BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

DAVID BUCKHOLZ, Claimant, v. MOBILE CONCRETE OF IDAHO, LLC, Employer, and IDAHO STATE INSURANCE FUND, Surety, Defendants.	**IC 2015-013382** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **Filed September 18, 2019**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Industrial Commission assigned this matter to Referee Michael Powers. He conducted a hearing in Boise on January 29, 2019. Dennis Petersen represented Claimant. Neil McFeeley represented Employer and Surety. The parties presented oral and documentary evidence. The parties took post-hearing depositions and submitted briefs. The case came under advisement on July 3, 2019. Upon Referee Powers' retirement and pursuant to *Ayala v. Robert J Meyers Farms, Inc.*, 165 Idaho 355, 445 P.3d 164 (2019), the Commission asked the parties on July 19, 2019, if they would like the recommendation to be written by another referee or if they desired a new hearing. Defendants and Claimant both responded that they did not desire a new hearing in the matter. The Commission reassigned the case to Doug Donohue on July 30, 2019, and the matter is ready for decision. The Commissioners reviewed the proposed recommendation, and have decided to issue their own conclusions of law and order in the matter.

ISSUES

The issues to be decided are:

1. Whether a below-the-knee amputation constitutes a reasonable and necessary medical care benefit; and

2. Whether Claimant is entitled to time-loss benefits during the period of recovery following the amputation.

All other issues were reserved.

CONTENTIONS OF THE PARTIES

Claimant contends that after he rolled his right ankle in a compensable accident, he underwent surgery to stabilize the ankle joint and repair a torn tendon. Subsequent conservative care, serial nerve blocks, and a surgery to remove hardware have not helped quell the unrelenting pain which has continued through the date of hearing. Since June 2018, one physician, Kaitlin Neary, M.D. has opined amputation to be "a viable option." Since August 2018 James Bates, M.D. has opined Claimant to be "a good candidate" for amputation. After subsequent psychological evaluation, Craig Beaver, Ph.D. did not find any contraindications for amputation nor for continued conservative measures.

Employer and Surety contend that Claimant suffers from Complex Regional Pain Syndrome (CRPS) as diagnosed by Dr. Bates and others, and that amputation is inappropriate treatment. Dr. Neary actually opposed amputation but belatedly deferred to Dr. Bates. Conversely, Dr. Bates believed it was Dr. Neary who initially recommended amputation. Prior surgery having successfully stabilized Claimant's ankle, Travis Kemp, M.D. and Karl Zarse, M.D. recommend conservative treatment with additional injections. They oppose amputation here. These doctors disagree about the possible efficaciousness of a spinal cord stimulator. Dr. Zarse has opined that amputation for CRPS symptoms is not reasonable medical treatment.

Moreover, a subsequent intervening car accident compounds the uncertainty. Although Surety has agreed to pay for treatment provided by Dr. Bates, Dr. Bates was sought outside the chain of referral and cannot be considered a "treating physician." Rather, Claimant interrupted his treatment with Dr. Zarse to seek out Dr. Bates. As a result, conservative measures have not been given a full opportunity to ameliorate Claimant's symptoms. The physicians disagree about Claimant's ankle instability and about what criteria constitutes a basis for or against amputation.

EVIDENCE CONSIDERED

The record in the instant case included the following:

1. Oral testimony at hearing of Claimant;
2. Joint exhibits A through X;
3. Post-hearing depositions of James Bates, M.D., Karl Zarse, M.D., Travis Kemp, M.D., and Kaitlin Neary, M.D

FINDINGS OF FACT

1. Claimant worked for Employer driving a concrete truck. On March 16, 2015, Claimant stepped out of the truck and rolled his right ankle. Ex. A; HT, 9. Claimant assumed he sprained his ankle and worked despite the pain. HT, 26. Claimant obtained and wore an over-the-counter ankle brace, and continued working for over two months before he first sought medical care. HT, 26.

Medical Care: 2015

2. On May 11, 2015, Claimant visited Primary Health. Ex. F, 5. Stephen Martinez, M.D., his physician's assistant, or his nurse practitioner, Travis Robbins, examined Claimant at this and later visits. Ex. F. Claimant's bruising had resolved, but pain and swelling remained. The examiner expressly noted an absence of instability in the ankle. *Id*. at 5. X-ray showed mild swelling, no fracture. *Id*. Diagnosis: ankle sprain. *Id*. at 6.

3. On May 18, 2015, Claimant returned to Primary Health for follow-up. Ex. F. Dr. Martinez opined that Claimant's condition was work related, prescribed a brace, and referred Claimant to physical therapy. *Id*. at 7-8. Dr. Martinez imposed a temporary restriction of occasional right leg weight-bearing. *Id*. at 9-10.

4. Claimant's physical therapy notes indicate that Claimant sprained his ankle three times around March 16, 2015, and again on May 5, 2015. Ex. M, 1. On May 26, 2015, Claimant reported two additional episodes of twisting his ankle, this time walking on uneven ground. *Id*. Claimant repeated these reports of flare-ups of pain, without an accompanied sprain or twisting incident, on two other visits. *Id*. at 3; 5. On June 8, 2015, Claimant still had pain and swelling, and decreased range of motion. *Id*. at 6. The examiner noted Claimant was tolerating modified work duty. *Id*. at 9.

