BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

MARIO AYALA, Claimant, v. ROBERT J. MEYERS FARMS, INC., Employer, and STATE INSURANCE FUND, Surety, Defendants.	**IC 2001-520958** **2009-029533** **2013-024075** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **Filed April 9, 2018**

INTRODUCTION

This matter came before the Industrial Commission for hearing on October 26, 2016. Appearing for Mario Ayala (Claimant) was L. Clyel Berry, Esq. Appearing for Defendants Robert J. Meyers Farms, Inc. (Employer) and its worker's compensation surety, the State Insurance Fund (Surety), was Paul Augustine, Esq. The testimony of Claimant and Morgan Meyers was adduced at hearing. The testimony of William Jordan, Nancy Collins, PhD, Paul Montalbano, M.D., and Richard Hammond, M.D., was taken by way of post-hearing deposition. At hearing, Defendants' Exhibits 1 through 10 were admitted into evidence. Claimant identified proposed Exhibits 1 through 33, but withdrew Exhibit 1, and pages 46 through 115 (inclusive) of Exhibit 3, Exhibit 25(a), and Exhibit 28(a).[1] Pursuant to Commission Orders of November 18,

[1] Pages 46-115 of Exhibit 3 consists of records from GFHC, and cover visits from 2004-2007. These records contain certain references to pre-injury low back/SI joint pain, and were reviewed by William Jordan and relied upon by Mark Harris, M.D., (See Clt. Ex. 20, p. 601, 629). Claimant's counsel referenced some of these records in his November 5, 2015 letter to Vernon McCready, PA-C. (Clt. Ex. 6, p. 349).These records are also implicit in Claimant's acknowledgement that he suffered from episodic bouts of low back pain in the years preceding the 2009

2016 and January 10, 2017, the balance of Claimant's proposed exhibits are admitted into evidence.

Per the Commission's Orders of July 19, 2016 and September 14, 2016, the following matters are at issue:

1. Whether Claimant's condition is due in whole or in part to a pre-existing injury or disease or cause not work-related;

2. Whether Claimant is entitled to reasonable and necessary medical care as provided for by Idaho Code § 72-432, and the extent thereof;

3. Whether Claimant is entitled to temporary partial and/or temporary total disability (TPD/TTD) benefits, and the extent thereof;

4. Whether Claimant is entitled to permanent partial impairment (PPI) benefits, and the extent thereof;

5. Whether Claimant is entitled to permanent partial disability (PPD) in excess of permanent impairment, and the extent thereof;

6. Whether Claimant is entitled to permanent total disability pursuant to the odd-lot doctrine, or otherwise;

7. Whether apportionment for a pre-existing condition pursuant to Idaho Code § 72-406 is appropriate; and,

8. Whether Claimant is entitled to attorney fees due to Employer/Surety's unreasonable denial of compensation as provided for by Idaho Code § 72-804.

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accident (See Clt. Ex. 20, p. 635). It seems preferable to consider the original of these notes rather than rely on second hand synopses. Therefore, and notwithstanding the Commission's previous accession to Claimant's proposal to withdraw these Exhibits, these portions of Exhibit 3 are considered in this decision. However, exclusion of these records would not change any aspect of the Commission's decision; as noted, there is other evidence of record which establishes that Claimant did have some pre-injury low back symptoms.

9. Whether, if it is determined that Claimant's low back injury, condition and/or presentment is casually related to or resultant of the industrial accidents/occurrences forming the basis of the instant consolidated proceeding; that Claimant does not yet present at maximum medical improvement related to said low back presentment; and that additional medical care, treatment and/or services are reasonably required by reason of said low back presentment, that the Commission reserve jurisdiction herein upon the issues of Claimant's entitlement to permanent impairment and permanent disability, inclusive of odd-lot states, with said issues to be considered/determined at the conclusion of Claimant's reasonably required medical care and achieving maximum medical improvement.

This matter was calendared for hearing following the consolidation of three claims; an accident of October 14, 2001 involving an injury to Claimant's back, an accident of October 6, 2009 involving multiple injuries to Claimant, and an accident of August 28, 2013 involving injuries to Claimant's right knee. At hearing, Claimant signified his intention to withdraw from consideration in the current proceeding, the October 14, 2001 claim. Accordingly, this matter is before the Industrial Commission for consideration of the October 6, 2009 and August 28, 2013 accidents only.

At hearing, the parties expressed their agreement that Claimant suffered a compensable injury to his right knee as a consequence of the August 28, 2013 accident, which injury eventually resulted in the need for a total knee arthroplasty. Similarly, the parties agreed that as a consequence of the October 6, 2009 motor vehicle accident, Claimant suffered injuries to his neck, left shoulder, and left elbow. Claimant has undergone surgical treatment for each of these injuries. Defendants have accepted responsibility for related medical care, income benefits owed

to Claimant during his period of recovery, and impairment attributable to the neck, shoulder, elbow, and knee.

Claimant contends that the evidence demonstrates that his low back condition is causally related to the 2009 motor vehicle accident, and that he is entitled to medical and income benefits related to that injury. Claimant asserts that should the Commission determine that Claimant's low back condition is causally related to the 2009 accident, it is inappropriate to consider Claimant's claim for disability at this juncture; Claimant requires further medical treatment for his low back and the Commission should retain jurisdiction over this case pending such treatment. In the alternative, Claimant contends that if the Commission determines that Claimant's low back condition is not a compensable consequence of the 2009 motor vehicle accident, Claimant is nevertheless totally and permanently disabled as a result of those injuries which the parties acknowledge to be causally related to the accidents of 2009 and 2013. In this regard, Claimant contends that the FCE performed by PT Wright best delineates the limitations/restrictions referable to Claimant's injuries, and as demonstrated by the testimony of Dr. Collins, these limitations/restrictions leave Claimant totally and permanently disabled.

Defendants dispute that the October 9, 2009 industrial accident caused anything more than a temporary aggravation of Claimant's documented pre-existing degenerative arthritis of the lumbar spine, and that to the extent Claimant may require further medical treatment for his low back, those consequences of Claimant's low back condition are entirely referable to Claimant's pre-existing low back condition and/or the natural progression of that condition unrelated to the October 9, 2009 motor vehicle accident. Defendants contend that PT Wright's FCE is flawed, and that the assertion of total and permanent disability is denigrated by the fact that Claimant has been continuously employed in his time-of-injury job since the 2009 accident. Defendants

contend that the evidence demonstrates that Claimant has a fund of essential skills which continue to make him a valuable employee and that he does not enjoy continued employment by virtue of his own superhuman effort or the Employer's sympathy. In view of Claimant's ongoing successful employment at his time-of-injury job, and the fact that no physician has authored limitations/restrictions for Claimant, Defendants contend that Claimant has failed to prove entitlement to disability in excess of impairment paid to date.

This matter was originally heard by Referee Powers. At the time this matter came under advisement, on November 3, 2017, the assigned Referee faced a significant case backlog that would result in a delay of this decision. In an effort to minimize the anticipated delay, the Commission contacted the parties to suggest that the case be decided on the record by the Commission. The parties responded, stating that due to observational credibility issues relating to Claimant's presentation at hearing, they preferred to have the case decided by the Referee who observed Claimant at hearing. However, as developed *infra*, the outcome in this case does not depend on an assessment of whether Claimant appeared to testify credibly at hearing. It does, to some extent, depend on a comparison of Claimant's testimony, with other evidence of record. While we are sensitive to the desires of the parties, our obligation to manage our docket to promote timely decisions supports assignment of this matter to the Commission.

FINDINGS OF FACT

1. Claimant was born on June 1, 1951. At the time of hearing, he was 65 years of age. Claimant was born in Mexico and attended school there for three years. He moved to the United States in 1974 and became a U.S. Citizen in 1992. He spoke no English when he moved to the United States. Claimant has pursued no formal education in the United States. He learned English on his own, and has good conversational English language skills. (Tr., p. 34:12-22). He

also testified that as time has passed, his English language abilities have improved. (Tr., pp. 53:15-2; 132:7-16). He has poor Spanish and English reading/writing skills.

2. Claimant did not admit to having any particular problem communicating with his physicians in connection with the treatment/evaluation he received following the accident. He testified that if he initially does not understand a question posed by a physician, he will ask for clarification. (Tr., p. 151:14-25). Nor do the medical records in evidence suggest that Claimant's providers/evaluators had any particular difficulty communicating with him. For example, in his August 2, 2010 report, Dr. Harris reported that Claimant provided the history recorded. Dr. Harris noted that Claimant was a "good historian." (Clt. Ex. 20, p. 602). In connection with his evaluation of September 10, 2010, Dr. Hammond noted that Claimant "can give a lucid history and has no language dysfunction." (Clt. Ex. 9, p. 458). In a follow-up visit of October 1, 2013, an employee of Dr. Hammond's office updated history taken from Claimant. She also noted that Claimant did not require an interpreter, and that his language preference was English. (Clt. Ex. 9, p. 466). Finally, Claimant's counsel acknowledged in his June 22, 2016 letter to Dr. Hammond, that Claimant speaks English well enough that Claimant does not require an interpreter to converse with English speakers. (Clt. Ex. 24, p. 659i).

3. Between 1974 and 1995, Claimant was employed primarily as a laborer on farms and ranches in the vicinity of Bruneau, Idaho. He was briefly employed by a trailer manufacturer in Boise where his job involved installing electrical wiring in trailers. He was employed as a laborer, not as an electrician. In 1995, he commenced his employment with Meyers Farms, Employer herein. Claimant was initially employed as the farm foreman, and still works in that capacity. Even though Claimant has always directed one or two employees since 1995, he was, before 2009, more of a working foreman. He testified that between 1995 and

2009, he did "everything" on the farm, including some heavy physical labor. (Tr., pp. 61:3-62:12). Claimant knows how to weld, and has some skills as a mechanic. However, his real value to Employer is his specific knowledge of the irrigation system, and how to maximize that system for the benefit of crops grown by Employer. Since the 2009 accident, Claimant does less heavy lifting, and gives more direction to his subordinates to perform this work. He intends to continue working for Employer as long as he can. Claimant's tax records reflect that for 2015, he earned approximately $43,000 in his job for Employer, approximately twice as much as he earned in 2009. (Tr., p. 169:3-13).

4. Morgan Meyers, one of the principals of Meyers Farms, testified to the business of Meyers Farms. Employer controls approximately 12,000 acres of farmland, at three different locations. Employer's Bruneau operation is managed by Claimant, whose expertise regarding the Bruneau farm irrigation system is important to that operation's success; the Bruneau tract is somewhat "gravelly" and does not hold water well, making irrigation management that much more important. According to Mr. Meyers, Claimant possesses the peculiar skills needed to make that operation successful. (Tr., pp. 173:14-185:19). Claimant does not require much in the way of supervision, and Meyers relies on Claimant to delegate work as Claimant sees fit. In addition to his expertise with the farm's irrigation system, Meyers depends on Claimant a great deal to oversee and supervise the annual harvest at Bruneau. Meyers testified that he would hire Claimant today, and that his knowledge and expertise is so important that Meyers "would be in a panic" if Claimant decided to leave or retire. (Tr., pp. 189:13-190:1).

Pre-Injury Medical Condition

5. Claimant testified that immediately prior to the October 6, 2009 motor vehicle accident, he had no limitations on his ability to perform his work. Specifically, Claimant denied

any problems with his neck, left shoulder, left elbow, or low back immediately prior to October 6, 2009. (Tr., pp. 82:15-85:12). However, the record reflects that Claimant did have periodic problems with low back pain/discomfort in the years prior to the October 6, 2009 motor vehicle accident. On November 6, 2001, Claimant was referred to chiropractor Jeffery Kieffer, D.C., by John Booth, PA-C for care of low back pain. PA Booth noted that Claimant had received no relief from conventional medical intervention. Evidently it was thought that chiropractic treatment might offer some relief. (Clt. Ex. 2, p. 31). However, Dr. Kieffer's records appear to reflect that he treated Claimant following November 6, 2001 for a principal complaint of cervical spine and upper extremity complaints. Nevertheless, Dr. Kieffer's January 3, 2002 report to the State Insurance Fund reflects that among his diagnoses of Claimant was a diagnosis of lumbar segmental joint dysfunction. (Clt. Ex. 2, p. 37).

6. On March 1, 2004, Claimant saw Dr. Kieffer with complaints of low back soreness. On March 8, 2004, he was again seen with complaints of low back pain and bilateral leg numbness. (Clt. Ex. 2, pp. 38-39). In a statement dated October 11, 2012, Dr. Kieffer, referring to the 2004 notes, stated:

> This is to verify that I evaluated and treated Mr. Ayala on two occasions for lower back and lower extremity "numb feeling" as secondary complaints to a cervical and mid-scapular injury. These treatment dates were March 1 and March 8, 2004. There were no significant objectives finding regarding his lower back complaints at that time. . . . .

(Clt. Ex. 2, p. 45). It is unclear at whose instance the October 11, 2012 statement was prepared, or what information/representations accompanied that request.

7. On June 23, 2004 Claimant was seen at the Glenns Ferry Health Center (GFHC) with a principal complaint of low back pain/soreness in the SI area. No neuroradicular symptoms were noted. The note reflects that Claimant expressed "multiple past experience[s]"

of similar discomfort. (Clt. Ex. 3, p. 65). Right SI soreness was noted on July 15, 2004 at the GFHC. On May 21, 2007, Claimant was again seen at the GFHC with complaints of right hip and SI joint pain "for over two years, with no recent trauma," although he did admit to an injury to this part of his back in 1974.[2] He admitted to discomfort associated with sitting in a tractor and walking in the fields. He did not complain of any neuroradicular symptoms. (Clt. Ex. 3, p. 115).

8. On February 25, 2009, Claimant underwent a musculoskeletal exam as part of his encounter of that date. Findings were as follows:

> On examination, the patient walks with a normal gait. There is no visible scoliosis. The shoulders and pelvis are well-balanced. There is no tenderness over the spine or SI joints. There is no inguinal adenopathy. There is full spine range of motion without pain, and the patient can touch their toes. There is full hip range of motion bilaterally. There is a negative Patrick's test, and a negative straight leg raising test on both sides. Motor strength is 5/5 in both lower extremities, and sensation is intact to light touch in both legs. Knee jerk and ankle jerk reflexes are 2+ bilaterally, and toes are downgoing. There is no clonus.

(Clt. Ex. 3, p. 129).

9. The GFHC notes of September 9, 2009 and October 5, 2009 figure prominently in the parties' arguments concerning whether or not Claimant's current low back complaints are causally related to the October 6, 2009 motor vehicle accident. Those notes deserve particular attention. On September 9, 2009, Claimant presented with the following history:

> Established patient for evaluation of
> 1. back pain.
> Location of symptoms: the upper back, mid back, and low back,
> Symptom(s) are described as persistant [sic] and achey [sic], Severity: mild and stable.
> Onset is/was abrupt. Symptoms have persisted for about one week.
> Context: Pt/ felt like he had an "internal fever" and felt restless and achey [sic]. His back along the paraspineous [sic] muscle straps, bilaterally have ached. He denies any vomiting but had some nausea. No change in bowel or bladder

[2] Per Dr. Hammond, hip pain is an indicator of nerve root impingement. (Hammond Depo., p. 39:1-8).

