BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

GEORGE WOODS, Claimant, v. HOBSON FABRICATING CORPORATION, Employer, and ALASKA NATIONAL INSURANCE COMPANY, Surety, and STATE OF IDAHO, INDUSTRIAL SPECIAL INDEMNITY FUND, Defendants.	**IC 2013-014178** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **Filed May 20, 2019**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Industrial Commission assigned this matter to Referee Douglas A. Donohue who conducted a hearing in Boise on April 12, 2018. Dan Luker represented Claimant. Lora Breen represented Employer and Surety. Ken Mallea represented ISIF. The parties presented oral and documentary evidence. The parties took post-hearing depositions and submitted briefs. The case came under advisement on December 4, 2018. This matter is now ready for decision. The Referee submitted proposed findings of fact and conclusions of law for the approval of the Commission. The Commissioners have reviewed the proposed decision and decline to adopt the same. This decision is issued to give different treatment to certain causation questions at issue and to the elements of ISIF liability.

ISSUES

The issues to be decided according to the Notice of Hearing are:

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

2. Whether Claimant's condition is due in whole or in part to a subsequent intervening cause;
3. Whether Claimant is medically stable and, if so, on what date;
4. Whether and to what extent Claimant is entitled to:
    a. Temporary disability,
    b. Permanent partial impairment,
    c. Permanent disability in excess of impairment, including total permanent disability, and
    d. Medical care;
5. Whether Claimant is entitled to permanent total disability under the odd-lot doctrine;
6. Whether apportionment is appropriate under Idaho Code § 72-406;
7. Whether ISIF is liable under Idaho Code § 72-332;
8. Apportionment to establish ISIF's share of liability under *Carey v. Clearwater County Road Dept.*, 107 Idaho 109, 686 P.2d 54 (1984); and
9. Whether and to what extent Defendants have a subrogated interest under Idaho Code § 72-223.

At hearing, the parties agreed that medical stability as of June 14, 2016 was not an issue. They stipulated that, for purposes of subrogation, Employer admitted a component of negligence in an unquantified amount such that *Maravilla*[1] precludes Employer from a subrogation interest. Whether ISIF is precluded from its subrogation interest remains an issue.

In briefing the parties acknowledged that as of the date of hearing Claimant is totally and permanently disabled.

[1] *Maravilla v. JR Simplot Company*, 161 Idaho 455, 387 P.3d 123 (2016).

CONTENTIONS OF THE PARTIES

Claimant contends he is totally and permanently disabled both under the 100% method and as an odd-lot worker. He fell about 20 feet from a ladder which provided roof access on May 17, 2013. This compensable industrial accident caused serious injuries. Claimant also had pre-existing conditions including lumbar and left hip impairments. He was working under and sometimes despite prior lifting restrictions. The Commission approved an Agreement for Lump Sum Settlement of certain issues on May 18, 2015. A civil suit regarding the subject accident was also resolved by settlement. Although the parties dispute the extent and causal connection of particular conditions, this should reflect more in *Carey* apportionment and not in compensability. The Commission should rule for future right shoulder surgery rather than retain jurisdiction. Other medical treatment and appliances have been denied and should be ordered paid per *Neel.*[2] *Maravilla* applies to deny Employer and Surety any recovery from the civil settlement. Idaho Code § 72-223 dictates that ISIF stands in Employer and Surety's shoes on this issue and is similarly denied any right of subrogation.

Employer and Surety contend that although Claimant is likely totally and permanently disabled, ISIF should be liable for an apportionment. *Carey* apportionment should be based upon a 46% pre-existing impairment. Prerequisites to imposition of medical care benefits under *Neel* have not arisen. Claimant is not entitled to additional past or future medical benefits.

ISIF contends that Employer cannot meet its burden of showing the "subjective hindrance" element to invoke ISIF liability. Likewise, it cannot show the "combining" requirement exists to the "but for" standard. Claimant was rendered totally and permanently disabled by the subject accident alone. Employer and Surety inaccurately characterize some of

[2] *Neel v. Western Construction, Inc.*, 147 Idaho 146, 206 P.3d 852 (2009).

his conditions as pre-existing where they actually result from injuries suffered in the accident. The entire liability rests with Employer and Surety. If liable, ISIF retains a subrogation right.

EVIDENCE CONSIDERED

The record in the instant case included the following:

1. Oral testimony at hearing of Claimant and his boss Ted Frisbee;
2. Joint exhibits 1 through 76; and
3. Post-hearing depositions of physicians Robert Friedman, M.D., Timothy Doerr, M.D., and of vocational experts Barbara Nelson, Mary Barros-Bailey, Ph.D., and Douglas Crum.

All objections raised in post-hearing depositions are OVERRULED.

FINDINGS OF FACT

1. Claimant worked for Employer as a roofer. His job title was "roofing foreman," but that does not mean that his work was less physically demanding than other roofers on the crew. Mostly he worked with hot-tar, flat roofs. A hot-tar mop can weigh 125 pounds. Heavier items are handled by two or more workers, or by cranes. On May 17, 2013, he fell nearly 20 feet from a ladder which accessed a roof hatch. He struck his head on shelving on the way down before landing on the concrete floor. His injuries were serious. This is accepted as a compensable claim.

2. At the time of hearing, the parties did not dispute that Claimant is totally and permanently disabled.

Medical Care: May 17, 2013—December 31, 2013

Emergency Response

3. Paramedics noted Claimant reported chest and right hip pain. They found

a contusion on the back of his head. He reported "the events seem fuzzy" but denied loss of consciousness. They observed no deficit in mental alertness. A paramedic from Boise Fire Department reported hearing a "pop" in Claimant's chest when he performed his initial assessment.

4. St. Al's emergency room recorded positive loss of consciousness with reported pain in the right front of Claimant's head as well as chest, back, and right groin pain. An examination revealed tenderness in his neck, mid-back, and sternum, with pain upon right hip motion. The examiner considered a cartilage tear at the sternum as well as a concussion. Claimant was admitted for hospitalization, and diagnostic imaging was ordered.

Initial Hospitalization: May 17-June 21, 2013

5. Initial x-rays showed no fractures. A CT scan showed "severe" degenerative joint disease in Claimant's right hip. "Extreme" left ankle swelling arose.

6. An MRI and chest CT showed compression fractures of T7, T8, and T9. Edema was noted in soft tissue from C4 through T1, indicating ligamentous injury. Additional CT scans showed laminar fractures at C6-7-T1 and a compression fracture at L1. (Dr. Morgan's note on that date inaccurately describes the compression fracture as occurring at L3 in one of three mentions. This is deemed a typographical error.) Repeat x-rays confirmed the spinal injuries. A right-hip MRI showed a "tiny" upper hamstring tear, joint effusion, and significant degenerative joint disease. A chest CT showed a slight fracture of Claimant's sternum. A CT of Claimant's head showed soft tissue swelling that would not affect the brain.

7. Timothy Johans, M.D., recommended 3 months in a cervical brace. He acknowledged a possible need for a lumbar fusion to remedy the compression fracture. He sought Dr. Michael Hajjar's opinion about extending Claimant's pre-existing lumbar fusion.

8. Michael Hajjar, M.D., tentatively opined that lumbar surgery would not be necessary. He noted that if Claimant's T-spine required surgery, it would be preferable to extend any fusion through the pre-existing L-spine fusions rather than leave one or two segments mobile between two multi-level fusions.

9. As early as May 22, 2013, care provided to Claimant included a "Network Manager," Diane Davis, RN, provided by Paradigm, as well as a "Case Manager," Nicole Wood, RN, provided by Intermountain Claims. Ms. Wood's involvement in management of the case was limited. Ms. Davis was involved through May 2014.

10. On May 16, 2013, the day before the industrial accident, Claimant underwent an esophagoscopy and gastroscopy to evaluate complaints of iron deficient anemia and refractory GERD. Dr. Tanabe reported the following findings:

> ESOPHYAGOSCOPY
> Upper, middle and lower thirds of the esophagus carefully inspected. The proximal two-thirds are unremarkable. Distal esophagus did show linear ulcerations to the SCJ which was encountered at approximately 40 cm. Biopsies taken for routine histology.
>
> GASTROSCOPY
> Upon entrance of the stomach, retroflexion of the cardia and fundus revealed a large paraesophageal hernia and possible intrathoracic stomach. There are ulcerations along the body of the stomach and along the hernia line, consistent with either Cameron lesion or NSAID gastropathies. Biopsies taken for routine histology. Despite multiple attempts at exiting the stomach, I was unable to identify the pylorus. The patient eventually [sic] tolerated the procedure well but it was difficult to hold the air so we were unable to get a full evaluation. No mass lesion are indentified.
>
> IMPRESSION
> 1. Reflex esophageal ulceration.
> 2. Multiple gastric ulcers.
> 3. Large paraesophageal hernia with probable intrathoracic stomach.

JE 3, p. 78. Dr. Tanabe's plan was to perform upper GI x-rays preparatory to a "probable laparoscopic repair."

11. During his period of hospitalization following the accident of May 17, 2013, Claimant was found to have anemia. It was noted that he had "a long history of anemia." JE 21, p. 32. Claimant's anemia was described on May 21, 2013 as "acute on chronic." *Id.* at 33.

12. On May 23, 2013, Claimant underwent another endoscopy to re-assess his hiatal hernia. From that study, it was noted that Claimant had a large hiatal hernia with what appeared to be a large paraesophageal component. Large erosions/ulceration were noted which were thought to explain his blood loss/anemia. A handwritten notation beneath the report reads as follows: "[p]atient had already had an EGD approximately one week prior by Digestive Health with same findings." *See* JE 21, p. 47. In follow-up to the May 23, 2013 EGD, Dr. Martin wrote:

> I just spoke with Dr. Steven Schutz over the phone who did an upper GI endoscopy on him and found him to have erosive gastritis in the area of the esophageal hiatal hernia from apparently erosions in that area just from the hernia itself.

Id. at 48. On May 25, 2013, Steven Casos, M.D., one of Claimant's physicians, offered his comments on Claimant's pending transfer to a rehab facility:

> Over the next few days, the patient continued to work with therapies. It was felt that he was a reasonable candidate for rehab and he was accepted, but someone had mentioned the need to fix this paraesophageal hernia prior to going to rehabilitation. I completely disagree with that recommendation because the patient has no evidence of acute ongoing upper GI bleed, not to mention the fact that because this is not injury related, his insurance would most likely not authorize this and he would be stuck with a very large hospital bill. I felt a reasonable alternative was to place the patient on aggressive GI prophylaxis including Protonix, Pepcid and sucralfate. He can then have this fixed electively as an outpatient and it would not prevent from going to the rehabilitation services.

Id. at 57.

13. Claimant was referred to physiatrist Michael McMartin, M.D., for evaluation. In his report of May 27, 2013, he noted the following concerning the etiology of Claimant's anemia:

> His hospital course was further complicated by acute on chronic anemia. The patient required a total of 5 units of packed red blood cells and transfusion prior to admission to our Rehabilitation Unit. He has undergone hematology consultation by Dr. Schultheiss who confirmed evidence of profound anemia, etiology initially indeterminate. He was subsequently seen by Dr. Schutz, who did perform EGD, revealing evidence of a large hiatal hernia with a large paraesophageal component. A large Cameron erosion was also see with ulceration. Dr. Schutz confirmed that this would explain his chronic GI blood loss and anemia.

JE 21, p. 65.

14. On May 31, 2013, Claimant's hiatal hernia repair was performed by Bren Heaton, M.D. As part of his presurgical assessment, Dr. Heaton stated: "[t]his is a 52-year-old male with longstanding chronic anemia who has a fairly large hiatal hernia with Cameron erosions that are most likely the cause for his chronic anemia." Dr. Heaton described the surgical repair as an "elective" procedure. *Id*. at 77.

15. Dr. McMartin treated Claimant through acute inpatient rehabilitation. He described Claimant as "very motivated" to participate in rehabilitation. At his initial examination, Dr. McMartin noted Claimant exhibited left foot drop, a symptom of which Claimant was unaware. Claimant was aware of longstanding left lower leg weakness and occasional numbness since his lumbar fusions.

16. Medical records throughout this hospitalization suggest Claimant was relatively stoic and attempted to comply with the attempts to return him to mobility despite significant pain issues.

17. On June 4, 2013, Claimant was again transferred to acute inpatient rehabilitation. Therapies provided improvement and pain management. However, increased activity also increased his right hip and groin pain. Dr. McMartin deemed him ready for discharge to home health therapy on June 21, 2013.

Post-Hospitalization Care

18. Dr. Hajjar provided significant follow-up care after hospitalization. He monitored Claimant's conditions for potential surgery as well as his use of a back brace.

19. On June 25, 2013, Claimant felt a pop and received a left shoulder X-ray. It showed mild to moderate degenerative changes there.

