BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

ANTHONY RAY CORNWALL, Claimant, v. SOUTH IDAHO PROPERTIES, L.L.C., Employer, and STAR INSURANCE COMPANY, Surety, and STATE OF IDAHO, INDUSTRIAL SPECIAL INDEMNITY FUND, Defendants.	**IC 2012-000050** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** September 9, 2019

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee John C. Hummel, who conducted a hearing in Pocatello on October 10, 2018. James D. Ruchti of Ruchti and Beck Law Offices represented Claimant, Anthony Ray Cornwall, who was present in person. David P. Gardner of Hawley Troxell represented Defendant Employer, South Idaho Properties, LLC, and Defendant Surety, Star Insurance Company. Paul J. Augustine of Augustine Law Offices represented Defendant State of Idaho, Industrial Special Indemnity Fund (ISIF). The parties presented oral and documentary evidence, took post-hearing depositions, and submitted briefs. The matter came under advisement on May 22, 2019.

ISSUES

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

1. Whether Claimant sustained an injury from an accident arising out of and in the course of employment.

2. Whether the industrial accident caused the condition or conditions for which Claimant seeks benefits.

3. Whether Claimant's condition is due in whole or in part to a pre-existing and/or subsequent injury or condition.

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

    a. Medical care;

    b. Temporary partial and/or temporary total disability benefits (TPD/TTD);

    c. Permanent partial impairment (PPI); and

    d. Permanent partial disability (PPD).

5. Whether Claimant is entitled to permanent total disability pursuant to the Odd Lot Doctrine or otherwise.

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

7. Whether ISIF is liable under Idaho Code § 72-332;

8. What is the correct apportionment under the *Carey* formula; and

9. Whether Claimant is entitled to attorney fees pursuant to Idaho Code § 72-804.

FACTUAL SUMMARY

Claimant worked as a laborer for Employer at its mobile home park properties in the Pocatello, Idaho area. On December 23, 2011, Claimant was picking up a heavy tire to remove from the property. As he lifted the tire, he felt a sharp pinching pain in his lower back; he recalled that everything below his waist went numb. He reported the injury to Employer's office and sought medical treatment and evaluation. He received a referral for physical therapy but continued to work for Employer. He still experienced radicular pain shooting down both legs.

On February 3, 2012, Claimant was working on a broken water line underneath a mobile home. He twisted himself while maneuvering underneath. He alleges that this action exacerbated his previous injury of December 23, 2011 and that the radicular symptoms in his legs worsened. He received approval from Surety for an MRI and a referral to Benjamin Blair, M.D., for further treatment. After conservative treatment with physical therapy and steroid injections, Dr. Blair performed a laminectomy and discectomy at the L5/S1 level on Claimant in April 2012.

Thereafter Claimant received further diagnostic tests, including an MRI, an EMG study, and a CT myelogram. He continued to complain of significant radicular pain in his legs that was unabated from his condition prior to surgery. Dr. Blair continued to prescribe narcotic pain medications and physical therapy.

On September 19, 2012, Surety's IME physician, Brian D. Tallerico, M.D., determined that Claimant was at maximum medical improvement (MMI). Surety suspended further medical and income benefits to Claimant. Dr. Tallerico found that Claimant had a nine percent whole person impairment (WPI), which Surety paid.

With Surety denying further him further health coverage, Claimant obtained health insurance through the Pre-existing Condition Insurance Plan (PCIP). This insurance covered a

lower back fusion surgery that Dr. Blair performed on April 16, 2013. Subsequently, Claimant also had implantation of a spinal cord stimulator (SCS) and two SI joint fusion surgeries, also paid for by the PCIP. His pain and numbness symptoms, however, persisted.

Claimant has not worked since February 3, 2012. He has not sought any further work or sought assistance in applying for work. He applied for and received Social Security Disability (SSD) benefits that were awarded solely on the basis of his back injury.