> function. Modifying factors include: OTC drugs, which does not alleviate or worse the problem.
> Denies drowsiness; trouble falling asleep;
> Reports appetite loss; which is/are mild; fatigue, restlessness, which is/are mild; restless sleep, muscle cramps, which is mild;

(Clt. Ex. 3, p. 136). Claimant denied fever. Examination of his back revealed mild vertebral muscle spasm. Claimant's diagnosis was obesity and back pain. Lab work was ordered and weight loss was recommended. Prescriptions for Cyclobenzaprine and Naprosyn were written. (See Clt. Ex. 3, pp. 136-140).

10. Claimant again presented to the GFHC on October 5, 2009, the day before the subject October 6, 2009 motor vehicle accident. He presented with complaints of a cough, which he described as a longstanding condition related to exposure to cold air and other irritants. Claimant was also noted to be obese. He reported mild joint pain, muscle aches, and back pain. Claimant's musculoskeletal exam was positive for grinding at the lateral aspect of the lateral joint line of the right knee. Diagnoses at this visit included obesity, asthma, and back pain. Claimant's prescription for Naprosyn was refilled, as were other prescriptions related to obesity and diabetes.

11. To other providers, Claimant also gave some history of low back problems predating the October 6, 2009 motor vehicle accident. When seen by D. Peter Reedy, M.D., on January 8, 2010, Claimant reported a past history of chiropractic visits for low back problems. (Clt. Ex. 5, p. 150). In his letter of January 7, 2016, Dr. Reedy proposed that the treatment notes from the GFHC reflect that Claimant was treated for complaints of low back pain immediately preceding the subject accident. Dr. Reedy also acknowledges that prior to the subject accident, Claimant suffered from a degenerative condition of the lumbar spine. He likened the subject accident to "the straw that broke the camel's back." (Clt. Ex. 5, p. 186). In a follow-up letter to

Claimant's counsel of January 19, 2016, Dr. Reedy acknowledged that Claimant had periodic episodes of low back pain which predated the 2009 motor vehicle accident, which was unsurprising to Dr. Reedy based on Claimant's vocation. (Clt. Ex. 5, p. 187).

12. Vernon McCready, PA-C, too, was asked by Claimant's counsel to comment on the nature of the complaints with which Claimant presented at the time of his evaluation by PA McCready and/or his staff on September 9, 2009 and October 5, 2009.

13. On November 5, 2015, December 14, 2015, and again on January 5, 2016, Claimant's counsel queried PA McCready about the nature of the problems with which Claimant presented on September 9, 2009 and October 5, 2009, suggesting a narrative that Claimant's problems were more-or-less systemic in nature and not reflective of a mechanical low back injury. (Clt. Ex. 6., p. 358). Also important in Claimant counsel's November 5, 2015 letter to PA McCready is the representation, which appears with some regularity in letters to Claimant's treating/evaluating physicians, that Claimant is the type of person who, on presenting for medical care, will only reference a primary complaint, declining to reference complaints of secondary importance:

> From my perspective, Mario presents as a straight-forward but rather unsophisticated individual. Following the industrial motor vehicle accident, Mario focused his complaints upon what was then causing him the greatest difficulty and produced the greatest symptomatology. Although logical, this approach results in an absence of medical records for other than primary or more obvious presentments, and oft-times in confusion or medical disagreement upon the issue of causal relation of the medical presentment to the injury at question.

(Clt. Ex. 6, p. 351). This assertion finds little, if any, support in the record, and must be distinguished from a related assertion, discussed *infra*, that Claimant did not discuss his post-injury low back complaints with Dr. Reedy because Dr. Reedy instructed Claimant to hold off discussing his low back until Dr. Reedy had completed his treatment of Claimant's cervical spine

condition. PA McCready failed to respond to the November 5, 2015 letter, the December 14, 2015 letter, but finally did respond to the January 5, 2016 letter. Rather than provide a narrative response, PA McCready simply acceded to the prepared statements offered by Claimant's counsel. (Clt. Ex. 6, p. 348).

Accident of October 6, 2009 and Subsequent Low Back Complaints

14. The accident giving rise to the first of the two claims in this consolidated proceeding occurred on October 6, 2009. On that date, Claimant was operating a Meyers Farms' vehicle heading north on Highway 51, intending to pick up a part for a piece of farm machinery when his left front tire blew out, causing his vehicle to pull to the left. Claimant over-corrected, and struck the guard rail on the right side of the road. The vehicle then came back across the roadway, hitting the west guard rail. (Clt. Ex. 26, p. 679). Claimant was not wearing a seatbelt at the time of the accident. He testified he was thrown about the interior of the cab in the course of the accident. Afterwards, he was driven to his home by a passerby and transported later that day to the Elmore Medical Center (EMC) in Mountain Home.

15. The EMC records of October 6, 2009 reflect that Claimant presented with a laceration to his left hand and with a history of striking his left chest wall as his vehicle swerved back and forth. Claimant denied any injury to his head, neck, abdomen, or other injuries. He admitted only to the hand laceration and chest contusion. Claimant was examined, and other than the aforementioned injuries to his left hand and chest wall, no abnormalities were noted. Diagnosis on discharge was left chest wall contusion and left hand contusion, with puncture wounds. Claimant was seen again in follow-up on October 13, 2009 at EMC complaining of left-sided rib pain and left anterior shoulder pain that radiated into the left arm. He stated that these symptoms began shortly after the accident of October 6, 2009. Claimant denied neck pain.

Neurological exam of the upper and lower extremities was normal. Gait was intact. The discharge diagnosis was expanded to include left rib fracture and left shoulder contusion. (Clt. Ex. 3, p. 148).

16. On October 16, 2009, PA McCready evaluated Claimant at GFHC. Claimant's primary complaint was diminished urinary stream, a complaint for which he had been seen in the past. Secondarily, Claimant presented for removal of sutures from his left hand and an authorization to return to work.

17. The November 4, 2009 chart note from the GFHC reflects that while Claimant did complain of left shoulder and left arm pain, he specifically denied low back pain or difficulty walking. Next, the GFHC records contain two separate chart notes, both signed by PA McCready, and both dated November 12, 2009. The first note from 11:41 a.m. reflects that Claimant was seen in follow-up for his neck and left upper extremity discomfort. The second note from 12:01 p.m. reflects that Claimant was seen for treatment of a chronic urinary problem. Neither of the November 12, 2009 notes reference the low back.

18. The GFHC record from November 16, 2009 reflects continued complaints of neck and left upper extremity symptoms. PA McCready recommended MRI evaluation of the cervical spine. PA McCready's note reflects that Claimant specifically denied low back pain or difficulty walking. (Clt. Ex. 6, p. 205). In treatment notes dated November 30, 2009 and December 11, 2009, PA McCready also specifically noted that Claimant denied complaints of low back discomfort or difficulty with walking. (Clt. Ex. 6, pp. 206-211).

19. While none of the aforementioned post-accident medical records reference complaints of low back or lower extremity difficulty, (even when Claimant appears to have been asked whether he had problems in these areas) the record does contain other references to post-

accident back pain. The Notice of Injury and Claim for Benefits prepared on or about November 17, 2009 reflects that as a result of the October 6, 2009 accident Claimant suffered injuries as follows: "Cut and bruised hand when hit driver's side window and hurt back." (Clt. Ex. 25, p. 673). On November 20, 2009, a State Insurance Fund investigator contacted Claimant to discuss the occurrence of the 2009 accident. In a claimant contact report, Claimant described the following problems which he evidently related to the subject accident:

> How are you doing? left arm is numb, neck, back entire back. No strength in my left arm, both hands went numb, left hand worse. Cut on left hand.
> Please give a brief description of your job: farming
> Please give a description of what you were doing when the accident occurred. I was going to get some part in town and on hwy 51. I was coming up on the part of the road where the guard rails were on both sides of the road and my left front tire blew out on the pickup, it all happened so fast. I pulled to[o] hard on the steering wheel and over corrected too far and hit the other guard rail. Both of my hands went numb. After hit the first guard rail on the right side and I went to grab the steering wheel I could not feel my left hand at all, shook my right hand it had some feeling. Accident happened about 2:30-3:00pm 10-04-09
> Describe the nature of your injury. Injuries from cart accident, left hand, back, neck (Emphasis in original).

(Clt. Ex. 25, p. 674a).

20. The Industrial Commission Rehabilitation Division opened its file on Claimant in March of 2010. While the Rehabilitation Division's initial April 18, 2010 interview of Claimant does not reflect that Claimant described complaints of low back pain, a subsequent note of May 12, 2010 does reflect that Claimant described complaints of numbness in his legs when standing at physical therapy for over 30 minutes.

21. The first post-accident medical record making reference to Claimant's low back or lower extremities is Dr. Reedy's letter of January 8, 2010 to PA McCready, who had referred Claimant to Dr. Reedy for evaluation. Per Dr. Reedy's letter, Claimant presented on January 8, 2010 with the following complaints:

> As you know, he is a pleasant 58-year-old farm foreman out at Robert J. Meyers farms in Twin Falls who comes in complaining of pain "everywhere." He has neck pain and left arm pain primarily that arose from a work related motor vehicle accident in October 2009. He tells me that if he stands for 20-25 minutes his legs go numb. He has seen a chiropractor in the past for low back problems but he has never had a neck problem before this. He tried oral steroids without much relief.

(Clt. Ex. 5, p. 150). Therefore, per the history recorded by Dr. Reedy, Claimant did relate his neck and left arm pain to the 2009 motor vehicle accident. However, Dr. Reedy's note does not explicitly reflect that Claimant also related his complaints of bilateral leg numbness to the motor vehicle accident. On exam, Claimant had findings suggestive of a cervical spine injury. Also, it was noted that lumbar range of motion was mildly decreased, although station and gait were normal. Deep tendon reflexes were 2+, and both ankle jerks were missing. Dr. Reedy went on to treat Claimant for his cervical spine condition, eventually performing surgery on Claimant's cervical spine on February 19, 2010, to include microdiscectomies at C5 thru C6 followed by instrumented fusions at the same levels. Claimant was seen in follow-up by Dr. Reedy on multiple occasions, but it was not until Dr. Reedy's December 5, 2011 office visit with Claimant that Claimant's low back and lower extremities are again referenced. On December 5, 2011, Dr. Reedy's office notes reflect that in addition to ongoing complaints with his cervical spine, Claimant presented with complaints of leg numbness and low back pain "ever since 10/09 accident," which had never been investigated. Claimant also described more low back pain in the 3-4 weeks prior to December 5, 2011. (Clt. Ex. 5, p. 168).

22. The December 5, 2011 office visit is further memorialized in Dr. Reedy's December 10, 2011 letter to PA McCready. This letter contains further information concerning the history of Claimant's low back and lower extremity complaints that was not captured in the December 5, 2011 chart note:

> He also complains about low back pain that he has had since the accident but that was never investigated. He said that when I first saw him I said lets work on the neck first and then we will deal with the lumbar issue but it never came up again. He describes what sounds like neurogenic claudication in that he can go into a store and walk around for 15-20 minutes but then he has bilateral leg pain, especially in the thighs when he is walking and he needs to sit down to get some relief. I think he certainly should have gotten an MRI of the lumbar spine and I will ask his attorney to get his case reopened so that we may pursue the lumbar end of things. I will also suggest to his attorney that he get a second opinion about his neck.

(Clt. Ex. 5, p. 166). This letter does not reflect that Dr. Reedy has a recollection of instructing Claimant, in December of 2009, that Claimant's back and lower extremity complaints would be sorted out after Dr. Reedy dealt with Claimant's cervical spine. (Indeed, Dr. Reedy's January 8, 2010 note does not reflect that he told Claimant to hold his low back complaints in abeyance). The letter only reflects that in December of 2011 Claimant came to Dr. Reedy stating that Dr. Reedy had previously told Claimant that investigation of Claimant's lumbar spine would be deferred pending treatment of the cervical spine.

23. However, in his December 10, 2011 letter to Claimant's counsel, Dr. Reedy reported the following history of Claimant's low back complaints following the 2009 motor vehicle accident: "In addition, his lumbar spine, which he has complained about since the accident, has never been investigated and I would request authorization to perform an MRI if you get his case file reopened." (Clt. Ex. 5, p. 176). If Claimant persistently claimed about low back and lower extremity complaints following the 2009 motor vehicle accident, he either did not share these complaints with Dr. Reedy, or Dr. Reedy failed to make note of these symptoms.

24. Nor does Claimant appear to have shared his persistent low back complaints with his attorney prior to December of 2011. Counsel's June 17, 2010 letter to Dr. Reedy describes Claimant's cervical spine and left upper extremity complaints and poses a number of questions to Dr. Reedy about Claimant's residual functional capacity, and whether Claimant is at risk for

accelerated degeneration of cervical spine segments above and below the C5-C7 fusion. However, that letter does nothing to suggest that counsel was aware of an as yet untreated low back complaints.

25. Between January of 2010 and December of 2011, Claimant also continued to be seen at the GFHC. (See Clt. Ex. 6). The GFHC note of March 15, 2010 makes no reference to Claimant's low back or lower extremities. The April 2, 2010 note reflects that Claimant was able to walk with a normal gait with no visible signs of scoliosis. He had full spinal range of motion without pain and was able to touch his toes. Hip motion was full bilaterally. Patrick's test was negative and Claimant had negative straight-leg raising on both sides. Motor strength was 5/5 in both lower extremities and sensation was intact to light touch in both legs. Knee jerk and ankle jerk reflexes were 2+ bilaterally. Identical findings were noted in an April 7, 2010 chart note and Claimant reported that the back pain associated with his cough was gone. The June 4, 2010 office visit note makes no reference to Claimant's low back or lower extremities and Claimant specifically denied that there were additional symptoms to report. On June 21, 2010 Claimant presented to the GFHC with complaints of back pain which Claimant described as "new." Claimant's discomfort was located in the right mid-back. He described a sudden onset of symptoms for three days. Claimant was seen in follow-up for these complaints of mid-back pain on July 21, 2010. On the occasion of that visit, PA McCready noted the same mid-back pain with symptoms persisting for about a month. On exam, Claimant had tightness in the paraspinous musculature of the lumbar spine with spasm from T12 to S1. By August 17, 2010, Claimant's complaints persisted in the right mid-to-lower back. PA McCready noted the persistence of symptoms over the past three months with insidious onset. However, on exam, no back abnormalities were noted. GFHC chart notes from August 30, 2010 reflect a past medical

history of chronic back pain and a 1975 right leg fracture. However, on the occasion of the August 30 exam, Claimant denied back pain or difficulty walking. On October 1, 2010 Claimant reported back pain, among his other complaints. GFHC notes from October 22, 2010, November 1, 2010, January 6, 2011, January 11, 2011 and February 11, 2011 make no reference to low back or lower extremity symptoms. A chart note from June 3, 2011 does reflect arthritic complaints in Claimant's wrists, ankles, and feet. However, no complaints of low back pain/discomfort are referenced. Gait and station were normal. Claimant's hips were normal, bilaterally. A chart note from August 3, 2011 does not reflect low back complaints, but does note that Claimant presented with normal gait and an ability to stand without difficulty. The note referencing the office visit of August 23, 2011 reflects that Claimant denied muscular weakness, tingling, or numbness. The August 23, 2011 chart note does not reflect any back complaints. Claimant had normal gait and station. Similar findings were noted in the October 14, 2011 office visit.

