type of pain exacerbation is commonly outside of an individual's control and cannot be alleviated without treatment.

[7] Dr. Moss did not list the physical therapy records from November and December in his records review. See JE 17.

Id. at 981 (emphasis supplied).

115. At hearing, Dr. Traughber explained Claimant's somatoform disorder pre-dates her industrial accident and fusion; that the disorder has a "long-term development process" and "starts fairly young." Hr. Vol II, p. 409 Claimant's pre-accident medical records document multiple visits to her primary care physician and the emergency room for physical symptoms, such as heart racing, lightheadedness, and chest pain which were diagnosed as anxiety. Claimant was prescribed Celexa, Valium, Zoloft, Prozac, and blood pressure medications to treat her anxiety and depression. Dr. Traughber agreed that her presentation during these visits was supportive of pre-existing somatoform disorder.

116. Dr. Traughber also agreed that her post-fusion pain was amplified and influenced by her somatoform disorder:

> a somatoform disorder is one where the individual has an unusually powerful connection between their brain and then the rest of their body in terms of experiencing psychological distress as physical problems, or as exacerbated physical problems. The common pathway is through the adrenal system through the vagal nerves. When someone experiences a lot of chronic emotional distress, one of the ways in which they may experience that is through basically having their adrenal system trigger and exacerbate preexisting medical problems and intensifying them or making them occur more frequently…
>
> Q: [By Mr. Esplin] Do you believe that Karri Penoyer experiences this amplification with regard to her back pain?
>
> A: **I do.** It's very common for people with chronic pain to experience overlapping mental health issues related to the pain.

Hr. Vol II, pp 386-387 (emphasis supplied).

117. As early as December 20, 2018, Claimant's physical therapist observed:

> patient demonstrates slow, cautious movements throughout exercises today with increased facial grimacing and moaning indicating increased pain today. **She has not had this amount of pain since starting therapy indicating that there is a strong correlation with mental and physical health** as she continually stated

> throughout treatment that now it is not healed all the way that that is why she is having so much pain. As compared to previous treatments when she had decreased pain and was motivated to get back to work. (emphasis supplied)

JE 7:419. Claimant went from reporting little to no pain to excruciating pain due to her understanding that she was "not healed all the way." Dr. Stromberg reported Claimant's symptoms were out of proportion to her physical exam findings, that he found signs of symptom magnification, that her pain complaints were non-anatomic and "unrealistic." Dr. Moss observed at the time of his report that "there were some inconsistencies in her physical exam and subjective complaints." JE 17:1069. His prognosis was guarded because "**her back pain and other associated complaints** could remain unchanged or become worse just as easily as they could improve with strict adherence to physical therapy, **individual psychotherapy, and psychotropic medication recommendations**." JE 17:1071. (emphasis supplied). Dr. Moss further explained at hearing that "this is kind of a unique case and **the mental health is contributing probably to the perception of pain**... there are several factors that are contributing to the complaints, whether that's **mental health**, physical limitations." Hr. Vol II, 320, 334. (emphasis supplied). Claimant's treaters and her even her own experts agree that her mental state is impacting her perception of her low back pain.

118. Claimant's current presentation and pain reports do not prove she has failed back syndrome on a more probable than not basis. As explained by Drs. Moss and Poulter, failed back syndrome is characterized by continued pain in spite of an objectively successful surgery. Claimant's ongoing debilitating pain is better explained by her somatoform disorder in light of her successful recovery from surgery for months and then sudden spike in pain with no objective change in her imaging or other physical findings and non-anatomic, inconsistent complaints. Claimant's somatoform disorder is not at MMI per Dr. Traughber, it requires extensive multiple

year treatment, and Claimant does not argue it is related to the injury.

119. Claimant suffered a low back injury but has failed to prove her continuing symptoms are due to failed back syndrome. Claimant's presentation for months after surgery and her successful return to work do not support that Claimant suffered from failed back syndrome; Claimant's experts, while credible, did not adequately explain or grapple with her post-fusion reports of low or no pain or her successful six month return to work. Claimant's somatoform disorder weakens the logic underlying her argument that she has failed back syndrome. The basis of failed back syndrome, continued pain in spite of an objectively successful surgery and no objective findings, is not supported by the evidence of record and is better explained by her somatoform disorder. Claimant has failed to prove she has failed back syndrome.