5. On July 13, 2015, Claimant had an MRI read by Curtis Coulam, M.D., that showed tenosynovitis and tendinopathy in the peroneus longus tendon, some additional tendon sprains, and some fluid which accounted for the continued swelling. Ex. F, 21-22. No tendon tears were evident, and some early arthritis was also noted. *Id*. at 22.

6. Dr. Martinez referred Claimant to board-certified orthopedic surgeon Travis Kemp, M.D., who specializes in foot and ankle conditions. Ex. G. On August 20, 2015, Claimant's examination showed significant swelling and tenderness; his range of motion was full but painful. *Id*. at 1-4. Dr. Kemp noted the earlier x-rays showed a "very small chip fracture/avulsion of the distal tip of the fibula," and the earlier MRI showed a possible tear of the peroneus longus tendon. *Id*. at 2. Fluoroscopic views under weight-bearing showed gross instability from a ruptured anterior talofibular ligament (ATFL). *Id*. Dr. Kemp recommended "major elective surgery." *Id*. at 3.

> This is an acute and complicated problem that poses a threat to bodily function and would benefit from major elective surgery.
>
> At this point, the patient has a gross instability of his right ankle demonstrated on stress views and confirmed by MRI as rupture of the ATFL. In addition, he has damaged the peroneus longus tendon with this injury. I had a long discussion with the patient regarding his options including continue nonoperative management with anti-inflammatories and physical therapy. Thus far, he has failed this regimen and is ready to pursue surgical intervention, which I think is the right decision.
>
> With a continued unstable ankle, the patient could expect instability to continue. He could expect future sprains, which would be frequent, and he could expect worsening of his arthritis due to continued damage of the ankle. He would like to avoid all of these scenarios.

Id. at 3.

7. On September 2, 2015, Dr. Kemp performed arthroscopic surgery. *Id*. at 5. Dr. Kemp re-anchored the AFRL, which had detached from the fibula. *Id*. He also shaved away arthritis and performed a syndesmotic repair to correct a high ankle sprain. *Id*. at 5-8. Afterward in visits, Claimant repeatedly described his ankle as "unstable" but Dr. Kemp's testing and observation revealed it objectively "stable." *Id*.

8. Claimant began another round of physical therapy on October 16, 2015. Ex. N, 1. Although he reported intermittently waxing soreness, a feeling "as though the ankle is going to break," and a "sensation of tearing through the ankle," he did not report incidences of again spraining or twisting the ankle. *Id*. at 46; 52. Claimant attended physical therapy regularly before his December 22, 2015 car accident. *Id*. Claimant reported that he was wearing his CAM boot during the accident, so he felt like his ankle was good; however, he had soreness in his back and right hip. *Id*.

9. Beginning October 23, 2015, Commission rehabilitation consultants, primarily Sean Courtright and Alie Tenne, assisted Claimant. Ex. T. Suitable jobs were identified and the

restriction against walking on uneven ground was seen to be significant. *Id*. at 9. The file closed after Claimant had obtained work with a new employer. *Id*.

10. By November 10, 2015, Dr. Kemp noted Claimant was recovering from surgery with minimal pain complaints. Ex. G, 14. Examination showed swelling remained and that pain restricted Claimant's range of motion. *Id*. Claimant was released to weight-bearing as tolerated and sedentary work. *Id*.

11. On December 8, 2015, Claimant returned to Dr. Kemp for follow-up. *Id*. at 15. Claimant complained of a "crushing sensation" when his ankle is full weight-bearing and nerve sensitivity. *Id*. Dr. Kemp's physical exam concluded that Claimant's ankle was stable, and the weight-bearing X-rays revealed "no fractures or dislocations, nothing on x-ray to suggest that this crushing feeling is concerning." *Id*. Dr. Kemp believed that Claimant's main issue was nerve dysfunction; he continued Claimant's sedentary restrictions and ordered the use of a more restrictive CAM boot instead of an ankle brace. *Id*.

12. On December 22, 2015, Claimant injured his left ribs and hip in a car accident. He was wearing a hard plastic boot on his right ankle, and reported that he did not hurt his ankle during the accident. Ex. K, 12. He later complained of a neck sprain arising from the car accident which took longer than expected to heal. *Id*.

13. Claimant continued attending physical therapy regularly through the end of the 2015. Ex. N.

Medical Care: 2016

14. Claimant continued regular physical therapy visits. He frequently reported additional soreness associated with use, but no spraining or twisting incidents. Ex. N, 61-120. These records indicate good compliance but very slow progress. *Id*. at 61-120.

15. On February 2, 2016, Dr. Kemp approved a job site evaluation (JSE) to allow Claimant to return to work as a cement truck driver on modified light-duty work on even ground. Ex. G, 16. Claimant complained of moderate, constant pain, made worse with activity. Dr. Kemp proposed hardware removal to ameliorate Claimant's nerve dysfunction. *Id*. at 19.

16. On February 25, 2016, Dr. Kemp removed a surgical screw. During removal surgery, stress X-rays showed no reason for concern about the tendons and prior surgical repair. *Id*. at 22-23.