26. Then, in the chart note memorializing a December 1, 2011 visit, Claimant presented to PA McCready with the following complaints:

> The patient is a 60-year-old other race, Hispanic or Latino male who presents a history of lumbar region pain which began two weeks ago. He describes the pain as moderate in severity and radiating into the right leg and left leg. The onset of the back pain was gradual and began without a clear precipitating event.
>
> The pain is aggravated by prolonged standing and sitting. The pain is alleviated by change of position and rest. He states that the pain does not wake him from sleep and the pain is improved in the morning. He also complains of left leg paresis, right leg paresis and cough, right lung discomfort, rhinorrhea…

(Clt. Ex. 6, p. 288). Neurologic exam of Claimant's lower extremities was normal. PA McCready diagnosed Claimant as suffering from sciatica. Five days later, Claimant was seen by

Dr. Reedy, who noted Claimant's low back and lower extremity complaints which had not been referenced in Dr. Reedy's records since January of 2010.

27. Following Claimant's cervical spine surgery, Dr. Reedy referred Claimant to Gregory Schweiger, M.D., for evaluation of persistent left upper extremity complaints. Dr. Schweiger first saw Claimant on April 28, 2010. His note does not reflect that Claimant described any lumbar spine or lower extremity problems. MRI evaluation of Claimant's shoulder demonstrated a rotator cuff tear.

28. Dr. Schweiger arranged for Claimant to be seen by Dr. Hessing, who first examined Claimant on November 2, 2010. (Clt. Ex. 8, p. 409). Dr. Hessing reported that Claimant injured his shoulder in the 2009 motor vehicle accident as well as his cervical spine. Dr. Hessing noted that Claimant had suffered from left shoulder pain since the motor vehicle accident. Per Dr. Hessing, Claimant's August 23, 2010 left shoulder MRI was read as showing a large intrasubstance tear of the supraspinatus tendon. EMG evaluation of Claimant's left upper extremity was also thought to show an ulnar neuropathy at the elbow. Dr. Hessing recommended shoulder surgery to include probable rotator cuff repair and decompression of the shoulder joint. (Clt. Ex. 8, p. 409). Dr. Hessing's initial evaluation of Claimant does not reflect that Claimant presented with complaints of low back or lower extremity problems.

29. On November 2, 2010 Claimant was also evaluated by Mark Clawson, M.D., for suspected left cubital tunnel syndrome. Dr. Clawson's initial evaluation does not reflect any complaints of low back or lower extremity problems.

30. On December 9, 2010, Claimant underwent left ulnar nerve neurolysis and anterior subcutaneous nerve transposition performed by Dr. Clawson, along with a left shoulder decompression, labral debridement, and rotator cuff repair performed by Dr. Hessing.

31. Claimant was rated and released by Dr. Hessing for his shoulder injury on April 20, 2011. Dr. Hessing reported that Claimant was working at his regular job, and felt that his residual left shoulder symptoms were tolerable. Claimant did note some residual neck difficulty, but Dr. Hessing noted that Claimant would be seen by Dr. Reedy for care/evaluation of these complaints. Dr. Hessing gave Claimant an impairment rating of 5% of the upper extremity and released him to return to his pre-injury job without restriction.

32. On November 8, 2011, Claimant was seen for a closing evaluation by Dr. Clawson. Dr. Clawson noted that recent electrodiagnostic testing demonstrated normal nerve function in the left upper extremity. Claimant described symptoms that were more compatible with cervical spine pathology. Dr. Clawson also noted, for the first time, that Claimant presented with complaints of lower back pain. Dr. Clawson recommended that Claimant visit with Dr. Reedy regarding his neck and low back complaints. (Clt. Ex. 8, p. 456).

33. As Claimant neared medical stability following his cervical spine surgery, Surety arranged for Claimant to be evaluated by Mark J. Harris, M.D. In his July 26, 2010 introductory letter, TJ Martin, Claims Examiner for Surety, introduced Claimant to Dr. Harris. He provided Dr. Harris with all medical records in possession of the Fund relating to Claimant's claim and provided a very brief history of Claimant's treatment. Importantly, Mr. Martin indicated that in his last conversation with Mr. Ayala, Claimant indicated that he was having some lower extremity pain and numbness. Mr. Martin's letter coincides with the GFHC treatment notes from June 21, July 21, and August 7, 2010 reflecting new onset of back pain. Mr. Martin posed a number of questions to Dr. Harris relating to Claimant's current status, need for medical treatment, impairment, and restrictions. Dr. Harris saw Claimant for evaluation on August 2, 2010. He took history from Claimant concerning the occurrence of the accident, his post-

accident symptoms, and his treatment to date. Dr. Harris also elicited from Claimant a description of Claimant's then-current complaints. Dr. Harris reported these complaints as follows:

> **CURRENT STATUS**: The examinee's chief complaint is decreased range of motion and pain in the neck and left arm pain. I asked him several times in several different ways if he has any other areas of concern and he stated no. It was not until later that I asked him about the left leg symptoms and he stated those have now resolved and he has no further concerns about that area. He reports difficulty with pain, primarily located in the neck and left arm. Pain is described as stabbing in the left shoulder anteriorly, laterally, and down the arm into the fingers, specifically the small, ring, and long fingers. He states he always has numbness in the thumb and index fingers as well. The pain is worsened by resting his arm after work and improved by taking pain medications. The pain is reported as constant. On a scale of 0/10 which is no pain and 10/10 which is excruciating pain he reports the pain is a 6-7/10. During the past month he has averaged 2/10-3/10 with a high of 10/10 and a low of 2/10-3/10. The examinee also reports difficulty with activity using the left hand carrying over 20 pounds and difficulty with grip. He denies any symptoms prior to the motor vehicle collision on 10/06/09.

(Clt. Ex. 20, p. 603). Therefore, Claimant was provided with a number of opportunities to describe all symptoms from which he was then suffering. Claimant was specifically asked about lower extremity complaints. Claimant said that his lower extremity complaints had resolved and were no longer an issue. Claimant did not describe any low back complaints. Dr. Harris did relate Claimant's cervical spine and left upper extremity complaints to the subject accidents and proposed that Claimant was in need of further medical care for treatment/evaluation of these conditions. Nevertheless, he felt that Mr. Ayala was capable of working at his time-of-injury job since he was evidently doing so at the time of Dr. Harris' evaluation. However, pending MRI evaluation of the shoulder, Dr. Harris felt it appropriate to limit Claimant's lifting to 50 pounds.

34. By letter dated June 27, 2011, Mr. Martin again asked for Dr. Harris to evaluate Claimant as he neared medical stability following the surgeries performed by Drs. Hessing and Clawson. Mr. Martin asked Dr. Harris to ascertain whether Claimant was at a point of medical

stability, and if so, whether he had permanent impairment referable to his work injuries, as well as work-related limitations/restrictions.

35. Claimant was seen by Dr. Harris for the second time on August 15, 2011. Dr. Harris again asked Claimant to describe his current complaints. Those complaints included left hand pain with some residual pain in the shoulder and neck. Claimant described his discomfort as cramping pain. He described the pain as constant. Dr. Harris did not record any low back or lower extremity difficulties as described by Claimant. Dr. Harris felt that Claimant had reached medical stability following his neck, shoulder, and elbow surgeries. Dr. Harris felt that Claimant was entitled to a 6% whole person impairment for his neck condition, a 5% upper extremity impairment for his shoulder condition, and no impairment for his ulnar nerve condition.

36. Dr. Harris noted that as of August 15, 2011, none of Claimant's treating physicians had imposed restrictions on Claimant's functional activities. However, Dr. Harris felt that Claimant should use caution in overhead activities and heavy lifting even though his treaters had not issued such restrictions. (Clt. Ex. 20, p. 618).

37. As developed *infra*, after Claimant presented to Dr. Reedy in December of 2011 with complaints of low back pain, Dr. Reedy referred Claimant to Michael Hajjar, M.D., for evaluation of the low back complaints. Dr. Hajjar eventually requested authorization to perform an L4-S1 decompression and fusion. By letter dated August 30, 2012, Claims Examiner Martin asked Dr. Harris to review additional records generated since August 15, 2011, and to provide his analysis of whether Claimant's low back condition is causally related to the subject 2009 motor vehicle accident. By letter dated September 21, 2012, Dr. Harris noted that at the time of his initial evaluation of Claimant, Claimant had been asked to describe his problems and only reported neck and left arm injuries. The pain diagram filled out by Claimant only denoted

burning and stabbing pain in the left upper shoulder area. Dr. Harris also noted the September 9, 2009 chart note from the GFHC and the May 21, 2007 chart note from the same facility, both of which, as discussed above, reference low back pain. Concerning the May 21, 2007 chart note, Dr. Harris noted:

> In reviewing the records from John Booth on 05/21/07 it shows hip pain under the subjective main complaint: "This is a 55-year-old farmer complaining of right hip and SI area pain for over two years with no recent trauma. He did have injury to the area in 1974; no fracture. He has more pain after Inactive [sic] sitting in tractor and then tries to walk. He also has progressive pain in the lateral hip when walking in the fields. He expresses no new radicular or neuritic pain."

(Clt. Ex. 20, p. 629). Dr. Harris also had the opportunity to review records generated by Drs. Clawson, Schweiger, and Hessing at Orthopedic Associates. Dr. Harris erroneously described Dr. Clawson's note of November 8, 2011 as having been authored on October 6, 2009. As developed above, Dr. Clawson's note of November 8, 2011 contains the first reference in the Orthopedic Associates notes of "lower back pain." At any rate, following his review of the records supplied by the State Insurance Fund, Dr. Harris opined that Claimant's complaints of low back pain are not causally related to the industrial accident. This conclusion is based on Dr. Harris' observations that there is evidence of low back pain which predates the subject accident and no medical evidence supporting the proposition that Claimant presented with complaints of low back pain following the subject accident. (Clt. Ex. 20, p. 630). Based on Dr. Harris' letter of September 21, 2012, Surety denied responsibility for Claimant's low back condition.

38. Following Dr. Reedy's letter to PA McCready of December 10, 2011, authorization for MRI evaluation of Claimant's lumbar spine was requested. That study was performed on January 16, 2012 and was read as follows:

> LUMBAR DISK LEVELS:
> L1-2: Normal for age.
> L2-3: Normal for age.

> L3-4: Disc desiccation with mild bulging. Mild bilateral facet arthropathy. Mild canal and mild bilateral foraminal stenosis.
> L4-5: Disc desiccation with mild bulging. Moderate bilateral facet degeneration. There is mild canal and moderate bilateral foraminal stenosis.
> L5-S1: Disc desiccation with mild bulging. Moderate bilateral facet degeneration. There is mild canal and moderate bilateral foraminal stenosis.
>
> …
>
> CONCLUSION: Old T12 compression fracture with mild height loss. No acute fracture. No listhesis.
>
> Lumbar spondylosis with moderate bilateral L4/5 and L5/S1 foraminal stenosis. There is mild canal and foraminal stenosis elsewhere, as detailed above.

Clt. Ex. 11, p. 488. Thereafter, Dr. Reedy ordered a CT myelogram of Claimant's lumbar spine which was performed on April 3, 2012. That study was read as follows:

> Stable mild vertebral spurring throughout the lumbar spine. Mild deformity of the ventral thecal sac contour particularly at the L4-5 level to a lesser extent through out the lumbar spine without significant lateralizing mass effect. In particular there is no significant displacement of lumbar nerve roots or underfilling of the nerve root sleeves at L1-L5 levels. There is underfilling of the thecal sac at the lumbosacral junction and for opacification of the S1 nerve root sleeves. There is facet arthropathy at L4-5 and L5-S1 levels. There is no new significant vertebral malalignment.

Clt. Ex. 11, p. 489

39. In April of 2012, Dr. Reedy referred Claimant to Dr. Hajjar for further evaluation of Claimant's lumbar spine.

40. Dr. Hajjar first saw Claimant on June 23, 2012. At that time, Claimant gave a history to Dr. Hajjar that he suffered from back and lower extremity pain which Claimant related to the motor vehicle accident of October 6, 2009. Dr. Hajjar reviewed prior radiological studies, concluding that they demonstrated anterolisthesis at L4-5 "likely degenerative in nature." Dr. Hajjar also noted findings of bilateral recess stenosis and foraminal stenosis at L4-5 and L5-S1. Per Dr. Hajjar, the studies demonstrated impingement of both the L4 and L5 nerve roots. Dr.

Hajjar counseled Claimant that his back condition might be amenable to surgical treatment. He recommended a bone scan to further evaluate Claimant's low back. When seen again by Dr. Hajjar on August 7, 2012, Claimant expressed continuing back and lower extremity pain, as well as difficulties with standing, walking, and other activities. Dr. Hajjar reiterated Claimant's radiographic findings, apparently consisting largely of degenerative pathology. Dr. Hajjar recommended L4 through S1 decompression and fusion.

41. By letter dated November 14, 2012 to Claims Examiner Martin, Dr. Hajjar responded to the several reports generated by Dr. Harris by this date. Dr. Hajjar erroneously noted that Dr. Harris had not, by this time, expressed an opinion on the etiology of Claimant's low back complaints.[3] Regardless, Dr. Hajjar stated that like Dr. Reedy, he believed Claimant's low back complaints are causally related to the subject accident, although his November 14, 2012 letter to Claims Examiner Martin does not elaborate on what persuaded him to this point of view. Time passed, and Dr. Hajjar was not again quizzed about the causation issue until the date of hearing approached.

42. By letter dated January 6, 2016, Defense counsel provided Dr. Hajjar with the pre-injury treatment records from the GFHC generated in the fall of 2009, and invited Dr. Hajjar to revisit the question of the cause of Claimant's low back and lower extremity complaints. In his response of January 27, 2016, Dr. Hajjar acknowledged receipt of the GFHC records from September 9, 2009 and October 5, 2009. His review of those records led him to agree with Paul Montalbano's, M.D., view that, at most, Claimant suffered a temporary and self-limiting exacerbation of his lumbar spine condition as a consequence of the October 6, 2009 accident. (Clt. Ex. 10, p. 472A). However, there the matter did not rest because, on February 4, 2016,

[3] In his September 21, 2012 report, Dr. Harris explained that certain pre-injury medical records, including GFHC records from May 21, 2007 and September 9, 2009 supported his conclusion that Claimant's low back complaints are not causally related to the subject accident.

Claimant's counsel authored an extensive letter to Dr. Hajjar in which Dr. Hajjar was again invited to visit the issue of the cause of Claimant's current low back complaints and need for surgery. Counsel's February 4, 2016 letter is worthy of further comment. As he did in other letters to providers/evaluators, Claimant's counsel introduced his questions with the following narrative:

> From my perspective, Mr. Ayala presents as a rather straight-forward but rather unsophisticated individual. Mr. Ayala's principal language is Spanish, although he can and does communicate in English at a base level. Following his industrial motor vehicle accident, Mr. Ayala focused his complaints upon what was then causing him the greatest difficulty and produced the greatest symptomatology. Although logical, this approach results in an absence of medical records for other than primary or more obvious presentments and oft-times in confusion or medical disagreement upon the issue of casual relation of the medical presentment to the injury in question, following a delay in appropriate diagnosis and treatment of that condition.