20. On July 8, 2013, Claimant began outpatient physical and occupational therapy. The therapists focused on Claimant's low back. They noted full right arm strength but acknowledged that spinal issues precluded a thorough assessment of Claimant's arms. Their notes do not suggest Claimant complained of right shoulder issues in July. Claimant was discharged from occupational therapy on August 9, 2013. Physical therapy sessions continued. August and September sessions included upper extremity strengthening but did not mention right shoulder complaints. The notes show Claimant was cooperative. In September, Claimant successfully began a component of independent physical therapy by swimming regularly. On October 10, 2013, Claimant was discharged from the brain injury component of therapy. On November 26, 2013, the therapist noted right shoulder pain—apparent bicep tendonitis with symptoms of rotator cuff damage. This prompted a new round of physical therapy directed at that shoulder.

21. On July 12, 2013, Robert Calhoun, Ph.D., performed a neuropsychological consultation. Dr. Calhoun characterized Claimant's cognition as "very close to baseline."

22. On July 24, 2013, Dr. McMartin examined all injured body parts and found no change. Dr. McMartin noted an MRI showed right hip avascular necrosis. He noted "traumatic brain injury" for what had upon initial hospitalization been called a "concussion." He also ordered a change in type of left ankle brace.

23. In a later letter based upon the examination of July 24, 2013, Dr. McMartin reported Claimant's traumatic brain injury "has improved significantly." He opined that the sternal fracture, C7 fracture, L1 compression fracture, acute-on-chronic anemia, and left ankle condition were related to the fall. He did not opine that other conditions were not related, but context is consistent with his earlier indication that the hiatal hernia was nonindustrial.

24. On July 31, 2013, Dr. McMartin, by telephone, informed Claimant his hiatal hernia was "a pre-existing condition and was unrelated to his industrial injury."

25. On August 28, 2013, Ron Kristensen, M.D., examined Claimant and opined that Claimant's right hip condition was exacerbated by the industrial accident and that a right hip arthroplasty would be needed after he had recovered sufficiently to undergo another surgery.

26. Also on August 28, 2013, Dr. McMartin addressed a complaint of left hand numbness along with other conditions. He considered the left hand and arm complaints to be consistent with a cervical radiculopathy. He also described "endstage degenerative arthritis of the right knee with superimposed trauma."

27. On October 11, 2013, an EMG showed left median nerve neuropathy, moderately advanced, but did not show cervical radiculopathy.

28. On October 31, 2013, Dr. Hajjar noted Claimant's neck was not improving and surgery was becoming likely.

29. A November 13, 2013 C-spine MRI showed a C6-7 left paracentral disc protrusion which appeared to compress the exiting C7 nerve. An L-spine MRI the same date showed degeneration above the prior fusions and the L1 compression fracture from the accident.

30. On November 21, 2013, Colin Poole, M.D. examined Claimant's right hip. He opined a causal link between the accident and the acceleration and exacerbation of Claimant's

right hip condition which would require arthroplasty. Ultimately, the actual surgery would be delayed until June 3, 2014.

31. At a November 26, 2013 visit to Dr. McMartin, Claimant complained primarily about his right hip and low back.

32. On December 4, 2013, Claimant received a steroid injection to his right hip.

33. On December 5, 2013, Claimant began physical therapy directed at his right shoulder. The initial PT note states:

> The patient reports pain began shortly after falling at work on 05/17/13. The patient reports receiving care to other injuries which were of greater importance than his shoulder prior to now. The patient reports shoulder pain significantly increased following his performing an upper arm bicycle at a local YMCA in late November.

Claimant noted that among other things, use of his cane worsened his right shoulder symptoms. The physical therapist noted strength loss in the right upper extremity on examination. Therapy for Claimant's other industrially related conditions continued as well. He was deemed "compliant and consistent" in his efforts and to have recovered enough to undergo additional surgeries. Claimant was discharged from physical therapy on April 4, 2014.

Medical Care: 2014

34. On January 9, 2014, Dr. Hajjar expressed hope that a less extensive C-spine surgery might be efficacious, but recognized a fusion would likely be required.

35. By February 19, 2014, Claimant was scheduled for C-spine surgery. Dr. McMartin also noted right shoulder and right hip pain with decreased function. A physical therapist had reported to Dr. McMartin that the hip was impeding PT goals.

36. On March 7, 2014, a right shoulder MRI showed some tendonitis, arthritis, and adhesive capsulitis. Claimant received another steroid injection in his hip to the right

trochanteric bursa as well.

37. On April 10, 2014, Timothy Doerr, M.D., reviewed records and examined Claimant. He relied upon the medical records for Claimant's history, some dating as far back as 1980. Upon examination Dr. Doerr found: "no real" C-spine tenderness, mild discomfort in the T-spine and L-spine, good strength in both upper extremities with some intermittent left arm paresthesias, right leg weakness, absent left ankle reflex, right shoulder impingement, left shoulder ok, limited range of motion in his right hip, and moderate swelling of the left ankle. He opined the accident caused the injury at C6-7 but not C7-T1. He opined the accident caused the T7-T9 compression fractures, that these are medically stable and ratable at 9% whole person with no apportionment, and they result in a 50-pound lifting restriction. He opined that the accident caused L1 compression fracture, that this was medically stable and ratable at 12% whole person with no apportionment and that it resulted in a 50-pound lifting restriction. He opined the fractured sternum had healed without impairment. He opined Claimant's right shoulder injury was unrelated to the accident. He opined Claimant's right hip surgery was unrelated to the accident. He opined Claimant's left knee symptoms were unrelated to the accident. He opined Claimant's left ankle condition was unrelated to the accident. He opined Claimant's hiatal hernia was unrelated to the accident. Using the combining table he rated Claimant's accident-related impairment at 20% whole person. He noted additional impairment would accrue when Claimant's neck injury became stable.

38. On May 8, 2014, Dr. Hajjar declared Dr. Doerr's recommendation for injections to be "foolish." Dr. Hajjar maintained his opinion that only surgery could help.

39. On June 3, 2014, Dr. Poole performed a right hip arthroplasty. Claimant was discharged from the hospital on June 6. Claimant reported hip improvement in post-operative

follow-up visits.

40. On June 24, 2014, Dr. McMartin "strongly disagree[d]" with Dr. Doerr's opinion, and opined that Claimant's right shoulder injury was related to the industrial accident. Dr. McMartin "strongly disagree[d]" with Dr. Doerr's opinion that Claimant's C7-T1 condition was nonindustrial. He opined against Dr. Doerr's treatment recommendations and in favor of Dr. Hajjar's.

41. On August 2, 2014, a T-spine MRI showed mild progression of the compression fractures at T7 and L1. Some additional degeneration caused mild spinal cord deformity at T6-7-8-9 and just a bit of deformity at T9-10.

42. On August 4, 2014, Dr. Hajjar opined in favor of C-spine fusion and against T-spine and L-spine surgery. He opined Claimant's "previous lumbar surgery, degenerative issues and his other issues, are clearly not related to the trauma." He opined about the range of likely impairment after recovery.

43. On August 20, 2014, Dr. McMartin reported to an attorney that he had comprehensively reviewed the medical records pertaining to Claimant's initial hospitalization in May and June 2013. Regarding Claimant's right shoulder, Dr. McMartin agreed there were no imaging studies or specific reference to right shoulder pain. Nevertheless, he recalled that Claimant had complained of right shoulder pain since the accident and before the medical record—dated January 9, 2014—which allegedly first identified such a complaint. Dr. McMartin opined that use of a walker after the accident likely contributed to an increase of symptoms related to the underlying degenerative arthritis in that shoulder. He suggested a 50/50% apportionment of causation.

44. On August 25, 2014, Claimant was hospitalized for surgery. Dr. Hajjar

performed a decompression and fusion at C6-T1. (Reference in the operative report to decompression of "both C8 neural foramen" is a typo.) After an uneventful post-operative recovery, Claimant was discharged on August 28.

45. On September 21, 2014, Claimant began another round of physical therapy. The physical therapist described him as "extremely diligent." Therapy completed on February 19, 2015.

46. On September 21, 2014, Dr. Hajjar deferred to Dr. McMartin any questions about return to work.

47. On September 30, 2014, William Linder, M.D., reported a Claimant-provided history which included right shoulder injury at the time of the industrial accident. Dr. Linder did not have access to all of Claimant's medical records. Dr. Linder focused on Claimant's right shoulder and ordered x-rays. Acknowledging that Claimant's right shoulder MRI was taken 10 months after the accident, Dr. Linder opined that without medical records to show a pre-existing shoulder condition, it was likely that the biceps tendon pathology he observed on examination was related to the accident. He analyzed the relative risks and benefits of treatment options including different surgeries. He recommended a tenolysis to ameliorate the traumatic injury. That surgery would not affect Claimant's nonindustrial right shoulder arthritis.

48. On October 2, 2014, Claimant exhibited to Dr. McMartin significant improvement in each of his traumatic conditions. Claimant described a vague complaint of periscapular pain radiating around the right to Claimant's chest. Although this had persisted for a few weeks, Dr. McMartin considered it "new." In deposition one week later, Claimant described symptoms consistent with paresthesias in fingers corresponding to his left ulnar nerve.

49. On October 8, 2014, Claimant gave a deposition. Among other things, he

testified he complained about his right shoulder immediately after the accident and repeatedly, despite the absence of such a notation in the records during the first two months or so after the accident.

50. On October 14, 2014, Bill Morgan, M.D., reported his recollection that Claimant did not express any right shoulder complaints between May 17 and June 3, 2013. Dr. Morgan was attending physician during that part of Claimant's hospitalization at St. Al's.

51. On November 24, 2014, PA Katrina Johnson at St. Luke's Orthopaedics evaluated Claimant's right shoulder pain. She found severe tenosynovitis at his biceps tendon and moderate-to-severe degenerative arthritis in the glenohumeral and acromioclavicular joints. She recommended conservative care and noted that the surgical result would not be better or worse if Claimant waited. Over the next several months, Claimant underwent steroid injections. On January 8, 2016, PA Johnson opined Claimant's use of a cane in his right hand was likely prolonging or exacerbating the symptoms.

Medical Care: 2015

52. By January 28, 2015, Claimant reported to Dr. McMartin that while he needed the walker elsewhere, he could ambulate with a cane inside his own home. Examination showed improvement.

53. On March 4, 2015, Dr. Hajjar again visited Claimant in follow-up. Claimant had nearly fully recovered. Dr. Hajjar was pessimistic that potential thoracolumbar surgery might help.

54. On March 18, 2015, Dr. Hajjar opined Claimant's pre-existing and traumatic spine conditions worked in "combination" to cause chronic symptoms. He opined this combination constituted "a complete hindrance to future employability … that the pre-existing

spinal condition coupled with the new injury has led to permanent disability where neither of these conditions by themselves would have led to the permanent disability alone."

55. On April 20, 2015, Dr. McMartin focused on Claimant's T-spine condition, his other conditions having stabilized and/or improved to lesser significance.

56. In April and May, Victoria Wilding, M.D., with St. Al's, provided steroid injections in Claimant's T-spine. In follow-up visits, she monitored Claimant's condition and/or provided an injection. Later, she provided radiofrequency ablation nerve blocks.

57. On May 26, 2015, Claimant performed a KEY functional capacity assessment (FCE). Considered valid, the evaluation found Claimant capable of working within the light-work category, but with additional limitations which precluded some light-work jobs.

58. On July 1, 2015, Paul Montalbano, M.D., examined Claimant as part of a neurosurgical consultation which focused on Claimant's T-spine injuries. He ordered x-rays and other diagnostic imaging. An MRI showed scoliosis and spondylosis. An "old compression fracture at T12" was noted in addition to the T7, T8, and T9 fractures which had been well documented. ("T12" is possibly a typo; the L1 compression fracture may have been seen.) In a follow-up visit on July 23, 2015, Dr. Montalbano recommended a T3-T10 fusion.

59. On July 20, 2015, a head-to-toe radionuclide study showed activity in the sternum, right tibiotalar joint, inferior right C-spine, mid T-spine (T7-T9), and lumbar area.

60. On July 24 and 27, 2015, Dr. Calhoun performed significant testing and evaluation of Claimant. Dr. Calhoun found Claimant's effort good without evidence of malingering, but that Claimant's subdued mood might result in understated neurocognitive ability. He found no objective impairment. He noted some depression and anxiety affected performance. Dr. Calhoun provided helpful follow-up visits.

61. On August 6, 2015, Dr. Hajjar reluctantly concurred with Dr. Montalbano's recommendation for a T6-7 fusion.

62. On September 3, 2015, Dr. Hajjar further opined, "Some of these conditions are clearly work related including the fractures, kyphosis and the nonhealing of the fractures and some of them are pre-existing and exacerbated, but not directly related to his prior trauma."

