BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

DAVID DOMKA, Claimant, v. RUAN TRANSPORTATION, Employer, and INDEMNITY INSURANCE COMPANY OF NORTH AMERICA, Surety, and STATE OF IDAHO, INDUSTRIAL SPECIAL INDEMNITY FUND, Defendants.	**IC 2014-024321** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **Filed February 22, 2019**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee John C. Hummel, who conducted a hearing in Boise on May 23, 2017. Douglas W. Crandall represented Claimant, David Domka, who was present in person. Matthew O. Pappas represented Defendant Employer, Ruan Transportation, and Defendant Surety, Indemnity Insurance Company of North America. Paul J. Augustine represented the State of Idaho, Industrial Special Indemnity Fund (ISIF). The parties presented oral and documentary evidence, took post-hearing depositions, and submitted post-hearing briefs. The matter came

under advisement on August 13, 2018 and was reassigned to the Commissioners on December 24, 2018.

ISSUES

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

1. Whether the industrial accident caused the condition for which Claimant seeks benefits;

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

   a. Medical care; and

   b. Temporary partial and/or temporary total disability benefits.

All other issues are reserved.

CONTENTIONS OF THE PARTIES

On September 10, 2014, Claimant was performing his customary duties as a truck driver for Employer, which consisted of transporting raw milk from farm producers to dairy production facilities in the Treasure Valley. When he stopped his truck on the highway while waiting for another vehicle to make a left-hand turn against traffic, a dump truck crashed into another dump truck behind him and both vehicles rear-ended Claimant's vehicle. Prior to the accident, Claimant had been diagnosed with Crohn's disease which had been treated with a colectomy; he had a stoma and colostomy bag affixed to his stomach.

Claimant alleges that as a result of the industrial accident, he suffered a series of injuries, including a rupture of his stoma that required surgical repair. The surgical repair of the stoma was not without complications and Claimant required extended hospitalization for a month; he alleges that these complications were related to the injury to his stoma caused by the accident.

He seeks medical benefits for the surgery, hospitalization, and ongoing care of his stoma, which he alleges has re-herniated and requires further repair, which should also be covered.

Claimant further alleges that he suffered injuries to his neck, low back, and right knee[1] that are also related to the industrial accident and for which he seeks medical benefits. Claimant also seeks temporary disability benefits covering periods of time in which he was in recovery from these conditions.

While Defendants[2] covered some initial costs of Claimant's medical treatment following the industrial accident, they deny liability for treatment of his various conditions because they allege that they were pre-existing. They argue that Claimant's gastrointestinal difficulties extend back to 2000. Claimant had colorectal surgery in 2011, which resulted in placement of a stoma. After that, Claimant had intermittent prolapse of his stoma. In 1999, Claimant fell on snow or ice and injured his low back. Claimant was involved in an automobile accident in 2003 in which he suffered injuries to his neck and back; he was also diagnosed with a medial meniscus tear as a consequence of the 2003 automobile accident. Claimant continued to complain of pain in all these areas in medical visits prior to the industrial accident. Claimant sustained a fall in March 2010, which injured his left elbow and back. In summary, Defendants argue that the industrial accident neither caused nor aggravated the medical conditions for which Claimant seeks coverage. For these reasons, Defendants argue that Claimant should receive neither medical benefits nor corresponding temporary disability benefits.

[1] The complaint includes injuries to Claimant's "arm," but this was not argued in brief, and it is deemed abandoned.

[2] The collective term "Defendants" herein refers to Employer and Surety. ISIF, while also a party Defendant, shall be referred to as "ISIF."

Employer/Surety filed a complaint against ISIF on December 14, 2016. ISIF joins Defendants in arguing that the medical conditions for which Claimant seeks covered treatment were not caused by the accident.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. Claimant's testimony taken at hearing and at his depositions of December 1, 2015 and March 9, 2017;

2. Claimant's Exhibits A through K, admitted at the hearing;

3. Claimant's Exhibit L; [3]

4. Defendants' Joint Exhibits 1 through 35;[4] and

5. The post-hearing depositions of the following witnesses:

   a. Ronald Kristensen, M.D., taken on May 26, 2017;

   b. Richard Radnovich, D.O., taken on June 1, 2017;

   c. Johnny B. Green, M.D., taken on June 2, 2017;

   d. Samuel Jorgenson, M.D., taken on October 27, 2017;

   e. Rodde Cox, M.D., taken on February 16, 2018; and

   f. Lee M. Kornfield, M.D., taken on February 28, 2018.

All objections preserved in the post-hearing depositions are overruled.

[3] At hearing Defendants objected to admission of Exhibit L because it contained the opinion letter of an expert, Johnny B. Green, M.D., that Claimant's counsel served on opposing parties on May 19, 2017, less than ten (10) days prior to the hearing on March 23, 2017. Ruling on admissibility was reserved until after the post-hearing deposition of Dr. Green. Tr., 5:25-6:21. Defendants' counsel reaffirmed their procedural objection at Dr. Green's deposition on June 2, 2017. Green Dep., 5:7-21. While the letter of Dr. Green contained in Exhibit L was not in compliance with JRP Rule 10(C), Dr. Green had written it only the day before. Furthermore, none of the Defendants have argued in post-hearing briefing or otherwise that the opinions that Dr. Green stated in the letter were prejudicial, and Defendants had a full opportunity to depose him on June 2, 2017. For these reasons, the objection is overruled and Exhibit L is hereby admitted to the record.

[4] These exhibits comprise the joint exhibits of all party Defendants, including Employer, Surety and ISIF.

FINDINGS OF FACT

1. **Claimant's Background; Employment History**. Claimant was born on February 8, 1949 in Stevens Point, Wisconsin. Claimant Dep. (12/1/2015), 6:21-23. He graduated from high school in Wausau, Wisconsin in 1967. *Id*. at 9:9-15. During high school he worked as a farmhand, a busboy, and a groundskeeper/general laborer at golf course and ski resort. *Id*. at 10:5-25. He had other miscellaneous jobs in his youth, including positions as a truck driver, painter, and construction worker. *Id*. at 18:24-19:2. After graduating high school, Claimant worked for Kraft Foods in Wausau as a shipping clerk. *Id*. at 11:16-23. In 1968, he enlisted in the Air Force, in which he served active duty for four years and inactive duty for two years. *Id*. at 12:3-14. After leaving active duty for the Air Force, Claimant returned to work for Kraft Foods in the shipping department in 1972. *Id*. at 14:2-9. He remained in that position for another three years. In 1975, he moved to Idaho, where he resided briefly in Boise, but settled in Meridian. *Id*. at 16:22-17:19.

2. After settling in Idaho, Claimant briefly worked in an electronics shop but found longer-term work in the construction industry. *Id*. at 17:24-18:1; 19:2. He worked for several residential and commercial construction companies performing general construction labor, painting, dry-wall fabrication, and similar tasks, but no electrical or plumbing work. *Id*. at 19:3-20:7. Claimant next operated a sole-proprietorship lawn and landscape business under the trade name "Dave's Green Thumb" for approximately ten years. *Id*. at 20:15-21:2. After closing his lawn business, Claimant went to work as a long-haul truck driver for Willis Shaw Express in 1985. *Id*. at 22:14-19; 27:9. In July 2003, Claimant began working for Dairy Farmers of America (DFA) as a short haul truck driver delivering milk from dairy farm producers to dairies and cheese manufacturers. *Id.* at 36:14-22. After Claimant worked for DFA for approximately five

years, Employer took over the contract for delivering milk for DFA in or about 2008. Claimant Dep. (3/9/2017), 17:17-19:9; Ex 30:1272.

3. **Subject Employment**. Employer hired Claimant effective July 1, 2008. Thereafter, Claimant continued to work for Employer in the same capacity he had worked for DFA, performing the same duties as a truck driver delivering milk from farm producers to dairies and cheese manufacturers. *Id*.

4. Employer's job description for Claimant's position stated his job title as "Driver of Semi-Tractor/Trailer." The physical requirements of the position included the following: "work 65-70 hours per week, within federal guidelines, including nights and weekends;" "pull, twist, bend and lift 75 pounds to shoulder height in loading and unloading process;" "climb in and out of tractor and to top of trailer for inspection;" and "sit and operate a vehicle for up to 10 hours per day." Ex 30:1279.

5. A typical workday for Claimant began at 2:00 a.m. when he arrived at Employer's work yard to prepare his truck and tanker trailer for the day. During the workday he used a 50 foot, 20 pound power cord and also routinely used a fifty pound ladder in the course of loading and unloading the tanker. Generally, he was required to climb on top of and off the trailer at least three to four times per day to accomplish all of his duties associated with transporting raw milk. An entire workday lasted 14 hours and concluded at 4:00 p.m. Tr., 16:1-24:5. Claimant summarized the physical demands of the job as follows: "The whole job entailed climbing up and down ladders and bending over. You had to bend over to get the power cord out for the pump. You had to bend over and open – pull the hose out." *Id.* at 27:4-7. During inclement weather, Claimant also had to pull and place heavy iron chains on the truck tires and use a shovel and heavy bag of rock salt. *Id*. at 13-21.

6. **Prior Medical Conditions and Injuries**.[5] Claimant suffered a left inguinal hernia as a child, which was repaired in 1959. Ex 7:106. Claimant also underwent left ulnar nerve release surgery in 1985. *Id.* In the 1980s, while operating Dave's Green Thumb, Claimant traded lawn services for adjustments from a chiropractor named Jack Long. Claimant Dep. (12/1/15) 45:1-10.

7. While working for Willis Shaw Express, Claimant injured his lumbar spine in an industrial accident on January 13, 1999; he "fell on [his] butt on the ice." Ex 1:1 (notice of injury); Tr., 99:23. In a general checkup with his primary care physician, Peter Giffen, M.D., of St. Luke's Internal Medicine on May 14, 2001, Claimant reported a history of chronic low back pain since the 1999 accident. He told Dr. Giffen that the pain had worsened recently, together with an intermittent sensation of "hot coals" in his left heel and distal leg. Ex 7:105. Dr. Giffen determined that Claimant was "neurologically intact" and advised him that based on his physical exam and history, it was most likely muscular pain. *Id.* at 107. Dr. Giffen further opined that Claimant's heel pain was not a radicular symptom or associated with his back pain. *Id.* At this same visit, Claimant underwent a lateral chest x-ray which showed "mild changes of early degenerative disk disease" in the thoracic spine. *Id.* at 111. At a follow-up visit on June 13, 2001, Claimant's low back pain and heel pain had improved after a course of Vioxx. *Id.* at 118.