CONTENTIONS OF THE PARTIES

Claimant alleges that the additional surgeries, SCS and other treatment not covered by Surety were helpful to him, partially alleviating his pain, despite initial difficulties and uneven results. Nevertheless, he alleges that he continues to have severe industrially-related pain symptoms and numbness in his legs that significantly interfere with his ability to work, specifically performing manual labor, and that these symptoms are unabated from his pre-surgical condition. He seeks reimbursement under the *Neel* Doctrine for past medical bills in the amount of $541,611 for the procedures and medical care that Employer and Surety did not cover. He also alleges that he is entitled to payment of a 13% WPI and additional temporary disability benefits to the date of medical stability found by Dr. Blair. Finally, Claimant alleges that he is now totally and permanently disabled solely due to industrial causation and is entitled to attorney fees for unreasonable denial of benefits.

Employer and Surety note that this was an accepted claim and that Claimant received both temporary disability benefits and medical benefits until Dr. Tallerico determined that he was at medical stability on September 19, 2012. They argue that Claimant properly received payment of a 9% WPI per Dr. Tallerico's assessment of his impairment at the time he declared Claimant at medical stability. Employer and Surety allege that Dr. Tallerico correctly determined

that Claimant was medically stable and capable of returning to work with certain restrictions, including no lifting or carrying in excess of 70 pounds and no repetitive lifting, pushing, pulling more than 50 pounds. They further argue that Claimant is not eligible for any additional medical or income benefits and that he is not permanently and totally disabled. In the alternative, if the Commission determines that Claimant is permanently and totally disabled, Employer and Surety argue that ISIF should be held liable for a proportional share of disability benefits under the *Carey* formula, representing Claimant's pre-existing conditions that were manifest at the time of the industrial injury and that contributed to his total and permanent disability.

ISIF denies that Claimant is totally and permanently disabled. In the alternative, if the Commission finds that Claimant is totally and permanently disabled, ISIF denies that any of Claimant's pre-existing conditions combined with his industrial injury to contribute to his disability and argues that he is totally and permanently disabled solely as a result of the back injury sustained in the industrial accident.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant and Claimant's former spouse, Rhonda Cornwall, taken at hearing;

2. Joint Exhibits 1 through 78, admitted at the hearing;

3. Joint Exhibits 79 and 80 admitted by stipulation after the hearing; and

4. The post-hearing deposition testimony of the following:

    a. Benjamin Blair, M.D.;

    b. Brian D. Tallerico, D.O.;

    c. Timothy E. Doerr, M.D.;

d. Phillip McCowin, M.D.;

e. Nancy E. Greenwald, M.D.;

f. Bart McDonald, MPT;

g. Delyn Porter, M.A., CRC, CIWCS; and

h. Nancy Jean Collins, PhD.

EVIDENTIARY RULINGS

All unresolved objections from the post-hearing depositions and the hearing are denied. At the conclusion of the hearing, counsel for Employer and Surety moved for admission of two DVDs of surveillance video of Claimant. Tr., 199:22-202:17. The Referee took the matter under advisement, *Id*. at 202:18-23, and issued a post-hearing order dated October 12, 2018 denying admission of the surveillance video. Nevertheless, Employer and Surety argued concerning the video surveillance in their post-hearing brief. The evidentiary ruling of October 12, 2018 stands, for the reasons stated therein, and will not be revisited again in this decision.

After having considered the above evidence and the arguments of the parties, the Referee submits the following findings of fact and conclusions of law for review by the Commission.

FINDINGS OF FACT

1. **Claimant's Background, Education, & Work Experience**. Claimant was born in Pocatello, Idaho, on June 24, 1985 and was 33 years old at the time of hearing. Tr., 46:23-47:3. He grew up in South Blackrock, which is located south of Pocatello. *Id*. at 47:5-10. At the time of hearing he lived in Pocatello with his former wife and five children. *Id*. at 11-15.

2. Claimant was born developmentally disabled due to fetal alcohol syndrome. As a result, he had learning disabilities that affected him at all levels of grade school through high school. He struggled in school and received low grades throughout; in particular, math, history,

and science were difficult subjects for him. Tr., 49:3-16. His school district assisted him with an Individual Education Plan from kindergarten through high school and he attended special education classes. *Id*. at 49:17-50:10.