120. **Suicidal Ideation.** Idaho Code § 72-451 only covers psychological injuries wherein their predominant cause was the accident/injury as compared to all other causes. "To be the predominant cause, the work injury must be a greater cause of the psychological condition than all other causes combined." *Warren v. Williams and Parsons CP CPAS*, 157 Idaho 528, 539, 337 P.3d 1257, 1268 (2014). Claimant must also show her industrial accident caused the psychological injury by clear and convincing evidence. Dr. Traughber is the only expert who testified that qualifies under Idaho Code § 72-451 as a licensed psychiatrist regarding Claimant's psychological injury.

121. Dr. Erwin listed suicidal ideation as a secondary diagnosis during Claimant's hospitalization and is a licensed psychiatrist. JE 12:640. Dr. Traughber did not diagnose Claimant with suicidal ideation, but with PTSD, depression, and somatoform disorder pursuant to the DSM. Claimant is not arguing that those conditions were caused by the industrial accident, only her suicidal ideation; she only seeks past payment of treatment for her suicidal ideation and future

treatment for suicidal ideation. Dr. Traughber's opinion is that Claimant's accident removed her natural coping mechanism, caretaking, which caused Claimant's suicidal ideation; Claimant developed this coping mechanism due to her extensive childhood trauma. Dr. Traughber did not opine her suicidal ideation was caused by the pain from Claimant's back injury.

122. Claimant has not met her burden to show her suicidal ideation was caused by the accident by clear and convincing evidence. Dr. Traughber's theory of causation is that Claimant was psychologically stable at the time of the accident, but then her industrial accident removed her natural coping mechanism, caretaking, which led to an abrupt worsening of her psychological state.

123. Dr. Traughber initially expressed this logic in his 2021 report. Dr. Traughber had limited records when issuing this opinion, namely just her Portneuf records, Stromberg's records, and Cook's IME. Dr. Traughber's opinion that Claimant was "stable" prior to the industrial accident is contradicted by multiple visits to her primary care physicians and the emergency room for anxiety and depression from 2013 to 2017 and her report to Dr. Moser that she had been dealing with depression for a year[8] prior to seeing him. At hearing, Dr. Traughber used the 2013-2017 visits to support that Claimant had pre-existing somatoform disorder and characterized her symptoms prior to the accident as in the "low hanging range where a person can still be functional" vs. a "level of impairment… high enough…where she needed to be hospitalized." Hr. Vol II, p. 401. If by functional, Dr. Traughber means able to maintain a full-time job, Claimant was able do that after her hospitalization as well (Dr. Traughber never explained or addressed why Claimant's job at Fairwinds, a similar caretaking position, did not alleviate or improve her suicidal ideation).

[8] Claimant's counsel's argument that Claimant was "stressed" and therefore not accurate in giving this timeline is contradicted by her own testimony that she was calm when she was talking to Dr. Moser. See Clt's Reply p. 11, Hr. Vol 1, p. 227.

Further, his hearing testimony seems to be downplaying the severity of Claimant's symptoms prior to the accident. It is not apparent from his testimony or report that Dr. Traughber ever reviewed the 2015 ER reports where Claimant reported she was very depressed and scored "very high" on the PHQ-9 and GAD-7, two tests Dr. Traughber explained were to assess depression and anxiety or Claimant's post-accident presentations to the ER for anxiety. At hearing, Dr. Traughber explained the only updated records he had were her Blackfoot Medical Center records and her 2009 report of low back pain. Dr. Traughber admitted that Claimant met the criteria for anxiety and depression prior to the industrial accident but maintained that she was "stable," and that the accident pushed her to become suicidal.

124. However, Claimant told Dr. Moser that she had been dealing with depression for about a year prior to seeing him, which would be prior to the industrial accident. Claimant's explanation for this report is that she may have been struggling with depression and other symptoms but was not suicidal for up to a year prior to seeing Dr. Moser. However, when asked specifically about this report at hearing, Claimant admitted that she always thinks about suicide and then immediately backtracked: "No. **I always think about it** but I had distractions. I didn't think about it because I had my kids. I had -- I took care of people. It wasn't on my mind." (emphasis supplied). Further, Claimant reported to Dr. Erwin at Portneuf that she had suicidal thoughts since childhood. Dr. Traughber was not confronted with Claimant's reports to Dr. Erwin that she had had suicidal thoughts since childhood or her testimony at hearing that she "always" thinks about suicide.

125. Claimant's hospitalization records also do not support that her loss of caretaking was the cause of her suicidal ideation. Claimant discussed her abuse, her hallucinations, her aunt and grandparents dying, and that she had been treated for depression since early childhood. There

are no mentions of her work injury or struggling without caretaking or more generally without her job in her daily logs at Portneuf. The work injury is mentioned as part of her intake, that she had been off work for months, and she mentioned back pain on intake and one day during her eight-day stay. Otherwise, her hospitalization records are silent with regard to her work injury, loss of caretaking, or not working more generally.