8. Claimant sustained another injury in the employment of Willis Shaw Express on February 12, 2003. On this occasion, Claimant was rear-ended while driving for the employer. Ex 2:1-2. The only medical record submitted regarding this accident is a June 23, 2003 return to work form filled out by Michael Gibson, M.D., diagnosing "medial meniscus tear/neck pain/low back pain" and noting Claimant was released back to work without restrictions. Ex 9:207.

[5] Claimant has extensive medical records and co-morbidities.

Claimant also testified to a short course of chiropractic treatments after this injury. *See*, Claimant Dep. (12/1/15) 45:15-23; Claimant Dep. (3/9/2017) 94:1-95:12.

9. Claimant returned to Dr. Giffen on August 30, 2004 for his annual physical. On that date, Claimant reported "intermittent pain in his knees attributed to previously diagnosed meniscal injury" and "intermittent pain in his lower back and neck since a motor vehicle accident in 02/03 that previously benefited from chiropractic treatments and physical therapy." Ex 7:127.

10. Claimant was diagnosed with Crohn's disease in April of 2005 by Robb Gibson, M.D., Claimant's gastroenterologist. Ex 6:21. Dr. Gibson noted under past medical history "degenerative joint disease." *Id.* at 18.

11. At Claimant's December 12, 2005 annual exam, Dr. Giffen noted pain in Claimant's knees, right side worse than left with occasional giving way, which he suspected was caused by osteoarthritis. Dr. Giffen charted that Claimant's knees were previously evaluated and that Claimant had been "advised to undergo arthroscopic surgery." He also noted Claimant had intermittent low back, wrist, ankle, and right index finger pain, all stable and tolerable. Ex 8:156-158.

12. On March 6, 2006, Claimant underwent a pelvis CT scan which showed "bilateral sacroiliac joint osteoarthritis change/ankylosis." Ex 6:31. On June 20, 2006, Claimant underwent surgery to repair a right inguinal hernia. Ex B:108. On December 12, 2006, Claimant reported intermittent tingling and numbness in his left 5th finger to Dr. Giffen, and he recommended Claimant follow up with a Dr. Care regarding further evaluation, including an EMG. Ex 8:174-175.

13. On February 28, 2007, Claimant reported to Ralph Sutherlin, D.O., "numbness and tingling… muscle back and neck pain with occasional weakness in the arms and legs, and

swollen painful joints secondary to arthritis." Ex 13:590. Claimant underwent a chest X-ray on December 26, 2007, which showed "degenerative arthritic changes and spur formation of the spine." *Id.* at 187.

14. On March 25, 2010, Claimant had a slip and fall at work and suffered a low back strain. Ex 3:4 (notice of injury). No medical records were submitted regarding treatment of this injury.

15. On November 2, 2010, Claimant presented to Dave McDermott, PA-C, reporting a history of muscle aches and weakness of approximately two to three months, including calf cramps and low back pain radiating downwards, right side greater than the left. Claimant reported he "feels he is unable to walk due to weakness." Ex 14:632. McDermott considered dehydration a possible cause, and ordered a urinalysis to rule out any rheumatological cause. *Id.* At follow-up on December 10, 2010, Claimant again reported back pain. *Id.* at 634. On February 16, 2011, Dr. Cohen recorded a "new" complaint of low back pain that came on without a precipitating event; he opined it was probably a muscle pull. Ex 14:645.

16. In the fall of 2010, Claimant's Crohn's disease significantly worsened. Ex 6:90. After a course of conservative treatment, Claimant underwent a total abdominal colectomy and ileostomy on April 4, 2011, performed by Shauna Williams, M.D., assisted by Johnny Green, M.D. Ex 12:253.

17. Claimant's post-surgery recovery was complicated by peripheral neuropathy and weakness. *Id.* at 267. He underwent nerve conduction studies by Mary River, M.D., which were read as follows: "could be consistent with steroid myopathy superimposed on (chronic) peripheral neuropathy. Other possibilities include acute inflammatory demyelinative polyneuropathy." *Id.* at 266. Claimant was evaluated by Rodde Cox, M.D., and transferred to

inpatient rehabilitation on April 10, 2011. *Id.* Claimant was discharged on April 21, 2011. *Id.* at 275.

18. Post-hospitalization, Claimant followed up with his gastroenterologist, Dr. Gibson, his primary care physician, Dr. Cohen, and his surgeons, Dr. Williams and Dr. Green. Ex 6:96; Ex 14:646; Ex 16:768.

19. On May 24, 2011, Dr. Williams recorded Claimant had "noticed a prolapse[6] of his toma [sic] a few days ago, then a second time yesterday, and was lifting, and [record cut off] inches." Ex 16:770. At follow-up on June 23, 2011, Dr. Williams noted the prolapse had "not gotten an bigg [sic – any bigger]" and that Claimant needed either an "ileorectostomy or revision of the ileostomy." *Id.* at 773.

20. On June 1, 2011, Dr. Cohen recorded Claimant had "new" complaints of bilateral shoulder pain and knee pain, which were mild, and which Dr. Cohen attributed to arthritis. Ex 14:650.

21. On September 6, 2011, Dr. Gibson noted Claimant was having problems with his stoma including "prolapse with minimal exertional activity" and leakage, but recommended that he be followed closely "without surgical intervention for his prolapse at this time." Ex 6:100. Dr. Gibson noted Claimant continued to suffer from peripheral neuropathy in his legs and fingers since the colectomy and referred Claimant to James Herrold, M.D., for neurologic workup. *Id*. at 102.

22. On September 28, 2011, Dr. Herrold evaluated Claimant and noted a history of chronic, intermittent neck pain and bilateral shoulder pain. He ordered MRIs of the cervical and

[6] At deposition, Dr. Green explained a prolapse occurs when the intestine turns inside out and protrudes beyond the abdominal wall. Green Dep. 13:14-23.

lumbar spine. Ex 17:836-837. At follow-up on October 20, 2011, Dr. Herrold recorded the MRIs showed:

> moderate central spinal canal stenosis at C4-C5 and C5-C6 due to broad-based disc osteophyte complex and facet arthropathy and thickening of the ligamentum. There was no cord signal abnormality. There was moderately severe right foraminal stenosis at C4-C5, but otherwise mild diffuse foraminal stenosis… Lumber MRI showed some mild DJD, but actually appeared quite intact based on his age of 62. There was no significant central or foraminal stenosis.

Id. at 844. He concluded: "[i]f his neck and upper extremity symptoms should worsen in the future then he may need referral to a spine surgeon, but I do not see any urgency at this point in time." *Id.* at 845.

23. Claimant presented to Dr. Green on December 13, 2011 for a pre-surgery consult to perform an ileostomy takedown with ileorectal anastomosis. Ex 16:776. Claimant reported back pain, muscle pain, joint pain, and muscle weakness. *Id.*

24. At his annual physical on December 27, 2011, Dr. Cohen recorded that Claimant continued to complain of peripheral neuropathy and stoma issues. Ex 14:659.

25. On May 27, 2012, Claimant suffered another slip and fall at work injuring his "neck, between shoulder blades, lf hip" and his "l/arm and elbow." Ex 4:7 (first report of injury). No medical records were submitted regarding treatment of this injury.

26. On July 17, 2012, Claimant met with Dr. Green again to discuss ileostomy takedown. Ex 16:785. Dr. Green noted Claimant: "[h]as frequent appliance leaks, especially when he is working and has intermittent ileostomy prolapse." *Id.* Claimant ultimately declined to undergo the ileostomy takedown.[7]

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[7] At deposition, Dr. Green explained the procedure would have reconnected Claimant's small bowel and rectum allowing normal, if urgent, functioning. Dr. Green testified that Claimant's career as a truck driver and the potential for further surgery if his Crohn's spread to his rectum contributed to the decision against the ileostomy takedown. See Dr. Green Dep. 9:5-15:22.

27. On January 14, 2013, Claimant presented to David Nielsen, M.D., with complaints of numbness and tingling into his right extremities. Ex 14:676. Dr. Nielsen noted Claimant's prior history of peripheral neuropathy and back pain, though he was not complaining of back pain at the time of this exam. *Id.* Dr. Nielsen diagnosed Claimant with right sided carpal tunnel syndrome and gave him a handout on stretches; Claimant declined surgical intervention. *Id.* at 678.

28. On August 27, 2013, Claimant presented to Dr. Cohen with complaints of non-radiating back pain. Dr. Cohen diagnosed a back strain and noted it was "probably due to 2 [sic] degenerative joint disease with sacroiliitis for muscle spasm." Ex 14:703.

29. At his annual exam on December 31, 2013, Dr. Cohen recorded:

> "[h]e does have [a] problem with his ostomy and prolapse which is close [sic] uncomfortable and she [sic] is trying to work and he has to push it in and his back sometimes weeks [sic - bag sometimes leaks] and I have sent him to the ostomy clinic which is helped somewhat."

Id. at 706-707.

30. **Industrial Accident**. On September 10, 2014, Claimant was driving his regular route when he was rear-ended, sequentially, by two dump trucks. Tr., 39:25-40:10; Ex F:4, 6. Claimant was transported by ambulance to West Valley Medical Center. Ex F:3.

31. On presentation at the ER, Claimant complained of neck and back pain. Ex 19:954. A CT scan of the cervical spine was ordered and read as follows:

> CERVICAL DISC LEVELS:
> C2-C3: Normal for age.
> C3-C4: Normal for age.
> C4-C5: Mild degenerative disc disease. Mild right foraminal stenosis. No central canal stenosis.
> C5-C6: Mild degenerative disc disease. No foraminal or central canal stenosis.
> C6-C7: Normal for age.
> C7-T1: Normal for age.

> Conclusion: No fracture or listhesis. Mild degenerative disc disease. Osteopenia. Mild emphysema.

Id. at 965. Claimant was diagnosed with a cervical strain, given a prescription for Flexeril and Percocet, and discharged. *Id.* at 957.

32. Claimant testified that following his discharge at the ER, he went home and discovered he had suffered a significant prolapse: "after the accident, it turned inside out…it filled the bag, the appliance. I had, like, a five- or six-inch sausage in the bag." Claimant Dep. (3/9/17) 68:21-25. Claimant took a cold washcloth, laid on his back for approximately 30 minutes, and worked the tissue back in. Tr., 53:15-22.

33. Claimant presented to Hala Rafla, PA-C, at St. Luke's Occupational Health Clinic on September 17, 2014. Ex 13:592. Claimant reported he was suffering from back, neck, shoulder, and right knee pain. *Id.* Claimant's physical exam revealed tenderness and muscle spasms in all parts of the spine, and tenderness along his shoulders, right worse than left. *Id.* at 594. Rafla ordered an X-ray of the thoracolumbar region which showed "mild malignments, disc degeneration, and facet arthropathy" and referred Claimant to physical therapy *Id.* at 594-595.