63. On October 14, 2015—after Claimant declined the T6-7 surgery—Dr. Hajjar opined Claimant to be medically stable and provided an impairment rating as follows: T-spine 9%, C-spine 6%, L-spine (15% pre-existing and) 12% accident-related for a 27% whole-person rating attributable to the accident. Dr. Hajjar noted other pre-existing conditions—notably a right hip condition—but did not rate them.

64. On December 1, 2015, Dr. McMartin reported that Claimant was still undecided about undergoing T-spine surgery.

65. On December 7 and 22, 2015, Claimant received additional T-spine injections.

Medical Care: 2016

66. On January 12 and February 2, 2016, Claimant received more T-spine injections. Dr. Wilding continued in follow-up visits to monitor and/or provide these injections.

67. On February 11, 2016, Dr. McMartin reported that Claimant had finally decided against undergoing T-spine surgery.

68. On March 9, 2016, repeat right hip x-rays showed no hardware complication. Claimant returned to Dr. Poole on that date with complaints of right hip pain. Dr. Poole examined Claimant and considered the recurrence of pain to be merely a temporary soft-tissue issue.

69. On March 20, 2016, Dr. Ringo noted, related to the industrial injuries, that

Claimant was ambulating with a cane rather than a walker and was off narcotic pain medications.

70. On April 5, 2016, Dr. McMartin noted that although Claimant was mostly stable he wanted Claimant to finish his pain-management regimen with Dr. Wilding before he would opine Claimant to be at MMI.

71. On April 20, 2016, Robert Friedman, M.D. examined Claimant at Claimant's request for forensic purposes. He reviewed significant medical records dated from 2009 to the date of examination. By history, Claimant reported he received "injections for pain in his head, back, right shoulder, and left ankle" from paramedics at the scene of the accident. Claimant's history of the accident and his pre-accident medical care included other errors as well. For example, he reported a pre-existing T12-L1 fusion; it was actually at L3-4. Upon examination, Dr. Friedman noted an absent left ankle reflex, rapidly fatiguing ankle dorsiflexors, limited lumbar range of motion, limited right shoulder range of motion, limited lateral bending at the neck, tenderness about the right shoulder musculature and AC joint, but no tenderness at the biceps tendon. (In deposition, Dr. Friedman acknowledged a typo about this examination; he found left calf atrophy, not right.) Dr. Friedman opined Claimant medically stable, despite persistent right shoulder complaints. He opined the accident aggravated a pre-existing right shoulder condition. He opined Claimant's hiatal hernia and surgery was caused by a GI bleed which was caused by stress from the industrial accident and hospitalization. He opined the brain trauma and neck injury were caused by the accident. He opined the accident caused a "clear aggravation of [Claimant's] GI disease." He opined the accident aggravated a pre-existing right hip condition. He opined the accident aggravated a pre-existing left ankle condition. Dr. Friedman rated impairment as follows: T-spine injuries 9%, L1 fracture 11%, C-spine injuries 6%, traumatic brain injury and mood issues 3% (out of 5%), right shoulder injuries 3% (out of

5% upper extremity) or 2% whole person, right hip injuries 13% (out of 25% lower extremity) or 5% whole person, and hernia surgery 3% after apportionment. Using the combining table, Dr. Friedman rated Claimant's permanent impairment related to the accident at 33% whole person. Pre-existing impairments were rated as follows: L-spine 19%, left hip 25% lower extremity, right hip 13% lower extremity which combines to a 14% whole person impairment for both hips, and sleep disorder 2%. After using the combining table, Dr. Friedman rated Claimant permanent impairment before the accident at 31% whole person. He further opined that Claimant's pre-existing conditions did not contribute to Claimant's fall.

72. On May 3, 2016, Dr. McMartin prescribed a three-wheeled recumbent bike. On June 14, 2016, he noted Claimant had to purchase it on his own. He rated Claimant for permanent impairment as follows: C-spine 8%, L1 compression fracture 8%, T7-9 compression fractures 6%, right hip with necrosis and arthroplasty 6%, TBI 0%, right shoulder 2%. Using the combined values table, this equaled 27% whole person. He considered the May 26, 2015 FCE valid and allowed light work. He recommended continuing therapeutic health club membership for 6 months, as well as specific medications for one year, industrially. The prescription pad for that date prescribed only 3 months' membership.

73. The parties agree that June 14, 2016 is the appropriate date of medical stability for industrially related issues. Surety began paying permanent disability benefits effective this date.

74. A December 16, 2016, follow-up examination of the right shoulder showed severe glenohumeral osteoarthrosis.

Medical Care: 2017

75. On March 2, 2017, right hip x-rays were taken at the 3-year postoperative date. These showed good position without cause for concern.

76. On March 16, 2017, Michael Curtin, M.D., examined Claimant's right shoulder as a follow-up. Claimant reported a recent injection had not helped. Examination showed continued pain and weakness at the biceps tendon. X-rays showed end-stage osteoarthritis. Dr. Curtin was in favor of surgery, but not until Claimant's weight dropped below 300 pounds.

77. On March 30 and April 27, 2017, Dr. Wilding provided left knee nerve blocks.

78. Another round of physical therapy for pain management began in June. The last note is dated July 24, 2017.

79. On October 24, 2017, Claimant visited Dr. Ringo to complain of left knee pain arising since February. X-rays showed degenerative changes and a noncontributory tiny metallic foreign body.

80. On November 16, 2017, Dr. Wilding repeated the T-spine nerve blocks.

81. On December 5, 2017, Helen Holley, Ph.D., provided mental health treatment upon referral from Dr. Wilding to help Claimant cope with lingering difficulty with his injuries.

Medical Care: 2018-Hearing

82. On March 8, 2018, Dr. Doerr performed a follow-up forensic examination. He reviewed medical records arising since his 2014 evaluation. He opined Claimant's neck was medically stable. He rated this at 3% (of 5%) whole person, apportioning out the C7-T1 condition and surgery there. He rated Claimant's prior lumbar fusions at 15% whole person, entirely pre-existing and would impose a 50-pound lifting restriction. He rated Claimant's left hip at 8% whole person, entirely pre-existing. He rated Claimant's right shoulder at 4% whole person, entirely pre-existing. He rated Claimant left knee at 8% whole person, entirely pre-existing. He rated Claimant's left ankle at 7% whole person, entirely pre-existing. Overall, using the combining table, Dr. Doerr rated Claimant's industrial impairment at 24% and

Claimant's pre-existing nonindustrial impairment at 42%. He opined Claimant "has no orthopedic conditions that preclude him from gainful employment." He noted Surety's acceptance of the right hip condition and surgery as well as surgical treatment at C6-T1 as the only things that impact his earlier opinions. He recommended no future medical care would be necessary. He opined Claimant's left ankle weakness was his greatest functional obstacle.

83. On March 21, 2018, Dr. Friedman performed a follow-up forensic examination. He reviewed medical records of treatment since his 2016 evaluation. He found no basis for changing his 2016 opinions regarding causation or impairment. The "sole differences" are the 100 or so pounds of weight Claimant had gained because of his diminished activity.

Prior Conditions and Medical Records - Generally

84. While hospitalized, a few days after the accident the Network Manager recited Claimant's medical history—pre-existing conditions—as including the following:

> Pre-injury history of smoking for 20 years but has abstained for the past 10 years; a two-level spinal fusion at L4-S1 from a fall from a roof many years ago; left hip arthroplasty; lumbar fusion L3-L4 several years ago; hypertension; hyperlipidemia; obesity; hypothyroidism; right ankle repair as a child; left orbital fracture repaired as a child from a motor vehicle accident; remote appendectomy; persistent numbness and weakness of the left lower leg as a result of the initial spinal fusion; right renal cyst; chronic anemia; peptic ulcer disease; prostate enlargement; and severe right hip degenerative disease.

85. As of June 17, 2013, the Network Manager expanded her list of pre-existing conditions also to include sleep apnea, hiatal hernia, hemorrhoids, rectal polyp, chronic Tramadol use, right hip arthritis, and dentures.

Prior Conditions Described in Claimant's 2014 Deposition

86. Claimant described a childhood automobile accident which left him with a dysfunctional tear duct. He recalls other car accidents which did not cause injury.

87. A roller-skating accident resulted in a fractured right ankle. Claimant's right

ankle “pops a little bit, but other than that, no problem.”

88. Claimant testified a 1987 finger injury healed without residua.

89. Claimant recalled his back injuries in 1987 and 2004, but got confused about which was caused how. The 1987 claim resolved unsatisfactorily for Claimant. He believes he was pushed into an unfair settlement while he still had back pain.

90. Claimant recalled that in the 2004 accident he may have twisted his right ankle falling off the edge of a roof.

91. Claimant recalled treatment for appendicitis in 2007.

92. Claimant recalled recurrent bilateral hip and back pain beginning about 2008. About this time he declined an offered shingle-roof job at Tamarack.

93. Claimant recalled conditions including hypertension, hypothyroidism, hypogonadism, and anemia, but vaguely as to onset and progression.

94. Claimant described occasional back pain since 2008, sometimes with radiation into his legs while working for Employer. He did not report it and saw a physician on his health insurance. Eventually it worsened, and he underwent the second fusion surgery in 2010. Claimant believes these conditions were not a subjective hindrance even during the imposition of a temporary 75-pound lifting restriction.

95. Claimant recalled his left hip surgery, but vaguely as to onset and progression.

96. After recovery from the second fusion and left hip surgery he denied any diminished ability to perform any physical motion or exertion required. He does not believe he ever refused a job or was not chosen by Employer to work any job because of these conditions.

97. Claimant had no right hip or leg pain for years after recovering from the 2010 back fusion. About the time of the left hip surgery he recalls a doctor saying he might

need future right hip surgery.

98. Claimant believes his leg-length discrepancy caused "a little bit of trouble getting off my knees." He believes the leg-length discrepancy was caused by the left-hip replacement and corrected by the right-hip replacement.

Prior Conditions Described in Claimant's 2016 Depositions

99. On July 26, 2016, Claimant was deposed about his workers' compensation claim. Claimant's testimony about his prior conditions was generally consistent with his 2014 deposition testimony. He more clearly described the onset of back pain in 2008.

100. On November 16, 2016, Claimant was deposed about his third-party claims arising from the industrial accident. He described his activity on the day of the industrial accident in detail. That testimony was generally consistent with other evidence of record.

101. Claimant recalls undergoing an endoscopy for his hiatal hernia the day before the accident.

Specific Prior Medical Records

102. In 1980, Claimant's broken right ankle was repaired by open-reduction-internal-fixation surgery.

103. A 2004, examination and X-ray of Claimant's right ankle revealed no fracture, but a sprain with much swelling.

104. At Claimant's 2007 appendectomy, a CT scan revealed a hiatal hernia.

105. On February 9, 1988, Dr. O'Brien described scoliosis in Claimant's thoracic and lumbar spine.

106. On February 10, 1988, an MRI revealed disc herniations at L4-5 and L5-S1.

107. In 1988, Dr. Johnson recommended Claimant avoid heavy bending or lifting or

other heavy labor. He expressly did "not recommend" a return to work as a roofer.

108. Upon recovery from his two-level fusion, in 1989, Dr. Floyd rated Claimant's PPI at 15%.

109. In 2009, Claimant weighed 275 pounds. His blood pressure improved from 177/99 to 137/73 with treatment.

110. In a January 14, 2010 Primary Health note, Claimant asked about his "chronic weakness in left lower leg and ankle since a back surgery when he was in his 20s, has been developing some intermittent aching in his left hip joint."

111. In December 2010, when Claimant underwent the L3-4 decompression and fusion surgery, diagnostic imaging revealed degeneration L2-S1 and degeneration in both hips.

112. At the April 2011 total hip left replacement, an MRI revealed osteoarthritis in his left hip and osteoporosis in his right.

113. In 2011, physical therapy notes after Claimant's hip-replacement surgery record Claimant's lifting had improved to 50 pounds, and it was considered "appropriate" for Claimant to return to work as a roofing foreman.

114. In 2012, Dr. Menzer considered Claimant able to work unrestricted on flat roofs.

115. On September 20, 2012, Dr. Sant imposed restrictions of 100 pounds pushing/pulling; lifting 75 pounds occasionally, 50 frequently, 30 continuously; and *ad lib* position changes. Claimant described his pain at 0 to 1 then.