126. The closest to an at-the-time report which would support Claimant's caretaking theory is Dr. Moser recording "the patient feels she is unable to care for herself or her dependents. Predisposing factors include: She currently lives with her daughter. She has a history of suicide attempts and major depression." JE 3:121. This singular report is not enough when compared to the rest of the record. Further, in context, the report that she feels she is unable to take care of herself or her dependents is well explained by her severe depression and is also not listed as a pre-disposing factor which led to her suicidal ideation.

127. Compare this case with *Benner v. The Home Depot*, IC 2005-004849 (Issued January 9, 2013). In that case, the claimant was claiming a number of psychological conditions were aggravated by her industrial accident. The Commission recognized that a pre-existing psychological condition could be found compensable under Idaho Code § 72-451:

> Dr. LaCroix acknowledged that Claimant would have qualified for a diagnosis of borderline personality disorder prior to the accident. This does not necessarily disqualify Claimant from receiving compensation for this condition, provided that she can prove that her post-accident condition is so much worse than her pre-accident condition that it can be said that the accident/injury is the predominant cause of the severity of the condition from which Claimant suffered post-accident.

That claimant was diagnosed with pre-existing anxiety according to the DSM IV among other conditions. In that case, the claimant suffered a panic attack, was hospitalized, and then five days later was hospitalized again for suicidal ideation after her husband caught her trying to swallow a handful of pills. The claimant had pre-existing borderline personality disorder, anxiety disorder,

and dysthymic disorder, but the Commission found these two hospitalizations were predominantly caused by her work accident by clear and convincing evidence. Although her anxiety condition was pre-existing, Claimant suffered from a panic attack which she reported was related to her fear of going outside and re-injuring her back and her suicide attempt was caused by her "smothering fear" related to her back injury and fear of further damage.

128. In contrast, Claimant here did not speak at all about the lack of meaning/loss of identity now that she could not caretake until her evaluation with Dr. Traughber more than three years after the accident. The notation that Claimant was "off work" for four months due a work injury does not provide clear and convincing evidence that being "off work" was the cause of her suicidal ideation versus what she actually reported to Dr. Erwin at intake and in her daily therapy regarding her abuse, her hallucinations, her aunt and grandparents dying, her prior suicide attempts, and suicidal ideation and depression since early childhood.

129. Claimant's insistence that she became suicidal due to the loss of her job/caretaking is not supported by *clear and convincing* evidence.

130. Even assuming Claimant had met the clear and convincing standard of evidence, Dr. Traughber's opinion is difficult to square with the predominant cause standard. He testified that the accident was the "greater immediate cause" of Claimant's suicidal ideation, but also acknowledged that Claimant would not have suicidal ideation at all without her pre-existing trauma. An analogy will show how this logic fails: assume a claimant has chronic pain from CRPS which she managed with pain medications. Her work accident then prevented her from taking her CRPS pain medications due to interactions with her accident-related medications. The predominant cause compared to all other causes for her chronic pain would still be her CRPS. Here the predominant cause is Claimant's pre-existing psychological state, not the loss of caretaking.

Claimant would not have suicidal ideation without her pre-existing psychological state the same as a claimant in the above example would not have chronic pain without her CRPS; the predominant cause is still the pre-existing condition, not the "but for" cause, i.e., the accident.

131. In other words, Dr. Traughber's opinion confuses the "but for" causation standard with the "predominant cause compared to all other causes combined" standard required by the statute. As noted above, the accident here could be viewed as the "but for" cause of Claimant's suicidal ideation; but for the accident, Claimant would not have become suicidal in October of 2018. However, this does not mean it was the predominant cause of her suicidal ideation as compared all other causes including her childhood trauma, chronic complex PTSD, depression, somatoform disorder, or bipolar type I. The evidence does not support that the accident was the predominant cause of Claimant's suicidal ideation compared to all other causes; her pre-existing psychological condition was the predominant cause compared to all causes.

132. There is no clear and convincing evidence that Claimant's suicidal ideation was predominantly caused by her industrial accident. Dr. Traughber's opinion is insufficient to meet the predominant cause compared to all other causes standard. Claimant has failed to prove her suicidal ideation and related medical care are compensable under the workers' compensation law.

133. As an additional issue, the "suicidal ideation" diagnosed by Dr. Erwin is not a diagnosis pursuant to the DSM as referenced in Idaho Code § 72-451(1)(e). Claimant has raised the novel argument that Idaho Code § 72-451(1)(e) does not apply to a claim where only medical treatment is sought. Subsection (e) itself references only permanent impairment and permanent disability. Regardless of the merits of this argument, it is immaterial due to the controlling application of the predominant cause and clear and convincing evidence standard.