34. On September 19, 2014, Claimant presented to Mark Holbrook, M.D., his then primary care physician, and reported substantially the same symptoms. Ex 14:732. Dr. Holbrook referred Claimant to Samuel Jorgenson, M.D., an orthopedic surgeon. *Id.* at 733.

35. Claimant saw Dr. Jorgenson on September 29, 2014. Ex 21:1017. Claimant reported a history of neck and back aches and pains, but no specific pathology; Dr. Jorgenson conducted a physical exam, reviewed imaging, and assessed cervical spondylosis, right cervical radiculopathy, lumbar spondylosis, and lumbar sprain. *Id.* at 1019.

36. Claimant saw PA Rafla again on September 23, 2014. Ex 13:605. Claimant's spine showed tenderness; his right knee was examined and showed tenderness and mild crepitus.

Id. at 606. Claimant was working part-time light duty, but was released to full-duty at this appointment. *Id.* at 607.

37. Claimant testified that his prolapse returned and worsened upon his full-duty return to work:

> And I was off work, so I could - - I didn't really - - it wasn't super major until I went back to work. And when I went back to work, then it just progressively was worse, I couldn't keep it in. And the more I worked, the longer the work hours, the days became - - they had me on light duty for a couple weeks. I was off for a week and then light duty… [t]hen like I said, they worked me in, trying to get me back into working my 14 plus hours a day again, and by doing so it just - - it was just going nuts.

Claimant Dep. (12/1/15) 76:2-8; 76:17-19.

38. Claimant's next appointment was October 3, 2014.[8] Ex 13:608. Claimant testified that at this appointment he told PA Rafla about his stomal prolapse, and that she directed him to discuss this condition with Dr. Shoemaker. Tr., 152:17-153:10; Claimant's Dep. (12/1/15) 77:16-20. PA Rafla ordered an X-ray of Claimant's right knee. Ex 13:609.

39. Claimant presented to Dr. Shoemaker on October 8, 2014. Ex 13:613. Dr. Shoemaker examined Claimant, ordered a cervical spine MRI, and gave Claimant a Kenalog shot in his right knee. Dr. Shoemaker recorded Claimant's report of blood in his ostomy bag; he recommended a referral to Dr. Green. *Id.* at 615. He noted Claimant had stopped going to physical therapy because it aggravated his knee and that Claimant had developed radicular symptoms in his right upper extremity after manipulation and physical therapy. *Id.* Dr. Shoemaker assigned restrictions of no repetitive bending, stooping, twisting; no kneeling; limit

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[8] The record for this appointment appears to be incomplete when compared to other similar appointments from the same time frame; the record itself is also significantly less clear than other records submitted by the parties, on both sets of exhibits. See Ex B: 279; Ex 13: 608.

climbing stairs and ladders; no lifting above 20 pounds; no pushing or pulling above 40 pounds; and no high-impact activities on his right sided lower extremity. *Id.* at 616.

40. On October 22, 2014, Claimant had his last appointment with Dr. Shoemaker. *Id.* at 625. He recorded Claimant's MRI showed right C4-C5 foraminal stenosis from a degenerative process, with no acute findings. He wrote that the MRI findings were non-concordant with Claimant's symptoms but wrote: "[n]evertheless the patient does have severe right C4-5 foraminal stenosis from a degenerative process there [sic] was pre-existing." *Id.* at 626. Dr. Shoemaker recommended Claimant undergo a physiatry consultation. *Id.* Regarding Claimant's ostomy bag, Dr. Shoemaker wrote:

> Patient states that he had some blood previous to his auto accident but now feels it is worse. We therefore recommend a one-time visit with Dr. Green who is his surgeon. The insurance company is requesting more information. We will try to answer their questions on the paperwork provided. In essence we cannot be sure at this time if these complaints are related to his work injury. They [sic] do want at least a one-time visit with Dr. Green. At that point Dr. Green can better address the nature of these complications.

Id. at 626. In a form letter to Surety dated that same day, Dr. Shoemaker opined that Claimant's right knee condition was related to the work accident as an aggravation of a pre-existing condition. *Id.* at 629. Claimant was released from care with restrictions of no lifting over 20 pounds and no push/pull over 40 pounds. *Id.* at 628.

41. Claimant testified that he was not authorized to see Dr. Green until he told his supervisor at work about his issues with his stoma:

> Q: [By Mr. Crandall] Close enough. How did Big Mike respond or did someone respond to your indication that you could not see Dr. Green?
>
> A: Oh he - - he - - he said that he was going to make a phone call…two days later Dr. Green's office called and said that work comp okayed you to come see Dr. Green one time.

Tr., 74:19-23; 75:6-9.

42. Claimant saw Dr. Green on November 4, 2014. Ex 17:788. Dr Green recorded:

> He is having lower back pain and is bleeding via the rectum, his mucus is tinged pink from blood and there are some blood clots. He states that his stoma is prolapsing and having blood on it. Prolapse is new since the accident and hard to control.
>
> …
>
> With no prolapse before the accident this is almost certainly related to his recent motor vehicle accident at his [sic] job related. addendum: photo documentation received later in the day shows several inches of ileostomy prolapse.

Id. at 788; 789.[9] Dr. Green took Claimant off work and scheduled him for surgical repair. *Id.* at 790.

43. Claimant was admitted to St. Alphonsus Regional Medical Center on December 8, 2014. Ex 12:300. During surgery to repair Claimant's stomal prolapse, Dr. Green discovered that Claimant had a peristomal hernia, which he also repaired. *Id.* at 283.

44. Claimant was on the verge of being discharged, when he began to experience nausea, vomiting, and abdominal distension. *Id.* at 300. A CT scan revealed a blockage near the site of the stoma, and Dr. Green recommended revision surgery. *Id.* at 366. Claimant underwent revision surgery on December 17, 2014, however, he continued to suffer the same symptoms afterwards. *Id.* at 284, 301. Dr. Green requested consults from other surgeons, who ordered multiple diagnostic tests to try to discover why Claimant was experiencing such complications. *Id.* at 301. Diagnostic testing eventually suggested that Claimant's gall bladder was to blame, and Claimant underwent a third surgery on January 8, 2015 to remove his gall bladder. *Id.* at 294. Claimant's symptoms began to resolve around January 13, 2015 and Claimant was discharged on January 15, 2015. *Id.* at 484; 301.

[9] This photo documentation appears at Ex 32:1485-1491 and Ex H:1-6.

45. Claimant began physical therapy January 18, 2015 and followed up with Dr. Green on January 27, 2015, who noted Claimant was recovering well. Ex 22:1045; Ex 16:795.

46. Defendants retained Lee Kornfield, M.D., to conduct a records review and he issued his report on February 16, 2015. Ex 23:1113. Dr. Kornfield's resume appears at Exhibit 23 and reflects he is board certified in internal medicine. Dr. Kornfield was asked to opine on whether Claimant's ileostomy repair was related to the industrial accident. *Id.* Dr. Kornfield opined that Claimant's ileostomy repair was not related to the industrial accident because Claimant had pre-existing issues with stomal prolapse as revealed by the medical records. *Id.* Dr. Kornfield also relied on 12/13/2011 note by Dr. Green which he mistakenly recorded as recommending an ileostomy repair, instead of the discussed ileostomy takedown with ileorectal anastomosis. *Id.* at 1117; Ex 16:776.

47. By February 17, 2015, Dr. Green noted Claimant's stomal prolapse had completely resolved. Ex 16:807. However, Dr. Green also documented findings suggestive of a post-surgical peristomal hernia and recommended to Claimant that he wear his stoma hernia belt. *Id*. At follow-up on March 17, 2015, Dr. Green diagnosed Claimant with a post-surgical peristomal hernia, instructed him to limit any lifting, straining, or significant exertion, and to wear his hernia belt daily. *Id.* at 810. He kept Claimant off work. *Id.* at 813; 816.

48. Defendants retained Rodde Cox, M.D., to perform an independent medical exam (IME) on May 29, 2015. Ex 24:1120. Dr. Cox's resume appears at Exhibit 24, and reflects he is board certified in electrodiagnostic medicine and physical medicine and rehabilitation. He conducted a physical exam, reviewed records[10], and took a history from Claimant; he

[10] Dr. Cox reviewed: Dr. Williams 4/4/11-6/23/11, Dr. Cox 4/13/11, Dr. Cohen 9/6/11, Dr. Green 12/13/11-1/15/15, Dr. Taylor 5/20/13-10/21/14, Notice of injury 9/10/14, ER 9/10/14, Hala Rafia PA-C 9/16/14-9/23/14, Dr. Holbrook 9/19/14, Dr. Shoemaker 10/8/14-10/22/14, Dr. Kornfield 2/16/15.

specifically noted he had no records prior to April 14, 2011 or after February 16, 2015. *Id.* Dr. Cox recorded Claimant's prior medical history in relevant part as follows:

> He denies any previous motor vehicle accidents. He denies any previous neck or back pain. He notes that he would simply have some sore muscle if he over did it… When asked about the reported low back pain relates [sic] to a fall in 1991[11], he states he does not recall this. He states that he has seen a chiropractor in the past, be [sic - he] believes that Dr. Long who he last saw about 15 years ago and would [sic] have some treatment for his back. He was also was seen at Simpson Chiropractic 2-3 years ago for some maintenance type of therapy for his back.

Id. at 1121, 1122. Dr. Cox ultimately diagnosed:

> 1) cervical strain;
> 2) lumbar strain;
> 3) preexisting low back pain;
> 4) Right knee pain, possible medial meniscus tear in the setting of likely preexisting degenerative arthritis;
> 5) ileostomy with stomal prolapse/status post surgical repair;
> 6) depression.

Id. at 1131. Dr. Cox did not find evidence of cervical radiculopathy. *Id.* at 1132. Dr. Cox concluded that Claimant's neck pain, low back pain, right knee pain, and stomal complications were causally related, to a degree of "medical certainty," to the reported injury and that he was not at MMI. *Id.* Dr. Cox recommended imaging and a course of physical therapy. *Id.*

49. Claimant retained Richard Radnovich, M.D., to conduct an IME on June 18, 2015. Ex B:503. Claimant signed a document entitled "Irrevocable Assignment of Benefits, Instruction and Authorization for Direct Payment to Physician."[12] *Id.* at 510. He conducted a physical exam, reviewed records[13], and took a history from Claimant. *Id.* at 501. Dr. Radnovich

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[11] This is most likely a mis-transcribed date from Claimant's 1999 accident and report of low back pain to Dr. Giffin mentioned at ¶ 7, it appears throughout the records after that encounter as a 1991 slip and fall. *See* Ex 7 and 14.

[12] This agreement is in contravention of Idaho's workers compensation law. *See Landeros v.Crookham Company 2018 WL 1830485* (March 9, 2018) discussion at ¶ 106-108.