116. At a 2012 follow-up visit, Claimant reported left knee edema and pain.

Vocational Factors - Generally

117. Born April 18, 1961, Claimant was 52 on the date of the accident.

118. Claimant did not complete high school but did earn a G.E.D.

119. ICRD involvement began in June 2013. Consultant Greg Herzog staffed Claimant's case. Mr. Herzog conducted an initial interview on September 27, 2013. Employer and Claimant disagreed about whether modified duty offered by Employer was "unrealistic." Over several months, Dr. McMartin repeatedly did not approve a JSE for Claimant to work as a roofing foreman. In January 2014, Employer did not have light-duty work for Claimant's 4-hours-per-day, 10-pound lifting, plus position and motion restrictions. In October 2014, consultant Megan Brown staffed Claimant's case. She reviewed an FCE with Dr. McMartin in June 2015. In July 2015, Ms. Brown closed the ICRD file because "extensive medical barriers" precluded an anticipated return-to-work date.

120. The Social Security Administration determined Claimant became disabled under its criteria as of the date of the accident, May 17, 2013.

Vocational Experts

121. Doug Crum, Barbara Nelson, and Mary Barros-Bailey offered opinions that Claimant is totally and permanently disabled as of the date of hearing. In addition, each expert offered an opinion on whether Claimant's total and permanent disability is the result of the combined effects of the work accident and Claimant's pre-existing conditions.

122. In her report of March 31, 2018, (see JE 56) Dr. Barros-Bailey emphasized Claimant's pre-injury low back and left hip restrictions. She noted that following Claimant's 1988 lumbar spine fusion, both Dr. Johnson and Dr. O'Brien cautioned Claimant against returning to roofing as a profession, urging him to find lighter-duty work. She noted that following Claimant's second low back surgery in 2010, Dr. Sant counseled Claimant to avoid pushing/pulling of more than 100 pounds and to limit lifting to 75 pounds occasionally, 50 pounds frequently, and 30 pounds continuously. Of course, both Dr. Friedman and Dr. Doerr

have imposed their own restrictions for Claimant's pre-existing lumbar spine fusions. As well, Dr. Friedman proposed certain restrictions for Claimant's pre-existing left hip arthroplasty. Considering these restrictions, Dr. Barros-Bailey opined that in continuing to work as a roofer, Claimant was working well outside his restrictions on a pre-injury basis, and was essentially working on borrowed time. However, she also believed that Claimant was employable at less onerous work on a pre-injury basis; she did not believe that Claimant was totally and permanently disabled by virtue of his pre-existing conditions alone.

123. Dr. Barros-Bailey believes that Claimant is now totally and permanently disabled, and she believes that this status is the result of the combined effects of the subject accident and Claimant's pre-existing conditions. However, her report is unclear on which of Claimant's current conditions she believes to be caused by the accident, and which of those conditions combined with Claimant's pre-existing conditions to cause total and permanent disability. Explaining her opinion she testified:

> Q: [By Ms. Breen] All right. I guess, you know, looking at the flip side, you know, vice verse [sic], so to speak, is it your opinion that if he had not have had the multitude of pre-existing conditions that he has, he would not be totally and permanently disabled, so not totally and permanently disabled just due to the industrial accident?
>
> A: I believe he had a lot of pre-existing stuff. There's evidence everywhere that existed.
>
> Q: And but for that pre-existing, would he - - you know, and I guess I'll just put it most simply. Did the industrial accident alone make him totally and permanently disabled, in your vocational opinion?
>
> A: No. I think it's the combination of both. So you have upper extremity, lower extremity, you have everything going between both.
>
> Q: Okay. Are there certain types of work that he could have done if you took away the ambulation issues related to the left ankle, the pre-existing bilateral hip issues, the low back surgeries, the right shoulder degeneration, is there - - an you're left essentially, with cervical and thoracic issues, there is work he could

do, then?

A: Just with 50 pounds, and then the 50 pound overall lifting and the 10 pounds overhead? Yeah, absolutely, some of the food service jobs he could have done. Most of them don't go over 50 pounds.

Barros-Bailey Depo., 24/22-26/6. This is the closest Dr. Barros-Bailey comes to describing particular conditions, both pre-existing and accident-caused, which, in her opinion, combine to cause total and permanent disability. Counsel's question was phrased such that in answering, Dr. Barros-Bailey was asked to assume that Claimant's pre-existing conditions include only his low back, right shoulder, left ankle, and bilateral hips, while his accident produced injures include only cervical and thoracic spine injuries. However, as developed *infra* the Commission concludes that Claimant's work produced injuries also include injuries to his left ankle, right shoulder, right hip, as well as his cervical, thoracic, and lumbar spine. The premise of Dr. Barros-Bailey's opinion on whether Claimant's accident produced injuries combine with pre-existing impairments to cause total and permanent disability is fatally flawed.

124. Ultimately, Dr. Barros-Bailey's report is unhelpful in explaining why Claimant is currently permanently and totally disabled, and why Claimant's total and permanent disability is a result of the combined effects of Claimant's cervical/thoracic spine injury, his prior low back fusion, his left lower extremity, bilateral hip, and right shoulder conditions. Her report falls short in explaining why it is <u>these</u> conditions, as opposed to some other subset of conditions that leave Claimant permanently and totally disabled. She did not approach this issue by examining the restrictions for each of the aforementioned conditions and explaining why the combination of the restrictions referable to each of these conditions leaves Claimant totally and permanently disabled. Rather, as noted above, in light of conflicting medical opinions on causation and restrictions, she arrived at a 50/50 apportionment of Claimant's total and permanent disability

because it seemed the "fairest" thing to do. Barros-Bailey Depo., 35-37.

125. Doug Crum, too, found Claimant to be totally and permanently disabled by virtue of his medical restrictions and non-medical factors. On the question of which of Claimant's pre-injury or post-injury restrictions caused him to become totally and permanently disabled, Mr. Crum noted Dr. Friedman's May 23, 2016 letter in which Dr. Friedman pronounced Claimant to be unable to engage in anything more onerous than sedentary work activity. Mr. Crum then stated:

> Based upon his currently having a sedentary or less-than-sedentary physical capacity, I believe that Mr. Woods is no longer employable in any well-known part of the local labor market and that he is unlikely to find employment on either a full-time or part-time basis, given the combination of age, education, skills, work history in combination with his restrictions.

See JE 54, p. 13. In his report, Mr. Crum did not offer an opinion on whether, or how, Claimant's accident-caused injuries combine with pre-existing conditions to cause total and permanent disability.

126. Explaining his conclusions at the time of his August 15, 2018 deposition, Mr. Crum acknowledged that Dr. Friedman's April 20, 2016 report and follow-up letter of May 23, 2016, make it difficult to understand what restrictions Dr. Friedman would assign to a particular work-related or pre-existing condition. Crum Depo., 16/18-19/6. In the final analysis, Dr. Friedman's report only makes it clear that on the whole, Claimant has restrictions which prohibit him from engaging in anything more onerous than sedentary activity. Regardless of the source, if Claimant is currently unable to engage in anything but sedentary activity, such restriction, in conjunction with relevant non-medical factors, leaves Claimant totally and permanently disabled. While Mr. Crum holds the opinion that Claimant is totally and permanently disabled, he did not have the information necessary to allow him to ascertain what physical condition, or combination

of physical conditions, resulted in the sedentary restrictions referred to by Dr. Friedman. He tellingly stated:

> A: Again, the 10,000 foot view here is prior to this industrial injury in 2013 he was working and doing fairly heavy work without any accommodations by the employer. He had been doing that work since the 1980s. Mostly continuously. And after the 2013 injury he is not. And so it appears that, you know, either restrictions from that injury specifically or a combination of the conditions he had before that injury, and the industrial injury, reduced his physical capacity to the pointer where he is not employable.

Crum Depo., 23/25-24/9. Therefore, though Mr. Crum's opinion supports the conclusion that Claimant is totally and permanently disabled as of the date of hearing, it does nothing to support a conclusion that Claimant's total and permanent disability is the result of the combined effects of the subject accident and Claimant's pre-existing conditions.

127. As did her cohorts, Ms. Nelson opined that Claimant is totally and permanently disabled. However, she concluded that Claimant's total and permanent disability derives solely from his accident-produced restrictions in conjunction with relevant non-medical factors. In her report of January 22, 2018, she stated:

> Whether I rely on the medical opinions that Mr. Woods' industrial accident of May 17, 2013 caused or aggravated his low back, right shoulder, and right hip condition, or I rely on the opinions that his cervical, thoracic, and lumbar spine are basically the only residual impairments from his industrial injury, the fact that he has essentially sedentary or less than sedentary permanent restrictions lead to my opinion that he meets the criteria for a total disability via the odd lot doctrine.

JE 58, p. 15. Ms. Nelson was evidently aware of the divergent medical opinions on the question of the extent to which Claimant's shoulder, hip, and lower extremity conditions are causally related to the subject accident. However, she concluded that Claimant is totally and permanently disabled even if the only permanent injuries he suffered as the result of the subject accident are his cervical, thoracic, and lumbar spine fractures. Therefore, she does not believe that Claimant's pre-existing conditions contribute to Claimant's total and permanent disability. Nor did she

believe that Claimant's pre-existing lumbar spine fusion and left total hip replacement were subjective hindrances to Claimant on a pre-injury basis. Supporting this conclusion is her observation that Claimant returned to physically-demanding work as a roofer following his low back and left hip surgeries. She succinctly defined the attributes of Claimant's total and permanent disability at Page 16 of her report:

> It is my final opinion that Mr. Woods is totally and permanently disabled due to the injuries he suffered to his cervical and thoracic spine in his fall at work on May 17, 2013, in combination with his morbid obesity and the other non-medical factors of his case. (Age, limited education and limited transferrable job skills). I do not believe that his prior impairments related to his low back and left total hip were subjective hindrances to his employment nor that they combine with the residual impairments he acquired from his catastrophic fall at work in May, 2013 to render him totally disabled. Rather, the undisputed residuals he has in his cervical and thoracic spine from the accident itself, coupled with his profound morbid obesity, render him unemployable.

Ms. Nelson does not address the impact of other physical conditions which have figured into populating Claimant's restrictions, i.e., the left ankle, right shoulder, and bilateral hips. Ms. Nelson expanded on her thinking at her August 16, 2018 deposition:

> Q: [By Mr. Mallea] Well, then, is it your opinion that none of his limitations or impairments prior to the industrial injury combined with the industrial injury render total and permanent?
>
> A: That's correct. That way I looked at it is: Let's pretend he didn't have any prior restrictions at all. Are there any jobs he could do still with restrictions and the problems he's acquired because of the industrial injury? And I couldn't think of any.

Nelson Depo., 17/3-12. Ms. Nelson acknowledged that there is a difference in medical opinion as to whether or not, or to what extent, Claimant's left ankle and right hip conditions were accident caused/aggravated versus pre-existing in nature. However, as noted, she eventually concluded that the cervical and thoracic restrictions alone, along with his morbid obesity, leave Claimant totally and permanently disabled. Therefore, Claimant's left ankle, bilateral shoulder, bilateral

hips, and lumbar spine fusion do not contribute to his total and permanent disability.

Subrogation Issue

128. A collateral lawsuit was initiated over this accident. OSHA investigated.

129. The parties stipulated that Employer cannot prevail on a claim for subrogation after the *Maravilla* decision.

130. Digital evidence from the collateral lawsuit was submitted but not reviewed in light of the stipulation. Depositions from witnesses other than Claimant were reviewed, but were deemed cumulative, at best, for any issues under consideration for this workers' compensation claim.

DISCUSSION AND FURTHER FINDINGS OF FACT

131. The provisions of the Idaho Workers' Compensation Law are to be liberally construed in favor of the employee. *Haldiman v. American Fine Foods*, 117 Idaho 955, 956, 793 P.2d 187, 188 (1990). The humane purposes which it serves leave no room for narrow, technical construction. *Ogden v. Thompson*, 128 Idaho 87, 88, 910 P.2d 759, 760 (1996).

132. 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). Uncontradicted testimony of a credible witness must be accepted as true, unless that testimony is inherently improbable, or rendered so by facts and circumstances, or is impeached. *Pierstorff v. Gray's Auto Shop*, 58 Idaho 438, 447−48, 74 P.2d 171, 175 (1937). *See also Dinneen v. Finch*, 100 Idaho 620, 626−27, 603 P.2d 575, 581−82 (1979); *Wood v. Hoglund*, 131 Idaho 700, 703, 963 P.2d 383, 386 (1998).

133. Claimant's demeanor appeared credible to the Referee. He appeared articulate and plain spoken. He made a good first impression as a hard worker. He walked with a cane.

The Commission finds no reason to disturb the Referee's findings and observations on Claimant's presentation or credibility.