> At this point, given the patient has not had stress views since his surgery, I elected to evaluate the stability of the ATFL, CFL, and syndesmosis using stress views including anterior drawer, talar tilt, supination, and eversion. All of these maneuvers revealed a perfectly stable and anatomically aligned ankle.
>
> *Id*. at 23.

On March 8, 2016, weight-bearing x-rays revealed a successful removal of hardware; Claimant remained on light-duty restrictions for the next six weeks with instructions to continue physical therapy. *Id*.

17. On April 19, 2016, Dr. Kemp noted Claimant's ankle was well aligned, but Claimant had incomplete recovery of strength and balance, and slight swelling without evidence of infection. Ex. G, 26. He gave a steroid injection and continued Claimant's light-duty restrictions. *Id*.

18. On May 31, 2016, Claimant returned to Dr. Kemp's office with complaints of right ankle pain and numbness. Ex. G, 27. Dr. Kemp referred Claimant to a work-hardening program. *Id*. On September 4, 2018, Claimant returned to Dr. Kemp, who referred Claimant to Karl Zarse, M.D., a board-certified anesthesiologist and board-certified pain management specialist. *Id*. at 27A-29.

19. The work-hardening program was administered through St. Al's STARS program,

Workstar, headed by Kevin Krafft, M.D. Ex. O. The Initial screening noted that Claimant's "problem areas" included:

> 1. Posttraumatic right ankle pain and numbness and tingling symptoms along the lateral ankle.
> 2. Decreased mobility.
> 3. Decreased strength.
> 4. Decreased endurance for functional and work activities.
> 5. Impaired body mechanics.
> 6. High fear of reinjury.

Id. at 3. Workstar notes show Claimant was motivated to obtain medical clearance so he could drive a school bus that fall. *Id*. at 11.

20. On June 27, 2016, Claimant visited Dr. Krafft. Ex. J, 1-5. Upon examination, he found swelling and reported pain in the right ankle. Ex. I, 1. He suggested Workstar's therapists include a focus on improving Claimant's antalgic gait, and neuropsychology to address chronic pain management techniques. *Id*. at 5.

21. Also on June 27, 2016, Robert Calhoun, Ph.D. evaluated Claimant for admission into the Workstar work-hardening program. Ex. I, 1-4. He performed psychological testing including an MMPI-2. *Id*. at 3. Dr. Calhoun found Claimant overly responsive to pain, highly somatically focused, and irritable and frustrated from his ongoing pain. *Id*. However, these factors did not preclude admission to Workstar. *Id*. at 4. Dr. Calhoun recommended ongoing education for the heightened somatic focus, fear of pain, and movement; work simulation to desensitize Claimant to movement; gait training to correct an abnormal gait; and, four to six sessions of cognitive behavioral pain management therapy in conjunction with Workstar. *Id*.

22. On July 5, 2016, Claimant began work-hardening. Ex. J, 6. On July 13, 2016, Claimant reported a successful camping trip while wearing his ankle brace. Ex. I, 9-11. On July 25, 2016, Claimant and Dr. Krafft discussed an EMG/NCS due to Claimant's constant pain

symptoms which was radiating into Claimant's right calf, which was performed on August 2, 2016, and suggested right sciatic nerve neuropathy. *Id*. at 12; 18. Dr. Krafft is unclear about whether sciatic neuropathy would be related to the work accident or to the later car accident; he recommended a lumbar MRI "unrelated to the industrial injury." *Id*. at 22. On August 5, 2016, Dr. Krafft rated Claimant's ankle at 1% whole person permanent impairment with restrictions against walking on "rough uneven ground." *Id*. at 23. He elaborated on the return-to-work form that Claimant was restricted from "lifting over 50 pounds occasionally and no pushing or pulling over 100 pounds." *Id*. at 25.

23. On August 4, 2016, a DOT driver's physical examination showed he was still taking muscle relaxers and anti-inflammatory medications, but did not mention any ankle problem. Ex. F, 33-34.

24. On August 5, 2016, Workstar issued its final report recommending discharge from the program. Ex. O, 72.

> The client continues to report right ankle pain averaging a 3/10. However, the client has learned various symptom control strategies as well as alternate positioning and has demonstrated he can function with this residual discomfort. The client has participated in our Work Hardening Program for a total of 5 weeks, up to 4 hours a day, 5 days a week with mild difficulty. The client has demonstrated good improvement in mobility, strength, endurance, body mechanics and work capacities. I recommend the client's discharge from Work Hardening at this time, as our treatment goals have been accomplished. The client has met his pre-injury Work Level.
>
> *Id*. at 74.

Workstar instructed Claimant to continue a home program to maintain his current level of conditioning. *Id*.

25. On August 16, 2016, new X-rays showed "no instability of the tibiotalar joint detected with stress views of the ankle as described above. Ex. R. No fracture or dislocation,

and no osteochondral lesion identified. *Id*. No significant tibiotalar joint space narrowing. *Id*. Subtalar joint ins also unremarkable appearing." Ex. R, 5. John Jackson, M.D., radiologist, concluded they showed no instability. *Id*.