(Clt. Ex. 10, p. 472G-472H). Concerning Claimant's past medical history, while Claimant's counsel did synopsize for Dr. Hajjar the GFHC records from September 14, 2007 forward, he did not advise Dr. Hajjar of earlier records from GFHC which do reflect a history of low back symptomatology. (Clt. Ex. 10, p. 472i). For example, Dr. Hajjar does not appear to have been made aware of the May 21, 2007 notes which reflect complaints of right hip and SI joint discomfort for two years without recent trauma. (Clt. Ex. 3, p. 115). Further, as he did in his letter to PA McCready of January 5, 2016, Claimant's counsel proposed to Dr. Hajjar that the complaints with which Claimant presented to PA McCready on September 9 and October 5, 2009 were not of the type that warranted further workup for injury to the low back. (Clt. Ex. 10, p. 472J). Claimant's counsel further represented that Dr. Reedy confirmed that he told Claimant to hold his low back complaints in abeyance until Dr. Reedy had finished treating Claimant's cervical spine. (Clt. Ex. 10, p. 472J). (Dr. Reedy has <u>never</u> confirmed that he recalls having this conversation with Claimant.) Finally, in his February 4, 2016 letter to Dr. Hajjar, Claimant's

counsel represented that Claimant's low back and lower extremity symptomatology has persisted ever since the October 6, 2009 motor vehicle accident. This is, assuredly, an assertion which Claimant now makes, but to say that it is a fact is not completely accurate; the record just as easily supports the proposition that Claimant's low back complaints have waxed and waned following the October 6, 2009 motor vehicle accident.

43. With that background, Claimant's counsel then asked Dr. Hajjar whether it would be appropriate to revisit the opinion he gave to Defense counsel on January 27, 2016.

44. In his February 19, 2016 letter to Claimant's counsel, Dr. Hajjar did, indeed, revise his opinion. Informing Dr. Hajjar's change of heart is his conclusion that the GFHC records do not demonstrate any history of low back complaints prior to the subject accident. Concerning the notes of September 9, 2009 and October 5, 2009, Dr. Hajjar concluded that these notes suggest a condition that "sounds more like a flu" versus any type of mechanical low back issue. He also noted that PA McCready did not order any follow-up radiological testing which would have been a logical next step had PA McCready entertained the possibility of mechanical low back problems in September 2009. These records and reasoning caused Dr. Hajjar to change his opinion and rejoin Dr. Reedy in supporting a causal relationship between the motor vehicle accident and Claimant's low back complaints. (See Clt. Ex. 10, p. 472E-F).

45. On August 28, 2013, Claimant suffered the second of the two accidents which are the subject of this proceeding. On that date, Claimant fell from an 8 foot ladder, landing on his feet, but, in the process, flexing his right knee. He experienced the immediate onset of right knee pain. He was initially evaluated at the Nampa Medical Center on the day of accident. He was seen for further treatment of his right knee by Miers Johnson, M.D., on September 11, 2013. Dr. Johnson noted Claimant's history of prior right knee surgeries, but also noted that Claimant had

had no significant problems with the right knee since the last surgery in 1987. He noted that as of the 2013 right knee injury, Claimant had been working full time, without restrictions, even though he had some pain/discomfort in his low back and lower extremities. Claimant admitted to being able to drive farm equipment, but to having trouble with any climbing or prolonged standing or pivoting. Claimant did not believe that the 2013 accident aggravated his low back condition and, indeed, no such assertion is made in these proceedings. MRI evaluation of the right knee revealed severe tri-compartmental degenerative changes and a chronic fracture of the posterior tibial plateau and the posterior lateral tibia. Also noted was a chronic avulsion of the posterior cruciate ligament tibial insertion. Within all three compartments of the knee, areas of full thickness cartilage loss were identified. Dr. Johnson noted that while Claimant assuredly had pre-existing osteoarthritis of the knee, some of the findings were likely referable to the subject accident. Dr. Johnson recommended a right total knee arthroplasty, and this procedure was performed on or about May 6, 2014. (Clt. Ex. 13, p. 514). Dr. Johnson released Claimant from care on or about September 24, 2014. At that time, Claimant denied any pain in the right knee, noting that he was driving tractor and otherwise performing his job. He denied any trouble walking on uneven surfaces, although he did admit to some difficulty after long periods of time on his feet. However, Dr. Johnson noted that Claimant related this discomfort to his back. Claimant indicated that long periods of standing and walking produced pain radiating into both anterior thighs and legs, and that he had permanent numbness in his left anterior thigh.

46. On September 22, 2014, Dr. Johnson released Claimant to full duty work. He did not give Claimant any restrictions regarding walking related to Claimant's right knee arthroplasty. However, he did believe that Claimant should be followed for his low back and lower extremity complaints. (Clt. Ex. 13, p. 525).

47. Dr. Johnson referred Claimant to Fred Shoemaker, M.D., for the purposes of rating Claimant's right knee injury. That rating was performed on October 6, 2014. Claimant told Dr. Shoemaker that he felt he had had a good result from the knee replacement surgery. Based on Claimant's good outcome, confirmed by clinical exam, Dr. Shoemaker felt it appropriate to give Claimant a 21% impairment rating of the lower extremity referable to his right knee, one-half of which Dr. Shoemaker related to Claimant's pre-existing right knee condition. Dr. Shoemaker was aware that Dr. Johnson had released Claimant without restrictions, but Dr. Shoemaker did not speak to limitations/restrictions as part of his evaluation. (Clt. Ex. 14, pp. 538-540).

48. From the record it appears that Dr. Johnson referred Claimant to Paul Montalbano, M.D., for further care/evaluation of Claimant's low back condition. Dr. Montalbano saw Claimant for the first time on October 15, 2014. Claimant gave Dr. Montalbano a history of the October 6, 2009 accident, and that he had suffered from low back pain ever since that event. Shortly after the motor vehicle accident, Claimant described noting bilateral and anterior thigh discomfort as well as numbness and tingling into his extremities going down into the lateral aspect of his leg to his foot. He denied having any lower extremity symptomatology prior to the motor vehicle accident. He described his back pain as constant burning pain at level 7 on a scale 0/10. Dr. Montalbano recommended new imaging of Claimant's lumbar spine to include x-rays and MRI evaluation. Instead, it appears that a myelogram and post-myelogram CT were performed on October 31, 2014. The post-myelogram CT was read as follows by Jeffrey Pugsley, M.D.,:

> T12-L1: 2 mm of grade 1 retrolisthesis of T12 on L1 with mild disc height loss. Mild central canal narrowing secondary to the retrolisthesis. Mild right neural foraminal narrowing secondary to the retrolisthesis.

> L1-L2: 2 mm of grade 1 retrolisthesis of L1 on L2 with mild disc height loss. Mild central canal narrowing secondary to the retrolisthesis, small disc bulge, and mild facet arthropathy. Moderate right and mild left neural foraminal narrowing secondary to the retrolisthesis and facet arthropathy.
> L2-L3: Mild central canal narrowing secondary to a small disc bulge and mild facet arthropathy. Mild bilateral neural foraminal narrowing secondary to facet arthropathy and disc bulge.
> L3-L4: Mild central canal narrowing secondary to a small disc bulge and mild facet arthropathy. Mild bilateral neural foraminal narrowing secondary to facet arthropathy and disc bulge.
> L4-L5: Mild central canal narrowing secondary to a small disc bulge and moderate facet arthropathy. Moderate to severe bilateral neural foraminal narrowing secondary to endplate osteophytes and facet arthropathy.
> L5-S1: Mild central canal narrowing secondary to severe facet arthropathy. Severe right and moderate left neural foraminal nerve secondary to facet arthropathy and endplate osteophytes.

(Clt. Ex. 19, pp. 591-592). Flexion/extension films of the lumbar spine demonstrated multi-level degenerative disc disease, most pronounced at T12-L1, multi-level facet degeneration, most prominent at L3-4 thru L5-S1, and a Grade I retrolisthesis of L1 on L2, unchanged on flexion/extension.

49. In his letter to Dr. Johnson of November 7, 2014, Dr. Montalbano expressed his agreement with Dr. Pugsley's interpretation of the post-myelogram CT. On exam, Claimant's muscle strength was 5/5 in both upper and lower extremities. Claimant did exhibit antalgic gait and station. Deep tendon reflexes were normal, and Claimant's sensory exam was intact.

50. Claimant was again seen by Dr. Montalbano on February 25, 2015, following a course of physical therapy. He presented with continued complaints of low back pain and lower extremity symptomatology. Dr. Montalbano ordered a bone scan in an effort to further sort out Claimant's problems. That study, performed on March 20, 2015, showed uptake at the right L4-5 facet joint, and bilaterally at L5-S1. (See Clt. Ex. 19, p. 595). In his note of April 8, 2013, Dr. Montalbano described the bone scan results as "quite mild." Dr. Montalbano recommended a facet joint injection from which Claimant enjoyed only limited improvement. Subsequent

neurological exam was normal. Dr. Montalbano recommended continuation of conservative modalities, including physical therapy and weight loss.

51. By June 3, 2015, Dr. Montalbano reported that Claimant was much improved with conservative modalities. Based on Claimant's improvement, and his limited findings on the post-myelogram CT, Dr. Montalbano did not believe that Claimant was a surgical candidate.

52. By letter dated June 22, 2015, Claimant's counsel queried Dr. Montalbano as to whether or not Claimant's lumbar spine condition is causally related to the subject MVA. Again, Claimant's counsel made the representation that Claimant's practice, when meeting with treaters, is to withhold history of secondary complaints and reference to treaters/evaluators only those problems that are of greater significance. (Clt. Ex. 17, p. 577)

53. Claimant's counsel's letter of June 22, 2015 does reflect that he provided Dr. Montalbano with selected medical records, including records from Dr. Reedy and Mountain Home Physical Therapy. Counsel's letter does not reflect that he provided Dr. Montalbano with copies of the September 9 and October 5, 2009 chart notes from the GFHC, but Counsel did offer the following comments concerning Claimant's pre-injury low back complaints:

> Upon Dr. Hajjer recommending lumbar surgery, the State Insurance Fund required that Mr. Ayala undergo an IME by Dr. Mark Harris, with Idaho Physical Medicine & Rehabilitation. Dr. Harris' opinions were not upon actual examination of Mr. Ayala, but were based upon a review of medical records provided by the State Insurance Fund. Following the records review, Dr. Harris noted that Mr. Ayala did present prior to the October 6, 2009, motor vehicle accident with sporadic complaints of low back symptomatology. When questioned about this, Mr. Ayala responded that he is a "farm-worker," and that all farm-workers experience low back pain upon occasion.

(Clt. Ex. 17, p. 579). Therefore, while Dr. Montalbano was generally apprised of Claimant's sporadic pre-injury back complaints, he was not specifically apprised of the September 9 and October 5, 2009 GFHC visits, nor was he provided with copies of those notes. He was, however,

provided with a synopsis of some of Claimant's medical contacts between October 5, 2009 and December 2011 chronicling Claimant's complaints of low back and lower extremity discomfort. Dr. Montalbano was asked whether, against this background, he would agree that the medical evidence establishes a causal connection between the motor vehicle accident and Claimant's current low back condition. Dr. Montalbano's reply of July 8, 2015 reveals something about the assumptions he made in forming a response to Counsel's question. Dr. Montalbano premised his conclusions on the observation that it was "clear" that Claimant suffered from symptomatic low back complaints "since that motor vehicle accident," but that he had been "asymptomatic" prior to the motor vehicle accident. Therefore, Dr. Montalbano concluded that Claimant's symptomatology is directly related to the October 6, 2009 MVA.

54. By letter dated September 30, 2015, Defense counsel provided Dr. Montalbano with the GFHC records from September 9, 2009 and October 5, 2009 and inquired of Dr. Montalbano how or whether those records would cause him to revisit his opinion that Claimant's low back complaints are causally related to the subject motor vehicle accident. In his reply of October 8, 2015 Dr. Montalbano explained that the opinions contained in his July 8, 2015 letter to Claimant's counsel were based on limited medical records. After reviewing the pre-injury GFHC records, Dr. Montalbano stated:

> After reviewing the additional medical records provided to me via your office, it is quite clear that Mr. Mario G. Ayala was symptomatic in terms of low back pain on at least two separate occasions. He was evaluated for low back pain on September 9, 2009 and once again on October 5, 2009. The latter was one day prior to his motor vehicle accident of October 6, 2009, in which Mr. Ayala attributes all of his symptomatology to be related to. Within these two visits of September 9, 2009, as well as October 5, 2009, Mr. Ayala started on treatment on two separate occasions for low back pain and even received a prescription for a nonsteroidal anti-inflammatory agent in order to manage such pain.

(Clt. Ex. 21, p. 639). Dr. Montalbano concluded that, at most, the October 6, 2009 motor vehicle accident caused but a temporary sprain/strain which he would have expected to be of relatively short duration. Dr. Montalbano's October 8, 2015 letter suggests that any care required later than 4-6 weeks after the motor vehicle accident would be related to Claimant's underlying degenerative condition. In his letter of October 3, 2016, Dr. Montalbano stated that none of the records/materials generated by Dr. Hammond would cause him to revise any of his previously-stated opinions.

55. Dr. Montalbano's testimony was taken by way of post-hearing deposition. Dr. Montalbano testified that he had the opportunity to review both the 2012 and 2014 post-myelogram CT studies. Those studies did not reveal any progression of Claimant's condition between 2012 and 2014. Dr. Montalbano also testified that none of the post-accident lumbar spine studies provide any support for the proposition that Claimant suffered an acute injury to his lumbar spine as a consequence of the motor vehicle accident. (Montalbano Depo., pp. 29:24-30:22; 37:8-38:9; 92:21-93:12; 116:12-22). While Claimant's lumbar spine studies do demonstrate severe multi-level degenerative arthritis, facet disease, and anterolisthesis, neither the studies, nor Dr. Montalbano's clinical examination demonstrated that Claimant has impingement of existing nerve roots. (Montalbano Depo., pp. 12:19-13:15; 16:23-17:6; 65:3-66:17). On exam, Claimant's lower extremity symptoms did not follow a dermatomal pattern suggestive of nerve root compromise. (Montalbano Depo., pp. 13:7-15; 16:23-6). Because of the lack of findings suggestive of nerve root compromise/radiculopathy, Dr. Montalbano does not believe that Claimant is a surgical candidate, especially after Claimant experienced improvement in symptoms following the course of physical therapy ordered by Dr. Montalbano.

56. Dr. Montalbano originally opined that based on Claimant's lack of pre-injury low back symptoms, and the development of symptoms following the accident, it followed that Claimant's low back condition must be, in some respect, referable to the subject accident. Dr. Montalbano changed his mind after reviewing the September 9 and October 6, 2009 GFHC notes. Contrary to the narrative proposed by Claimant's counsel, Dr. Montalbano saw nothing in those notes which suggested that Claimant's low back complaints were mediated by some type of systemic ailment such as the flu, or other illness. Medications prescribed for Claimant on September 9, 2009, Naprosyn and Flexeril, are medications typically prescribed for musculoskeletal pain. (Montalbano Depo., pp. 26:24-28:23; 79:25-92:7). Therefore, from his review of the medical records, Dr. Montalbano concluded that in the years preceding the October 6, 2009 motor vehicle accident, Claimant had periodic problems with low back pain and that immediately prior to the motor vehicle accident, he had one of these episodes.

57. Dr. Montalbano recognized that Claimant's course following the subject accident is equally important. For example, he appears to concede that if Dr. Reedy is correct in supposing that Claimant had "unrelenting" low back/lower extremity discomfort since the subject accident, this fact would auger in favor of a conclusion that the subject accident did something to aggravate or accelerate Claimant's low back problems on a permanent basis. However, the medical records do not support the proposition that Claimant suffered from persistent/unrelenting low back pain ever since the subject accident. (Montalbano Depo., pp. 30:23-31:19; 32:11-37:3). Based on the failure of the record to document persistent and unrelenting low back pain following the October 6, 2009 MVA, the existence of medical records which document a lack of low back symptoms/findings at various times after the October 6, 2009 accident, and other medical records which document new occurrences of low back pain

following periods of no low back symptomatology, Dr. Montalbano believed that the subject accident caused, at most, a temporary exacerbation of Claimant's documented pre-existing low back condition.