Causation

134. A claimant must prove that he was injured as the result of an accident arising out of and in the course of employment. *Seamans v. Maaco Auto Painting*, 128 Idaho 747, 751, 918 P.2d 1192, 1196 (1996). Proof of a possible causal link is not sufficient to satisfy this burden. *Beardsley v. Idaho Forest Industries*, 127 Idaho 404, 406, 901 P.2d 511, 513 (1995). A claimant must provide medical testimony that supports a claim for compensation to a reasonable degree of medical probability. *Langley v. State, Industrial Special Indemnity Fund*, 126 Idaho 781, 785, 890 P.2d 732, 736 (1995). Magic words are not necessary to show a doctor's opinion is held to a reasonable degree of medical probability; only their plain and unequivocal testimony conveying a conviction that events are causally related. *Jensen v. City of Pocatello*, 135 Idaho 406, 412-13, 18 P.3d 211, 217-18 (2001). Aggravation, exacerbation, or acceleration of a pre-existing condition caused by a compensable accident is compensable in Idaho Worker's Compensation Law. *Nelson v. Ponsness-Warren Idgas Enterprises*, 126 Idaho 129, 879 P.2d 592 (1994).

135. Here, physicians dispute which injuries were caused by the accident, which were entirely pre-existing, and which pre-existing conditions were aggravated, exacerbated, and/or accelerated by the accident. These will be sorted separately.

136. The medical record establishes that Claimant suffered numerous injuries as a consequence of the subject accident. However, the Commission will focus on those conditions which resulted in permanent restrictions which may be implicated in contributing to Claimant's disability. Certain injuries are acknowledged by all parties caused by the subject accident, or aggravated by the subject accident. These include Claimant's cervical, thoracic, and lumbar

compression fractures, C6-7 injury, and right hip. The parties dispute whether certain other of Claimant's orthopedic injuries represent accident-produced/aggravated injuries versus pre-existing conditions. These include Claimant's injuries at C7-T1, right shoulder, and left ankle.

Thoracic and Lumbar Spine

137. For Claimant's thoracic and lumbar spine fractures, Dr. Doerr gave Claimant restrictions against lifting more than fifty pounds. Dr. Friedman, too, addressed restrictions for Claimant's accident caused thoracic and lumbar spine compression fractures. However, he did so in a way that makes it impossible to tease out specific restrictions for those conditions:

> Combining his recent cervical fusion with his previous lumbar fusions, increased weakness in the left leg, and compression fractures, I would decrease his lifting restrictions to light duty, i.e., 20 pounds occasional and 10 pounds repetitive. He does require the use of an AFO for ankle stabilization for any community based activities, and should use it in the household, though he acknowledged he does not always do so. This markedly decreases his risk for touching his toe and decreases the risk for tripping and falling.

JE 50, p. 7. Therefore, Dr. Friedman conflates both pre-existing and accident caused conditions to arrive at his restrictions.

C6-T1

138. While Dr. Doerr acknowledged that Claimant's injury and need for surgery at C6-7 is causally related to the subject accident, he declined to reach a similar conclusion for the treatment Claimant received at C7-T1. Dr. Doerr acknowledged that Claimant suffered a C7 transverse process fracture as the result of the accident, along with an associated disc herniation at C6-7. However, at C7-T1, Claimant suffers from bilateral foraminal stenosis associated with a longstanding degenerative condition. Dr. Doerr believed that while Claimant's C6-T1 decompression and fusion was appropriate, the cost of surgery should be apportioned equally between Claimant's pre-existing and accident-caused conditions. Doerr Depo., 39/13-40/24. He

awarded Claimant a 6% PPI rating for the C6-T1 condition and apportioned this impairment rating equally between Claimant's pre-existing and accident-produced injuries. In terms of restrictions for this condition, Dr. Doerr recommended that Claimant observe a permanent restriction of no lifting over 10 pounds overhead and no repetitive overhead work. Again, he apportioned this restriction on a 50-50 basis between Claimant's pre-existing cervical spine condition and his work-related injury at C6-7. Dr. Doerr's apportionment scheme is not particularly helpful in allowing the Commission to understand the specific restrictions assignable to Claimant's pre-existing cervical spine injury at C7-T1.

139. Dr. Hajjar, the physician who performed Claimant's C6-T1 surgery, is in essential agreement with Dr. Doerr concerning the cause of the need for surgery:

> He is about a year our [sic - out] from the injury and he has failed conservative therapies. Therefore, I believe the surgery including a fixation and fusion is an appropriate surgery. The C7-T1 fusion would likely be related to George's degenerative issues underneath the C6-C7 trauma. It is a good idea to address this at the time of the original issue. The other thoracic degenerative issues apart from the thoracolumbar fracture are not in any way related to the trauma. This includes the C7-T1 degenerative issues which will be treated as well as other upper thoracic degenerative issues.

JE 23, p. 19. Dr. Friedman also addressed the cause of Claimant's C6-T1 injury, albeit somewhat obliquely. In his report of April 20, 2016, he observed that Claimant underwent "cervical fusion at C6-7 for symptomatic radiculopathy as a result of his industrial injury." *See* JE 50, p. 6. Dr. Friedman does not appear to have specifically addressed the question of whether Claimant's C7-T1 condition is causally related to the subject accident. He did, however, join with Dr. Doerr in proposing that Claimant is entitled to a 6% PPI rating for the C6-T1 fusion. Dr. Friedman did not give any specific limitations for the C6-C7 injury, but, as noted above, gave limitations against lifting more than 20 pounds occasionally and 10 pounds repetitively for the combined effects of Claimant's cervical fusion, lumbar fusion, left leg weakness, and lumbar compression fractures.

See JE 50, p. 7. Again, this provides very little assistance to the Commission in understanding what limitations/restrictions are referable to the C6-7 injury.

140. From the foregoing, we conclude that Claimant did suffer a work-related injury at C6-7 which necessitated surgical treatment. We further conclude that the evidence is insufficient to establish that Claimant's degenerative condition at C7-T1 was either caused or aggravated by the subject accident. Claimant is entitled to a 3% PPI rating for the effects of the C6-7 injury. We are unable to come to a conclusion concerning the restrictions referable to the C6-7 injury. The least unhelpful opinion in this regard emanates from Dr. Doerr who has proposed that Claimant should never lift more than 10 pounds overhead as the result of the C6-T1 condition, and should further avoid repetitive overhead work. However, his decision to simply apportion these restrictions equally between the pre-existing condition and the work accident leaves the Commission unable to come to a conclusion concerning the specific restrictions referable to each of Claimant's conditions, i.e., the pre-existing C7-T1 condition and the C6-7 work-related injury.

141. Concerning responsibility for the payment of medical expenses associated with the C6-T1 fusion, the Commission recognizes that Dr. Doerr has proposed that the cost for that procedure should be apportioned equally between the subject accident and Claimant's pre-existing C7-T1 condition. However, there is nothing in the record to suggest that Claimant was a surgical candidate at C7-T1 on a pre-injury basis. Dr. Hajjar stated that in view of the need to address Claimant's work-related C6-7 lesion, it would be a "good idea" to address the C7-T1 degenerative changes at the same time. Dr. Hajjar's notation strongly suggests that absent the need to treat Claimant at C6-7, surgery at C7-T1 would not be indicated. Accordingly, Defendants are responsible for the entirety of surgical/medical costs associated with the C6-T1 fusion, notwithstanding that apportionment of responsibility for impairment is also appropriate.

Right Hip

142. Both Dr. Friedman and Dr. Doerr agree that Claimant suffered from pre-existing degenerative disease of the right hip which was aggravated by the subject accident. Dr. Friedman gave Claimant a 10% whole person rating for his right hip condition, with 5% referable to the pre-existing condition and 5% referable to the work-related aggravation. Dr. Friedman did not identify any specific restrictions referable to the right hip.

143. Dr. Doerr assigned Claimant a 7% whole person rating for his pre-existing right hip condition and a 2% whole person rating for the accident-produced aggravation of his pre-existing right hip condition. In terms of restrictions, Dr. Doerr recommended that Claimant avoid hip flexion greater than 90 degrees, hip adduction, and high impact activities. Dr. Doerr apportioned these restrictions 80% to Claimant's pre-existing right hip condition and 20% to the effects of the work accident. Again, this apportionment scheme is of little assistance in helping us reach a conclusion about the specific restrictions referable to each of the two entities at issue, i.e., Claimant's pre-existing right hip disease and the work-caused aggravation of Claimant's right hip disease.

144. From the foregoing, we conclude that Claimant suffers a 10% whole person impairment for his right hip condition, 5% referable to the subject accident and 5% referable to the work-caused aggravation. In our view, Dr. Doerr's opinion overemphasizes Claimant's functional limitations from his pre-existing right hip condition. While the pre-injury medical records document pre-existing right hip degenerative disease, Claimant testified, and his work history substantiates, that he was not particularly troubled by his right hip in the years preceding the subject accident.

Left Ankle

145. As with Claimant's right shoulder, Dr. Doerr concluded that Claimant's left ankle condition is entirely pre-existing in its genesis, without contribution from the work accident. He based this conclusion primarily on his review of pre-injury medical records and his clinical evaluation of Claimant's left ankle. Essentially, Dr. Doerr concluded that Claimant's current left ankle weakness/dysfunction is identical to his pre-injury level of left ankle function. The fact that Claimant required an AFO brace since the accident, but had been able to manage without one on a pre-injury basis, did not sway Dr. Doerr in his reasoning. It was more important to Dr. Doerr that Claimant exhibited almost the same weakness on dorsiflexion of the ankle on a pre-injury and post-injury basis.

146. Dr. Doerr believes that Claimant's left ankle weakness is, more likely than not, attributable to the neurologic consequences of his pre-existing three-level lumbar fusion. Claimant's left ankle condition warrants a 7% whole person rating which is entirely pre-existing, per Dr. Doerr. According to Dr. Doerr, the permanent restrictions referable to Claimant's left ankle are among his most significant; Dr. Doerr recommends that for his left ankle, Claimant observe sedentary activity restrictions, walking only as required, and wearing an AFO brace at all times.

147. Dr. Friedman acknowledges that Claimant suffered from pre-existing weakness in his ankle and foot. However, it was significant to Dr. Friedman that immediately prior to the subject accident, Claimant did not require a left AFO brace. By the time of the subject accident Dr. Friedman believed that Claimant's pre-existing left foot drop had largely resolved, only to recur following the accident. These facts supported Dr. Friedman's conclusion that the subject accident permanently aggravated Claimant's pre-existing left ankle condition. Dr. Friedman did

not give Claimant an impairment rating for his left ankle weakness. However, he did specify that Claimant requires the use of an AFO brace for ankle stabilization for any community-based activity. It is unknown whether Dr. Friedman would have assigned any restrictions to Claimant of his left ankle on a pre-injury basis.

148. With respect to the competing opinions of Drs. Doerr and Friedman, the Commission concludes that Dr. Friedman's opinion concerning the contribution of the subject accident to Claimant's left ankle condition is the more credible. Dr. Doerr is of the view that Claimant's left ankle dysfunction is just as bad currently as it was on a pre-injury basis. Further, Dr. Doerr is of the view that Claimant is severely restricted because of his left ankle, so much so that he is essentially incapable of anything more onerous in sedentary activity. The problem with this argument is that Claimant has a well-documented history of working at a physically demanding job which required of him to climb ladders, walk on uneven surfaces, etc., notwithstanding Dr. Doerr's belief that he must have been incapable of engaging in such activities. Dr. Doerr's conclusion that Claimant's ankle injury entirely predates the subject accident, and that he is restricted to sedentary activity as a result of that condition, is inconsistent with what we know of Claimant's pre-injury employment. We conclude that Claimant did have pre-existing left ankle weakness, but that this condition was permanently aggravated by the work accident. We conclude that Claimant is currently entitled to a 7% whole person rating, but we are unable to reach any conclusion concerning the extent to which this impairment rating should be apportioned between the subject accident and Claimant's pre-existing condition.

149. Similarly, the conflicting medical evidence leaves us unable to reach any conclusion concerning the extent to which Claimant reasonably had pre-injury restrictions referable to his left ankle. There may have been some, but the record leaves us unable to quantify

their extent and degree. For his part, Claimant has testified, and his work history substantiates, that he was able to engage in the strenuous work of roofing notwithstanding whatever left ankle problems he may have had.