[13] Dr. Radnovich reviewed records from St. Alphonsus Hospital, office notes from Dr. Green, offices notes from the Spine Institute, office notes from St. Luke's Occupational Medicine, Norco Surgical Supply, St. Luke's Regional Medical Center, Elk's Rehabilitation, St. Luke's Internal Medicine, the Digestive Health Clinic, and Ada

opined that, on a more likely than not basis, the following conditions were related to the industrial injury:

> 1) Symptomatic cervical spondylosis, possible herniated nucleus pulposus with likely C6 root compression on the right.
> 2) Right greater than left shoulder pain with possible rotator cuff tendinopathy.
> 3) Symptomatic lumbar spondylosis and spondylolisthesis, possible spondylolysis.
> 4) Destabilization of previous colostomy requiring surgical revision.
> 5) Peri-incisional abdominal wall hernia.
> 6) Right knee pain, symptomatic degenerative changes, likely internal derangement, possible cartilage fracture.

Id. at 502. He opined Claimant was not stable and required further diagnostics to explore the full extent of his injuries. *Id.*

50. Claimant presented to Dr. Jorgenson again on June 15, 2015. Ex 21:1021. He ordered cervical, lumbar, and thoracic spine MRIs. On June 22, 2015, Claimant was seen by Amanda VanSant, PA-C, and Claimant's MRIs were read as follows:

> C4-5 minimal disc bulge, mild cord defoeminty [sic] moderately severe rt foraminal stenosis, mild left foraminal stenosis.
> C5-6 very mild disc bulge very mild canal stenosis very mild bilateral foraminal stenosis
> C6-7 very mild disc bulge
> Chronic compression fractures of T8-10
> T11-12 very mild disc bulge mild to moderate bilateral stenosis
> L1 chronic compression fracture
> L2-3 and L3-4 very mild disc bulge mild bilateral facet hypertrophy
> L4-5 mild bulge and facet hypertrophy moderate canal stenosis mild right foraminal stenosis
> L5-S1 very mild disc bulge moderate bilateral facet hypertrophy

Id. at 1033. Dr. Jorgenson met with Claimant on June 29, 2015, and reviewed his MRIs. Dr. Jorgenson recorded "has symptoms which may be consistent with carpal tunnel or cervical radiculopathy. will get EMG to differentiate[.] Lumbar spine consistent with central stenosis. will recommend ESI." *Id.* at 1037.

County Ambulance.

51. On July 1, 2015, Claimant returned and Michael Spackman, M.D., performed bilateral L4-5 transforaminal ESI injections. *Id.* at 1040.

52. On July 9, 2015, Dr. Green authored a letter to Claimant's attorney summarizing his opinions as follows:

> Mr. Domka underwent total abdominal colectomy with ileostomy and Hartmann pouch in March 2011 for severe refractory Crohn's colitis. Due to the severity of his pre-existing disease and need for steroids prior to surgery she [sic] did have prolonged recovery phase. He was able to return to full-time employment. He did have intermittent mild ileostomy prolapse which was well-controlled with a stoma prolapse belt and always reduced readily until he was involved in a motor vehicle accident where his truck was rear-ended in September 2014. After that event his ileostomy prolapse became frequent was much larger often filling the entire stoma appliance and was very difficult to reduce… He is currently able to eat well and his ileostomy functions well however he has developed a relatively large peristomal hernia despite wearing a stoma hernia belt the bulk of the time and her Foley [sic] managing his activity level to avoid any abdominal straining. It is anticipated he will need repair of the peristomal hernia and [sic - in] the not too distant future.

Ex 16:821.

53. On August 20, 2015, Claimant returned to Dr. Green for follow-up of his post-surgical peristomal hernia. *Id.* at 822. Dr. Green continued to recommend Claimant lose weight prior to undergoing hernia repair to prevent recurrence. *Id.*

54. Claimant presented to Robert Walker, M.D., on September 29, 2015 for evaluation of his right knee condition. Ex 26:1158. Claimant related a history of the accident and the knee treatment he had received since the accident; he reported physical therapy aggravated his knee and the Kenalog shot given by Dr. Shoemaker in October of 2014 provided only temporary pain relief. *Id.* Dr. Walker ordered an MRI of the right knee. *Id.* at 1159.

55. Claimant followed up with Dr. Walker on November 19, 2015 to discuss his MRI results. Dr. Walker recorded the MRI showed: "moderately advanced chondral wear of the medial compartment and subchondral edema of the tibia. There is a degenerative tear of the

medial meniscus and acute chondral changes of the patella." *Id.* at 1164. Dr. Walker's impression was a chondral injury to Claimant's right patella and medial compartment osteoarthritis of the right knee with a degenerative medical meniscal tear. *Id.* Dr. Walker discussed treatment options with Claimant, but opined that only a knee replacement would predictably control Claimant's pain due to the extent of the medial compartment changes. *Id.* He referred Claimant to his surgical partner Ronald Kristensen, M.D. *Id.* at 1166. Lastly, Dr. Walker recorded:

> We discussed causality today, as well. David relates that he has some occasional, minor knee pain prior to his work related injury, but his knee has been much more painful after his accident. On a more likely than not basis, David's knee had some level of arthritic change prior to his work accident, but with increased symptoms due to his accident.

Id. at 1164.

56. Claimant met with Dr. Kristensen on December 17, 2015. *Id.* at 1166. He conducted a physical exam, reviewed imaging, and took a history from Claimant. He agreed with Dr. Walker's recommendation for a knee replacement and that Claimant's knee condition was causally related to his industrial accident. Dr. Kristensen wanted to delay surgery until Claimant underwent his hernia repair due to risk of infection. *Id.* at 1173.

57. Claimant returned to Dr. Jorgenson on December 21, 2015 and reported only short-term relief from the ESI shot performed by Dr. Spackman in July. Ex 21:1042. Claimant reported a medical history including arthritis, headaches, hypertension, and spine/back problems. Claimant underwent an EMG, which showed evidence of bilateral carpal tunnel syndrome. *Id.* Dr. Jorgenson concluded Claimant had cervical stenosis requiring an anterior cervical discectomy and fusion, carpal tunnel requiring bilateral tunnel release, and L4-5 central stenosis requiring bilateral laminectomy. *Id.* at 1044.

58. Claimant followed up with Dr. Green on January 29, 2016 regarding his post-surgical hernia. Ex 16:832. Dr. Green observed that Claimant's hernia had not significantly worsened in the prior six months and that it was reasonable for Claimant to proceed with his knee and back surgeries before undergoing a hernia repair. *Id.*

59. **Expert depositions. Dr. Kristensen** was deposed by Claimant on May 26, 2017. He opined Claimant had some pre-existing changes in his knee, but that the motor vehicle accident made Claimant's knee more symptomatic. Kristensen Dep. 13:19-25. Regarding the meniscus tear, Dr. Kristensen opined he could not state with certainty whether it was caused by the accident or pre-dated the accident because the MRI was a year after the accident. *Id.* 19:20-25. Dr. Kristensen opined that Claimant's need for arthroplasty was more likely than not related to his industrial accident because:

> I have no indication he had significant symptomatology prior to the accident. He then had the accident, and since then has been symptomatic to the point where the factors we reviewed are present, with difficulty of activities of daily living and the like. He has failed the trials that we talked about. And therefore the only surgery that will be beneficial would be an arthroplasty.

Id. 29:12-19.

60. On cross-examination, Dr. Kristensen was confronted with Claimant's diagnosis of a medial meniscus tear from his prior industrial injury of February 2003, his reports of knee pain in 2004, 2005, and 2011, and the 2005 reference to a recommended, but deferred, arthroscopy. *See*, Kristensen Dep. 39-43; ¶ 8, 9, 11, 20, *supra*. He testified Claimant did not inform him of these prior incidents, but that they could have been interesting and helpful regarding the timeline of Claimant's injuries. *Id.* Regarding the impact of these records on his opinion, Dr. Kristensen testified:

> Q: [By Mr. Augustine] So I guess what I'm saying is we don't have that continuum of care and reported problems for at least three years and three months

> prior to his accident. We have some from June of 2011. So what I'm gathering is that these examples in the past where he reported knee pain or symptoms in his knee would not change your opinion as to whether this accident caused the need for his total knee arthroplasty which you're recommending?
>
> A: I think I believe what you're saying. So if a patient has a prolonged period where there was no medical treatment sought, no treatment that they are receiving, then I would feel that those prior events likely are not significant for the need for surgery.

Id. at 57:4-17. Regarding the need for a total knee replacement versus other interventions, Dr. Kristensen explained that if Claimant only had the medial meniscus tear, he would recommend arthroscopy, but with the addition of the chondral injury and arthritis, an arthroplasty was required. *Id.* at 53:14-54:3.

61. **Dr. Radnovich** was deposed by Defendants on June 1, 2017. He is board certified in family medicine, sports medicine, and pain management. Radnovich Dep. 6:2-4. He testified consistent with his report that all of the conditions he diagnosed were causally related to the industrial accident. *See*, *Id.* 19-28. However, he clarified that Claimant's neck, low back, and knee arthritis pre-existed the accident, but was aggravated by the accident. *Id.* 23:12-25; 28:2-10; 30:1-25.

62. Dr. Radnovich stated most of the records he reviewed in connection with his report were generated after the accident in question, with the exception of some documents related to Claimant's gastrointestinal surgery.[14] *Id.* at 43:1-11. Dr. Radnovich confirmed he was unaware of Claimant's 2003 accident, 2004 and 2005 reports of knee pain, 2011 reports of knee and shoulder pain, 2011 reports of numbness and tingling in his legs and thighs, and neurological consult with Dr. Herrold in 2011. *Id.* 44-50. Dr. Radnovich testified it was possible that those

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[14] Dr. Radnovich IME report lists records for "St. Luke's Internal Medicine." This testimony seems to suggest that Dr. Radnovich had records from St Luke's Internal Medicine at Cloverdale vs. St. Luke's Internal Medicine, as the later Claimant exhibit is dated beginning 2001 and the former begins in 2014.

records would have been helpful and in general he likes to have as complete a set of records as possible. He testified he did not review the 2011 C-spine MRI performed by Dr. Herrold. *Id.* at 50:9-51:8. Dr. Radnovich testified that his conclusions were based on the records and information he had, and that pre-existing reports of pain and arthritis would not necessarily change his opinion; specifically he testified: "People with arthritis in any joint are allowed to have occasionally flare-ups and see doctors and have treatment occasionally. The difference is in the character of those flare-ups and the persistence, perhaps, of those flare-ups." *Id.* at 59:4-10; 58:9-19.