58. Richard Hammond, M.D., first saw Claimant on September 10, 2010, on referral from PA McCready. Dr. Hammond took a history from Claimant concerning the accident and the cervical spine surgery previously performed by Dr. Reedy. Dr. Hammond noted that since the accident Claimant suffered from continued pain across the top of his left shoulder and had difficulty using his left arm. Dr. Hammond did not report that Claimant presented with any complaints of low back or lower extremity pain. Nor did Dr. Hammond's clinical exam suggest any findings indicative of low back problems. Dr. Hammond believed that Claimant had possible ulnar nerve and left shoulder problems and recommended further evaluation. (See Clt. Ex. 9, pp. 458-459). Dr. Hammond next saw Claimant on October 1, 2013 for complaints of blacking out. On the occasion of that visit, Dr. Hammond noted that Claimant did have some low back complaints for which he had been evaluated by Dr. Hajjar. Also noted was the 2013 industrial injury to Claimant's right knee. Claimant was next seen by Dr. Hammond on August 1, 2016, at the instance of Claimant's counsel. Counsel re-introduced Claimant to Dr. Hammond by way of a letter dated June 22, 2016.[4] Among other things, Claimant's counsel inquired of Dr. Hammond whether Claimant's low back condition is causally related to the October 6, 2009 motor vehicle accident. To Dr. Hammond, Claimant gave a history of having significant low back pain commencing immediately after the subject motor vehicle accident. Concerning the September 9, 2009 and October 5, 2009 GFHC notes, Claimant told Dr. Hammond that the back

[4] As he did with Dr. Hajjar, Counsel synopsized Claimant's pre-injury medical history, noting that Claimant had not presented to the GFHC with any low back complaints between September 14, 2007 and September 9, 2009. Claimant's Counsel did not include a synopsis of GFHC and Kieffer Chiropractic records generated between November 2001 and September of 2007. As noted *infra*, these records do reference episodes of low back, SI joint, or hip pain during this time frame.

complaints he had prior to the motor vehicle accident were of an entirely different nature than the low back complaints he developed thereafter. He reiterated that his low back complaints have been persistent since the motor vehicle accident. Based on Claimant's history, the records provided by Claimant's counsel , and his examination of Claimant, Dr. Hammond concluded that Claimant's low back condition is causally related to the subject accident.

59. Dr. Hammond's deposition was taken on December 16, 2016. He testified that Claimant had radiographic evidence of L4-5 anterolisthesis with significant bilateral stenosis at L5-S1. Dr. Hammond testified that Claimant's anterolisthesis closed-off Claimant's neuroforamina, bilaterally, causing exiting nerve root impingement. Concerning the GFHC records from September 9, 2009 and October 5, 2009, Dr. Hammond agreed with Claimant's counsel that these notes are consistent with Claimant's treatment for some type of systemic complaint, as opposed to a musculoskeletal low back complaint. (Hammond Depo., pp. 17:18-20:19). At most, Dr. Hammond believed that the September 9 and October 5, 2009 chart notes reflected muscular pain, while Claimant's current complaints are referable to a structural abnormality. (Hammond Depo., pp. 20:20-21:17).

60. Concerning his September 10, 2010 evaluation of Claimant, Dr. Hammond testified that unless Claimant had presented with significant low back or lower extremity problems, he probably would not have made note of these, since he was seeing Claimant for left upper extremity problems. (Hammond Depo., p. 59:3-19). However, review of Dr. Hammond's September 10, 2010 chart note demonstrates that he did take a complete history from Claimant that involved inquiries well beyond the ambit of the nature and extent of Claimant's left upper extremity complaints. His history and exam of Claimant included Claimant's eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genital/urinary, musculoskeletal, neurologic

and neurogenic systems. Claimant was invited to admit to any problems in these areas. Dr. Hammond also conducted a limited exam of Claimant's lower extremities. Knee jerk and ankle jerk were 1+. Claimant's gait and station were normal. Per Dr. Hammond, the knee and ankle jerk findings, though not normal, were not significant enough to warrant follow-up at that time. (Hammond Depo., p. 61:6-24). In summary, in September of 2010, Dr. Hammond noted nothing regarding Claimant's low back which would have caused him to refer Claimant for further evaluation or treatment.

61. Dr. Hammond testified that trauma can be one cause of anterolisthesis of the type seen in Claimant's lumbar spine. (Hammond Depo., pp. 15:21-16:19). However, he also acknowledged that wear and tear in populations that perform heavy labor "can certainly cause" anterolisthesis. (Hammond Depo., p. 85:15-21). Dr. Hammond believes that the subject accident caused injury to Claimant's lumbosacral spine and is responsible for Claimant's need for surgery. His reasons for coming to this conclusion are several. Dr. Hammond was willing to acknowledge that Claimant did have disease of the lumbar spine which predated the subject accident. However, he believed that the pre-injury and post-injury medical records he reviewed support the conclusion that the subject accident aggravated the pre-existing condition. Dr. Hammond believed that Claimant's pre-injury complaints consisted of a one or two-time visit to PA McCready for complaints of low back pain on September 9, 2009 and October 5, 2009, while his post-injury complaints have been persistent and unrelenting. (Hammond Depo., pp. 42:11-43:7; 79:1-13; 92:15-93:23; 107:18-108:14; 109:23-110:12; 111:14-24; 123:6-124:1). Dr. Hammond did not believe that the GFHC notes of September 9, 2009 and October 5, 2009 were significant.

62. Dr. Hammond was not provided with medical records generated by Dr. Kieffer and the GFMC, and discussed at ¶ 5-7, *infra*. Those records cover a period from a 2001 through May, 2007 and do reflect more longstanding complaints of hip/low back discomfort. It is unknown whether, or how, the additional notes which he did not see would cause him to amend any of the opinions he expressed concerning the significance of the subject accident to the development of Claimant's current low back condition.

63. As noted, Dr. Hammond's opinion is also supported by his belief that Claimant's complaints were different in character following the motor vehicle accident and have been persistent and unrelenting since that time. In this belief he joins with Dr. Reedy:

> Q: [By Mr. Berry]: Basically, Dr. Reedy advised Mr. Augustine that just because Mr. Ayala may have had a backache once in a while prior to the motor-vehicle accident that - - and here I'm quoting "… does not preclude the fact that the exacerbation of the accident led to the persistent, unrelenting pain in the back and leg with neurogenic claudication-like symptoms, and he clearly has pathology to demonstrate the validity of those claims." Do you agree with that?
>
> A: I couldn't have said it better.

(Hammond Depo., p. 111:14-24). However, as developed *infra*, the medical records do not support the conclusion that Claimant's low back/lower extremity complaints have been persistent and unrelenting since the subject accident, at least until the late fall of 2011.

64. Dr. Hammond was in general agreement with the FCE performed by Brian Wright, DPT. However, he believed that it might be appropriate to assign more of Claimant's sitting, standing, and walking restrictions to the low back condition as opposed to Claimant's knee injury.

65. As noted, Dr. Reedy treated Claimant through December 2011, but thereafter, engaged in some back-and-forth with Claimant's counsel concerning the etiology of Claimant's low back complaints. In a letter dated November 20, 2012, Claimant's counsel introduced a

number of questions to Dr. Reedy by first synopsizing medical records tending to support the proposition that while Claimant may have had some periodic flares of low back pain prior to the subject accident, his complaints have been persistent and unrelenting since the subject accident. Claimant's counsel asked Dr. Reedy to confirm that Claimant's low back complaints were, in some respect, referable to the subject accident. In his response of December 12, 2012, Dr. Reedy stated:

> I clearly think Mr. Ayala's lumbar presentment and need for surgery that both I and Dr. Hajjar issued is causally related to the October 6, 2009 motor vehicle accident. Obviously, he did have pre-existing spine (he had worked hard for a living for his entire life)! However, he was asymptomatic until the time of the MVA which precipitated the need for intervention. Please contact me if I can be of any further assistance.

(Clt. Ex. 5, p. 177). Counsel's November 20, 2012 letter did not specifically reference the much-discussed GFHC records of September 9, 2009 and October 5, 2009.

66. By letter dated December 17, 2015, Defense counsel advised Dr. Reedy that Dr. Montalbano had ultimately concluded that Claimant's low back condition is not referable to the subject accident. He also provided Dr. Reedy with copies of the chart notes from September 9, 2009 and October 5, 2009, which Dr. Montalbano had found to be significant. He asked for Dr. Reedy's comment. By letter dated January 7, 2016, Dr. Reedy acknowledged that Claimant had a pre-existing degenerative condition of the lumbar spine, but proposed that the subject accident was a "straw that broke the camel's back," causing Claimant to suffer "persistent unrelenting" pain in the back and leg since the motor vehicle accident. (Clt. Ex. 5, p. 186). He minimized the GFHC notes from September 9, 2009 and October 5, 2009, explaining that just because Claimant had a back ache prior to his industrial accident did not mean that the industrial accident did not cause additional injury to Claimant's lumbar spine. (Clt. Ex. 5, p. 186). In a January 19, 2016 follow-up letter to Claimant's counsel, Dr. Reedy again elaborated on his view of what is and is

not significant in this case in terms of Claimant's clinical presentation. He stated Claimant may well have suffered from periodic bouts of low back pain prior to the motor vehicle accident, and he clearly did have degenerative disease of the lumbar spine prior to the industrial accident; however, it was only following the industrial accident that Claimant suffered from persistent and intractable low back pain, and therefore, the motor vehicle accident is directly related to Claimant's current lumbar spine condition. (Clt. Ex. 5, p. 187).

Further Discussion Concerning Claimant's Lumbar Spine

67. It is well established by a long line of authorities that in any proceeding before the Industrial Commission, a claimant has the burden of proving, by a preponderance of the evidence, all facts essential to his recovery. See *Ball v. Daw Forest Products Co.*, 136 Idaho 155, 30 P.3d 933 (2001); *Evans v. Hara's, Inc.*, 123 Idaho 473, 849 P.2d 932 (1993). Where medical causation is at issue, a claimant must provide medical evidence that supports the claim for compensation to a reasonable degree of medical probability. *Langley v. State Industrial Special Indemnity Fund*, 126 Idaho 781, 890 P.2d 732 (1995). Probable is defined as having more evidence for than against. *Fisher v. Bunker Hill Co.*, 96 Idaho 341, 528 P.2d 903 (1974). Magic words are not necessary to convey that a doctor's opinion is given with the requisite degree of medical probability; all that is needed is testimony demonstrating the physician's plain and unequivocal conviction that a causal connection exists between an accident and an injury. See *Jensen v. City of Pocatello*, 135 Idaho 406, 18 P.3d 211 (2001).

68. In the instant matter, the parties have devoted reams of exhibits, testimony, and argument for and against the proposition that Claimant's lumbar spine condition is, in some respect, causally related to the subject accident. The opinions are numerous, and vacillating, but they generally acknowledge that Claimant has degenerative disease of the lumbar spine which

predated the subject accident. All physicians who have reviewed the films taken in connection with evaluation of Claimant's lumbar spine acknowledge that there is no finding in any of those studies which, standing alone, constitutes evidence of acute injury of Claimant's lumbar spine. The studies alone do not provide evidence sufficient to demonstrate that the subject accident contributed something to Claimant's pre-existing low back condition. However, while the radiographic evidence demonstrates longstanding disease of the lumbar spine, the studies are not inconsistent with the proposition that these processes may have been aggravated by the subject accident. As is not uncommonly the case, the objective medical evidence must be correlated with Claimant's history and clinical examination to inform an opinion on whether or not the subject accident did cause some permanent injury to Claimant's lumbar spine.

69. It is clear from review of the causation opinions in this case that the treating/evaluating physicians are cognizant of the importance of correlating the objective medical evidence with Claimant's history, clinical presentation, and exam. The parties, too, recognize the importance of this correlation, and have pulled out the stops to posit questions to treating/evaluating physicians premised on the facts they deem most important to their case.

70. Having reviewed the record in its entirety, and having considered the writings and testimony of all the physicians who have rendered an opinion on the cause of Claimant's low back condition, the Commission concludes that Claimant has failed to demonstrate, to a reasonable degree of medical probability, that his current low back complaints are causally related to the subject accident.

71. First, the radiological studies unambiguously establish that Claimant has multi-level degenerative disease of the lumbar spine which predated the subject accident. The record also establishes that Claimant presented, in the years preceding the October 6, 2009 accident

with periodic complaints of low back pain. Claimant endorses this, as does Dr. Reedy. (Clt. Ex. 5, pp. 179, 180, 187; Clt Ex. 20, p. 635). However, Dr. Hammond was not aware of the Kieffer Chiropractic and GFHC records which reflect some complaints of low back/hip pain between 2001-2007. On September 9, 2009, Claimant was seen at the GFHC for a number of complaints, including, *inter alia*, low back pain. He was seen again on October 5, 2009, the day before the subject accident, with complaints of a cough, which he described as longstanding and mild joint pain, muscle aches, and back pain. Having reviewed the testimony and records of the numerous providers who have commented on the September 9 and October 5, 2009 notes, the evidence does not establish that the back pain or low back pain with which Claimant presented on those occasions was simply a manifestation of a systemic illness such as the flu. PA McCready's January 19, 2016 reply to counsel's check-the-box questionnaire is not particularly persuasive, and it is given little weight. Such evidence is always regarded with some skepticism. Rather than the physician's unalloyed opinion, what is received is an opinion formulated by the party offering it, to which the physician is asked to give his assent. It is unclear whether PA McCready's reply represents his actual opinion, or was simply his way to buy some peace; Claimant's counsel contacted him on three occasions seeking a response to certain questions, and only obtained it after advising PA McCready that failing a written response, it would be necessary to notice McCready's deposition. Further, PA McCready's response does not discount the possibility that the complaints with which Claimant presented on September 9, 2009 included musculoskeletal low back complaints. All that PA McCready admitted to is that as of September 9, 2009 and October 5, 2009, Claimant's low back complaints did not indicate "serious or significant" injury to the low back. How serious or how significant an injury Claimant's symptoms might have indicated, is left to speculation. PA McCready next signified

his agreement with the assertion that absent the October 5, 2009 accident, he would not have expected Claimant to "thereafter" present with a significant low back injury as later documented by Drs. Hajjar and Reedy in 2012. The term "thereafter" admits a lot of leeway, and it is unclear how or whether PA McCready's opinion might change if Claimant did not develop significant low back symptoms until several months following the accident or, if, he had waxing and waning symptoms between the date of the subject accident and Dr. Reedy's chart note in December of 2011. Accordingly, PA McCready's January 19, 2016 response to Claimant's counsel is not especially probative of the question of whether Claimant's low back condition is related to his MVA.

72. Both Dr. Hammond and Dr. Montalbano have speculated on the significance of the complaints with which Claimant presented on September 9 and October 5, 2009. In general, Dr. Montalbano's reasoning is more persuasive. He has pointed out that Naprosyn and Flexeril are typically prescribed for musculoskeletal complaints, thus denigrating the suggestion that Claimant merely had the flu. He also noted that if PA McCready had suspected the flu, he would undoubtedly have ordered a quick flu test in addition to the other labs he ordered. Dr. Montalbano also noted other of PA McCready's findings that ran counter to a systemic condition or infection as the explanation for Claimant's presenting complaints. Dr. Hammond was far less persuasive in this regard.