26. On September 15, 2016, Claimant returned to Dr. Krafft, who increased Claimant's PPI to 6% whole person entirely attributable to the work accident, based on Claimant's report of superficial numbness preceding the car accident. Ex. I, 29. He noted, "[t]here is no objective basis to support restrictions. He is released to his pre-injury employment without restrictions." *Id*. Dr. Krafft recommended continued pain control management for three to six months. *Id*.

27. Claimant visited Dr. Krafft for follow-up on November 23, 2016 and February 21, 2017. *Id*. at 31-36.

Medical Care: 2017-Hearing

28. On June 9, 2017, Claimant visited James Bates, M.D. Ex. K, 1. Dr. Bates is board certified in physical medicine and rehabilitation. Claimant arranged this appointment on his own initiative. Surety initially denied Dr. Bates' treatment as outside the chain of referral, but eventually reversed its denial. Ex. K. Claimant reported ankle pain. *Id*. Upon examination Dr. Bates noted "prominent antalgic gait," extreme sensitivity to light touch, and diminished reflexes including 1 out of 4 at the left ankle and the right ankle reflex was not tested. *Id*. at 2. Dr. Bates recommended therapy and home exercises to desensitize the area. *Id*.

29. At a June 30, 2017 visit, Dr. Bates noted "fairly significant" improvement which Claimant was unable to discern. Ex. K, 5. Dr. Bates noted the presence of some criteria for a CRPS diagnosis to be made, but not quite enough. *Id*. On an August 10, 2017 visit, Dr. Bates opined that Claimant's CRPS symptoms were "limiting his ability to make any significant

changes in the soft tissue around the treatment to the ankle" and should be treated "prior to any consideration of invasive treatment to the ankle." *Id*. at 6-7. On an October 30, 2017 visit, Claimant first described to Dr. Bates the 2015 car accident and claimed continuing low back and rib pain from it. *Id*. at 12. In subsequent visits, Dr. Bates' focus and treatment appears to include Claimant's low back and rib complaints as well as his right ankle. *Id*. at 12-24.

30. On October 27, 2017, Commission rehabilitation consultants reopened Claimant's file and provided assistance. Exh T, 22.

31. On a November 6, 2017 visit, Dr. Bates called a dorsal column stimulator a "last resort" - - meaning a last resort in Claimant's mind according to Dr. Bates' deposition testimony - - not to be considered until other conservative measures were completed. Ex. K, 14-15. He noted musculoskeletal issues in Claimant's back significantly coexisted with right ankle complaints as a basis for additional physical therapy. *Id*. Claimant continued to treat with Dr. Bates. *Id*. Dr. Bates recommended that Claimant see Dr. Zarse for a lumbar sympathetic block in order to address his neuropathic pain. Ex. L, 1. Dr. Zarse agreed and performed the lumbar sympathetic block and asked Claimant to return in one week. Ex. L, 3. Unfortunately, Claimant was in a car accident on the day following the lumbar sympathetic block procedure, which made it difficult for Dr. Zarse to assess whether the injection helped as intended. Ex. L, 3. Dr. Zarse planned to repeat the right lumbar sympathetic block procedure, and reaffirmed his suspicions of CRPS. Ex. L, 4. Claimant did not promptly return to Dr. Zarse for the proposed second lumbar sympathetic block. Ex. L, 5.

32. After a January 2, 2018 examination, Dr. Zarse diagnosed CRPS. Ex. L, 3. In an undated correspondence addressed "To Whom it May Concern" Dr. Zarse explained why amputation is contraindicated for a CRPS patient. *Id*. at 5-6.

> When people have long-standing complex regional pain syndrome and nerve dysfunction, you would not recommend amputation. The lesion is in the central nervous system, not in the foot. It is a condition of the central nervous system that results in chronic hypersensitivity and abnormal nerve function. With an amputation you are taking a hypersensitized limb and causing tremendous stimulation with the amputation and potentially making it worse. He also has a high chance of phantom limb pain, where he has intractable pain in the foot but no longer has a limb.
>
> *Id*. at 5.

Moreover, Dr. Zarse noted Claimant had not exhausted reasonable options, including multiple lumbar sympathetic blocks, peripheral blocks, and a trial of a spinal cord stimulator. *Id*. He opined that Claimant's height and weight carries additional risks of a suboptimal outcome. *Id*.

> I think the patient is essentially exhausted from dealing with this issue and wants it fixed, obviously. However, to those of us that treat this condition on a regular basis, we know it can get much worse. The patient feels it can't and this is his only option. However, I can tell you from personal experience that it can get much worse.
>
> *Id*. at 6.

Dr. Zarse recognized Claimant's earnest desire to resolve his pain; however, amputation is not the solution.

33. On a January 17, 2018 visit, Claimant told Dr. Bates he did not receive a second injection from Dr. Zarse because "that injection was cancelled due to workmen's comp not providing the authorization." Ex. K, 22. On January 31, 2018, Dr. Zarse performed a second lumbar sympathetic block. Zarse Dep., Exh 2.