63. On June 2, 2017, Defendants deposed **Dr. Green.** Dr. Green is board certified in general surgery and colon and rectal surgery and has been performing surgeries since 1980. Green Dep. 7:10-17. Dr. Green explained that the December 13, 2011 appointment with Claimant was to determine whether Claimant would be a good candidate for reconnecting his small bowel to his rectum so he would not have to have a permanent ileostomy. *Id.* 8:11-9:8. He confirmed Claimant did not pursue removal of his ileostomy and reconnection surgery because of (1) the risk of recurrence of his Crohn's disease which would require another surgery to recreate the ileostomy and (2) if the surgery was successful, he would require reliable access to bathrooms, which his job duties prevented. *Id.* 15:5-22; 9:25-10:9.

64. Dr. Green specified the stomal prolapse noted in his February 2, 2012 note was approximately "two to four inches" on that date and well controlled by his prolapse binder. *Id.* at 12:16-20. Dr. Green explained a prolapse occurs when the intestine turns inside out and protrudes beyond the abdominal wall and a peristomal hernia is when another portion of the bowel pushes through an "area not attached to the soft tissues under the skin." *Id.* at 13:14-23. Dr. Green explained that he noted mild prolapse in July of 2012 and testified:

> A: Generally in my scale, a mild prolapse would be perhaps an inch, maybe two at the most, that is readily contained and does not expose any risk of the inverted part of the bowel compromising his blood supply and does not interfere with the ability of the ostomy appliance or function of the appliance.
>
> …
>
> Q: [By Mr. Gilman]: With that, let me just inquire a little further. You saw no evidence that his prolapse was filling the appliance and turning inside out?
>
> A: It was turning inside out an inch or two, but no where near to the degree we would consider any type of surgical repair.

Id. at 7:7-12; 7:19-25. In contrast, his description of the prolapse in November 2014 is as follows:

> A: At that point he was noting that after his accident, the degree of prolapse had dramatically increased to the point that it now came out far enough to completely fill his ileostomy bag on multiple occasions.
>
> Q: [By Mr. Gilman]: So you use the words "significant prolapse" on November 25, 2014. Can you differentiate that - - what a significant prolapse would be as opposed to a mild prolapse?
>
> A: Well, significant prolapse is a degree of prolapse that is functionally limiting and - - for instance, much of the volume of ileostomy appliance was filled with the bowel itself with very little room for any stool to be contained in the appliance. Also a degree that potentially puts blood supply to the tissue prolapse at risk because it can be confined - - the blood supply is within that layer that is turned inside out.

Id. at 18:23-19:16. Dr. Green indicated that at the time of surgery, the prolapse was approximately six to eight inches. *Id.* at 20:17.

65. When asked what caused the pre-admission hernia discovered during surgery, Dr. Green explained that a peristomal hernia is a very common complication of having a stoma; when asked whether the industrial accident caused Claimant's pre-admission peristomal hernia, Dr. Green stated: "I can't speculate on causal relationship or relationship there. I think the

temporally significant finding was an acute increase in the magnitude of his prolapse. And that's really the only thing I can document or comment on with any degree of authority." *Id.* at 23:2-7.

66. Dr. Green then explained his notes from Claimant's six week stay in the hospital with persistent nausea and vomiting. Regarding the decision to remove the gall bladder, Dr. Green could not state within a degree of reasonable medical probability what caused Claimant to have gallbladder trouble post-surgery; he stated it was not typical to see acaulous (no gallstones) gall bladder dysfunction after an operation. *Id.* 37:2-20. Dr. Green explained that he and his colleagues never got a reliable explanation for why Claimant had persistent nausea and vomiting after his surgery. *Id*. at 41:16-22.

67. Regarding the post-surgical hernia Claimant developed after his discharge from the hospital, Dr. Green opined it was most likely related to having the second surgery to enlarge the opening. *Id.* at 43:4-16. He recommended Claimant continue to wear his stoma hernia belt, and stated he no longer recommended surgery to repair Claimant's current hernia unless it enlarged and caused blockage or appliance problems. *Id.* 44:6-14. Specifically, he did not want to operate on Claimant again due to the complications with his prior revision, especially without a satisfactory explanation for his complications in the first place. *Id.* at 44:19-24. Lastly, Dr. Green opined Claimant would be limited to sedentary work with his hernia in its current state. *Id.* at 47:1-20.

68. Claimant took the deposition of **Dr. Jorgenson** on October 27, 2017. He is board certified in orthopedic surgery. Jorgenson Dep. 7:3-7. Dr. Jorgenson testified that essentially all of the findings on the June 22, 2015 MRIs were degenerative, chronic changes due to arthritis, specifically the facet degenerative hypertrophy, the mild disc bulging, and the spinal stenosis; Claimant's L1 compression was also felt to be "old and chronic." *Id.* at 20:1-8. Dr. Jorgenson

opined that the facet degenerative hypertrophy would have pre-dated Claimant's industrial accident. *Id.* at 20:19-21:2. He explained that Claimant's radiographic findings and EMG confirmed that he had both neurological compression in his C-spine as well as carpal tunnel, more symptomatic on the right side. *Id.* at 31: 15-20; 25. Dr. Jorgenson ultimately opined that he thought Claimant's injuries were "caused partially" by the industrial accident; he later elaborated that because the changes on imaging were "clearly pre-existing, longstanding, and not acute or caused by the accident" and because he had no history to indicate the Claimant had symptoms prior to the accident, he believed the accident aggravated his pre-existing conditions. *Id.* at 41:23-24; 42:21-43:5.

69. On cross, Dr. Jorgenson confirmed that Claimant only reported "aches and pains" in his neck and low back prior to the accident. *Id.* at 48:1-5. Dr. Jorgenson was not aware of the 2001, 2005, 2010, 2011 and 2013 reports of low back pain, the 2003 MVA, the prior ulnar repair in the 80s, Claimant's history of peripheral neuropathy, or his neurologic consult with Dr. Herrold. *Id.* at 50-57. He confirmed that he had not reviewed Claimant's prior 2011 lumbar and cervical MRIs. *Id.* at 56:4-11. In light of these prior records, Dr. Jorgenson could not opine "to a reasonable degree of medical certainty" whether Claimant's spine injuries were directly related to the industrial accident. *Id.* at 59:24-60:6. He concluded:

> I would say that determination of causation requires reviewing past medical records and history and timeline of all those, and combined with the mechanism of injury and the new findings. And I have not had the opportunity to review all that information.

Id. at 60:14-19.

70. Defendants deposed **Dr. Cox** on February 16, 2018. Dr. Cox testified that based on his exam, he had wanted Claimant's earlier records to confirm his suspicion of chronic low back pain. Cox Dep. 14:11-18. Employer/Surety counsel walked Dr. Cox through Claimant's

prior medical records including the 2001, 2004, 2005, 2010, and 2011 reports of back pain, the 2003 MVA, and Dr. Herrold's neurological consult; Dr. Cox confirmed he was unaware of these records. *Id.* at 18-26. Dr. Cox then reversed his prior written opinion and stated he could not state "to a reasonable degree of medical certainty" that Claimant's lumbar and cervical conditions were related to his industrial accident. *Id.* at 26:18-25. Dr. Cox testified he would defer to Dr. Kornfield and Dr. Green regarding Claimant's stoma issues. *Id.* at 29:19-22. Regarding Claimant's right knee, after Dr. Cox was apprised of Claimant's prior reports of knee pain and previously diagnosed meniscal tear, he was questioned as follows:

> Q: Doctor, to a degree of medical certainty based upon the information we've discussed today, knowing now about the past significant issues, would you relate his knee condition and problems after the accident, to an injury, or to his preexisting problems?
>
> …
>
> A: I would be hard pressed to say. I could not say on a more probable than not basis that his knee conditions were related to the accident…

Id. at 32:6-10;12-17.

71. On February 28, 2018, Defendants deposed **Dr. Kornfield**. Dr. Kornfield testified consistent with his report. *See*, Kornfield Dep. 10-20. Dr. Kornfield testified he had the opportunity to review more records generated after his report and they did not change his opinion. *Id.* Regarding the post-surgical peristomal hernia that Claimant developed after the 2014 ileostomy repair, Dr. Kornfield testified it was related to both the first and second surgery Claimant underwent because it weakened his abdominal tissues. *Id.* at 20:16-22.

72. On cross, Dr. Kornfield confirmed he had never examined Claimant. *Id.* at 25:14-18. Claimant's job description[15] was read into the record and Dr. Kornfield was questioned on

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[15] Demonstrates sound judgment in the operation of a vehicle, work 65 to 70 hours a week within federal

how Claimant could have been doing his extremely strenuous job with a prolapse as extensive as was documented after the accident:

> Q: [By Mr. Gilman] With regard to his physical requirements that I just listed off there would you be concerned that those could aggravate his parastomal prolapse?
>
> A: Yes.
>
> Q: And that that could have happened for - - let's see, his surgery was April 4 of 2011… Would you be surprised that he continued to work at that job day after day, week after week, normally 14 hours a day, if he had an unmanageable prolapse problem like he had after the accident?
>
> A: Would I be surprised if he continued to work?
>
> Q: Yes.
>
> A: Maybe to preface it. He had the identifiable prolapse in May certainly. But I will tell you that in my review of the record Mr. Domka is a hard working guy. He works hard and he works a job that I couldn't work. And I think he just did what he needed to do. So without meeting - - I don't think I met the fellow before. But in reading about him it doesn't surprise me he was doing that. He is just a hard worker and pressed on regardless.

Id. at 36:12-37:20. Lastly, Dr. Kornfield explained that with both stomal prolapse and hernias that "you can have no symptoms," localized discomfort, and/or intestinal complications. *Id.* at 38:17-22.

73. **Claimant's condition at hearing.** Claimant's back was bothering him more and more and "going downhill" since the accident. Tr., 88:12-14. Claimant's stoma was "fixed," but the hernia caused pain. *Id.* at 169:11; 66:12. Claimant was receiving Social Security retirement benefits. *Id.* at 150:23-24.

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guidelines, including nights and weekends, pull, twist, bend, and lift 75 pounds to shoulder height in loading and unloading process. Climb in and out of tractor and to top of tractor for inspection. Sit and operate a vehicle for ten hours a day. Drive vehicle and load, unload in extreme winter and summer temperatures and conditions. And communicate, read, understand, and write as required to perform essential functions. Ex 30:1279.

74. **Credibility.** At hearing, Claimant's recall of his medical history was poor, and he frequently deferred to the records as more accurate than his memory, however, he testified credibly. Where Claimant's testimony conflicts with the medical record, the medical record will be given more weight.

DISCUSSION AND FURTHER FINDINGS

75. The provisions of the Idaho Workers' Compensation Law should be liberally construed in favor of the employee. *Haldiman v. American Fine Foods*, 117 Idaho 955, 956, 793 P.2d 187, 188 (1990). Facts, however, need not be construed liberally in favor of the worker when evidence is conflicting. *Aldrich v. Lamb-Weston, Inc.*, 122 Idaho 361, 363, 834 P.2d 878, 880 (1992).