73. The most problematic, and hardest fought, aspect of this case lies in making some determination as to whether or not, or to what extent, Claimant suffered from low back complaints following the October 5, 2009 accident. Based on the medical opinions that have been adduced, if Claimant's low back complaints following the 2009 accident were persistent and unrelenting, it would be rather easy to conclude that the subject accident must have

aggravated Claimant's pre-existing low back disease; objective findings consistent with an accident caused aggravation of a pre-existing condition could be correlated with a medical history of new and unrelenting back and lower extremity symptoms since the accident to support the conclusion that the accident caused permanent injury to Claimant's low back. On the other hand, if the evidence is more susceptible of a conclusion that Claimant did not present with persistent low back complaints following the subject accident until the late fall of 2011, then it becomes much more difficult to conclude that the subject accident is implicated in the cause of Claimant's low back condition. The evidence on this issue is conflicting but, as developed below, the record offers less support to the proposition that Claimant suffered from persistent and unrelenting low back pain since the October 5, 2009 MVA, and more support to the proposition that his low back complaints began, in earnest, in late 2011.

74. Claimant testified that he has suffered from low back and lower extremity numbness unremittingly since the accident of October 6, 2009. (Claimant Depo., p. 33:11-22; Tr., p. 95:13-17). However, there are multiple post-accident medical records which are silent on the issue of whether Claimant complained of low back and lower extremity pain; these records admit the possibility that Claimant had low back symptomatology which he simply did not describe to his providers. However, the post-accident medical records generated between the date of accident and the late fall of 2011 contain an equal number of records in which Claimant specifically denied low back/lower extremity symptoms, or which reference an exam of the low back and lower extremities which turned up nothing untoward. These records are much harder to reconcile with Claimant's current insistence that he has suffered from unrelenting low back/ lower extremity symptomatology ever since the subject accident. Moreover, the post-injury medical records generated between the date of accident and the late fall of 2011 also reflect that

on several occasions when Claimant did complain of back or low back discomfort the onset of these problems was not related to the subject accident, but was described as being of more recent origin. It is clear that Claimant did describe suffering from back pain immediately after the accident to Employer and the SIF. It is also clear that he complained of back pain in the spring of 2010, and again, in the late fall of 2011. However, these records are not sufficient to support a finding that Claimant's symptomatology following the motor vehicle accident was persistent and unrelenting in light of the other medical records which show that Claimant's history of low back symptomatology following the motor vehicle accident was, at most, intermittent. Dr. Reedy was prepared to acknowledge that on a pre-injury basis Claimant suffered from intermittent low back and/or lower extremity problems. Claimant's post-accident history does not persuasively demonstrate more significant or persistent low back symptoms, at least not until the fall of 2011. Of particular interest, are medical records from a number of sources generated in the late fall of 2011. These records reflect a new onset of low back and lower extremity discomfort in November of 2011.

75. Claimant has explained the failure of the medical records to uniformly reflect persistent and unrelenting low back pain since the subject accident by his practice to only reference to the many providers he saw following the subject accident his most predominant complaint, leaving unstated any secondary complaint such as low back and lower extremity discomfort. Having reviewed Claimant's testimony, both at hearing, and at the time of his prehearing deposition, there is little-if-any support for this proposition in the record. For example, following cervical spine surgery Claimant was referred to Mountain Home Physical Therapy. He was first evaluated at that facility on March 25, 2010, and was last seen on June 9, 2010. Claimant was again referred to Mountain Home Physical Therapy by Dr. Hessing

following Claimant's shoulder and elbow surgery. During the first session of physical therapy (March 25, 2010 – June 9, 2010) Claimant was seen for treatment on 31 occasions. Claimant contends that the physical therapy chart notes from March 25, April 7, April 19, April 27, and May 25 reflect that Claimant presented on those occasions to the physical therapist with complaints of hip/lower extremity pain. The notes reflect that throughout the course of physical therapy, Claimant's primary complaints related to his neck and left upper extremity. However, on March 25, 2010 the therapist noted that Claimant had complaints of pain in the left foot. (Clt. Ex. 7, p. 361). The note from April 7, 2010 reflects that Claimant complained about hip soreness after riding the bike. The chart note from April 19, 2010 reflects that Claimant presented with complaints that his hip had been bothering him more and was waking him at night. The chart note from April 27, 2010 reflects that Claimant's hip did better with a different type of exercise bicycle. The note from May 25, 2010 reflects that Claimant told his doctor about his hip pain but the doctor did not have an answer. Therefore, for the period March 25, 2010 through June 11, 2010 there is reference to hip discomfort in four of the 31 chart notes. They do not reveal complaints of low back pain or lower extremity numbness. Between January 18, 2011 and April 7, 2011 Claimant was seen at Mountain Home Physical Therapy on 21 occasions. These notes make no reference to complaints of hip or lower extremity discomfort. In all, the Mountain Home Physical Therapy records lend little support to the proposition that Claimant complained of persistent and unrelenting back and lower extremity discomfort at all times following the industrial accident of October 5, 2009. However, these records do denigrate Claimant's other insistence that the medical records do not contain reference to low back complaints either because (1) he only told physicians about his most significant complaint; or (2) Dr. Reedy counseled Claimant to withhold discussion of the low back until Claimant's neck/upper

extremity complaints were dealt with. Nor do the PT notes support the proposition that if Claimant was seeing a particular provider for his neck or upper extremity complaints, he would not discuss any other complaints he was having with such provider.

76. As noted, Dr. Reedy has reported that Claimant told Dr. Reedy in December of 2011 that he (Dr. Reedy) had advised Claimant back in January of 2010 that Dr. Reedy would concentrate first on Claimant's neck problem, and after resolution of the same, attention would be turned to the low back. Dr. Reedy has never endorsed this; he has only reported that this is what Claimant has said. That the narrative proposed by Claimant to Dr. Reedy in December of 2011 does not accurately represent a discussion had between Dr. Reedy and Claimant in January of 2010 is perhaps best demonstrated by Dr. Reedy's letter of November 18, 2010 to PA McCready. By that time, Claimant was thought to be medically stable following his cervical spine fusion performed by Dr. Reedy. However, rather than take-up the next of Claimant's complaints, i.e. his low back, which had been held in reserve pending resolution of Claimant's cervical spine condition, Dr. Reedy released Claimant from his care. (Clt. Ex. 5, p. 164)

77. Claimant saw Dr. Harris for the purposes of an IME. Dr. Harris was not designated to treat Claimant for his back, shoulder, or any other condition. Claimant was invited to describe the nature and extent of the complaints he related to the work accident and low back complaints were not among those described. Claimant treated with Dr. Clawson for his left upper extremity, yet in November of 2011 shared with Dr. Clawson the low back complaints he was having. In short, Claimant's explanation for the failure of the medical record to document persistent and unrelenting complaints in the low back is not persuasive. The record better supports the proposition that Claimant suffered from periodic, but not unrelenting, low back and lower extremity discomfort between October 6, 2009 and the late fall of 2011, just as he had

suffered from periodic bouts of low back pain in the years prior to October 6. 2009. The opinions of Dr. Reedy, Dr. Hammond, and Dr. Hajjar are all premised on the assumption that Claimant's low back symptomatology increased precipitously following the industrial accident. This assumption is important because it provides support for the proposition that Claimant's objective degenerative changes were more likely-than-not aggravated by the subject accident. Otherwise, how is one to explain the sudden and precipitous worsening described by Claimant? Absent this underlying assumption there is little-to-no support for the proposition that the objective changes noted on radiology studies are, in some respect, referable to the subject accident. As described by Drs. Hammond, Montalbano, and Reedy, Claimant's lumbar spine films demonstrate degenerative findings with no clear evidence of an acute injury which could be related to the subject accident. For these reasons, Claimant has failed to establish that his low back condition is causally related to the subject accident.

Further Findings and Discussion Relating to Neck, Left Upper Extremity, and Right Knee

78. As initially explained, the parties are in agreement that Claimant's cervical spine, left shoulder, left ulnar nerve, and right knee injuries are causally related to the accidents of 2009 and 2013. There remains the issue of Claimant's disability referable to these compensable conditions.

79. Dr. Reedy released Claimant to return to work without restriction on May 20, 2010. (Clt. Ex. 5, p. 161). He continued to follow Claimant during Claimant's treatment with Dr. Clawson and Dr. Hessing. By June of 2011, Claimant presented with complaints of experiencing acute cervical discomfort after he tilted his head and felt a "pop" in his neck. Follow-up MRI evaluation did not reveal anything untoward although Dr. Reedy did comment on persistent foraminal encroachment at the C6-7 level. On December 10, 2011, Claimant

presented to Dr. Reedy with continuing complaints of having difficulty turning his neck, more so on the left than the right. Dr. Reedy did not believe that Claimant's situation could be improved by further surgery, but recommended that Claimant obtain a second opinion. (Clt. Ex. 5, p. 166). Dr. Reedy has not seen Claimant since December 5, 2011, and, despite Claimant's recurrent cervical spine complaints, did not ever revise his release to return to work without restrictions, at least not until he received a copy of the September 25, 2015 FCE performed by PT Wright. On November 2, 2015, nearly four years after he last saw Claimant, Dr. Reedy expressed his full agreement with the restrictions proposed by PT Wright and the apportionment of those restrictions between Claimant's cervical spine/upper extremity complaints and his low back condition. (Clt. Ex. 5, p. 182). Concerning the impairment referable to Claimant's cervical spine condition, Dr. Reedy deferred to the rating proposed by Dr. Harris. (Clt. Ex. 5, p. 173).

80. Dr. Hessing, who performed Claimant's left shoulder surgery, was aware of Claimant's work as a farm laborer. (Clt. Ex. 8, p. 415). Following surgery, he gave Claimant a 5% upper extremity rating and released Claimant to return to work at his preinjury job without restrictions. (Clt. Ex. 8, p. 445).

81. Dr. Clawson, who performed Claimant's ulnar nerve surgery, released Claimant to return to work without restrictions, and without reference to residual impairment, on January 11, 2011.

82. Claimant was first seen by Miers Johnson, M.D., for treatment of his right knee, on September 11, 2013. Dr. Johnson's note of that date reflects that Claimant described working as a farm laborer, without restrictions, although he did complain of some lower extremity and low back difficulties. Following the right knee arthroplasty performed by Dr. Johnson, he noted, on July 14, 2014, that Claimant was doing quite well vis-à-vis the right knee:

> He seldom has trouble with the knee except maybe the next day after physical therapy and if he tries to kneel on his kneecap. He is driving a tractor and otherwise doing his job. He has trouble walking on uneven ground. He is able to walk, but has trouble when he is on his feet for very long periods of time. Most of this seems secondary to his back. . .

(Clt. Ex. 13, p. 522). On September 22, 2014 Claimant was released from care by Dr. Johnson with these comments:

> Patient can work full duty. I have no restrictions regarding his walking with his total knee. His biggest problem seems to be sciatica and should be re-evaluated by the spine surgeon.

(Clt. Ex. 13, p. 524). Dr. Johnson did not offer impairment rating for Claimant's right knee arthroplasty. In this regard, he deferred to Dr. Shoemaker.

83. Dr. Shoemaker saw Claimant for the purposes of evaluation on October 6, 2014. Dr. Shoemaker noted Claimant's pre-existing right knee surgeries, as well as the surgery performed by Dr. Johnson. He gave Claimant a 21% impairment rating of the lower extremity based on Claimant's good surgical outcome and the fact that Dr. Johnson did not deem it necessary to provide Claimant with any permanent restrictions. Dr. Shoemaker apportioned one-half of the 21% lower extremity rating to Claimant's documented pre-existing right knee problems. (See Clt. Ex. 14, pp. 539-540). In his report, Dr. Shoemaker referenced a separate "activity status report" which he prepared, and which discussed work restrictions/precautions applicable to Claimant. However, that document is not contained in the record.

84. At the instance of Defendants, Claimant was evaluated by Dr. Harris following Claimant's release by Drs. Hessing, Clawson, and Reedy. To Dr. Harris, Claimant described the requirements of his job and indicated that as of August 15, 2011 he was performing this work without physician-imposed restrictions. (Clt. Ex. 20, p. 614). Claimant complained of neck and upper extremity discomfort, but no low back/lower extremity difficulties. Dr. Harris gave

Claimant a 6% whole person rating for his cervical spine, concurred with Dr. Hessing's 5% upper extremity rating for the left shoulder and awarded no impairment for the left ulnar nerve transposition surgery performed by Dr. Clawson. (Clt. Ex. 20, pp. 617-618). Concerning permanent limitations/restrictions, Dr. Harris offered the following:

> At this point, Mr. Ayala has no work restrictions as noted by the treating physicians in this case and I would agree that he should use caution in overhead activities and heavy lifting, although no permanent restrictions are given or suggested.

(Clt. Ex. 20, p. 618).

85. Claimant's counsel referred Claimant to Brian Wright, DPT, for the purpose of a functional capacities evaluation. In his cover letter, Counsel cautioned PT Wright that because Claimant's low back condition might ultimately be determined to be unrelated to the 2009 accident, it would be important for PT Wright to distinguish between limitations/restrictions referable to Claimant's right knee/neck/left upper extremity injuries and his low back condition. (See Clt. Ex. 23, pp. 656-659). PT Wright performed this functional capacity evaluation on September 25, 2015. PT Wright noted that Claimant participated in the evaluation with "full objective signs of maximum effort and cooperation." He also noted that "between similar functional tests, client consistently performed as expected and these findings correlated well with each other." PT Wright did not have access to the job site evaluation prepared by the ICRD. He relied on Claimant to describe the functional components of his job, and this informed his ultimate conclusion that the physical abilities demonstrated on exam constituted a significant barrier to Claimant's performance of his job. Per PT Wright, the limitations referable to Claimant's specific areas of injury are as follows:

> 1. Cervical spine/neck, status-post microdiskectomy and fusion by Dr. Reedy - This particular presentment is responsible for the limitations in the following

> functional categories: Waist to floor lifting, waist to crown lifting, lift-carry, elevated activity and forward bend - stand activities.
>
> 2. Left upper extremity, status -post left ulnar nerve neurolysis, anterior subcutaneoustransposition by Dr. Clawson. This particular presentment is responsible for the limitations in the following functional categories: Waist to floor lifting, waist to crown lifting, lift-carry and elevated activity.
>
> 3. Left shoulder, status-post arthroscopic subacromial decompression, distal claviculectomy, labral and joint debridement with rotator cuff repair by Dr. Hessing. This particular presentment is responsible for the limitations in the following functional categories: Waist to floor lifting, waist to crown lifting, lift-carry and elevated activity.
>
> 4. Right knee, status-post right TKA by Dr. Johnson. This particular presentment is responsible for the limitations in the following functional categories: Walking (low back is contributing 20-40% of this in my opinion), Waist to floor lift (low back is contributing 20-40% to this), lift-carry (10-20% contribution from low back), forward bend - stand (20-40% contribution) and sitting (60-80% contribution from the low back).
>
> 5. Low back / lumbar spine, currently presenting as non-surgical. This particular presentment is responsible for the limitations in the following functional categories: Walking (low back is contributing 20-40% of this in my opinion), Waist to floor lift (low back is contributing 20-40% to this) lift-carry (10-20% contribution from low back), forward bend - stand (20-40% contribution) and sitting (60-80% contribution from the low back).