34. In deposition, Dr. Zarse testified he "did not see structural instability" in Claimant's ankle, rather he observed "sensation symptoms" that he diagnosed and treated as CRPS. Zarse Dep., 10-11. He recommended additional lumbar sympathetic blocks for treatment, and explained that Claimant's chronic hypersensitive pain arises in the dorsal root ganglia, which is in the spinal cord, and that is the reason why the lumbar sympathetic blocks are

needed. *Id*. at 10. Dr. Zarse's could not assess the efficacy of the first lumbar sympathetic block treatment due to Claimant's intervening motor vehicle accident; there was simply no way to delineate Claimant's soreness from a failed block or an acute injury from the motor vehicle accident. *Id*. Dr. Zarse performed a second injection on January 31, 2018, but Claimant did not follow-up after the second injection. *Id*. at 15-16. After that point, Dr. Zarse was asked to opine on whether a below-the-knee amputation would be reasonable. *Id*.

> Q. All right, back to your letter of November 2018, could you discuss or explain what your opinions were at that point?
> A. Sure. The first question I was asked was whether I felt a below-the-knee amputation was likely to fix his condition and I stated that it would not. His issue was hypersensitivity and nerve-related issue, which really originated in the spinal cord, so cutting off the leg is not going to take away where the pathology is and was likely to actually make it worse and cause phantom limb pain.
> Q. So bottom line, did you believe that it was a reasonable thing to perform the amputation?
> A. I did not.
> Q. And then you indicated that you'd never recommended amputation for CRPS before; is that accurate?
> A. Yes, and in fact, often surgeries will be delayed until the CRPS gets controlled, because we know that if you cause another significant injury like a surgery to an affected limb, you could make it permanent.
>
> *Id*. at 20/14-21/3.

Dr. Zarse recommended a spinal cord stimulator, and also suggested trials of anticonvulsants and tricyclic antidepressants as reasonable measures which should precede consideration of amputation. *Id*.

35. By the February 14, 2018 visit, Dr. Bates was ready to refer Claimant to a foot and ankle specialist. Ex. K, 27.

36. On a February 28, 2018 visit, Dr. Bates noted "[t]here has been a recent request for surgical evaluation." *Id*. Dr. Bates did not record who made this request and whether it refers to the possible amputation. *Id*.

37. Dr. Bates referred Claimant to Kaitlin Neary, M.D., an orthopedic surgeon. Ex. K, 27. Dr. Neary completed an orthopedic surgery residency, and then sub-specialized in foot and ankle problems. Neary Dep., 9. Dr. Neary is board-eligible and is taking oral boards in July. She previously practiced medicine in Nebraska and California, but is relatively new to the Boise area. *Id*. On April 16, 2018, Dr. Neary examined Claimant. Ex. P, 1-4. Claimant's hypersensitivity limited his examination. *Id*. at 3; Neary Dep., 12. She noted swelling and discoloration.

> . . . . Mechanically his ankle appeared fairly stable. He didn't necessarily have, you , know, any obvious signs of mechanical pathology on exam, but he did have very severe hypersensitivity in multiple nerve distributions both near where the surgery had occurred and even nerves that should not have been affected by the actual incision and surgery themselves.
>
> *Id*. at 3-4; Neary Dep., 12/12-18.

She looked at X-rays taken that day and found no evidence of abnormalities. *Id*. She diagnosed CRPS. *Id*. at 4. She suggested an MRI to rule out any mechanical or other explanations for his pain. Neary Dep., 13. She warned Claimant that "invasive treatments or procedures on his right foot or ankle wi[ll] only make his nerve hypersensitivity worse." Ex. P, 4. The MRI and x-rays were unrevealing; they were "essentially normal" and were "nothing other than normal post-operative change that you would expect from his previous surgery." Neary Dep., 13/20-23.

38. On May 16, 2018, Dr. Neary performed a follow-up examination. Ex. P, 5. An MRI showed mild arthritis. *Id*. at 6; Neary Dep., 15. Dr. Neary explained that an MRI will not look "normal" for patient's with reconstructed lateral ligaments, even though the surgery performed by Dr. Kemp appeared mechanically successful. Neary Dep. 16. The arthritis seen does not explain the hypersensitivity. Ex. P, 6. She performed an injection in the subtalar joint for both diagnostic and therapeutic purposes. *Id*. at 7; Neary Dep., 16-17.

39. On June 25, 2018, contrary to Dr. Neary's expectation, Claimant reported the injection had exacerbated his symptoms and resulting in excruciating pain for a few days following the injection. *Id*. at 8; Neary Dep. 18. Claimant asked for amputation. *Id*.; Neary Dep., 18. Dr. Neary suspected that Claimant's pain was "purely related to his nerve hypersensitivity." *Id*. at 19-20. Claimant reported that Dr. Bates had discussed and approved this course. Ex. P, 8. Dr. Neary deemed the request "a viable option." Dr. Neary noted that Claimant was fairly adamant about wanting a below-the-knee amputation, and she cautioned Claimant as follows:

> . . . it was going to be an elective procedure that doesn't necessarily have the most predictable results. So it was something I wanted [Claimant] to really think through and make sure that we have all of the right conversations. And he really understands truly both what the risks of dong this are, as well as what life will look like after an amputation. So I had him actually go to Brownfield's, which is one of our prosthetic places in town, and recommended that he meet with a prosthetist to at least discuss what life with a below-the-knee amputation and a prosthesis would be like.
>
> Neary Dep., 20/14-25.