76. Claimant bears the burden of proving that the condition for which compensation is sought is causally related to an industrial accident. *Callantine v. Blue Ribbon Supply*, 103 Idaho 734, 653 P.2d 455 (1982). There must be medical testimony supporting the claim for compensation to a reasonable degree of medical probability.[16] A claimant is required to establish a probable, not merely a possible, connection between cause and effect to support his contention. *Dean v. Dravo Corporation*, 95 Idaho 958, 560-61, 511 P.2d 1334, 1336-37 (1973). The compensable consequences doctrine is recognized in Idaho. "The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury." *Castaneda v. Idaho Home Health, Inc.*, IIC 96-029370 (Issued July 27, 1999). The permanent aggravation of a preexisting

[16] Defense counsel for both Employer/Surety and ISIF asked experts at deposition whether they held their opinions to a "reasonable degree of medical certainty." See Jorgenson Dep. 5:19, 25; Kornfield Dep. 5:21, 23:9; Cox Dep. 5:17, 18:13, 26:20, 32:6, 46:25; Radnovich Dep. 58:22; Kristensen Dep. 48:2-20, 51:17. This is not the current worker's comp evidentiary standard, but is the standard for medical malpractice. (See *Lepper v. Eastern Idaho Health Services Inc.*, 160 Idaho 104, 369 P.3d 882 (2016)).

condition or disease is compensable. *Bowman v. Twin Falls Construction Company, Inc*., 99 Idaho 312, 581 P.2d 770 (1978).

77. No special formula is necessary when medical opinion evidence plainly and unequivocally conveys a doctor's conviction that the events of an industrial accident and injury are causally related. *Paulson v. Idaho Forest Industries, Inc.*, 99 Idaho 896, 901, 591 P.2d 143, 148 (1979). While a temporal relationship is always required to support a finding of causation between an accident and the injury, the existence of a temporal relationship alone, in the absence of substantive medical evidence establishing causation, is insufficient to satisfy Claimant's burden of proof. *Swain v. Data Dispatch, Inc.* IIC 2005-528388 (February 24, 2012). The Industrial Commission, as the fact finder, is free to determine the weight to be given to the testimony of a medical expert. *Rivas v. K.C. Loggin*g, 134 Idaho 603, 608, 7 P.3d 212, 217 (2000). "When deciding the weight to be given an expert opinion, the Commission can certainly consider whether the expert's reasoning and methodology has been sufficiently disclosed and whether or not the opinion takes into consideration all relevant facts." *Eacret v. Clearwater Forest Industries,* 136 Idaho 733, 737, 40 P.3d 91, 95 (2002).

78. An employer is required to provide reasonable medical care for a reasonable time. Idaho Code § 72-432(1). A reasonable time includes the period of recovery, but may or may not extend to merely palliative care thereafter, depending upon the totality of facts and circumstances. *Harris v. Independent School District No. 1*, 154 Idaho 917, 303 P.3d 604 (2013). What constitutes reasonable medical care is to be determined by a totality of the circumstances approach. *Chavez v. Stokes*, 158 Idaho 793, 353 P.3d 414 (2015). It is for the physician, not the Commission, to decide whether the treatment is required; the only review the Commission is

entitled to make is whether the treatment was reasonable. *Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989).

79. **Prolapse.** Claimant has met his burden of showing his stomal prolapse is related to his industrial accident. Claimant did experience problems with his stoma and ostomy bag prior to the accident including leaking, skin irritation, discomfort, and mild prolapse, but of the many physicians Claimant complained to about these issues, *supra* at ¶ 19, 21, 24, 26, 29, no physician ever referred him for surgical repair. Dr. Gibson, Claimant's gastroenterologist, specifically noted in September 2011 that Claimant should be followed without surgical intervention for his prolapse. Ex 6:100.

80. Dr. Green unequivocally opined in July 2015, and again at deposition, that prior to the accident Claimant's prolapse was mild and well controlled, and after the accident, severe and very difficult to control such that it required surgical correction. Ex. 16:825; Green Dep. 20-23. Dr. Green explained he would only consider prolapse repair when it interfered with the function of the appliance and that Claimant's pre-accident prolapse was no where near that degree. Green Dep. 19:7-25; 16:23-25. Dr. Green testified that the surgery that he and Claimant discussed after his colectomy was not an ileostomy repair or revision but was an ileostomy takedown and ileorectal anastomosis, and was not to treat Claimant's stomal prolapse. *Id.* at 9:5-10:11.

81. Defendants argue that because the first complaint of stoma issues happened four weeks after the accident, it is impossible to link it to his industrial accident. However, Claimant well explained that his stomal prolapse was aggravated by his return to work. He returned to full duty after his September 23 appointment and reported problems by October 3, or at the latest, October 8. *See*, Ex. 13. Moreover, Claimant's prior medical records show even when his

prolapse was mild it was aggravated by "exertional activity," lending further support to his explanation of when and why his prolapse was aggravated. Ex 6:100.

82. Lastly, Dr. Green's causation opinion is more credible because he was Claimant's treating physician for many years, his surgeon on both his colectomy and stoma repair, and is an expert in colon and rectal surgery. Dr. Green's opinion was expressed cautiously, and he was careful to only opine on those issues with which he thought he could speak to with authority.

83. Dr. Kornfield is less convincing regarding the cause of Claimant's post-accident prolapse. Dr. Kornfield did not examine Claimant and his deposition opinions were couched in terms of "a degree of medical certainty," and as such, are difficult to judge. Dr. Kornfield's mistaken recitation in his report and at deposition that Dr. Green recommended ileostomy repair after Claimant's colectomy further undermines his opinion. Dr. Kornfield's explanation that Claimant just worked through his stomal prolapse is not a medical opinion and is unpersuasive.

84. Claimant's December 8, 2014 ileostomy repair was reasonable medical treatment for his stomal prolapse. It was required by Claimant's treating physician, Dr. Green, and Claimant's stomal prolapse issues have since resolved. Claimant is entitled to recover 100% of the invoiced amount of medical bills incurred in connection with that procedure. *Neel v. Western Construction, Inc.*, 147 Idaho 146, 206 P.3d 852 (2009). Attempts to diagnose and treat Claimant while he was hospitalized were required by Claimant's treating physician, reasonable under the circumstances, and are compensable and related to Claimant's ileostomy repair.

85. **Pre-Admission Hernia.** Claimant did not meet his burden of showing his pre-admission hernia (repaired at the same time as his ileostomy repair) is related to his industrial accident. Dr. Green would not speculate on the causal relationship between the pre-admission hernia and Claimant's industrial accident; he also opined that the most common contributing

factor to a peristomal hernia is having a stoma. Green Dep. 22:10-23:7. The only expert who opines it is related, Dr. Radnovich, does not explain why he thinks Claimant's pre-admission hernia is related to the accident. Radnovich Dep. 29:13-18. Defendants are not liable for surgical and other costs that can be wholly related to treatment of the pre-admission hernia.[17] In sum, if the cost/procedure was at all necessitated by the compensable injury, it is a compensable cost.

86. **Ileostomy Revision and Gall Bladder Removal Surgery.** Following his first surgery of December 8, 2014, Claimant was able to eat and had normal bowel function. However, within 3-4 days following the surgery he began experiencing nausea and vomiting accompanied by abdominal distention. Green Dep. 23:14-21. Claimant was extensively worked up by Dr. Green during his hospital stay in an effort to explain these persistent complaints. Claimant ultimately underwent two further surgeries in an effort to address suspected causes of these complaints. Dr. Green first entertained the possibility that the ileostomy he performed on December 8, 2014 was too "tight," such that it acted as a physical obstruction to the small bowel. Although, to physical examination, the ileostomy appeared to be adequately sized, Dr. Green performed additional surgery on December 17, 2014 to revise the ileostomy:

> Q: [By Mr. Gilman]: What is page 196?
>
> A: That is a revision of the ileostomy repair where I loosened the mesh around the bowel.

---

[17] In sorting what portion of the December 8, 2014 surgical costs are related to the hernia repair vs. the stomal repair, the parties are cautioned that unless the cost can be solely related to the hernia repair, it is compensable, and Defendants are liable. For example, Claimant's Exhibit C reads:

DATE	DESCRIPTION	QTY	AMOUNT
12/8/2014	ANES GENERAL Add 15 MIN	7	$1120.00

Id. at 48. Claimant would have required anesthesia for repair of the ileostomy even in the absence of the need to address the hernia. Therefore, Defendants should bear responsibility for 100% of this charge. However, there maybe other charges that were clearly not incurred to facilitate repair of the ileostomy. For example, as also noted in Claimant's Exhibit C, there is a discreet charge for "Mesh Level 10." If this is a discreet charge for a hernia repair mesh, it is clearly singularly associated with the hernia alone, and would not be payable by Defendants.

Q: The purpose of that?

A: In light of the CAT scan, it showed that the small bowel was dilated all the way down to the ileostomy. It was functioning as functionally too tight, even though anatomically it should have been adequate. So I re-operated to revise the size of the abdominal wall opening.

Green Dep. 27:9-18. Therefore, the December 17, 2014 surgery was undertaken to address a problem thought to have been created by the December 8, 2014 surgery.

87. Unfortunately, following this procedure, Claimant's problems with nausea, vomiting, and abdominal distention continued unabated. Even so, we conclude that the need for the December 17, 2014 surgery is a compensable consequence of the subject accident, notwithstanding that it proved, in retrospect, ineffective in relieving the complaints of nausea, vomiting, and abdominal distension. The surgery was indicated to address what was thought to be an accident produced problem: an inadequately sized ileostomy. Even though this surgery did not relieve Claimant's symptoms, it is still compensable. *Chavez*, *supra*.

88. In *Chavez*, the claimant suffered a partial amputation of his finger in a rural area; the EMT who was first to arrive elected to have Claimant flown (at considerable expense) by helicopter to a hospital, on the assumption that Claimant's finger could be reattached. This assumption later proved to be unfounded, making air transport retrospectively unreasonable. Even so, the Commission found surety responsible for the cost of the air transport. The Court affirmed stating: "[w]e also caution against a retrospective analysis, which relies on the benefit of hindsight. That kind of analysis would serve only to second-guess the treatment requirement of the physician without a fair consideration of the information known at the time and place of treatment and any exigent circumstances." *Id.* at 798, 419. Here, although the surgery did not resolve Claimant's symptoms, it was reasonable and required medical treatment at the time Dr. Green performed the surgery, a time when it was thought by Dr. Green that the repair he

performed on December 8, 2014 needed to be resized. Defendants are liable for the costs of this surgery.