134. **Aggravation of Pre-existing Pars Defect.** In briefing, Defendants do not contest that Claimant suffered a compensable low back injury or argue her fusion was unrelated to the accident. Drs. Moss, Stromberg, Poulter, and Cook agreed Claimant suffered from a pre-existing pars defect, which was aggravated by the accident. Only Dr. Friedman argued that Claimant's lumbar fusion was unrelated to the industrial accident, a position that Defendants did not adopt in briefing. The appropriate impairment and apportionment, if any, will be discussed *infra*.

135. Claimant's somatoform disorder makes any assessment of her underlying low back condition difficult. However, Claimant is at MMI for her low back condition.

136. Palliative, pain-killing treatments can be compensable even though they will not necessarily cure the employee's condition. *Rish v. The Home Depot*, 161 Idaho 702, 706, 390 P.3d 428, 432 (2017). Maximum medical improvement occurs when a person has reached medical stability, and no further material improvement is expected with time or treatment; a claimant can still have symptoms and pain from her injury and be at maximum medical improvement. *Shubert v. Macy's West, Inc*, 158 Idaho 92, 102, 343 P.3d 1099, 1109 (2015).

137. Defendants argue that Claimant's low back is not MMI according to Drs. Poulter and Moss. See Def's Brief, p. 16-17. However, both these physicians were discussing Claimant's proposed treatment for failed back syndrome, a condition Claimant has not proven is related to her industrial accident. Second, this is a misreading of Dr. Moss's testimony. Dr. Moss opined in his report and in his testimony that Claimant was MMI. Dr. Moss felt that none of the proposed treatments, injections, ablations, or pain pump would cure Claimant, so much as provide "periodic relief." Hr. Vol I, pp. 320-321. Dr. Moss confirmed that his opinion differed from Dr. Poulter's hearing opinion that Dr. Poulter's proposed pain treatments were curative:

> But I would say nine times out of 10, you know, those ablations, the spinal pumps or whatever, the underlying complaint resurfaces whether -- you know, it's not

> exactly the same, but that underlying complaint is still there. Not always. You know, I can't say that definitively. It's called the "practice of medicine" for a reason.. But, you know, I guess that's where my -- my opinion would probably differ with his.

Hr. Vol I, p. 352.

138. Dr. Poulter's opinion that his treatments are curative is at odds with his records, weakened by his other testimony of record, and well contradicted by Drs. Friedman and Moss. On April 2, 2020, Dr. Poulter noted that Claimant's pain "is likely not curative" and that she would need long-term pain management, namely prescriptions and injections, but potentially a spinal cord stimulator. JE 8:488. Essentially, the same treatment Dr. Poulter is now describing as curative was not curative at that time for the same pain complaints.

139. Dr. Poulter's testimony at hearing was clearly motivated by compassion and empathy for his patient:

> So this point I think it's been five years since Karri had her surgery. **I think if time was going to kick in, it would have done so by now. I anticipate that Karri will likely need some degree of pain management support for the rest of her life.** I don't think we as pain management doctors have exhausted by any means the options that we have to try and help Karri. I think she has a great - - there's a great likelihood that we will be able to improve Karri's course. **I want Karri to have some hope that we have some things for her.** (emphasis supplied).

Hr. Vol I, p. 274. When asked directly whether Claimant was at MMI, Dr. Poulter offered that he was at a disadvantage because he did not normally perform IMEs, but he did think there were a lot of pain management options which may help Claimant; he again reiterated he wanted "Karri to have some hope." *Id.* at 290-291. He wanted to increase Claimant's quality of life and function by reducing her pain. *Id.* Dr. Poulter's motivation is commendable and understandable; however, it does not provide evidence on a more probable than not basis that the treatment he is offering is "curative" vs. palliative and to treat Claimant's pain. Per his own testimony, Claimant will need pain management for the rest of her life. In other words, assuming Claimant still has accident-

related pain (after treatment for her somatoform disorder), her pain will never be cured, it will persist and require treatment. This closely matches Dr. Moss's prediction that Claimant's complaints will resurface.

140. All the pending care recommendations were made for Claimant's failed back syndrome, and Claimant has failed to prove she has that condition or that it is related to the industrial accident. There is the potential that Claimant will require palliative care after her somatoform disorder has been treated, but there is no present entitlement to ongoing palliative care based on the evidence of record. Claimant's low back condition is at MMI.