40. On a July 30, 2018 visit to Dr. Bates, Claimant reported that Dr. Neary "sent him to Brownfield's to start looking at prostheses. . . . It appears they are progressing towards amputation." Ex. K, 43-A. Dr. Bates further recorded:

> [Dr. Bates and Claimant] Discussed that I [Dr. Bates] support the approach of looking at the amputation. The amputation after all appropriate evaluations have been performed is appropriate. We would then consider the amputation as the beginning of recovery, and the beginning of regaining function. He has enough remaining strength to be a good community ambulator[1] with a prosthesis. I am not concerned with the CRPS. He may have phantom pain, but this current underlying constant pain has really not been the restricting factor for him, it has been the mechanical limitation, and mechanically re-injuring it numerous times per day. Therefore, he would be a good candidate for the amputation, prosthesis,

[1] By "community ambulator" Dr. Bates referred to a person who could walk and function in the community vis-à-vis someone who would use a prosthetic only at home but required a wheelchair in the community. Ex. K, 43-B; Bates Dep., 36-37.

and beginning recovery.

Id. at 43-B.

This mention of "mechanically re-injuring" the ankle is the first in the medical records in which Claimant asserted - - or a physician noted - - re-injury had occurred, let alone on multiple occasions. Nevertheless, in deposition Dr. Bates considered re-injuries "an everyday occurrence," … "reinjury numerous times per day," or even "just about every step he takes." *Id*.

41. On August 6, 2018, Dr. Neary discussed with Claimant the risks and possible complications of amputation. Ex. P, 12. Dr. Neary explained to Claimant that he would remain "high risk for nerve hypersensitivity post-operatively" post amputation. *Id*.; Neary Dep., 23. Claimant remained "adamant" for amputation. *Id*.

42. On September 4, 2018, Claimant returned to Dr. Kemp. Ex. G, 28. Dr. Kemp recorded Claimant's history out of order; inaccurately indicating Dr. Zarse's treatment preceded the screw removal. *Id*. By history, Dr. Kemp noted he had repaired torn peroneal tendons, but in deposition acknowledged that although a possible tear was suspected, surgery showed no peroneal tendon tear. *Id*. Claimant reported to Dr. Kemp that another physician had recommended amputation. *Id*. Upon examination, Dr. Kemp found the ankle stable but with significant sensitivity reported by Claimant. *Id*. at 28-29. Dr. Kemp advised against amputation in favor of sural nerve blocks to locate the issue with possible nerve ablation to follow. *Id*. He anticipates amputation would produce "high risk of phantom pain and a poor functional outcome." *Id*. Claimant's weight augurs against optimal prosthetic function. *Id*.

43. On October 22, 2018, Dr. Bates reiterated his belief that Claimant's ankle instability is his major limiting factor. Ex. K, 43-F. On January 9, 2019, Dr. Bates checked a box affirming he had reviewed Dr. Kemp's September 4, 2018 chart note and Dr. Beaver's

evaluation, and still agreed with Dr. Neary's recommendation for an amputation. *Id*. at 44.

44. In December 2018, Craig Beaver, Ph.D. reviewed records and performed a psychological evaluation in two visits, one week apart, related to Claimant's request for amputation. Ex. W. After testing, he diagnosed mild somatic symptom disorder, with predominant pain, but without other disorder. *Id*. at 11. Dr. Beaver found Claimant's somatic focus to be an understandable response to chronic pain. *Id*. He did not see any psychological contraindications to amputation, spinal stimulator, or other therapy. *Id*. at 12.

45. In deposition, Dr. Kemp affirmed that under sedation at both the surgical repair and hardware removal he tested Claimant's ankle for stability and found it stable. Kemp Dep., 10-12; 17-18. Dr. Kemp considers CRPS a reasonable name for Claimant's reports of hypersensitivity to light touch. *Id*. at 13. He observed that Claimant's hypersensitivity had persisted between his last 2016 visit and his 2018 visit. *Id*. at 16-18. Dr. Kemp examined Claimant, and confirmed that his ankle remained stable. *Id*. Claimant's remaining problem, CRPS, poses additional risks for Claimant's desired amputation.

> Q. Did you advise against a below-the-knee amputation at that point?
> A. I recall talking about it. I don't—yeah, I mentioned it here. I think it is—I think it is a high-risk problem in a patient that could have CRPS. CRPS, the problem isn't at the foot, it is at the brain and the spinal cord. So to remove a structure that is otherwise normal or to fix a problem that is not on that structure, it is not a good idea. You're not going to –you could have significant phantom pain and make the CRPS a lot worse.
> I didn't think amputation was the best option for him. It is going to take his leg away. He's a big guy. It is going to affect his gait, and it has a good chance of not relieving his pain.

Id. at 18/19-19/10.

Dr. Kemp recommended that Claimant continue treatment with Dr. Zarse. *Id*. at 20. Dr. Kemp disagrees with Dr. Bates' instability assessment, and even if instability exists or arises, corrective procedures short of amputation are appropriate. *Id*. at 22-23. Claimant's continuing feelings of

ankle instability are:

> . . . likely due to his nerve dysfunction. He doesn't feel his foot like he should. His muscles don't work like they should because the nerves aren't working well. That's not going to be fixed by me taking a stable ankle and performing an Elmslie procedure and making a stable ankle. It is a stable ankle.
>
> HT, 23/19-24/1.