Right Shoulder

150. Concerning Claimant's right shoulder, Dr. Doerr concluded that this condition is entirely unrelated to the subject accident and is, instead, the result of long-term degenerative processes. Supporting this conclusion is his observation that Claimant's right shoulder condition did not appear as a symptomatic complaint until many months following the work accident. He would not agree that Claimant's post-accident use of a cane or walker is a medically probable cause of Claimant's right shoulder condition. Doerr Depo., 27/9-28/21. On the other hand, Dr. Friedman acknowledged that Claimant had radiographic evidence for pre-existing degenerative disease of the right shoulder. He proposed that Claimant's post-accident use of a cane/walker is likely responsible for the acceleration of Claimant's right shoulder degeneration. He reasoned as follows:

> A: But using it in his right hand, if he already has limits, because he has to put weight through it, that's what it's designed to do. But your shoulder really isn't designed to be a weightbearing joint. I would expect that he would accelerate any arthritic degeneration he had.
>
> Q: [By Mr. Luker] And he's a pretty big guy, isn't he?
>
> A: He is a big man and getting bigger.
>
> Q: And if the Commission determines the need for that, the use of that cane as to be related to the injury, from a medical standpoint, what would you relate the acceleration to of that shoulder degeneration?
>
> A: Well I'd relate it to the weightbearing and the use which he needs for balance and coordination. So he's putting weight through his right arm and right shoulder, which is not designed to do that. And if he's already got a degenerative disease, he's going to make it worse. The bigger he is, the more rapid it will occur.

Friedman Depo., 23/1-20. Therefore, Claimant's use of a cane or walker for treatment of the effects of the work injury placed an abnormal load on Claimant's right shoulder which, in turn, aggravated Claimant's degenerative disease of the shoulder.

151. Dr. Doerr did not adequately explain why he rejected the theory that Claimant's use of a cane or walker aggravated his pre-existing shoulder condition. On the other hand, Dr. Friedman explained how the use of such a device or devices places an unnatural load on the shoulder, requiring it to in turn act as a weight-bearing appendage. His explanation that this, in turn, aggravates Claimant's pre-existing shoulder arthritis is plausible. Accordingly, the Commission concludes that Claimant's right shoulder condition, though pre-existing, was permanently aggravated by the effects of the work accident.

152. Dr. Doerr awarded Claimant a 7% upper extremity rating for his right shoulder, representing end-state, or near end-stage degenerative joint disease. Dr. Doerr opined that this impairment is entirely pre-existing. Dr. Friedman gave Claimant a 5% upper extremity rating with 3% referable to the subject accident and 2% referable to Claimant's pre-existing degenerative joint disease.

153. Dr. Doerr gave Claimant restrictions against lifting over 5 pounds with the right arm, and avoiding overhead use of the right arm. He assigned these restrictions to Claimant's pre-existing condition in their entirety.

154. Dr. Friedman recommended that for Claimant's right shoulder, he avoid over-the-shoulder repetitive activity involving lifting of more than 20 pounds. Dr. Friedman did not speak to whether, or to what extent, Claimant's pre-existing degenerative disease of the right shoulder warranted restrictions.

155. As we did with respect to Dr. Friedman's opinion on causation, we adopt his

opinion on the extent and degree of Claimant's right shoulder impairment, and apportionment of the same between the effects of the pre-existing condition and the subject accident. However, Dr. Friedman's testimony is insufficient to allow the Commission to come to some conclusion concerning the extent and degree of the restrictions referable to Claimant's pre-existing right shoulder condition. Dr. Doerr, of course, has given Claimant very onerous restrictions for his right shoulder, and assigned these restrictions entirely to Claimant's pre-existing condition. However, because we reject Dr. Doerr's opinion on causation, we must also reject his finding that all of Claimant's limitations/restrictions are pre-existing in nature. Therefore, the evidence of record leaves the Commission unable to identify specific physician-imposed restrictions for Claimant's pre-existing right shoulder condition. However, per Dr. Friedman, we conclude that the work accident is responsible for right shoulder restrictions of avoidance of over the shoulder repetitive activity exceeding 20 pounds.

Traumatic Brain Injury

156. Claimant was evaluated and treated for a traumatic brain injury. Fortunately, he eventually recovered from this injury. Physicians do not dispute causation here, although the minority raise a question about the nature and extent of the injury.

Anemia and Hiatal Hernia

157. Early in Claimant's hospitalization following the May 17, 2013 fall, his anemia was characterized as "acute on chronic." However, following the May 23, 2013 endoscopy, it does not appear that the subject accident was contemplated as a contributing cause of this condition. See, also, Transfer Summary by Billy Morgan, M.D. of June 13, 2013, JE 21, p. 55. Compared to the pre-injury endoscopy of May 16, 2013, the endoscopy of May 23, 2013 showed the "same" findings of reflux esophageal ulcerations, multiple gastric ulcers, and large paraesophageal hernia. JE 21, p. 47. Dr. Casos explained his view that Claimant's need for hiatal

hernia repair was unrelated to the subject accident. Dr. Doerr noted that the pre-injury endoscopy revealed a large paraesophageal hernia with ulcerations and multiple gastric ulcers. He also noted Dr. Heaton's finding that Claimant had longstanding chronic anemia. These medical records, and others referenced above, informed his judgment that Claimant's need for hiatal hernia repair was entirely unrelated to the subject accident. Doerr Depo., 33/1-35/25. Dr. Friedman opined that Claimant's anemia was causally related to an exacerbation of Claimant's hiatal hernia and gastric ulcerations. However, in reaching this opinion, Dr. Friedman was unaware of the May 16, 2013 endoscopy. He acknowledged that it might be reasonable to suppose that Claimant's GI bleed is pre-existing, but he was unable to comment further, not having seen the study.

158. The Referee expressed concern in his recommendation that Nurse Case Managers Diane Davis and Nicole Wood may have had some hand in shaping the opinions of Claimant's treating physicians as to whether Claimant's worker's compensation insurance carrier should be held responsible for the payment of medical costs associated with the evaluation/treatment of Claimant's hiatal hernia. For example, in her note of May 30, 2013, Ms. Davis stated:

> Ms. Wood forwarded an electronic message to Paradigm's network manager, stating that Mr. Woods would be discharged from the in-patient rehabilitation unit on May 31, 2013 for hiatal hernia surgery that day, and he would be in the surgical unit until he was ready to return to in-patient rehabilitation. The hiatal hernia surgery and the hospital stay were to be billed to Mr. Woods' private health insurance.

JE 19, p. 3 Ms. Davis's note is substantially similar to an entry from Ms. Wood's final report of June 17, 2013:

> I received a call from Mr. Woods' nurse on May 30, 2013 letting me know the claimant was being transferred out of the inpatient rehabilitation unit for anticipated Nissen and hiatal hernia repair surgery by Dr. Bren Heaton the following morning. The information was passed on to the adjustor and Nurse Davis. At the time of the call, I asked that billing for the personal medical issues be kept separate from the workers' compensation injuries. Personal medical insurance was verified.

JE 19, p. 17. Of course, Dr. Casos' comment concerning the non-industrial cause of Claimant's hiatal hernia was made on May 25, 2013, and the record does not reveal that this judgment was made on the basis of anything other than his independent expertise. Accordingly, the Commission cannot conclude that either Ms. Davis or Ms. Wood made any effort to improperly shape the opinions of Claimant's treating physicians. Rather, the evidence seems to reflect their reporting of medical opinion. Claimant's hiatal hernia and resulting surgery are not causally related to the subject accident.

Prior Lumbar Fusions

159. The preponderance of medical opinion evidence shows Claimant's condition related to his L4-S1 fusion in 1987 and L3-4 fusion 2010 was not aggravated, exacerbated, or accelerated by the accident.

Left Hip

160. The preponderance of medical opinion evidence shows Claimant's condition related to his left hip arthroplasty in 2011 was not aggravated, exacerbated, or accelerated by the accident.

Left Shoulder

161. The preponderance of medical opinion evidence shows Claimant's condition related to his left shoulder was not aggravated, exacerbated, or accelerated by the accident.

Other Conditions

162. Before the accident Claimant had received treatment for several conditions–neither orthopedic nor neurological–including COPD, hypertension, hyperlipidemia, hypothyroidism, hypogonadism, etc. Medical opinions support a finding that none of these was aggravated, exacerbated, or accelerated by the accident.

Medical Care Benefits

163. A claimant is entitled to reasonable medical care for a reasonable period of time for an industrial injury. Idaho Code §72-432. 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).

164. Except as qualified below, every aspect of treatment during the initial hospitalization was to assess, treat, or repair whether and to what extent Claimant's fall caused injury. Charges associated with Claimant's hiatal hernia repair are not shown to be related to the subject accident. However, charges incurred in diagnosis of Claimant's anemia are compensable. All other aspects of treatment on these dates constitute merely complicating factors to Claimant's recovery from the compensable industrial accident, not separate unrelated treatment for pre-existing conditions. All charges for care provided from the date of accident through June 21, 2013 are compensable, and those charges which were denied as unrelated to the accident are to be paid per *Neel*, *supra*.

165. Similarly, all charges for treatment for conditions found here to be causally related to the accident, but which were previously denied by Surety, if any, are compensable and payable per *Neel*, *supra*.

166. A recumbent bike was prescribed, but Surety denied this charge. It also is payable per *Neel*, *supra*.

167. All medical care provided to the date of medical stability, for which any aspect was related to a compensable condition described above, if any remains unpaid as pre-existing, is payable.

168. Palliative treatment for any causally related condition to the date of hearing

is compensable.

169. Surgery for Claimant's right shoulder is a compensable consequence of the accident. He is entitled to this future surgery.

170. He is entitled to future palliative care, including a YMCA or other membership. This will help maintain mobility and reduce chronic pain.

Medical Stability and Temporary Disability

171. Medical stability arises after "maximal medical rehabilitation has been achieved and which abnormality or loss, medically, is considered stable or nonprogressive at the time of evaluation." Idaho Code §72-423. It is reached when "no fundamental or marked change in the future can be reasonably expected." *See,* Idaho Code §72-423. Upon certain conditions, a clamant is entitled to temporary disability benefits until he becomes medically stable. *Jarvis v Rexburg Nursing Center*, 136 Idaho 579, 38 P.3d 617 (2001); *Malueg v Pierson Enterprises*, 111 Idaho 789, 727 P.2d 1217 (1986).

172. The parties stipulated the MMI date at June 14, 2016. The record shows this is a reasonable date.

173. Claimant's TTD issue is directed at future medical care for right shoulder surgery. This TTD benefit has not yet arisen or been denied. In light of the findings and conclusions herein, the Commission anticipates that Claimant will again be in a period of recovery at such time, if any, that he undergoes compensable repair of his right shoulder.[3]

ISIF Liability

174. It is conceded by the parties that Claimant is totally and permanently disabled as of the date of hearing, and the Commission so finds. The central dispute in this case is over

[3] However, since Claimant is adjudged totally and permanently disabled, it is not clear that he would be entitled to TTD benefits under Idaho Code § 72-408, while receiving benefits for total and permanent disability under that same section.

whether or not Claimant's total and permanent disability should be apportioned between employer and the ISIF. In connection with ISIF liability, it is not contended by any of the parties that Claimant is totally and permanently disabled by virtue of his pre-existing impairments alone, as was the case in *Bybee v. State Industrial Special Indemnity Fund*, 129 Idaho 76, 921 P.2d 1200 (1996). Rather, the dispute is over whether Claimant is totally and permanently disabled by virtue of the work accident alone, or whether that status can only be reached by considering the consequences of the work accident in combination with all or some of Claimant's pre-existing impairments.

175. Per Idaho Code § 72-332, responsibility for Claimant's total and permanent disability may be apportioned between Employer and the ISIF if specific elements of ISIF liability are satisfied. Idaho Code § 72-332(1) specifies:

> 72-332(1) If an employee who has a permanent physical impairment from any cause or origin, incurs a subsequent disability by an injury or occupational disease arising out of and in the course of his employment, and by reason of the combined effects of both the pre-existing impairment and the subsequent injury or occupational disease or by reason of the aggravation and acceleration of the pre-existing impairment suffers total and permanent disability, the employer and surety shall be liable for payment of compensation benefits only for the disability caused by the injury or occupational disease, including scheduled and unscheduled permanent disabilities, and the injured employee shall be compensated for the remainder of his income benefits out of the industrial special indemnity account.

As construed by the Court, in order to establish ISIF liability, the party seeking to invoke the liability of the ISIF has the burden of proving the following elements: (1) claimant suffered from a pre-existing impairment; (2) the pre-existing impairment was manifest; (3) the pre-existing impairment was a subjective hindrance to employment; and (4) the combined effects of the pre-existing impairment and the subsequent injury were occupational disease resulted in total and permanent disability; or the subsequent injury or occupational disease aggravated and

accelerated the pre-existing impairment to cause total and permanent disability. *Aguilar v. State of Idaho, Industrial Special Indemnity Fund,* 164 Idaho 893, 436 P.3d 1242 (2019).[4] The party seeking to impose liability on the ISIF must prove all four elements. *Garcia v. J.R. Simplot Co.,* 115 Idaho 966, 772 P.2d 173 (1989).