3. Although he graduated from high school in 2003, Claimant currently reads at an elementary grade level. *Id*. at 50:11-14; 51:1-4. Claimant's former wife Rhonda Cornwall observed that his reading and writing skills are as good "as my fourth grader." She explained that when Claimant "reads things, he has a hard time understanding. He doesn't remember what he's read. He tries to sound out words. You know, sometimes it's not correct." *Id*. at 172:8-16.

4. Claimant also has significant difficulty with math skills such as calculating a tip or measuring amounts. Id. at 50:15-25. Rhonda Cornwall agreed that Claimant struggles a great deal with math, as follows: "Yes. Measurements are a big thing." Percentages, simple dollar amounts, and similar math skills are difficult for him. *Id*. at 171:11-172:7.

5. Claimant did not undergo or complete any post-high school training or education. *Id*. at 51:23-25.

6. Claimant's work experience began during high school when he tended horses for neighbors, moved hay, and helped his brothers on "side jobs." *Id*. at 52:22-53:6.

7. After high school, Claimant first worked for RWL Seamless Siding, a house and building siding contractor. He installed siding, removed siding, and prepared houses for new siding. Occasionally he assisted in the installation of small roofs. He obtained the job through a high school placement program. His tenure in this job lasted only three to four months due to poor training, a strained relationship with the owner and irregular paychecks. *Id*. at 53:7-54:19. While Claimant enjoyed the outdoor and "hands on" nature of the job, he struggled with applying math skills to measuring siding and other materials and required close supervision to

accomplish tasks. Tr., 54:20-55:14. The job required a lot of climbing ladders, heavy lifting, and repetitive movement. *Id*. at 55:15-56:15.

8. Claimant next went to work for Dairy Queen, a job that his wife helped him secure because she already worked there. At Dairy Queen he was a regular line worker who performed cash register duties, cooking and food preparation, counter duties, and cleaning. He struggled to follow the instructions for food preparation and counting money at the cash register. He remained in that job only for three to four months. Rhonda Cornwall was the assistant manager at the Dairy Queen when Claimant worked there. She observed that Claimant "had a hard time keeping orders together, remembering how to put certain things together, or measurements of things, how big they needed to be. He struggled with that." She also observed that Claimant struggled to work around larger groups of people, becoming nervous in crowds and during busy times in the restaurant. *Id*. at 56:24-58:17; 173:14-174:15.

9. Claimant next worked for Deseret Industries (a sheltered workshop) for six months to a year. He initially worked on the loading dock sorting furniture and other donated items such as clothes. He also placed donated items on the floor for display/purchase. He liked the job at Deseret except when it involved working around large groups of people that made him anxious. The position including lifting heavy items such as dishwashers. *Id*. at 58:18-61:24.

10. **Subject Employment**. Claimant next worked for Affordable Residential Communities (ARC), a Salt Lake City corporation that owned and operated mobile home communities in Pocatello. *Id*. at 61:25-62:6. He began this employment in or about 2004. *Id*. at 17-19. ARC was the predecessor to Employer in this case and Employer purchased ARC's business in or about 2009. *Id*. at 67:24-68:20. Claimant performed the same duties for ARC and Employer. He began at the minimum wage of $6.25 per hour and his final rate of pay was $10.25

per hour plus benefits. Tr., 62:20-23; 63:6-9; 68:21-24. He worked a typical 40-hour workweek, eight hours per day. *Id*. at 63:11-13. He got the job because his "step mom's daughter's husband was the manager." *Id*. at 62:11-12.

11. Claimant's position was identical for ARC and Employer; he was the "maintenance guy." *Id*. at 63:18-19. He undertook minor repairs of mobile home trailers, cared for the mobile home park grounds, mowed lawns, cleaned streets, and removed snow, among other similar duties. *Id*. at 63:19-23. Repair work included renovating mobile homes after tenants moved out, repainting, re-carpeting, and fixing breaks in water and sewer lines underneath mobile homes. *Id*. at 63:24-64:7. The properties where Claimant worked consisted of two mobile home park communities in the Pocatello area. *Id*. at 64:8-12. Claimant used a variety of tools on a daily basis to perform his job, including but not limited to rakes, brooms, hand tools, shovels, weed whackers, blowers, lawn equipment, snow equipment, ladders, and trucks. *Id*. at 13-17.