89. Investigations into the cause of Claimant's persistent complaints continued after the revision surgery following multiple lines of inquiry. *Id.* at 23:14-31:12. Eventually, Dr. Green's attention turned to Claimant's gall bladder. A January 4, 2015 ultrasound revealed that Claimant did not suffer from gallstones. Further tests were performed to evaluate Claimant's gall bladder for functional abnormalities. A HIDA scan demonstrated that Claimant's gall bladder was not emptying as expected. *Id.* at 36:4-37:1. It was thought that this finding might explain Claimant's persistent complaints of nausea, vomiting, and abdominal distention. As Dr. Green explained:

> Q: [By Mr. Gilman]: So apparently there was - - could you explain the decision to go ahead and remove the gallbladder? No stones, but the ejection fraction was very low?
>
> A: At this point we have a patient who has been in the hospital for over a month with almost - - almost two months with ongoing nausea and vomiting, inability to eat. The only abnormalities we've come up with is that his gallbladder doesn't work right. The potential there is that perhaps this is the cause of his ongoing nausea. If so, if we take it out, then there's a chance he can recover and be able to be discharged and recover his health.

Id. at 38:10-22.

90. On January 8, 2015, Claimant underwent a third surgery to remove his gall bladder. Around January 13, 2015, Claimant's symptoms began to resolve. However, Dr. Green was unable to testify that Claimant's diagnosed gall bladder abnormality was in fact responsible for causing his nausea, vomiting, and abdominal distension:

> Q: [By Mr. Gilman] Do you have an opinion, to a medical probability, what was the cause of Mr. Domka being hospitalized through basically the months of December and early January 2014 to 2015?

A: We never got a reliable explanation as to the cause of his persistent nausea that continued even after enlarging the ileostomy opening and after relief of his distension and return of the bowel wall or bowel diameter to normal size. He continued to have nausea and vomiting that prolonged his hospital stay. I would have to say, no, we never did.

Id. at 41:12-22. More importantly, even had he been persuaded that Claimant's persistent abdominal systems were causally related to a gall bladder abnormality, Dr. Green was unable to relate that abnormality to the original accident, or to the December 8, 2014 surgery:

Q: [By Mr. Gilman] Do you have any opinion, to a reasonable medical probability, why he would now all of a sudden be having gallbladder trouble postsurgery on December 6?[18]

A: No sir. Gallbladder troubles, with stones and without stones, are common. Whether this would have become an issue without the surgery at some other time, that would be speculation. It is not typical to see postoperative gallbladder dysfunction in the absence of stones. It's a common enough thing that frequently if we are doing a major abdominal operation and we have somebody that has gallstones, we would want to take the gallbladder out so we don't have difficulty identifying a gallbladder problem that has erupted when they have a different reason for having pain in that area anyway because we just operated there. But an acalculous gallbladder dysfunction after surgery is uncommon.

Q: Acalculous means no stones?

A: No stones.

…

Q: [By Mr. Gilman] Was anything of significance found with regard to, say, pathology findings for the gallbladder?

A: Well the pathology findings are not contained in this report. That would be separate.

Q: Did you do the procedure?

A: Yes, I did.

[18] Throughout Dr. Green's deposition, the parties mistakenly refer to Claimant's ileostomy repair as occurring on December 6, 2014, however, the medical record demonstrates it was performed December 8, 2014. Ex B:389.

> Q: Did you see anything unusual about the gallbladder?
>
> A: We usually don't when we are operating for acalculous cholecystitis. It usually looks normal. It just doesn't work.
>
> …
>
> Q: [By Mr. Gilman] Do you have an opinion, to a medical probability, what was the cause of Mr. Domka being hospitalized through basically the months of December and early January 2014 to 2015?
>
> A: We never got a reliable explanation as to the cause of his persistent nausea that continued even after enlarging the ileostomy opening and after relief of his distension and return of the bowel wall or bowel diameter to normal size. He continued to have nausea and vomiting that prolonged his hospital stay. I would have to say, no, we never did.

Id. at 37:2-22; 39:11-24; 41:12-22. A temporal relationship exists between the December 8, 2014 surgery and Claimant's complaints of nausea, vomiting, and abdominal distention. However, the medical evidence, in the form of testimony from Dr. Green, altogether fails to establish that Claimant's gall bladder abnormality was the cause of these abdominal symptoms or that the gall bladder abnormality is somehow causally related to the December 8, 2014 surgery. Absent medical evidence establishing a causal connection between Claimant's gall bladder abnormality and the December 8, 2014 surgery, we conclude that Defendants cannot be held responsible for medical expenses which can be clearly identified with the gall bladder surgery.

91. We believe it important to explain a critical difference that obtains between the ileostomy revision and the gall bladder removal. In the former case, Dr. Green explained that the revision surgery was initially thought to be necessary because the December 8, 2014 ileostomy resulted in a constricted opening. This reasoning, even if subsequently called into question by the persistence of Claimant's symptoms, nevertheless establishes a relationship between the two procedures. On the other hand, Dr. Green does not appear to have <u>ever</u> entertained the notion that Claimant's gall bladder abnormality had any connection whatsoever to the original accident or to

the December 8, 2014 surgery. At all times relevant hereto, Dr. Green appears to have assumed that the gall bladder findings were coincidental to the December 8, 2014 surgery. Had Dr. Green testified that he removed Claimant's gall bladder in the belief that the gall bladder abnormality was causally related to the subject accident, a different outcome might obtain vis-à-vis the compensability of that treatment. Defendants are not liable for the costs of Claimant's gall bladder removal surgery.

92. **Other Expenses of Hospitalization.** With respect to Claimant's hospitalization, we have found that charges associated with surgeries of December 8, 2014 (except for charges solely attributable to repair of the hernia) and the December 17, 2014 are compensable, while costs connected with the January 8, 2015 gall bladder surgery are not. While it may be fairly easy to identify certain costs with certain procedures, for some it will not. (*See*, Discussion at ¶ 86, *supra*). We have found that Claimant's persistent abdominal complaints kept him in the hospital through January 15, 2015. We have also found that neither the ileostomy revision of December 17, 2014, nor the gall bladder surgery, relieved those complaints. Left unanswered is the question of whether Claimant's persistent nausea, vomiting, and abdominal distension were related to the December 8, 2014 surgery, or some other aspect of Claimant's hospitalization. If so, then Claimant's hospitalization, except for the costs associated with the gall bladder surgery and December 8, 2014 hernia repair, are compensable. If not, then at some point following the December 17, 2014 ileostomy revision, Surety should no longer be held liable for Claimant's costs of hospitalization; if Claimant's ongoing hospitalization is because of a problem unconnected to the original accident or compensable surgeries, then Surety should bear no responsibility for these costs.

93. There was no direct evidence on the question of whether Claimant's nausea, vomiting, and abdominal distension were associated with his surgery for a work caused injury. We decline to make any judgment on this issue in the absence of persuasive evidence. The parties are directed to adduce additional proof on the question of whether Claimant's persistent nausea, vomiting, and abdominal distension are causally related to his December 8, 2014 surgery, some other cause connected to his hospitalization, or merely coincidental.

94. **Post-Surgical Hernia.** Claimant currently suffers from what has been called both a peri-incisional hernia and a peristomal hernia. Dr. Radnovich opined that Claimant's current "peri-incisional" hernia was related to the industrial accident because the accident destabilized the previously stable stoma. Radnovich Dep. 29:13-18; 13:3-6. He explained a peri-incisional hernia is "an abdominal wall defect that occurs around the site of a previous surgery." *Id.* at 52:1-3.

95. Dr. Kornfield confirmed he was familiar with Claimant's records documenting a peristomal hernia after his 2014 ileostomy repair. Kornfield Dep. 20:12-15. Dr. Kornfield testified:

> Q: [By Mr. Pappas] Is [a peristomal hernia] another fairly common complication of the second surgery he had?
>
> A: It is in the sense that the first surgery led to weakening of that general area. The second surgery will also have a higher likelihood because of disruption of the abdominal tissues with further weakening is certainly an identified possible problem.

Id. at 20:16-22. It is unclear in this exchange if the "first surgery" is the 2011 colectomy or the 2014 repair and if the "second surgery" is the 2014 repair or the 2014 revision. Regardless, Dr. Kornfield did not relate the post-surgical hernia to the industrial accident.

96. Dr. Green opined:

> Q: [By Mr. Gilman] Do you have an opinion to a reasonable medical probability, whether this parastomal hernia, which you're documenting on April 30, 2015, was caused by the accident of September 10, 2014?
>
> A: Well, probably more accurately caused by the need to enlarge the opening. Initially we sized the opening in the abdominal wall to make it just a little bit bigger than the bowel with normal contents. If you make it bigger than that, then you make a bigger opening with the possibility for hernia, which is why the repair was sized as it was on December 6. Having to enlarge that ten days later, it increases the risk of having a hernia. So tangentially related to having to have an operation when he had a parastomal hernia to start with. As I said before, most common complication of having a stoma is having a hernia.

Green Dep. 42:25-43:16. All three doctors agree that Claimant's multiple surgeries weakened his abdominal wall, pre-disposing him to herniation. The evidence is close to equipoise on whether Claimant's post-surgical hernia was caused by the stoma and 2011 colectomy (pre-existing) and/or his 2014 surgical repair and subsequent surgical revision (industrially related). However, when read carefully, all physicians seem to point to the "second" surgery as the predominant factor causing Claimant to re-herniate. Regardless of whether Dr. Kornfield meant the repair or revision, the result would be the same as both are compensable; Dr. Kornfield's opinion that Claimant's hernia is not related to the industrial accident is dependent on his opinion that Claimant's stomal prolapse was not related, an opinion we have rejected. Dr. Green states his opinion in two different ways in the same paragraph: it was "caused by" the repair surgery or "tangentially related" to having an operation with a pre-existing hernia. Either way, he relates it to Claimant's compensable surgeries, making the hernia a compensable consequence. Drs. Green, Kornfield, and Radnovich each relate the post-surgical hernia to one of the two compensable surgeries. Claimant has met his burden of showing his post-surgical hernia is related to his industrial accident as a compensable consequence of his two compensable surgeries.

97. Dr. Green, Claimant's treating physician, no longer requires or recommends Claimant undergo repair surgery for his current hernia. *See*, Green Dep. 44-45. However, should this surgery become necessary, Defendants are liable for the cost. Defendants are liable for the cost of any palliative care related to the hernia such as replacement hernia binders.