141. **Temporary Disability Benefits.** Income benefits for temporary disability are to be paid to an injured worker during the period of recovery. Idaho Code § 72-408. If an injured employee refuses or unreasonably fails to seek physically or mentally suitable work, or refuses or unreasonably fails or neglects to work after such suitable work is offered to, procured by or secured for the employee, the injured employee shall not be entitled to temporary disability benefits during the period of such refusal or failure. Idaho Code § 72-403.

142. Claimant has not argued for or proven additional entitlement to temporary disability benefits. Claimant is at MMI for her accident-related low back condition as discussed *supra*.

143. **Permanent Partial Impairment (PPI).** "Permanent impairment" is any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved and which abnormality or loss, medically, is considered stable or nonprogressive at the time of evaluation. Permanent impairment is a basic consideration in the evaluation of permanent disability, and is a contributing factor to, but not necessarily an indication of, the entire extent of permanent disability. Idaho Code § 72-422. The Commission is the ultimate evaluator of impairment. *Waters v. All Phase Construction*, 156 Idaho 259, 262, 322 P.3d 992, 995 (2014). In

cases where two physicians have issued conflicting impairment ratings for the same body part(s), the Commission has the discretion to average the impairment ratings or choose the impairment rating that more closely aligns with the evidence. *Waters*, 156 Idaho at 262, 322 P.3d at 995. Impairment for asymptomatic pre-existing conditions can be apportioned. *Boehler v. Heglar Creek Electric, LLC*, IC 2017-011793 (Issued November 17, 2023); see also *Thompson v. Burley Inn*, IC 2019-013978 (Issued June 13, 2022) (finding an asymptomatic, but permanently aggravated, condition of hip osteoarthritis was appropriately apportioned) and *Eacret v. Clearwater Forest Industries*, 136 Idaho 73, 40 P.3d 91 (2002) (finding impairment apportioned for a low back injury with prior reports of low back pain insufficiently explained by the physician and no apportionment of impairment appropriate).

144. Claimant suffered a low back injury and assignment of a permanent impairment rating for this condition is appropriate. Drs. Stromberg and Friedman assessed a 7% overall PPI and apportioned 6% to her pre-existing pars defect, leaving 1% related to the industrial accident. Dr. Cook assessed a 20% PPI with no apportionment. Dr. Moss assessed a 7% PPI with no apportionment as Claimant had no pre-existing symptoms for her industrial injury.

145. Dr. Cook's rating is an outlier and not well explained by his report. Dr. Cook rated Claimant for a spondylolisthesis with surgery "at multiple levels," when she was only operated on at L5-S1, and also rated her for radiculopathy, which was well-critiqued by Dr. Stromberg at the time and radiculopathy was not found by Drs. Moss or Friedman or Stromberg. Dr. Cook's rating is rejected.

146. Drs. Stromberg, Friedman, and Moss all agreed that Claimant's base impairment was 7% and only disagreed about the level of apportionment. All three physicians utilized the AMA Guides Sixth Edition, Table 17-4, and rated Claimant at 7% for spondylolisthesis, Class 1.

Impairment for asymptomatic spondylolisthesis with no residual signs or symptoms is 0%.

147. Dr. Moss is correct that Claimant's low back condition was largely asymptomatic for nine years prior to the industrial accident, with only one report of low back pain in 2009. Claimant worked as a janitor and as a caretaker without restriction. Claimant hunted, fished, and enjoyed other recreational activities without limitation. There is no evidence other than one appointment in 2009 which documents low back pain of any kind. Claimant did have pre-existing bilateral pars defect and this condition was asymptomatic. Apportioning impairment for this pre-existing condition is not appropriate.

148. Claimant's impairment is 7% related to the accident with no apportionment.

149. **Total and Permanent Disability/Permanent Partial Disability.** Claimant argues she is an odd-lot worker. An odd-lot worker is one "so injured that he can perform no services other than those which are so limited in quality, dependability or quantity that a reasonably stable market for them does not exist." *Bybee v. State of Idaho, Industrial Special Indemnity Fund*, 129 Idaho 76, 81, 921 P.2d 1200, 1205 (1996). Such workers are not regularly employable "in any well-known branch of the labor market — absent a business boom, the sympathy of a particular employer or friends, temporary good luck, or a superhuman effort on their part." *Carey v. Clearwater County Road Department*, 107 Idaho 109, 112, 686 P.2d 54, 57 (1984).