In summary, Claimant's problem is not a mechanical problem, and should not be treated as such; amputation is unlikely to ease Claimant's pain and carries additional risks. Kemp Dep., 28-29.

46. In deposition, Dr. Neary acknowledged that Claimant's desired below-the-knee amputation was a drastic measure with risks, yet she believed this treatment could benefit Claimant as a "last resort" for his unrelenting pain. Neary Dep., 24-25. Although there are certainly additional conservative procedures Claimant could undergo, Dr. Neary respectfully departed from Dr. Kemp's opinion that these should be pursued given Claimant's poor quality of life and his reasonable compliance with medical treatment. *Id*. at 26-28; 33. Dr. Neary also respectfully disagreed with Dr. Zarse's opinion on the below-the-knee amputation, because she has observed multiple patients improve post-amputation. *Id*. at 28.

47. In deposition, Dr. Bates opined that the below-the-knee amputation is the most reasonable treatment for Claimant and has the greatest probability of helping him improve his functional status. Bates Dep., 40. Claimant has CRPS with related hypersensitivity. Dr. Bates advised Claimant to continue with the injections, because "it's not going to have a complete reversal of symptoms with one or two shots." *Id*. at 23/25-24/1. After Claimant failed to improve with the injections, Dr. Bates sought information on the structural integrity and condition of Claimant's ankle, and referred the matter to Dr. Neary. *Id*. Dr. Bates described two components to Claimant's problems—the first is Claimant's CRPS, which is a neuropathic condition, and the second is structural—mechanical limitations in his ankle. *Id*. at 37-38.

48. Dr. Bates is persuaded that the below-the-knee amputation will benefit Claimant, and the benefits outweigh the risks of phantom pain:

> . . . . And so yes, he may have the phantom pain, and I would expect that he could, but he would then get off of that worn out, unstable, inefficient joint that makes his leg painful, and the limiting factor of his day. It's a messed-up, beat-down, broken-down ankle, and that's why he would do better without the ankle.
>
> *Id*. at 39/7-14.

Dr. Bates was optimistic that Claimant's determination would aid him in becoming proficient at using prosthesis to ambulate.

Additional Findings

49. Born July 17, 1964 Claimant was 54 years old at the date of hearing. HT, 15. He served in the Navy about six or seven years. *Id*. at 18-21. At hearing he stood 6' 5" and weighed 298 pounds. At his first doctor's visit his weight was recorded at 332.3 pounds. Ex. F, 5. While there are medical records documenting that Claimant believed his accident caused an 80 or 100 pound weight gain, Claimant clarified at hearing that he believed his weight gain was due to a thyroid condition, and not inactivity from his injury. HT, 73.

50. At hearing, Claimant described his condition:

> The best way to describe it, if you slam you thumb in a car door and touch it, that's what it feels like 24 hours a day. It never stops. It's – it's unstable. I just – I want it gone. I want to be able to walk again. I want to be able to ride my bike. I want to go fishing. My granddaughter wants to learn how to hunt and track. I can't teach her how to do that with this.

Claimant repeatedly stated he wanted the "instability" fixed. He did not want mere masking of pain. Claimant is uninterested in a spinal cord stimulator. *Id*. at 56-57.

> Q. Okay. Did he also talk to you anything about a potential spinal cord stimulator?
> A. I have absolutely no interest in a spinal cord stimulator. I have two friends that have had them, they said it was their worst nightmare and I don't want to be hooked up to a machine for the rest of my life to mask pain to cover a problem

that can't be fixed. . .
Q. Okay. But he—
A. —other than by amputation. That's why I want the leg gone, so I can get on with my life. *Id*. at 71/11-20.

DISCUSSION AND FURTHER FINDINGS OF FACT

51. 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).

52. 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).

53. Reasonable medical care is statutorily provided by Idaho Code § 72-432. It is for the physician, not the Commission, to decide whether the treatment is required. The only review the Commission is entitled to make is whether the treatment was reasonable. *See Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989). A claimant must provide medical testimony that supports a claim for compensation to a reasonable degree of medical probability. *Langley v. State, Industrial Special Indemnity Fund*, 126 Idaho 781, 890 P.2d 732 (1995). "Probable" is defined as "having more evidence for than against." *Fisher v. Bunker Hill Company*, 96 Idaho 341, 344, 528 P.2d 903, 906 (1974). No "magic" words are necessary where a physician plainly and unequivocally conveys his or her conviction that events are causally

related. *Paulson v. Idaho Forest Industries, Inc*, 99 Idaho 896, 901, 591 P.2d 143, 148 (1979). A physician's oral testimony is not required in every case, but his or her medical records may be utilized to provide medical testimony. *Jones v. Emmett Manor*, 134 Idaho 160, 997 P.2d 621 (2000).