98. **Lumbar Spine** and **Cervical Spine.** Claimant has not met his burden to show that his neck and low back conditions are causally related to the accident. Dr. Jorgenson couched his opinion, even on direct, on his understanding that Claimant had no prior reports of symptoms in his low back and neck:

> Q: [By Mr. Gilman] Do you have an opinion to a reasonable medical probability, once again based upon your training, experience, education, and these notes we've gone through, whether Mr. Domka's condition which you observed and for which you were treating him and for which further treatment and/or surgery is recommended was caused by the motor vehicle accident of September 10, 2014, either entirely or partially?
>
> A: Yes, I believe that there were caused partially by the motor vehicle accident.
>
> …
>
> A: So with regard to the cervical spine, the cervical radiculopathy, he has cervical spinal stenosis, which is causing pain to his right arm, cervical radiculopathy. The radiographic findings **are clearly preexisting, longstanding, and not acute or caused by the accident; however, I don't have any records or history to indicate that the patient had any symptoms prior to the accident. So it appears that the need for treatment is combined from the preexisting radiographic findings, progressive degenerative findings, and aggravated by trauma from the motor vehicle accident.**
>
> Q: Thank you. Would the same be true for the cervical and lumbar areas of the spine? Would your answer be the same?
>
> A: Yes. The lumbar spine appears to be a very similar situation. Longstanding preexisting degenerative findings that, based on the notes that I reviewed here, at least, don't seem to have a preexisting history of being symptomatic where those preexisting, longstanding findings were aggravated by the traumatic motor vehicle accident.

Jorgenson Dep. 41:15-24; 42:17-43:16 (emphasis supplied).

99. This conclusion is not denigrated by Defendant's misstatement of the medical standard[19] on cross, when Dr. Jorgenson completely disavowed his causation opinion; Dr. Jorgenson had already explained his opinion depended on the absence of prior reports of neck and back symptoms.

100. Dr. Radnovich's opinion was also predicated on his understanding that Claimant had no prior symptomatology: "I have no idea, based on the information at hand, whether these were congenital or pre-existing, there for a long time or not. **My issue is now they're symptomatic.** And becoming symptomatic is related to the motor vehicle accident." Radnovich Dep. 28:5-10 (emphasis supplied). Dr. Radnovich was unwilling to change his opinion without having reviewed the prior records, but he acknowledged that Claimant's neck and low back conditions pre-dated the accident. *Id.* at 23:12-25; 28:2-10; 30:1-25.

101. This conclusion is also supported by Claimant's testimony and the medical record. Dr. Shoemaker recognized almost immediately after the accident that Claimant's C-spine MRI revealed a condition that was non-concordant with his symptoms, but that still required treatment. Ex 13:626. Claimant testified he received chiropractic care in the 1980s from a Dr. Long and degenerative changes in Claimant's spine were noted as early as 2001. Claimant Dep. (12/1/15) 45:1-10; Ex 7:111. Claimant reported "intermittent" neck and back pain to multiple providers over many years. *See*, Ex 7, 14, 17, 18. In 2011, Claimant's pre-accident complaints were such that Dr. Herrold specifically opined that he may need a referral to spine surgeon in the future if his symptoms should worsen. Ex 17:845. As recently as August 2013, Claimant was presenting to his primary care physician <u>solely</u> for treatment of his back pain. Ex 14:703. At

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[19] Dr. Cox's opinion is omitted because he was asked to opine under the incorrect standard both in his report and in his deposition. See Ex 24:1132, Cox Dep. 26:18-25.

hearing, Claimant affirmed that he had reported back pain prior to the accident. Tr., 117:8-22; 118:2-7; 125:24-126:5; 144:14-19. Claimant's conclusion that these prior reports were just "aches and pains" is an understandable layman's conclusion but is contrary to the documented medical record. Defendants are not liable for the costs of any prospective surgery for Claimant's low back and neck conditions.

102. **Right Knee.** Claimant has met his burden of showing his right knee condition is related to the industrial accident; Claimant had pre-existing arthritis and a degenerative meniscus tear, which were asymptomatic for three and half years prior to the accident, and were aggravated by the accident. The last time Claimant complained about his knee to a physician was in June of 2011. Ex 14:650. Dr. Shoemaker's initial impression was that Claimant had pre-existing arthritis, but that the accident aggravated it. Ex 13: 629. Dr. Cox's initial impression, to a degree of medical certainty, was also that Claimant had pre-existing arthritis but that his knee pain was related to the industrial accident. Ex 24: 1131. Drs. Walker, Kristensen, and Radnovich all noted Claimant had degenerative changes that pre-dated the accident and that became symptomatic after the accident. *See*, Ex 26 and Ex B. All of these examining doctors, even without the benefit of Claimant's prior medical records, recognized that Claimant's knee had some pre-existing degeneration, but nevertheless opined that Claimant's current knee condition was related to the industrial accident. The proposed surgeon, Dr. Kristensen, even when apprised of the specifics of Claimant's prior complaints at deposition, still retained his opinion that Claimant's knee condition was aggravated by the accident because of the remoteness of those reports. Kristensen Dep. 37-42; 57:4-17.

103. In addition to the aggravation of Claimant's pre-existing knee conditions, there is also evidence of a chondral injury to Claimant's patella. Dr. Walker referred to it as an "acute"

injury in his notes, but Dr. Kristensen was unwilling to characterize it as such because the MRI was a year after the initial injury. Ex 26: 1164; Dr. Kristensen Dep. 50:17-51:4. However, Dr. Kristensen opined that Claimant's need for arthroplasty was due to three conditions: his meniscus tear, his arthritis, and the chondral injury to the patella. *Id.* at 53:14-54:3; 27:10-28:2. He testified that the first two conditions standing alone could be treated with an arthroscopy, but "the patella did complicate issues." Kristensen Dep. 27:22-25. In other words, Claimant's knee condition is related to both the aggravation of his pre-existing conditions and the chondral injury, and is related to his industrial accident.

104. Dr. Kristensen well explained why a total knee arthroplasty is both required and reasonable treatment for Claimant's knee conditions. Defendants are liable for the costs of this prospective surgery.

105. **TTDs/TPDs.** The next issue is Claimant's entitlement to temporary disability benefits.[20] Idaho Code § 72-408 provides that income benefits for total and partial disability shall be paid to the disabled employee during a period of recovery. The burden is on Claimant to present expert medical evidence of the extent and duration of the disability to recover income benefits for such disability. *Sykes v. C.P. Clare and Company*, 100 Idaho 761, 763, 605 P.2d 939, 941 (1980). Under *Malueg v. Pierson Enterprises*, 111 Idaho 789, 727 P.2d 1217 (1986), once a claimant establishes by medical evidence that he is within a period of recovery from the industrial accident, he is entitled to TTD benefits unless and until evidence is presented that he has been medically released for light work and (1) that an employer has made a reasonable and legitimate offer of suitable employment to him or that (2) there is employment available in the

[20] Though raised as an issue for hearing, the parties did not address Claimant's entitlement to TTD benefits in briefing.

general labor market which claimant has a reasonable opportunity of securing, and which is consistent with his physical abilities.

106. Claimant's stomal prolapse was fixed and stable as of February 17, 2015. *Supra*, ¶ 47. However, the stability (or lack thereof) regarding Claimant's hernia is less clear; Dr. Green changed his recommendation for surgery at deposition, but he did not go so far as to pronounce Claimant medically stable. The testimony was as follows:

> Q: [By Mr. Gilman] Does he need further treatment at this point? I see you're recommending that he continued to wear the stoma hernia belt. Is that a life-long thing?
>
> A: Yes. Unless his hernia enlarges to the point where it starts having blockages issues or it can no longer keep an appliance on it and it's leaking frequently, I would not recommend he undergo further surgery.
>
> …
>
> Q: So the bottom line is you don't recommend that he have any further surgical attempts to try to cure the problems he has with his stoma even if he has a parastomal hernia?
>
> A: The presence of the hernia does not, per se, mean that it should be repaired. The indications that are pretty much agreed on by everybody is if you're getting blockages in the hernia or the hernia is big enough that you can't keep an appliance on it, just the size and shape of the hernia causes the appliance to come off, then you should fix it. Other than that, it's a matter of how much of a functional impediment to the patient's activity is the current hernia. His hernia is reasonably well controlled with his hernia belt.

Green Dep. 44:6-14; 46:11-25.

107. It unclear whether Dr. Green would consider Claimant presently medically stable for his hernia condition. We are not equipped to make the determination as to whether "well controlled" equals "medically stable." Dr. Green was clear, however, that Claimant was limited to sedentary work with his hernia in its current condition. Green Dep. 47:12-13.

108. Also, Claimant has presented evidence he is still in a period of recovery for his

right knee. However, neither Dr. Kristensen nor Dr. Walker were asked to issue work-related restrictions. *See*, Ex 26; Kristensen Dep. 63:15-21. Dr. Kristensen wrote Claimant had "significant limitations" with activities of daily living and confirmed that opinion again at deposition, but never clarified what Claimant's capacity for work is with his knee in its current condition. Ex 26:1173; Kristensen Dep. 29:12-19.

109. Inasmuch as we are unable to ascertain whether Claimant is medically stable, or if not, whether any of the factors enumerated in *Malueg* would curtail his right to time loss benefits, we conclude that Claimant is entitled to time loss benefits at the appropriate rate from the date of injury forward, with credit for time loss benefits paid to date.

110. **Attorney Fees.** Claimant asserts a right to attorney fees in brief, but as this issue was not noticed for hearing, we decline to address it.

CONCLUSIONS OF LAW AND ORDER

1. Claimant has proven entitlement to costs associated with his December 8, 2014 ileostomy repair and his December 17, 2014 revision surgeries. He is not entitled to recover costs wholly related to the December 8, 2014 hernia repair, and January 8, 2015 gall bladder surgeries. As to day-to-day expenses of hospitalization required by Claimant's persistent nausea, vomiting, and abdominal distension, the parties are directed to submit such additional evidence as they wish the Commission to consider on the question of whether Claimant's persistent abdominal complaints are causally related to the December 8, 2014 surgery or subsequent hospitalization. The parties shall have sixty days from the date of this Order to adduce such proof. Defendants are liable to pay compensable costs at the full invoiced rates pursuant to *Neel v. Western Construction, Inc.*, 147 Idaho 146, 206 P.3d 852 (2009).

2. Claimant is entitled to additional reasonable and necessary medical care, including a total right knee arthroplasty and palliative care related to his post-surgical hernia.

3. Claimant has not proven his low back and neck conditions are causally related to the industrial accident.

4. Claimant is entitled to temporary total disability benefits from November 25, 2014, until he reaches medical stability.

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

DATED this ___22nd___ day of __February__, 2019.

INDUSTRIAL COMMISSION

_______/s/__________________
Thomas P. Baskin, Chairman

_______/s/__________________
Aaron White, Commissioner

_______/s/__________________
Thomas E. Limbaugh, Commissioner

ATTEST:

_______/s/_______________________
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the ___22nd___ day of __February__, 2019, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** was served by regular United States Mail upon each of the following:

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