150. Permanent disability results when the actual or presumed ability to engage in gainful activity is reduced or absent because of permanent impairment and no fundamental or marked change in the future can be reasonably expected. Idaho Code § 72-423. Evaluation of permanent disability is an appraisal of the injured employee's present and probable future ability to engage in gainful activity as it is affected by the medical factor of impairment and by pertinent nonmedical factors provided in Idaho Code § 72-430. Idaho Code § 72-425. Idaho Code § 72-

430(1) provides that in determining percentages of permanent disabilities, account should be taken of the nature of the physical disablement, the cumulative effect of multiple injuries, the age and occupation of the employee at the time of the accident causing the injury, consideration being given to the diminished ability of the employee to compete in an open labor market within a reasonable geographical area considering all the personal and economic circumstances of the employee, and other factors as the Commission may deem relevant. In sum, the focus of a determination of permanent disability is on the claimant's ability to engage in gainful activity. *Sund v. Gambrel*, 127 Idaho 3, 7, 896 P.2d 329, 333 (1995). Generally, the proper date for disability analysis is the date of the hearing. *Brown v. Home Depot*, 152 Idaho 605, 272 P.3d 577 (2012). Permanent disability is a question of fact, in which the Commission considers all relevant medical and non-medical factors and evaluates the purely advisory opinions of vocational experts. See, *Id.* at 136 Idaho 733, 40 P.3d 91; *Boley v. ISIF*, 130 Idaho 278, 939 P.2d 854 (1997). Pain may be considered as a medical factor, a non-medical factor, or both, but it must be considered. *Funes v. Aardema Dairy*, 150 Idaho 7, 11, 244 P.3d 151, 155 (2010).

151. Claimant argues she is an odd-lot worker and totally and permanently disabled on the basis of her physical restrictions alone. Claimant also urges that her psychological factors should be considered as a non-medical factor per *Smith v. ISIF*, 165 Idaho 164, 443 P.3d 178 (2019).

152. The claimant in *Smith* was diagnosed with depression, adjustment disorder, pain disorder, and mixed personality disorder. At his initial hearing in 2008, claimant failed to prove the industrial accident, a wrist injury, was the predominant cause of his psychological condition. The claimant then filed another complaint against the ISIF alleging he was totally and permanently disabled as a result of his physical limitations and psychological condition. The referee found that

claimant was not totally and permanently disabled. In making this finding, the referee concluded that although claimant's psychological conditions were a barrier to employment, they were treatable and not permanent in nature. The Supreme Court affirmed the Commission's finding that claimant had not met his burden to show he was permanently and totally disabled and that the referee properly concluded that the claimant's psychological condition was treatable and not a permanent, stable barrier to employment. Because his psychological condition was essentially temporary it did not meet the requirement as of a stable permanent barrier to employment under Idaho Code § 72-425 or § 72-332(2). Similar to the Claimant here, the claimant in *Smith* suffered abuse as a child and had pre-existing psychological conditions, which were made worse by the industrial accident, but not predominantly caused by the industrial accident. *Smith v. ISIF*, IC 2007-002698 (July 7, 2017).

153. Regarding Claimant's physical restrictions alone, she is not totally and permanently disabled. The restrictions identified by Dr. Ellis are based on Claimant's reported pain during testing and are not accepted as a basis for her disability due to her diagnosed somatoform disorder and its clear influence on her pain reports as discussed *supra*. Dr. Moss's opinion merely adopts Dr. Ellis's opinion and is rejected for similar reasons. Dr. Cook's opinion that Claimant was below sedentary working capacity at the time of his examination, when she was working full-time at Fairwinds, is not credible and is rejected.

154. Dr. Friedman issued medium duty restrictions related to her fusion and low back condition; these include no lifting more than 50 pounds occasionally, 25 pounds repetitively, and no twisting or torquing her back at his deposition. These restrictions do seem to match her physical ability post-fusion when she was able to work as an aide at State Hospital South, as a server/cook at the Idaho Potato Museum, and as a caretaker at Fairwinds, but not her time-of-injury

employment, which Mr. Porter characterized as "heavy."

155. Dr. Traughber did not issue restrictions related to her psychological condition and opined that Claimant was not at MMI. Dr. Friedman did not impose any restrictions related to her psychological conditions but did rate her psychological conditions at 15% PPI, unrelated to the industrial accident.

156. Dr. Traughber opined that Claimant should be able to improve her PTSD, depression, and somatoform disorder with weekly psychological therapy, psychotropic medication, and EMDR treatment to process her trauma; this treatment would last four years. Claimant has had inconsistent treatment for her psychological condition including depression and anxiety medications, at least three in-patient stays, and on/off counseling. The record is unclear how long or how consistently Claimant took her medications or attended counseling; Claimant's testimony regarding counseling is conflicting and unreliable. See Hr. Vol I, pp. 148-150.