12. For both ARC and Employer, Claimant worked under the close supervision of a manager who instructed him in a detailed manner how and when to perform maintenance tasks. Claimant was generally unable to perform the work in a self-directed manner. *Id*. at 69:15-22.

13. Claimant's employment involved frequent climbing on ladders and roof, practically on a daily basis. *Id*. at 65:17-25. It also involved frequent heavy lifting, shoveling, crouching, kneeling, and twisting. *Id*. at 66:1-67:20.

14. Prior to his work accident and injury, Claimant also worked a side job for Mower Office Systems, two to three nights per week for two to three hours per night. The job involved repairing and rebuilding used laser printer toner cartridges. It did not involve lifting heavy items. He stopped working at that job when he was injured. *Id*. at 70:8-72:1.

15. Rhonda Cornwall also worked at ARC as an office assistant who also cleaned out mobile homes after renters moved out. She had an opportunity to observe how Claimant worked for ARC (and later Employer), as follows:

> Things he did well there, like, plowing, mowing the lawns, the clean-up, things like that. Things that, to me, seemed like he struggled with a little bit was part of the remodel, when it came to, like, measurements. He would struggle with that sometimes, and it was really nice when he had a person he worked with helping him out.

Tr., 175:9-15.

16. **Pre-Accident Medical Conditions**. In addition to the fetal alcohol syndrome previously noted, Claimant was diagnosed with anxiety and depression disorders prior to his industrial accident. He began seeking treatment for these conditions in or about 2004 to 2005 and received a referral to the Idaho Department of Health and Welfare from his family doctor for treatment. He initially received treatment for three to four years, lasting until approximately 2007 or 2008. *Id*. at 72:18-73:19.

17. During the same time period that he received treatment for mental health conditions, Claimant received a diagnosis of alcohol dependency/alcoholism for which he also received treatment. *Id*. at 75:21-76:8.

18. Claimant had an overdose suicide attempt that occurred on or about January 6, 2005. *Id*. at 87:1-9; Ex. 66:1462-1463. Portneuf Medical Center admitted Claimant after the overdose suicide attempt and treated him until January 9, 2006. *Id*. Claimant overdosed on Tylenol and Hydrocodone and was unconscious before transport to the hospital. *Id*. He had also been consuming alcohol on the day of the overdose. *Id*. at 1464. The hospital released Claimant to psychiatric care follow-up. *Id*. at 1466.

19. Claimant also has a diagnosis of post-traumatic stress syndrome from trauma he experienced as a child. The traumatic events were finding his mother and uncle dead in separate incidents. Tr., 81:19-83:19.

20. Claimant's treatment for his anxiety, depression, alcoholism, suicide attempt with opiate abuse, and post-traumatic stress syndrome included medication, group counseling, and individual counseling therapy. He also underwent intensive treatment in a 30-day rehabilitation inpatient program in the mid-2000s. Although Claimant had several alcoholic relapses, with the last brief one taking place in 2005, he has been in remission from active alcoholism since 2005. *Id*. at 74:-77:16.

21. Claimant injured his knee during high school gym class. He did not receive medical treatment for it at the time and assumed it was a mere strain. Three to four years prior to hearing, he began receiving treatment for an arthritic knee in the form of epidural injections. Claimant states that his knee condition did not interfere with ability to work prior to his accident. *Id*. at 79:19-80:21.

22. Claimant suffered pre-accident from severe sinusitis that occasionally flared up and required medical help. This condition was related to his fetal alcohol syndrome. Ex. 70 (medical records of David L. Donaldson, M.D., ENT specialist, August 2014).

23. Claimant did not have any medical problems with his lower back or numbness in his legs prior to the industrial accident. Tr., 83:20-84:4.