176. Application of these rules for evaluation of ISIF liability is made difficult by the Claimant's many potential impairments, some of which are entirely pre-existing, some of which are wholly related to the subject accident, and some of which represent accident produced aggravations of pre-existing impairments. This task is made more difficult by virtue of the manner in which medical opinions have been expressed concerning pre-existing impairments and restrictions. For some pre-existing conditions, no impairment rating has been expressed. For some pre-existing conditions, no separate restrictions have been identified. As well, some conditions are deemed to be entirely pre-existing or the result of the aggravation of a pre-existing condition, depending on which medical opinion is consulted. Although the circumstances of this case make proof of ISIF liability difficult, Employer/Surety, the party seeking to invoke ISIF liability, is nevertheless obligated to prove each element.

[4] In *Aguilar,* the Court emphasized the disjunctive nature of the "combining with" inquiry. This element of ISIF liability may be met by demonstrating that a pre-existing impairment combined with an accident-produced impairment to some other body part to result in restrictions which cause total and permanent disability or by demonstrating that claimant suffered from a pre-existing condition which was aggravated or accelerated by the work accident to result in total and permanent disability. For example, the restrictions relating to a pre-existing hip condition may combine with a different set of restrictions resulting from a work-related shoulder injury to cause total and permanent disability. As well, the combining-with element of the case may be satisfied where restrictions for a pre-existing low back impairment are permanently increased as the result of a work-related low back injury such that claimant is totally and permanently disabled. In both cases, it must be demonstrated the pre-existing impairment and work-caused injury in some way combine to result in total and permanent disability. *Vawter v. United Parcel Service, Inc.*, 155 Idaho 903, 318 P.3d 893 (2014). The disjunctive nature of the inquiry is historically recognized by the Commission, most recently in *Blake v. State of Idaho Industrial Special Indemnity Fund,* IIC2013-020032 (June, 2018).

Pre-existing Impairment

Lumbar Spine Fusions

177. There is close agreement between Drs. Friedman and Doerr that Claimant has pre-existing impairments for three-level lumbar spine fusion and left hip arthroplasty. Dr. Doerr gave Claimant a 15% whole person rating for his lumbar fusions, while Dr. Friedman awarded a 19% whole person rating for the same condition. Both opinions are equally credible. The Commission concludes that Claimant has a 17% impairment rating for his pre-existing lumbar spine fusions.

Left Hip

178. For Claimant's left hip arthroplasty, Dr. Doerr gave Claimant an 8% whole person rating, while Dr. Friedman awarded a 25% lower extremity (10% whole person) rating. Again, we find both opinions in this regard equally credible and conclude that Claimant has pre-existing impairment for his left hip of 9% of the whole person.

Left Shoulder

179. From this point it becomes more difficult to identify and quantify Claimant's pre-existing impairments because of a lack of medical consensus. Although Dr. Friedman specified certain pre-existing restrictions for Claimant's left shoulder, he failed to give Claimant an impairment rating for his pre-existing left shoulder condition. Dr. Doerr gave Claimant neither an impairment rating, nor restrictions for his pre-existing left shoulder condition. The Commission concludes that Employer/Surety has failed to demonstrate a pre-existing impairment for the left shoulder.

Right Hip

180. Both Dr. Doerr and Dr. Friedman have concluded that Claimant suffered from a pre-existing right hip condition which was aggravated by the subject accident. Dr. Friedman

gave Claimant a 25% lower extremity (13% whole person) rating for his right hip, with that impairment equally split between Claimant's pre-existing right hip condition and Claimant's work-caused aggravation of the same (5% whole person for each). Dr. Doerr gave Claimant a 7% whole person rating for his pre-existing right hip condition, and assigned 2% to the subject accident. As developed above, we have concluded that Dr. Friedman's opinion is more persuasive. Claimant has a 5% right hip impairment on a pre-injury basis.

Right Shoulder

181. With respect to Claimant's right shoulder, Dr. Friedman concluded that Claimant is entitled to a 5% upper extremity rating for this condition with 2% (1% whole person) referable to pre-existing degenerative joint disease and 3% (2% whole person) referable to the subject accident. Dr. Doerr felt that Claimant's right shoulder condition is entirely pre-existing and awarded 7% upper extremity (4% whole person) to this pre-existing condition. As developed above, we conclude that Dr. Friedman's opinion is more persuasive, and find that Claimant has pre-existing right shoulder impairment of 1% whole person.

Left Knee

182. Dr. Doerr gave Claimant an 8% whole person rating for his pre-existing left knee condition. Dr. Friedman did not address Claimant's left knee in his evaluation. We are unable to conclude whether Dr. Friedman would concur with Dr. Doerr's impairment rating and Dr. Doerr's conclusion that this rating is pre-existing. Because it is the only evidence on the issue, we adopt Dr. Doerr's opinion.

Left Ankle

183. For Claimant's left ankle, Dr. Doerr concluded that Claimant is entitled to a 7% whole person rating, and that this rating is entirely referable to Claimant's pre-existing and well-

documented left ankle weakness. As developed above, while we accept Dr. Doerr's opinion on the extent and degree of Claimant's current left ankle impairment, we are unable to accept his opinion on the cause of Claimant's left ankle condition. We are more persuaded by Dr. Friedman's opinion that Claimant suffered from a pre-existing left ankle condition which was aggravated by the subject accident. However, Dr. Friedman did not offer an opinion on the extent and degree of Claimant's pre-existing left ankle impairment, and we are unwilling to speculate on what that pre-existing left ankle impairment might be.

C7-T1

184. As developed above, Dr. Doerr found that Claimant's C7-T1 injury is entirely pre-existing. This opinion is not credibly challenged by the opinions of Dr. Friedman. As proposed by Dr. Doerr, we find that Claimant is entitled to a 3% whole person rating for the pre-existing C7-T1 injury.

Manifest

185. "Manifest" means that either the employer or employee was aware of the condition so that the condition can be established as existing prior to the injury. *Royce v. Southwest Pipe of Idaho*, 103 Idaho 290, 647 P.2d 746 (1982).

186. On a pre-injury basis, Claimant was aware of his pre-existing lumbar spine fusions and left hip arthroplasty. Similarly, the medical record reflects that Claimant was aware that he suffered from significant degenerative changes in his right hip. Claimant exhibited left ankle weakness on a pre-injury basis, and for a period used an AFO brace on a pre-injury basis as well. Immediately prior to the subject accident, Claimant exhibited weakness on dorsiflexion of the ankle. From this we conclude that Claimant was aware of his pre-existing left ankle problems. However, we do not find that the record contains persuasive evidence that Claimant's

C7-T1 condition or right shoulder condition were manifest as of the date of injury. Therefore, even though Dr. Friedman did award impairment for Claimant's pre-existing shoulder condition, along with restrictions for the same, the failure of proof on the question of whether the right shoulder condition was manifest means that the right shoulder condition cannot be considered in evaluating ISIF liability. Finally, as revealed in Dr. Sant's records, discussed below, we conclude that Claimant's left knee condition was manifest immediately prior to the subject accident.

Subjective Hindrance

187. Next, Claimant must demonstrate that the aforementioned preexisting impairments constituted a "subjective hindrance" to obtaining employment. The Idaho Supreme Court set out the definitive explanation of the "subjective hindrance" requirement in *Archer v. Bonners Ferry Datsun*, 117 Idaho 166, 686 P.2d 557 (1990):

> Under this test, evidence of the claimant's attitude toward the preexisting condition, the claimant's medical condition before and after the injury or disease for which compensation is sought, nonmedical factors concerning the claimant, as well as expert opinions and other evidence concerning the effect of the preexisting condition on the claimant's employability will all be admissible. No longer will the result turn merely on the claimant's attitude toward the condition and expert opinion concerning whether a reasonable employer would consider the claimant's condition to make it more likely that any subsequent injury would make the claimant totally and permanently disabled. The result now will be determined by the Commission's weighing of the evidence presented on the question of whether or not the preexisting condition constituted a hindrance or obstacle to employment for the particular claimant.

Archer makes it clear that an injured worker's attitude towards a preexisting condition is but one factor to be considered by the Commission in determining whether or not the preexisting impairment constituted a subjective hindrance to Claimant. After *Archer*, the Commission is required to weigh a wide variety of medical and nonmedical factors, as well as expert and lay testimony, in making the determination as to whether or not a preexisting condition constituted a hindrance or obstacle to employment for the particular claimant as of the date of the work injury.

188. It is Employer/Surety's contention that Claimant's pre-existing low back, bilateral hips, left knee, and left ankle were each a subjective hindrance to his employment pursuant to the rule set forth above. See Defendants Brief, p. 21. The opinions of medical providers of the effect of the pre-existing condition on Claimant's employability is one of the factors the Commission may consider in determining whether such condition was a subjective hindrance to Claimant prior to the subject injury.

189. With respect to Claimant's three-level lumbar spine fusion, both Drs. Friedman and Doerr are in general agreement that Claimant should have had restrictions against lifting of 50 pounds occasionally, 25 pounds repetitively. These restrictions were authored subsequent to the subject accident. Dr. Sant authored restrictions for Claimant's lumbar spine condition prior to the subject accident, and his are the restrictions generated closest in time to the 2013 accident. Claimant first saw Dr. Sant for evaluation following the 2010 fusion surgery performed by Dr. Little and the left hip arthroplasty performed by Dr. Menzner. Claimant was referred to Dr. Sant for treatment and evaluation of his persistent pain. Dr. Sant recommended physical therapy and continued to follow Claimant. Claimant made progress, and by August 11, 2011, Dr. Sant allowed Claimant to return to medium/heavy work. Claimant did return to work and reportedly did well until returning to Dr. Sant on March 1, 2012 with complaints of some left knee swelling. However, he reported that his back and hip were doing "okay." Dr. Sant's note of March 2, 2012 does not reflect that he amended Claimant's restrictions.

190. Dr. Sant's note of September 20, 2012 reflects that Claimant had been doing well with his back, hip, and knee pain until recently being released from his job. Dr. Sant noted that Claimant planned to look for new employment, and this caused Dr. Sant to "update" Claimant's job restrictions. He advised Claimant to limit bending, twisting and stooping. He recommended

that Claimant avoid pushing/pulling in excess of 100 pounds. He recommended that Claimant be allowed to change positions as needed. Finally, he recommended that Claimant should be able to lift 75 pounds occasionally, 50 pounds frequently, and 30 pounds continuously. He felt that Claimant was capable of performing full-time work with the aforementioned restrictions. Claimant was not seen again by Dr. Sant until March 21, 2013 at which time Claimant reported that he had gotten his old job back and that things were going "okay." Dr. Sant did not revisit the restrictions given in September 2012.

191. There is no indication that Dr. Sant's restrictions were inappropriate or unrealistic. Indeed, Claimant appears to have been able to function, albeit with some aches and pains as reported by Dr. Sant, in his time-of-injury position with Employer. Dr. Sant was aware of Claimant's low back, left hip, and left knee injuries, but did not issue restrictions for each of these conditions separately. Drs. Doerr and Friedman authored separate restrictions for Claimant's pre-existing low back condition, as referenced above. In addition, Dr. Doerr provided separate restrictions for Claimant's left hip and left knee. Dr. Sant was the physician most familiar with Claimant's orthopedic injuries immediately prior to the subject accident. His observations and recommendations concerning Claimant's ability to work are more persuasive than the retrospective restrictions for these pre-existing conditions imposed by Drs. Doerr and Friedman.

192. With respect to Claimant's right hip, it does not appear that any of Claimant's treating physicians gave specific restrictions for Claimant's degenerative joint disease prior to the subject accident. Medical records generated by Primary Health Medical Group, Shelley Ringo, M.D. and Ken Little, M.D., all in 2010, suggest that Claimant was experiencing difficulty in his hips, bilaterally. However, it does not appear that Claimant was ever given any specific

right hip restrictions until Dr. Doerr proposed certain restrictions in 2018:

> I would recommend a permanent restriction of no hip flexion greater than 90 degrees, no hip adduction and no high impact activities as it relates to the patient's right total hip arthroplasty; with 20% of this restriction apportioned to the patient's 5-17-2013 industrial injury and 80% apportioned to the patient's pre-existing right hip degenerative joint disease.

JE 52, p. 37. From the quoted opinion it might be inferred that Dr. Doerr does believe that Claimant reasonably had restrictions of some type for the pre-existing right hip condition. However, as couched, it is difficult to identify the specific physical restrictions which Dr. Doerr would have assigned to the right hip on a pre-injury basis. Dr. Friedman did not identify any specific pre-existing right hip restrictions in his evaluation. The Commission is unable to conclude that Claimant had pre-existing right hip restrictions.

193. Regarding the left ankle, we have found Dr. Friedman's opinion the most persuasive, and he gave no pre-injury restrictions for the same.