(Clt. Ex. 23, p. 647).

86. Concerning his findings relating to Claimant's low back, PT Wright did not explain his conclusion that 20-40% of Claimant's waist-to-floor lifting limitation should be attributed to Claimant's low back condition. For example, does this mean that since Claimant was found to be capable of occasional waist-to-floor lifting in the range of 15 pounds, subtracting out the low back condition's contribution to this limitation would result in increasing Claimant's waist-to-floor lifting by 20-40%? Neither Mr. Jordan nor Dr. Collins were able to offer any insights on this question, and PT Wright was not deposed.

87. In summary, there is general agreement that Claimant has the following impairments referable to his industrial injuries: cervical spine – 6% of the whole person; left shoulder – 5%; upper extremity; ulnar nerve transposition – 0%; right knee – 21%; lower extremity -- 50% attributable to pre-existing condition, 50% referable to 2013 accident. Claimant's low back condition is not deemed stable and ratable.

Vocational Testimony

88. William Jordan conducted a forensic vocational evaluation of Claimant at the instance of Defendants. His report reflects that Claimant has been employed primarily as a farm laborer/foreman since approximately 1990. Since 1999, Claimant has been employed by Meyers Farms. Social Security earnings records reflect a steady annual increase in earnings since 1999, the only exception being the years 2009, 2010, and 2013, when Claimant lost time from work referable to his work-related injuries. In 2008, for example, the year preceding the 2009 accident, Claimant earned $24,170. In 2015, Claimant's earnings are reported at $42,911. Mr. Jordan had the opportunity to interview both Claimant and Robert Meyers, the principal of Meyers Farms. Per Mr. Meyers, Claimant is a good worker who Meyers expects to retain as an employee, notwithstanding that Claimant has been forced to modify how he performs his work as farm foreman. From Mr. Meyers, Mr. Jordan recorded the following:

> Mr. Meyers indicated that he was aware that the Claimant has modified his work activities so that he does less lifting: he estimated that the Claimant probably lifts a maximum of 50 pounds. He uses equipment for lifting, can get help with lifting or he can delegate heavier lifting to the other two employees. The Employer stated that the Claimant still does about all of the same job tasks that he has always done - he just goes about it a little differently.
>
> Mr. Meyers indicated that the Claimant possesses knowledge that is helpful on the farm. He gave the example of how they draw water out of the river using pumps. The 14 pivots that they use for irrigating have to be balanced to manage the use of the water. The Claimant is in charge of this task.

> Mr. Meyers reiterated that he is not planning on terminating the employment relationship with the Claimant as he continues to be productive, although he noted that he has heard through some of the chemical distributors that the Claimant has been considering quitting. Mr. Meyers is aware that the Claimant is getting older, and is approaching full Social Security Retirement age (approximately within the next year).

(Def. Ex. 9, pp. 207-208). Mr. Jordan also elicited from Claimant, Claimant's sense of his functional abilities. Per Mr. Jordan, Claimant's sense of what he can do from a functional standpoint is somewhat more generous than the maximum functional capabilities outlined by PT Wright. Mr. Jordan noted that Claimant has a fund of agricultural skills valuable to his current employer, and to other similarly-situated employers. Mr. Jordan's report illustrates the importance of understanding the extent and degree of Claimant's limitations/restrictions: absent limitations/restrictions, as might be suggested by the work releases of Drs. Hessing, Clawson, Harris, and Johnson, Claimant has suffered no disability as a consequence of the work injuries since he has no functional limitations that would impede his ability to engage in gainful activity. On the other hand, Mr. Jordan acknowledged that if one accepts the limitations/restrictions identified in the September 2015 FCE, Claimant has suffered significant loss of his ability to engage in gainful activity as compared to the labor market access he enjoyed prior to the 2009 accident. Based on Claimant's status as an able-bodied individual, and taking into account his relevant non-medical factors, Mr. Jordan proposed that Claimant had access to approximately 17% of his labor market prior the 2009 accident. However, assuming the limitations/restrictions identified in the September 2015 FCE, Claimant has lost 62% of his pre-injury labor market with an anticipated wage loss of 32%. Employing a convention frequently utilized by vocational rehabilitation experts, Mr. Jordan proposed that the limitations/restrictions outlined in the FCE, coupled with Claimant's non-medical factors, yield disability in the range of 47%, inclusive of PPI. (62 + 32 = 94 ÷ 2 = 47).

89. Nancy Collins, Ph.D., was engaged by Claimant's counsel to perform a forensic vocational assessment of Claimant's residual employability following the subject accidents. Her report appears at Claimant's. Exhibit 32. She reviewed medical records, interviewed Claimant, and undertook an assessment of Claimant's employability. Her report reflects that the subjective complaints described by Claimant have been consistent. Over time she noted that none of Claimant's treating physicians, with the exception of Dr. Reedy, felt that Claimant required any physician-imposed limitations/restrictions following his dates of medical stability. Even Dr. Reedy initially proposed no limitations/restrictions. Dr. Collins did note that the FCE imposed significant restrictions, and these were generally adopted by Dr. Reedy and Claimant's expert, Dr. Hammond. Dr. Collins also took a detailed history from Claimant concerning his subjective sense of what he can and cannot do. Claimant's subjective sense of his functional abilities is much more consistent with the FCE than it is with the opinions of his treating physicians. Generally speaking, Dr. Collins found that the FCE results are consistent with the ability of Claimant to perform limited light-duty work. Per Dr. Collins, Claimant's skills are as a farm laborer and foreman. He also has supervisory skills and some skills in operating/repairing farm and irrigation equipment. Although Dr. Collins did not perform an analysis of Claimant's percentage access to his labor market on a pre-injury basis, she did conclude that based on Claimant's age, education, work experience, and other non-medical factors, he was best suited to working as a farming supervisor, agricultural equipment operator, farm worker/laborer, or landscaper/grounds keeper.

90. As did Mr. Jordan, Dr. Collins acknowledged that absent functional limitations/restrictions, Claimant has suffered no loss of earning capacity as a consequence of the subject accidents. However, considering the limitations/restrictions suggested by the FCE, led

Dr. Collins to propose that Claimant is totally and permanently disabled at present. Although Dr. Collins acknowledged that she did not understand how to apply PT Wright's attempt to subtract low back limitations from the totality of Claimant's limitations, she believes that even if Claimant's low back restrictions are not considered, Claimant is totally and permanently disabled by virtue of his knee, neck, and left upper extremity limitations. Dr. Collins is of the opinion that were it not for Claimant's "superhuman" effort, and the accommodation offered by a "sympathetic employer," Claimant would not be employed at this time, and absent his current job, he is, essentially, totally and permanently disabled. On the matter of the effort Claimant has gone to in order to retain employment, Dr. Collins noted that he has been forced to delegate work he can no longer perform to his subordinates, and to work longer hours in order to accomplish the things he can still do. At the time of her post-hearing deposition Dr. Collins acknowledged that if Claimant has no limitations/restrictions, he has no disability. However, Dr. Collins did not consider this assumption in formulating her opinion. Her concluding remarks make it clear that it is her opinion that Claimant is 100% disabled but for the one job he is currently performing for an accommodating and sympathetic employer.

Discussion and Further Findings Relating to Claim of Disability

91. Claimant contends that he is totally and permanently disabled under the odd-lot doctrine. Defendants contend that Claimant has suffered no disability, but if he has, it is less than total and permanent. Moreover, Defendants contend that Claimant's less-than-permanent and total disability must be apportioned between the subject accident and a pre-existing condition pursuant to the provisions of Idaho Code § 72-406.

92. "Permanent Disability" or "under a 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. (See Idaho Code § 72-423). The evaluation of permanent disability is an appraisal of the injured worker's present and probable future ability to engage in gainful activity as it is affected by the medical factor of permanent impairment and by permanent non-medical factors as set forth at Idaho Code § 72-430. (See Idaho Code § 72-425). The test for determining whether a claimant has suffered a permanent disability greater than permanent impairment is whether the physical impairment, taken in conjunction with non-medical factors, has reduced the claimant's capacity for gainful employment. *Graybill v. Swift & Co*., 115 Idaho 293, 766 P.2d 763 (1988). The focus of a determination of permanent disability is on the claimant's ability to engage in gainful activity. *Sund v. Gambrell*, 127 Idaho 3, 896 P.2d 329 (1995).

93. The labor market to be considered in evaluating Claimant's disability is ordinarily the labor market in which Claimant resides as of the date of hearing. *Brown v. The Home Depot*, 152 Idaho 605, 272 P.3d 577 (2012). Whether Claimant has a permanent disability is a question of fact, and Claimant bears the burden of proving that he has suffered disability in excess of impairment. *Boley v. State Industrial Special Indemnity Fund*, 130 Idaho 278, 989 P.2d 854 (1997). An odd-lot worker is one who is so injured that he is unable to perform services other than those limited in quality, dependability or quantity, such that a reasonably stable market for such services does not exist. *Boley v. State Idaho Special Indemnity Fund*, *supra*. An odd-lot worker need not be physically unable to do anything worthy of compensation, but he does need to demonstrate that he is so handicapped that he will not be employed regularly in any well-known branch of the labor market absent the business boom, the sympathy of a particular employer or friends, temporary good luck, or superhuman effort on his part. *Lyons v. Industrial Special Indemnity Fund*, 98 Idaho 403, 565 P.2d 1360 (1977).

94. Claimant bears the burden of adducing proof sufficient to establish, on a *prima facie* basis, his odd-lot status. A claimant may prove odd-lot status by showing that he has unsuccessfully attempted other types of employment, that he, or a vocational expert on his behalf, has searched for other work but other work is not available, or that any efforts to find suitable employment would be futile. *Boley v. State Industrial Special Indemnity Fund, supra*.

95. Once a claimant has satisfied his burden of proving a *prima facie* case of odd-lot status by one of the three aforementioned methods, the burden of proof shifts to the employer to prove claimant's employability. *Hoye v. Daw Forest Products, Inc.*, 125 Idaho 582, 873 P.2d 836 (1994). Employer cannot meet this burden merely by showing that claimant is able to perform some type of work. *Lyons v. State Industrial Special Indemnity Fund, supra*. Rather, Employer must show that there is an actual job within a reasonable distance from Claimant's home which he is able to perform or for which he can be trained that he has a reasonable opportunity to be employed at that job. *Lyons, supra*.

96. Apportionment of disability, while not at issue in this case if Claimant is adjudged totally and permanently disabled, is at issue in the event the Commission determines that Claimant is not totally and permanently disabled. Idaho Code § 72-406(1) provides:

> 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.

Under this section, and *Page v. McCain Foods, Inc.*, 145 Idaho 302, 179 P.3d 265 (2008), where apportionment is at issue in a less-than-total case, a two step process must be employed. First, claimant's disability must be evaluated in light of all physical impairments resulting from the

industrial accident, and any pre-existing conditions. Thereafter, the amount of permanent disability attributable to the industrial accident(s) must be apportioned.

97. As noted above, evaluation of Claimant's disability depends, in the first instance, on making some judgment about the extent and degree to which Claimant has permanent limitations/restrictions. Here, Defendants argue that because neither Drs. Reedy, Clawson, Hessing, or Harris initially imposed any restrictions on Claimant at medical stability, and, in fact, released him to return to a job that they probably knew was fairly onerous, Claimant has no disability in excess of impairment. On the other hand, Claimant argues that the limitations/restrictions identified in the September 2015 functional capacities evaluation are a much more accurate portrayal of Claimant's ability to engage in physical activities, and these limitations/restrictions support a conclusion that Claimant is totally and permanently disabled.

98. There is evidence to support a finding that Claimant has no physical limitations/restrictions relating to his right knee, neck, left shoulder, and ulnar nerve transposition. Drs. Clawson, Hessing, Reedy, Harris, and Johnson have all rendered opinions that support this conclusion. Only Dr. Reedy has changed his mind, but his conclusion is subject to criticism because he had not seen Claimant for nearly four years prior to his wholesale adoption of the FCE findings. However, when last seen by Dr. Reedy on December 5, 2011, Claimant was no longer enjoying good relief from cervical spine surgery previously performed by Dr. Reedy. In fact, Dr. Reedy recommended a second opinion in an effort to better understand Claimant's recurrent cervical spine problems. As well, by December 2011, Dr. Reedy was aware that Claimant was having low back problems which would go on to be evaluated by Dr. Hajjar. Following December of 2011, Dr. Reedy was updated on Claimant's status by Claimant's counsel, especially regarding Claimant's progress with lumbar spine

evaluation. Therefore, even though Dr. Reedy had not seen Claimant since December 5, 2011, it is possible that he was well enough apprised of Claimant's status to embrace a set of restrictions without the need to see Claimant for confirmation. Regardless, Dr. Reedy's enthusiastic embrace of the FCE is the weakest evidence of its legitimacy.

99. The FCE has also been explicitly endorsed by Dr. Hammond. Dr. Hammond testified to his general agreement with the recommendations of the FCE, even though neither did he understand PT Wright's reasoning in apportioning low back limitations the way he did. In fact, Dr. Hammond testified that probably more of Claimant's limitations relating to sitting and walking are related to the lumbar spine condition. (Hammond Depo., pp. 50:19-51:12). Even though Claimant had been released by Dr. Reedy for his cervical spine, Dr. Hammond did not quarrel with the FCE results which suggested that Claimant continued to have significant neck and upper extremity difficulties. (Hammond Depo., pp. 52:10-56:2). In fact, Dr. Hammond reported that Claimant still had complaints of cervical spine pain when he evaluated Claimant in August of 2016. However, Dr. Hammond's August 1, 2016 office note reflects the following about the history he received from Claimant concerning his neck and upper extremity:

> Dr. Reedy did surgery on his neck and he says he has some decreased limitation but no other significant pain. His left shoulder feels well and occasionally is stiff but he can pretty much do everything he wants with this. There was also the left ulnar nerve difficulty. This was transposed and he has a little bit of numbness into his palm of his left hand, but there was no difficulty with grip or using the left arm or hand otherwise.

(Clt. Ex. 24, p. 569A). The record also contains medical records from the GFHC entered contemporaneous with the September 2015 FCE. On September 1, 2015, Claimant was seen by Dr. Ensminger at the GFHC, for complaints of left knee pain which Claimant related to work that Claimant was doing during potato harvest which required him to work bent over or kneeling. Dr. Ensminger noted that Claimant's artificial knee (on the right) was doing well. Finally, it was

noted that Claimant's degenerative disc disease of his neck and low back were "stable." On physical exam, no spinal tenderness or misalignment was noted. Spine range of motion was normal. Paraspinal muscle strength and tone was within normal limits. Concerning Claimant's left upper extremity, no tenderness was noted to palpation. Claimant's shoulder, elbow, and wrist joint were stable. He had normal range of motion, without crepitus or pain in the left upper extremity.

100. Dr. Hessing's note from August of 2016, and more particularly, Mark Ensminger's, M.D., note from September 2015 are not entirely consistent with Claimant's presenting complaints on the occasion of the September 25, 2015 FCE. To PT Wright, Claimant made the following pain report:

> Reported discomfort in the lumbar spine, knee, shoulder and cervical spine was part of the reason for limitations with lifting, carrying, elevated activity, crouching or low level activity, walking, forward bending. Objective signs coincided with the Client's reports of discomfort.

(Clt. Ex. 23, p. 646). On exam, Claimant was noted to have decrease in neck and left shoulder range of motion, inconsistent with the September 1, 2015 findings by Dr. Ensminger.