54. Here, Claimant, on his own initiative, has lobbied his physicians for a below-the-knee amputation to resolve his ongoing pain complaints.[2] Claimant relies on Drs. Bates and Neary to provide the needed medical opinion establishing the reasonableness of his desired below-the-knee amputation. Dr. Bates asserts that Claimant ongoing ankle's instability support this course of treatment. Dr. Bates is also optimistic that Claimant can become proficient at using prosthesis. Dr. Neary endorses the below-the-knee amputation based, in large part, on Claimant's insistence for the treatment, and on her observation that this drastic measure has helped other patients. Dr. Neary was initially reluctant to endorse the below-the-knee amputation, and even dedicated several sessions to counsel Claimant against such a procedure. However, as a self-described patient advocate who believes Claimant has reasonably participated in conservative treatment without success, she will support his desires. She demonstrated her awareness of the risks involved, including the chance that Claimant's condition may worsen, but

[2] The Referee's recommendation characterized Claimant as withholding and misstating relevant historical facts with Dr. Bates, and manipulating Drs. Bates and Neary into thinking the other had proposed amputation. For example, Dr. Bates' July 30, 2018 chart notes reflect that Claimant reported to him that Dr. Neary was "progressing towards amputation" and that she had sent him to Brownfield's to consider prosthesis. Ex. K, 43-A. At that point, Dr. Neary testified that she was reluctant to proceed with the amputation and was actively counseling Claimant against such a course and the great risks involved. Dr. Neary's notes reflect that Claimant had reported that Dr. Bates had discussed and approved this course of treatment, meaning the amputation, when Dr. Bates recorded that he had sent Claimant to Dr. Neary to evaluate Claimant's ankle structure. *Id*. at 27; Ex. P, 8. Dr. Bates' February 14, 2018 note also reflects that Claimant had "not heard back from Dr. Zarse of the next treatment option." However, Dr. Zarse testified that Claimant did not follow-up after the second injection, and that additional conservative measures should be attempted. *Id*. Claimant's reports do not match the physician's notes and show a concerted effort to proceed with amputation. Dr. Zarse has a more flattering view of Claimant's behavior as being the result of "essentially exhausted from dealing with this issue" and desiring to move on with his life. None of the physicians characterized Claimant's self-advocacy for an amputation as deceitful. Ultimately, the question of reasonable medical treatment turns on the expert medical testimony presented, not on the intensity with which Claimant has sought this treatment.

ultimately yielded to Claimant's personal desire for amputation.

55. Defendants strongly disagree with the recommendation for amputation. Drs. Kemp and Zarse both testified that Claimant's CRPS diagnosis drastically decreases Claimant's chances of a good outcome with the below-the-knee amputation, and may, in fact, exacerbate Claimant's pain symptoms. In addition, both Drs. Kemp and Zarse find Claimant's ankle stable. Claimant does not have a mechanical problem; Claimant has a nerve dysfunction as part of his CRPS. CRPS is causing his present symptoms—not instability in his ankle. As such, the below-the-knee amputation is not reasonable and will not alleviate his symptoms. Claimant will be worse off with the requested treatment, and would be better served with conservative treatment. Both physicians proposed conservative treatment for Claimant's symptoms.

56. Claimant sincerely believes that his ankle is "unstable" and that amputation is the solution. Except for vague language by Dr. Bates, other physicians agree the ankle is anatomically stable. Dr. Bates asserted instability without adequately explaining anatomically how Claimant's ankle is "worn out" or shows "a mechanical limitation." He also did not explain why the other doctors and their radiological evidence were incorrect. On the other hand, Drs. Kemp and Zarse provided foundation for their respective opinions and they are given more weight than those expressed by Dr. Blair.

57. Drs. Kemp and Zarse are unequivocally against amputation given Claimant's ankle stability and CRPS symptoms. They testified that CRPS most likely precludes a good outcome from amputation, even if there were a mechanical or anatomical basis for amputation. Dr. Zarse opined that it is wise to delay surgeries until a patient's CRPS is controlled, and that Claimant's hypersensitivity increases the chance of a poor outcome, leaving Claimant in a worse condition. Dr. Bates glosses over the potential impact of Claimant's CRPS on this potential

amputation. Drs. Kemp and Zarse opined that Claimant's hypersensitivity could be addressed with conservative measures such as nerve blocks, nerve ablation, or a spinal cord stimulator. Drs. Kemp and Zarse appear willing to continue to perform conservative treatments as needed. Claimant is adamantly opposed to a spinal cord stimulator, and has focused his efforts on securing the amputation. One can understand Claimant's frustration with his situation. However, the persuasive medical testimony is that Claimant's desired amputation is not reasonable medical treatment.

Temporary Disability Benefits

58. Claimant requested time-loss benefits during the period of recovery following the amputation. For the reasons discussed above, Claimant has not shown that the amputation is reasonable medical treatment and the issue of time-loss benefits during the period of recovery following the amputation is moot.

CONCLUSIONS OF LAW AND ORDER

1. Claimant failed to show amputation is reasonable medical treatment.

2. The issue of time-loss benefits during the period of recovery following the amputation is moot.

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

DATED this ___18th___ day of ____September____, 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 __18th__ day of __September__, 2019, a true and correct copy of **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** was served by regular United States Mail upon each of the following:

DENNIS R PETERSEN
PO BOX 1645
IDAHO FALLS ID 83403-1645

NEIL D MCFEELEY
PO BOX 1368
BOISE ID 83701-1368

el

_____/s/_____