24. **Industrial Accident and Subsequent Events**. Claimant's industrial accident occurred on the morning of December 23, 2011. *Id*. at 89:18-90:1; Ex. 1 (First Report of Injury). He was performing "trash rounds" pursuant to his supervisor's instructions; his supervisor had directed him to remove trash and rubbish left on the grounds of the mobile parks. Claimant was

lifting a heavy tire that had been abandoned in the yard of one of the mobile home units. He described the tire as "a standard SUV tire with a heavier rim." Tr., 90:8-91:12. As Claimant lifted the tire to remove it, he felt that everything below his waist went numb and felt an "excruciating pain" began in his mid, lower back. The sharp pain felt like something had "slipped" in his back, and Claimant lost feeling in his legs. The pain and numbness did not go away so he reported it by calling the company office. *Id*. at 92:2-15.

25. Office staff instructed Claimant to retrieve the tire and bring it back with him. Although that was difficult for him due to the pain he was in, Claimant did so by putting the tire in the back of the trailer. He was in "excruciating pain" as he drove back to the office. *Id*. at 93:20-94:16. Office staff apparently did not instruct Claimant to seek medical help; not knowing what to do, Claimant sought out his immediate supervisor who was busy remodeling a home in one of the communities. The maintenance supervisor told Claimant to get his back "checked out," so Claimant went to the emergency room at Portneuf Medical Center in Pocatello. *Id*. at 95:11-96:1.

26. Claimant's examination at the Portneuf emergency room included an X-ray of his lumbar spine. His complaint was of "low back pain." Alan Eng, M.D., interpreted the X-ray and concluded in pertinent part as follows: "The lumbar spine is otherwise normal. The disc spaces are unremarkable. No signs of any acute fractures or dislocations. The soft tissues are normal." Dr. Eng noted that Claimant had improved since admission to the emergency department. He directed Claimant to follow up with his primary care physician, referred Claimant for physical therapy, and also prescribed Flexeril for back pain. Ex. 7:134-135.

27. While receiving physical therapy, Claimant continued to work for Employer until on or about February 3, 2012. He worked normally, although in pain. He had assistance on

heavier work from his supervisor. On February 3, 2012, because his supervisor was not available, Claimant was repairing a water line break underneath a mobile home in the middle of the night. Tr., 96:19-98:5. The working conditions were wet and cold and Claimant felt that he "twisted" his back, exacerbating his previous injury. Claimant recalled in pertinent part as follows: "I was under there [the house] fixing it, I guess for – my body had enough. I got too cold, frozen. My back just escalated, I couldn't take anymore. I physically knew I was done. I needed to go get some help." *Id*. at 98:10-20.

28. In the morning after the episode with the pipe underneath a mobile home, Claimant reported the incident to Employer's office. He told the office staff that he did not feel he could continue working and they told him to go home. *Id*. at 99:6-25

29. Claimant did not return to work and has not worked since. *Id*.

30. **Medical Treatment & Evaluations**. Up until February 2012, Claimant had been treating with his general medical practitioner at Pocatello Family Medicine. He also received physical therapy three times per week at the Center for Orthopedic Rehabilitation in Pocatello. Ex. 7, 8. On February 8, 2012, Claimant received a referral from Pocatello Family Medicine to Benjamin Blair, M.D., an orthopedic surgeon with the Pocatello Orthopaedics & Sports Medicine Institute. Ex. 10:362; Tr., 100:4-8. The reason for the referral was that a recent MRI showed a posterior disc bulge at the L5-S1 level and Claimant reported no improvement in symptoms after physical therapy. Ex. 10:362.

31. Dr. Blair diagnosed Claimant with a herniated disc in his lumbar spine and ordered that Claimant remain off work on February 16, 2012. *Id*. at 367. After his first consultation with Claimant, Dr. Blair noted in pertinent part as follows:

> This is the first visit for this 26 year-old male … who complains of low back pain radiating into the bilateral lower extremities. This was sudden in onset, beginning

> 12/23/11 while picking up a tire at work and noted sudden onset of severe pain. Over the ensuing month, despite physical therapy, he has had increased onset of pain. However, on 2/3/12, he again twisted his back while working under a trailer on a water pipe while at work. He noted marked aggravation of his pain to the point that it is severe. He is currently unable to work secondary to the pain… He tried physical therapy for eight weeks with minimal relief and traction provided minimal relief. He took Ibuprofen with some relief. He has associated radiation into the groin and significant weakness in the lower extremities.