101. On the other hand, to Defendants' criticism that the FCE must be invalid because greater problems are noted with Claimant's unaffected extremities, i.e. the right shoulder and the left knee, is nonsensical. Claimant's left shoulder was surgically repaired, as was his right knee. Claimant has documented left knee arthritis, and it would be unsurprising if a manual laborer of his age also did not have right shoulder arthritis. That Claimant's surgically-addressed extremities exhibit less severe findings than his contralateral extremities does not cause the Commission to question PT Wright's examination. After all, if the surgeries were not intended to improve Claimant's function or reduce his pain, there would be little purpose in doing them. Defendants also criticize PT Wright's report because validity testing, measured in what

Defendants call the customary manner, is not identified in PT Wright's report. This criticism is rejected because PT Wright has clearly expressed his conclusion that in performing Claimant's evaluation PT Wright was satisfied that Claimant gave full effort, and that the test results are consistent with this conclusion. Nothing in PT Wright's report suggests that it should be discounted because Claimant was consciously manipulating the evaluation.

102. Finally, the Commission is impressed by the fact that Employer is obviously aware that Claimant does not retain the same physical ability he had prior to the 2009 accident. The Employer is aware that Claimant has physical limitations/restrictions and that he has found a way to accommodate his limitations by assigning more tasks to his subordinates. There is nothing in the Employer's testimony that would support the conclusion that Claimant is now just as physically capable as he was prior to the October 6, 2009 MVA.

103. Claimant continued to have cervical spine complaints after being released to full duty by Dr. Reedy; Dr. Reedy's notes confirm it. Claimant's ulnar nerve transposition does not seem to have resulted in any limitations/restrictions. It is less clear whether or not Claimant has continued to have left shoulder complaints following Dr. Hessing's surgery, and the dissonance between Dr. Ensminger's September 1, 2015 office note and the nearly contemporaneous FCE is troubling. Further, by his own statements to Mr. Jordan, Claimant appears to be able to engage in physical activities somewhat more onerous than those described in the FCE.

104. In summary, while it is certainly possible to challenge certain aspects of the FCE, it is a better prognosticator of Claimant's limitations than the choice offered by Defendants' suggestion that Claimant has no physician-imposed limitations/restrictions, and therefore no disability.

105. Therefore, the FCE will be used as a guide to evaluating Claimant's disability from all causes combined.

106. Having determined that the September 2015 FCE provides the best snapshot of Claimant's functional limitations/restrictions, it is next necessary to evaluate how those limitations/restrictions, in conjunction with Claimant's relevant non-medical factors, affect his ability to engage in gainful activity. Per the two-step process envisioned by *Page v. McCain Foods, supra*, attention is first directed to understanding Claimant's disability from all causes.

107. As reflected in his testimony, and in the reports and testimony of Dr. Collins and Mr. Jordan, Claimant is an older worker of Hispanic extraction who, while bilingual, has limited education and limited ability to read and write in either English or Spanish. He has limited computer skills, but is able to use a computer to perform some parts of his current job, i.e. searching for replacement parts. He has some transferable vocational skills; he can weld, and has some abilities relating to repair and maintenance of farm and other equipment. He also has abilities in the area of heavy equipment operation. As foreman at Meyers Farms, he has necessarily acquired some skills as a supervisor; he supervises and delegates work to two subordinates. Claimant's past relevant work experience has largely been in the agricultural field, although he has done some work in the remote past in a manufacturing environment. Based on his job at Meyers Farms, Claimant has a demonstrated ability to assume responsibility for the day-to-day operation of a relatively large farming operation. His skills are somewhat unique to the Meyers Farm's operation; the Bruneau Farm has unique soil characteristics which make irrigation challenging.

108. Mr. Jordan proposed that on a pre-injury basis, Claimant had reasonable access to 17% of the jobs in his geographic locale. Dr. Collins did not quantify Claimant's pre-injury

access to his local labor market, but proposed that based on Claimant's non-medical factors, he would have access to agricultural and landscaping-type work absent physical limitations. These assessments seem reasonable and not inconsistent.

109. Mr. Jordan and Dr. Collins part ways, however, when it comes to the impact of Claimant's current functional status on his employability. With no explanation other than his reliance on OASYS software, Mr. Jordan opined that assuming the FCE recommendations, and further assuming that Claimant loses his current employment with Meyers Farms, Claimant has suffered 62% loss of access to his pre-injury labor market. Mr. Jordan also calculated a 32% wage loss based on his belief that even with the limitations/restrictions derived from the September 2015 FCE, Claimant has access to work paying in the range of $8.00 per hour. An $8.00 per hour hourly wage in the labor market at large seems reasonable for any job that Claimant might obtain in light of his current limitations/restrictions.

110. The real issue is whether there are in fact suitable jobs for Claimant within his limitations/restrictions. In his report, Mr. Jordan did not articulate the types of employment that Claimant could compete for, assuming the limitations/restrictions outlined in the FCE and in Dr. Hammond's testimony. However, in the course of his deposition, Mr. Jordan did offer some comments on the types of employment he believed Claimant could still compete for in his labor market should he lose his job with Meyers Farms. Mr. Jordan thought that Claimant's light-duty restrictions would enable him to perform the physical requirements of a greeter, car porter at a car dealership, security work, shuttle bus driving, school bus driving, sandwich making, job coach monitor, pizza deliveryman, and sorter. (Jordan Depo., pp. 53:24-54:6). Mr. Jordan was uncertain with what frequency jobs of these types become available in Claimant's labor market. On cross examination, Mr. Jordan admitted that some aspects of school driving, sorting, and

security jobs might be in excess of what is contemplated by the FCE. (Jordan Depo., pp. 160:20-168:9). While it is probably true that Claimant can perform some, or even most, of the jobs described by Mr. Jordan, there was little evidence about the number of jobs in the labor market that remain for Claimant in his geographic area.

111. Certainly, this was Dr. Collins' concern. She proposed that in view of the limitations/restrictions identified in the FCE, and elaborated-on by Dr. Hammond, Claimant is essentially unemployable in his geographic area, particularly when one takes into account the fact that he is relatively unsophisticated, has minimal reading/writing skills, and was 65 years of age as of the date of hearing. Dr. Collins acknowledged, of course, that Claimant has continued to work for Employer since the subject accident, but she contends that he has required a great deal of accommodation by his employer, that Claimant must make a "superhuman" effort to continue in his current job and that the Employer is a "sympathetic employer." These factors lead Dr. Collins to conclude that even though Claimant is currently employed, this fact does not denigrate her conclusion that he is nevertheless totally and permanently disabled. However, Dr. Collins had a poor understanding of the actual physical requirements of Claimant's current job, and an equally poor understanding of to what extent Claimant required the assistance of other workers to perform this work. (Collins Depo., pp. 78:6-80:25; 84:20-92:5). Dr. Collins' uncertainty about the specific requirements of Claimant's current position, coupled with her uncertainty of whether or how Claimant finds a way to perform this work, denigrates her conclusion that Claimant is only able to continue working in his current job because of his superhuman effort. Claimant has the ability, endorsed by his Employer, to delegate work to his subordinates as necessary. Therefore, Claimant is not required to perform physical tasks which are too difficult for him. While it's true that Claimant now takes longer to perform certain work,

and now performs some of his work with more difficulty than he once did, the record does not support the conclusion that it is only by dint of superhuman effort that Claimant is able to continue in his current job.

112. Relatedly, the record does not support the conclusion that Meyers Farms is a "sympathetic" employer. Morgan Meyers' testimony is that Claimant is a valuable employee who has a peculiar knowledge of Employer's operation such that his loss an almost untenable proposition for Employer. This sentiment is perfectly expressed in Morgan Meyers' observation that "we would be in a panic if he were gone." (Tr., pp. 189:24-190:1). The record supports the conclusion that the job Claimant performs is real and that his service is valuable, perhaps essential, to Employer's business. However, Claimant's ability to perform his current job and his value to his current employer is not necessarily inconsistent with a finding that Claimant is totally and permanently disabled under the odd-lot doctrine. In other words, in the presence of proof that Claimant is not "regularly employable in any well know branch of the labor market," the conclusion that Claimant is totally and permanently disabled under the odd-lot doctrine via the route of futility (his only available route) would not be foreclosed by the fact that he is demonstrably employable. After all, an odd-lot worker need not be unable to perform <u>any</u> work at all. *Gooby v. Lake Shore Management Co.*, 136 Idaho 74, 29 P.3d 390 (2001). However, Claimant's current job is nevertheless relevant, because once Claimant establishes, by *prima facie* evidence, that he is an odd-lot worker, the burden shifts to the Employer to demonstrate employability. Employer must show that there is an actual job within a reasonable distance from Claimant's home which he is capable of performing, and which he has a reasonable opportunity to obtain. Claimant's current job more than satisfies Employer's obligation to rebut a *prima facie* case of total and permanent disability. There is no reason to believe that Claimant's job

will not continue, or that he will be unable to perform the requirements of that job until he decides to retire.

113. Based on the foregoing, even if Claimant had met his burden of proving a *prima facie* case of odd-lot status, Defendants have clearly met their burden of proving that Claimant is capable of performing an actual job which is likely to continue. However, the evidence does establish that Claimant nevertheless suffered disability as a consequence of his limitations/restrictions. Defendants' argument that Claimant's disability must be assessed at zero because Claimant continues in his employment with Employer is rejected; this argument ignores Claimant's significant limitations/restrictions and the consequences of those restrictions on his ability to engage in gainful activity. However, the fact that Claimant has engaged in continuous employment since 2009, with significant annual increases in earnings, must be taken into account. These facts set up the central conundrum of evaluating Claimant's disability: the fact that in the labor market at large he has suffered a significant loss of access must be reconciled with the seeming likelihood that Claimant will never suffer the financial impact of his disability.

114. Claimant's age is, of course, one of the nonmedical factors which must be considered when evaluating his disability under Idaho Code § 72-430. In many cases, the fact that a claimant is an older worker is a factor which tends to support higher disability; everything else being equal, employers are less inclined to hire an older worker, particularly one with some functional limitations. In this case, Claimant's status as an older worker has the opposite effect. If Claimant was 20 years of age, the Commission would be much less impressed by the fact that Claimant has a job for which he is well suited, and an Employer who values his service. A lot could happen in the forty or fifty years remaining in such an employee's work life. Here, though, Claimant is near the end of his work life and holds employment in which he is likely to remain

until he retires. This makes the fact of Claimant's current job much more significant in evaluating his disability.

115. Based on the foregoing, the Commission concludes that absent Claimant's current employment, his disability, as of the date of hearing, would be profound, and possibly total and permanent under the odd-lot doctrine. However, the fact that Claimant's current employment is likely to continue at his current or higher wage must be taken into account. Based on these facts, Claimant's proven disability is 40% of the whole person, inclusive of impairment. Even though Claimant may never suffer a wage loss, there is no dispute that the accident has left him without access to a large swath of his pre-injury labor market, thus constraining his employment options now and in the future, should he, for whatever reason, lose his current job. However, it seems likely that Claimant's current employment will continue. Nor does he seem inclined to change his current situation.

Apportionment

116. Since Claimant is less than totally and permanently disabled and since Claimant's low back condition is not related to his employment, apportionment of disability between Claimant's accident-produced condition and his low back condition under Idaho Code § 72-406 must be considered.

117. Where a claim for disability less than total is before the Commission, so is the issue of whether Employer bears full responsibility for Claimant's disability. See *Page v. McCain Foods, Inc.*, 145 Idaho 302, 179 P.3d 265 (2008). In keeping with *Barton v. Seventh Heaven Recreation, Inc.*, 2010 IIC 0379 (2010), Claimant bears the burden of persuasion on the issue of whether he has suffered disability referable to the subject accident. However, once Claimant makes a prima facie showing in this regard, the burden of going forward with evidence

that some portion of Claimant's disability is, in fact, referable to a pre-existing condition, shifts to Defendants. See *Albright v. MGM Construction, Inc.*, 102 Idaho 269, 629 P.2d 665 (1981); *Keenan v. Brooks*, 100 Idaho 823, 606 P.2d 473 (1980) (Bistline, J., and Donaldson, J. specially concurring).

118. In the instant matter, it is asserted that some part of Claimant's disability is referable to Claimant's non-work related and pre-existing low back condition, because both PT Wright and Dr. Hammond have established that some part of Claimant's limitations against sitting, walking, and perhaps other functions, are referable to his low back condition. No one, including the two vocational experts who were quizzed about the matter, could decide how these opinions, as couched, could be applied to apportion responsibility for Claimant's disability. Nor will the Commission attempt to do so. Defendants have adduced insufficient evidence to allow consideration of how or whether Claimant's 40% disability should be apportioned to Claimant's pre-existing low back condition.

Attorney Fees

119. Claimant argues that because Defendants did not provide certain medical records to Dr. Montalbano and Mr. Jordan, the opinions of Dr. Montalbano and Mr. Jordan are faulty, and it was therefore unreasonable for Defendants to rely on these opinions to defend the claim, such that Defendants are liable for an award of attorney fees under Idaho Code § 72-804. These arguments are not persuasive. There may be several reasons Defendants chose to proceed the way they did, and these reasons do not even include simple oversight. There is insufficient evidence that Defendants had designs on obtaining unsupported opinions on which to rely in defending the claim. The Commission declines to award attorney fees.[5]

[5] Moreover, we note that Claimant's counsel, too, chose what records to provide to the recipients of his several letters.

CONCLUSIONS OF LAW AND ORDER

1. Claimant has failed to establish that his low back condition is causally related to the 2009 accident. Claimant is not entitled to benefits for this condition.

2. Claimant has established that he suffered injuries to his neck, left shoulder, and left upper extremity as a consequence of the accident of October 5, 2009.

3. Claimant has established that he suffered injuries to his right knee as a consequence of the accident of August 28, 2013.

4. As a consequence of the October 5, 2009 accident Claimant has suffered permanent impairment as follows: cervical spine – 6% of the whole person; left shoulder – 5% of the left upper extremity; ulnar nerve transposition – 0%.

5. With respect to the accident of August 28, 2013, Claimant has suffered impairment as follows: right knee – 21% lower extremity, 50% attributable to pre-existing condition and 50% attributable to the 2013 accident.

6. Claimant is not totally and permanently disabled under the odd-lot doctrine, or if he is, Defendants have met their burden of proving that there is an actual job within a reasonable distance from Claimant's home which he is capable of performing.

7. Defendants have failed to come forward with evidence which would support apportionment of disability pursuant to Idaho Code § 72-406.

8. Claimant has suffered disability of 40% of the whole person, inclusive of impairment, referable to the 2009 and 2013 accidents.

9. Claimant is not entitled to an award of attorney's fees under Idaho Code § 72-804.

10. There is no basis for the Commission's retention of jurisdiction over this case.

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

DATED this ___9th___ day of ___April___, 2018.

INDUSTRIAL COMMISSION

_____/s/_____
Thomas E. Limbaugh, Chairman

_____/s/_____
Thomas P. Baskin, Commissioner

_____/s/_____
Aaron White, Commissioner

ATTEST:

_____/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the ___9th___day of ___April_____, 2018, a true and correct copy of the foregoing **FINDINGS OF FACT, CONLUSIONS OF LAW, AND ORDER** was served by regular United States Mail upon each of the following:

L. CLYEL BERRY
PO BOX 302
TWIN FALLS ID 83303

PAUL J. AUGUSTINE
PO BOX 1521
BOISE ID 83701

esl _____/s/_____