157. Claimant's psychological conditions were clearly a barrier to employment at the time of hearing. Dr. Traughber opined her depression, PTSD, and somatoform disorder were more severe after the accident, although still ultimately rooted in her childhood trauma and not caused by the industrial accident. Claimant is clearly less employable than she was prior to the injury due to her psychological condition. Claimant did not meet the rigorous standard set out by Idaho Code § 72-451 to prove her suicidal ideation was predominantly caused by the industrial accident by clear and convincing evidence and did not argue that her PTSD, depression, or somatoform disorder met the requirements for Idaho Code § 72-451. Nevertheless, she is not at MMI for her multiple psychological conditions which can and must be treated prior to determining her permanent disability, total or partial.

158. Prior treatment for her conditions has been inconsistent, piecemeal, and usually on

an emergent basis presenting as chest pain resulting in anxiety/depression medications and at least three trips to the emergency room for depression or anxiety. Similar to the claimant in *Smith*, Claimant here has treatable psychological conditions; Dr. Traughber believes that Claimant can improve and with consistent treatment she may yet become employable again.

159. Any determination of disability, her present and probable future ability to engage in gainful activity, is premature due to Claimant's need for ongoing treatment for her psychological conditions and their clear impact on her employability. Claimant does not argue that her somatoform disorder, PTSD, or depression are related to the accident and Defendants are not liable for this treatment.

160. The Commission may retain jurisdiction in any case where permanent disability is not yet ripe and subject to a future determination. *Horton v. Garrett Freightlines, Inc.*, 106 Idaho 895, 684 P.2d 297 (1984). Therefore the Commission will retain jurisdiction over Claimant's disability determination to enable Claimant time to treat her psychological conditions and reach medical stability.

161. There is evidence Claimant's current pain is due to her somatoform disorder, but Claimant may also have pain from her industrial injury after treatment for her somatoform disorder. Per *Funes*, *supra*, pain must be considered in a disability analysis as a non-medical factor or medical factor, and this evidence must be developed prior to a determination of Claimant's disability.

162. Claimant's restrictions may also need to be revised after treatment for her somatoform disorder. The current evidence suggests that her low back condition is stable, but not what her accident produced restrictions will be. Claimant's FCE was extremely influenced by her pain complaints and Dr. Moss merely adopted the FCE's findings; as noted above, Dr. Cook's

opinion regarding her restrictions are rejected as he found her incapable of work while she was working a full-time position. Dr. Stromberg released her without restrictions. Dr. Friedman's restrictions (50 pounds lifting overall, 25 pound lifting frequently, no twisting or torquing) are related to Claimant's fusion and may end up being the most appropriate for her physical condition, but further assessment may be required depending on Claimant's potential for residual pain after treatment for her somatoform disorder.

163. **Apportionment.** Where a claimant's disability from an industrial accident is increased or prolonged by a pre-existing impairment, Idaho Code § 72-406 anticipates that employer may only be held responsible for accident caused disability. That section provides: "(1) In cases of permanent disability less than total, if the degree or duration of disability resulting from an industrial injury or occupational disease is increased or prolonged because of a preexisting ***physical*** impairment, the employer shall be liable only for the additional disability from the industrial injury or occupational disease." (Emphasis added.) In assessing apportionment of disability, a two-step process is employed: (1) evaluating the claimant's permanent disability in light of all of his physical impairments, resulting from the industrial accident and any pre-existing conditions, existing at the time of the evaluation; and (2) apportioning the amount of the permanent disability attributable to the industrial accident." *Page v. McCain Foods, Inc.*, 145 Idaho 302, 179 P.3d 265 (2008); *Horton v. Garrett Freightliners, Inc.*, 115 Idaho 312, 772 P.2d 119 (1989).

164. Apportionment of partial disability is premature as Claimant is not medically stable from a condition which impacts her disability.

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

> 72-804. ATTORNEY'S FEES — PUNITIVE COSTS IN CERTAIN CASES. If the commission or any court before whom any proceedings are brought under this law determines that the employer or his surety contested a claim for compensation made by an injured employee or dependent of a deceased employee without reasonable ground, or that an employer or his surety neglected or refused within a reasonable time after receipt of a written claim for compensation to pay to the injured employee or his dependents the compensation provided by law, or without reasonable grounds discontinued payment of compensation as provided by law justly due and owing to the employee or his dependents, the employer shall pay reasonable attorney fees in addition to the compensation provided by this law. In all such cases the fees of attorneys employed by injured employees or their dependents shall be fixed by the commission.