194. Although not relied upon by Defendants to satisfy the subjective hindrance element of the case against ISIF, Dr. Friedman did not articulate any restrictions for Claimant's pre-existing right shoulder impairment. Dr. Doerr found Claimant's right shoulder impairment and attendant restrictions to be entirely pre-existing, an opinion which the Commission has rejected. Accordingly, there is no persuasive medical evidence establishing that Claimant had restrictions referable to his pre-existing shoulder impairment.

195. Further, while the evidence supports the existence of an impairment rating for Claimant's pre-existing C7-T1 condition, the evidence fails to demonstrate what restrictions should be referred to this condition. Rather than articulating restrictions for the work caused C6-C7 lesion and separate restrictions for the pre-existing C7-T1 lesion, Dr. Doerr gave one set of restrictions against lifting no more than 10 pounds overhead, with avoidance of repetitive

overhead work. He apportioned these restrictions equally between the pre-existing and accident caused conditions. This approach is altogether unhelpful in meeting our need to understand the specific restriction referable to the pre-existing condition.[5]

196. Of course, the opinion of treating/evaluating physicians on the injured worker's ability to engage in gainful activity is but one factor to consider in assessing whether or not Claimant's pre-existing impairments constituted a subjective hindrance to his employability. Other facts of record must be considered as well.

197. Dr. Barros-Bailey, Mr. Crum, and Ms. Nelson each offered opinions on the extent to which Claimant's pre-existing impairments constituted a hindrance to Claimant's employability prior to the subject accident. Their opinions on this issue necessarily depend on which of the several medical opinions they considered in evaluating Claimant's employability. Of the vocational experts, only Dr. Barros-Bailey offered an opinion that Claimant's pre-existing lumbar spine impairment reasonably impacted his access to certain segments of the labor market on a pre-injury basis. In coming to this conclusion, she relied on evidence of record associated with Claimant's filing of his complaint with the Idaho Human Rights Commission, along with the testimony of Mr. Frisbee and Mr. Warner. Explaining Claimant's apparent ability to perform his job notwithstanding Dr. Sant's restrictions, Dr. Barros-Bailey surmised that Claimant was probably struggling with his work. JE 56, p. 25.

198. Doug Crum did not assign much significance to the pre-injury restrictions given by Drs. Johnson and O'Brien for Claimant's low back condition. He regarded these restrictions as mainly "philosophical" since the evidence clearly demonstrates that Claimant returned to heavy work, and was capable of heavy work immediately prior to the work accident. Mr. Crum

[5] Does Dr. Doerr's apportionment scheme mean that for the C7-T1 condition, Claimant could lift 20 pounds overhead, or 10 pounds for twice as long?

had difficulty understanding which of the various restrictions given by Dr. Friedman attached to a particular injury-caused or pre-existing condition. He noted that from Dr. Friedman's conclusion that Claimant is incapable of more than sedentary work, it follows that Claimant is totally and permanently disabled, whether as a result of the 2013 accident alone, or the 2013 accident in combination with pre-existing conditions, he could not say. *See* Crum Depo., p. 24. Ultimately, Mr. Crum's testimony lends no particular support to the proposition that any of the pre-existing impairments identified by the Commission impacted Claimant's employability on a pre-injury basis. Mr. Crum did not have the opportunity to consider Dr. Doerr's evaluation at the time Mr. Crum prepared his report, nor did he review prior ICRD records or Mr. Warner's deposition.

199. Ms. Nelson, too, noted the difficulty in understanding the extent of the injuries emanating from the industrial accident. For example, she understood that depending on which medical opinion one considers, Claimant's left ankle condition and right shoulder condition are either pre-existing in their entirety, or pre-existing conditions which have been aggravated by the industrial accident. *See* Barbara Nelson Depo., p. 11. However, her report reflects that it is her opinion that Claimant's low back and left hip were not a hindrance to Claimant in seeking or keeping employment prior to the work accident.

200. Of course, Claimant himself offered testimony on how he views the impact of his various pre-existing impairments on his ability to engage in gainful activity on a pre-injury basis. Claimant testified consistently, both at hearing and in deposition, that he was able to perform his time of injury job without restriction. At hearing, Claimant testified that he worked in excess Dr. Sant's lifting restriction, that he "pretty much did everything like everybody else" at his job, and that he was able to consistently lift 90 pounds at the gym. Tr. p. 42; 47; 92.

201. However, Claimant did not altogether deny that he had some minor pre-injury restrictions. For example, Claimant acknowledged that he had a leg length discrepancy following his left hip replacement. While this caused him to walk with a bit of a limp, it did not impact his ability to carry heavy loads. Nor did it interfere with his ability to climb ladders. The only effect of Claimant's leg length discrepancy was that it was slightly more difficult for him to get off his knees. Claimant (10/08/2014) Depo., 42/14-43/23.

202. Claimant also acknowledged that at some point in the years prior to the subject accident he was advised that he might require right hip surgery at some future date. Claimant (10/08/2014) Depo., 89/8-90/9. Claimant also acknowledged that prior to the subject accident he was aware that his left ankle was "a little bit weaker" than his right ankle. Claimant (07/26/2016) Depo., 101/19-102/10. However, he denied that his left ankle resulted in any "conditions" on his employment.

203. As Defendants have pointed out, the record reflects that Claimant did file a Charge of Discrimination with the Idaho Human Rights Commission in October of 2012, following his September 2012 termination. JE 66, p. 1. Claimant averred discrimination on the basis of age, sex, and disability. He claimed to have been denied reasonable accommodation for his back and hip impairments. He claimed that when he returned to work in September of 2011, he returned with certain permanent restrictions which limited his lifting. He claimed that these restrictions were honored for a period of time, only to later be violated at the direction of his immediate supervisor, Shane VonWald. However, at his 2014 deposition, Claimant offered testimony suggesting that the claim of discrimination on the basis of disability was not central to his complaint:

> Q: [By Mr. Gardner]: I just want to know what your claim was. I don't care about the agreement. I want to know what your claim was.

A: It was age discrimination, sexual harassment, and - - I don't remember the other part.

Claimant (10/8/2014) Depo., 45/10-14. With some prompting, however, he recalled the disability component of the claim and testified consistent with the aforementioned Charge of Discrimination. However, Claimant also testified that notwithstanding his immediate supervisor' refusal to honor Claimant's restrictions, Claimant was nevertheless able to perform all aspects of his work without difficulty. Claimant (10/8/2014) Depo., 45/15-46/3.

204. Standing alone, Claimant's testimony does little to advance Employer/Surety's argument that Claimant's pre-existing conditions constituted a hindrance to Claimant in keeping or obtaining employment. Perhaps the most compelling fact relating to Claimant's functional capacity is Claimant's demonstrated work history in the years immediately preceding the subject accident.

205. Employer/Surety urges the Commission to consider other lay testimony of record which challenges Claimant's narrative. Employer/Surety argue that the testimony of Mark Warner and Ted Frisbee establishes that Claimant was obviously restricted in his ability to perform his work on a pre-injury basis. Mark Warner, an employee of Steed Construction, testified that based on his observations of Claimant, it was "a battle" for Claimant to climb a ladder. He also testified that it appeared to him that Claimant was unable to climb stairs without the assistance of a handrail.

206. Ted Frisbee, one of the principals of Hobson Construction, testified that he noticed Claimant's limp, and that it appeared to him that Claimant had difficulty getting around. Tr. 112-113; 118. However, it is clear from Frisbee's testimony at hearing, and at his December 2016 deposition, that his knowledge of Claimant's day-to-day physical abilities was limited. He

relied largely on Claimant's immediate supervisor, Shane VonWald, to inform his (Frisbee's) judgment that Claimant was too physically "beat up" to continue in his work for Hobson.[6] Frisbee's testimony makes it clear that while he acceded to VonWald's judgment that Claimant was "beat up," he also doubted that VonWald would have employed Claimant if Claimant were unable to do the job. Frisbee Depo., 7/25/14-25. He also testified that no one else, besides VonWald, ever brought any of Claimant's alleged physical shortcomings to his attention. Specifically, he testified that it would surprise him to learn that Claimant had difficulty ascending ladders or stairs. Frisbee Depo., 62-65, 107. In fact, it is unclear that Mr. Frisbee actually equates his term "beat up" with physical incapacity. He testified that he was unaware of any facts suggesting that Claimant had difficulty climbing ladders, or had other obvious physical limitations. Nevertheless, Mr. Frisbee reiterated that he thought Claimant was "beat up," because he walked with a limp and was not "straight." Frisbee Depo., 108/20-22. Possibly, by use of the term "beat up" Mr. Frisbee refers only to Claimant's postural abnormalities. By the same token, Mr. Warner's observations may do nothing more than describe the difficulties that an individual with a leg length discrepancy might have when negotiating ladders or stairs. None of these observations are inconsistent with Claimant's testimony, in which he acknowledged his leg length discrepancy, but, importantly, also testified that this posed no difficulty to him in performing the requirements of his job.

207. In summary, neither the testimony of Mr. Warner or Mr. Frisbee significantly challenge Claimant's testimony.

208. Based on the foregoing, the Commission finds that Employer/Surety has failed to meet their burden of demonstrating that any of the pre-existing impairments identified above

[6] Unfortunately, VonWald's testimony was not taken in this matter.

subjectively hindered Claimant in his ability to obtain or keep employment.

Combining With

209. Having determined that none of the impairments we have identified as pre-dating the subject accident constituted a subjective hindrance to Claimant's employability, we need not address the fourth element of the claim against the ISIF, i.e., whether Claimant's pre-existing impairments combined with the injuries Claimant suffered as a result of the subject accident to cause total and permanent disability.

210. However, even had the Commission determined one or more of the pre-existing conditions described at page 21 of Employer/Surety's brief constituted a subjective hindrance to Claimant's employability, Employer/Surety has failed to prove, by a preponderance of the evidence, that the "combining with" element of the claim against ISIF is satisfied. This failure is largely the result of the confusion that exists in the medical record concerning the restrictions referable to what we have determined to be the accident caused / aggravated injuries. Dr. Friedman assigned restrictions for Claimant's accident caused injuries that are commingled with restrictions he would give for Claimant's lumbar spine fusion. See JE 50, p. 7. Dr. Doerr has apportioned restrictions for Claimant's cervical spine and right hip between accident caused and pre-existing conditions in a way that makes it impossible to understand the specific restriction that applies to a work caused injury. See JE 52, p. 37-39.

211. Further, for the reasons explained *infra*, under the heading "Vocational Experts," the Commission finds the forensic report and testimony of Dr. Barros-Bailey insufficient to prove that Claimant's total and permanent disability would not exist but for his pre-existing impairments.

212. The Commission concludes that Claimant is totally and permanently disabled and

that his total and permanent disability did not pre-date the subject accident. However, Employer/Surety has failed to prove the elements of ISIF liability that would allow responsibility for Claimant's total and permanent disability to be shared between the ISIF and Employer/Surety.

Subrogation Right of ISIF

214. Idaho Code § 72-223 and *Maravilla v. J.R. Simplot, Co.*, 161 Idaho 455, 387 P.3d 123 (2016) are the major landmarks for determining subrogation rights in workers' compensation cases. The question of whether ISIF is or should be impacted by an employer's negligence appears to be an original question.

215. The issue is not ripe for decision here. ISIF bears no liability. The issue in this setting is purely theoretical.

CONCLUSIONS OF LAW AND ORDER

1. Claimant suffered serious compensable injuries as a result of a compensable accident. These injuries included five compression fractures, a left ankle injury, a traumatic brain injury, and aggravation and acceleration of pre-existing conditions in Claimant's right hip and right shoulder. The accident did not aggravate nor accelerate Claimant's pre-existing low back condition which had been treated by surgical fusions L3-S1. No subsequent intervening cause for or affecting these injuries was established;

2. Claimant was medically stable as of June 14, 2016;

3. Claimant is entitled to medical benefits related to compensable injuries to the date of hearing. To the extent that payment for any treatment for an injury found compensable has been denied as pre-existing, Surety is liable for such treatment per *Neel*, *supra*. Surety is similarly liable per *Neel* for charges for the prescribed recumbent bike and YMCA membership;

4. Claimant is entitled to future medical benefits including right shoulder surgery

and palliative care for any compensable condition;

5. The issue of temporary disability after the future right shoulder surgery is not ripe;

6. Claimant is totally and permanently disabled;

7. Defendants have failed to prove the elements of ISIF liability.

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

DATED this __20th__ day of _____May_____, 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 _____20th_____ day of _____May_____, 2019, a true and correct copy of the **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** was served by regular United States Mail upon each of the following:

DANIEL J. LUKER P.O. BOX 6190 BOISE, ID 83707-6190	LORA RAINEY BREEN 1703 W. HILL ROAD BOISE, ID 83702	KENNETH L. MALLEA P.O. BOX 857 MERIDIAN, ID 83680

_____/s/_____