The decision that grounds exist for awarding attorney fees is a factual determination which rests with the Commission. *Troutner v. Traffic Control Company*, 97 Idaho 525, 528, 547 P.2d 1130, 1133(1976). It is axiomatic that a surety has a duty to investigate a claim in order to make a well-founded decision regarding accepting or denying the same. *Akers v. Circle A Construction, Inc.*, IIC 1998-007887 (Issued May 26, 1999). Defendants' grounds for denying a claim must be reasonable both at the time of the denial and in hindsight. *Bostock v. GBR Restaurants*, IIC 2018-008125 (Issued November 9, 2020).

166. Claimant argues she is entitled to attorney's fees for Defendants' denial of an MRI requested by Dr. Poulter in the fall of 2019, denial of pain medications prescribed by Dr. Poulter for failed back syndrome, and the denial to pay for Claimant's treatment for suicidal ideation.

167. Defendants did deny the requested MRI but referred Claimant back to Dr. Stromberg who ordered a CT scan which showed a stable fusion, the same finding on the MRI that Claimant did eventually obtain in April 2020. Defendants' actions were not unreasonable; they referred Claimant for a follow-up appointment to see if she needed more treatment with her prior treater and reasonably relied on Dr. Stromberg's opinion that she did not require further treatment.

168. Defendants reasonably relied on Dr. Stromberg's opinion that Claimant did not

require ongoing pain medication; this is not the case where the Defendants had no contemporaneous medical predicate to deny treatment. Defendants reasonably relied on Claimant's treating physician to conclude that Claimant did not need ongoing pain medications.

169. Defendants also did not unreasonably deny payment for Claimant's treatment for her suicidal ideation. Claimant did not obtain an opinion that it was related to her industrial accident until three years after the hospitalization. As found by this decision, there was little evidence that it was related to the industrial accident at the time of the denial and the later expert opinion was not persuasive. Defendants did not unreasonably deny Claimant's treatment for suicidal ideation.

CONCLUSIONS OF LAW

1. Claimant has not proven she is entitled to ongoing medical care for failed back syndrome;

2. Claimant is not entitled to additional temporary partial or temporary total disability;

3. Claimant has proven she is entitled to 7% permanent partial impairment related to the aggravation of her pre-existing asymptomatic bilateral pars defect without apportionment;

4. Claimant has not proven entitlement to attorney's fees;

5. Claimant has not met the requirements of Idaho Code § 72-451 to prove her suicidal ideation was compensable;

6. Determination of Claimant's permanent disability, partial or total, is premature based on Claimant's current treatable psychological condition. The Commission retains jurisdiction over this case to determine Claimant's permanent disability once Claimant reaches medical stability.

RECOMMENDATION

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

DATED this 5th day of January, 2024.

INDUSTRIAL COMMISSION

Sonnet Robinson

Sonnet Robinson, Referee

CERTIFICATE OF SERVICE

I hereby certify that on the 16th day of February, 2024, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by *E-mail transmission* and by regular United States Mail upon each of the following:

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BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

KARRI S. PENOYER, Claimant, v. GABLES HOLDINGS, LLC., Employer, and WCF NATIONAL INSURANCE COMPANY, Surety, Defendants.	**IC 2018-012160** **ORDER**

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

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

1. Claimant has not proven she is entitled to ongoing medical care for failed back syndrome.

2. Claimant is not entitled to additional temporary partial or temporary total disability.

3. Claimant has proven she is entitled to 7% permanent partial impairment related to the aggravation of her pre-existing asymptomatic bilateral pars defect without apportionment.

4. Claimant has not proven entitlement to attorney's fees.

5. Claimant has not met the requirements of Idaho Code § 72-451 to prove her suicidal ideation was compensable.

6. Determination of Claimant's permanent disability, partial or total, is premature based on Claimant's current treatable psychological condition. The Commission retains jurisdiction over this case to determine Claimant's permanent disability once Claimant reaches medical stability.

7. Pursuant to Idaho Code § 72-718, this decision is final and conclusive as to all matters adjudicated. Jurisdiction is retained over the nature and extent of Claimant's permanent disability, including total and permanent disability from the accident alone. Per this finding, Claimant or Defendants may request calendaring on the issue of Claimant's disability when the matter is ripe.

DATED this _16th_____ day of ____February_____, 2024.

INDUSTRIAL COMMISSION

Thomas E. Limbaugh, Chairman

Claire Sharp, Commissioner

Aaron White, Commissioner

INDUSTRIAL COMMISSION SEAL STATE OF IDAHO

ATTEST: Kamerron Slay
Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 16th day of February 2024, a true and correct copy of the foregoing **ORDER** was served by *E-mail transmission* and by regular United States Mail upon each of the following:

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