Ex. 10:368.

32. Based upon MRI imaging, Dr. Blair diagnosed a herniated disc, L5-S1. He recommended a trial of epidural steroid injections as the next treatment option. Dr. Blair released Claimant from further work in the interim. *Id*. He also prescribed Hydrocodone for pain. *Id*. at 369.

33. Claimant received bilateral epidural steroid injections at Dr. Blair's clinic from Dr. Blair's colleague, Dr. Joseph, on March 15, 2012. He tolerated the procedure well. *Id*. at 373-375. Nevertheless, the injections did not relieve his pain or radiculopathy discomfort and numbness. Tr., 101:5-6. At their April 2, 2012 consultation, Dr. Blair noted that the epidural steroid injections actually worsened Claimant's symptomatology and that Claimant remained "remarkably symptomatic." Dr. Blair discussed with Claimant his treatment options, which included additional steroid injections. Claimant chose to proceed with the surgical option, a bilateral lumbar laminectomy and discectomy at L5, S1. Ex. 10:384.

34. At another follow-up consultation on April 18, 2012, Dr. Blair discussed the risks and benefits of possible surgery in detail, including the possibility that the surgery would fail to relieve his symptomatology and/or require further surgical intervention. Claimant chose to proceed with surgery despite these risks. *Id*. at 387.

35. Having obtained pre-authorization from Surety for the procedure, Dr. Blair proceeded to perform the bilateral lumbar laminectomy and discectomy at L5, S1 at Portneuf

Medical Center on April 24, 2018. Ex. 10:395-399. There were no complications and Claimant tolerated the procedure well. *Id*.

36. In a two-week follow up consultation on May 7, 2012, Dr. Blair noted as follows: "Overall he notes significant improvement from his preoperative status." Dr. Blair's plan was to reevaluate in three weeks and begin physical therapy. If tolerated, Claimant would be released to light duty. *Id*. at 406.

37. Claimant described the results of the surgery as follows: "It took away a little bit of the pressure, but not the pain." Tr., 101, 21-22.

38. At the follow-up consultation held on May 30, 2012, Claimant was four weeks status post lumbar discectomy bilaterally. Claimant "notes some significant bilateral paresthesias. It is particularly worse with activity although he has some at night. They are fairly severe." X-rays were unremarkable for any acute findings. Dr. Blair believed an aggressive physical therapy program was warranted and then Claimant would be reevaluated. If Claimant remained symptomatic, Dr. Blair would consider another MRI to rule out the "unlikely possibility of continued neurological impingement." Ex. 10:408.

39. At a June 13, 2012 follow-up consultation, Dr. Blair noted that after two weeks of physical therapy, Claimant had "increasing onset of back pain but also lateral paresthesias. They are worsening and severe." Dr. Blair considered the next option to be an MRI, meanwhile physical therapy would continue and Claimant would remain off work. *Id*. at 414.

40. Surety approved a lumbar MRI with contrast for Claimant, which was scheduled for June 25, 2012. *Id*. at 417. The conclusions of the study, as read by George H. Stephens, M.D., were in pertinent part as follows: "Postoperative changes at L5-S1 with perithecal inflammatory tissue and enhancement. No evidence of recurrent or new disc herniations." *Id*. at 418-419.

41. At the June 27, 2012 follow-up consultation, Dr. Blair read the MRI to demonstrate no significant neurological impingement, however the MRI was "significant for postoperative changes… There is fairly severe internal disc derangement, however, at the 5-1 level." Dr. Blair believed that an EMG nerve conduction study would be reasonable to "evaluate for the possibility of associated neurologic problems outside the spine." If the results of the EMG study were unremarkable, Dr. Blair would continue physical therapy as the indicated plan. Ex. 10:421.

42. With approval from Surety, Dr. Blair's office scheduled Claimant for a bilateral lower extremity EMG study on July 16, 2012. *Id.* at 423. The study revealed evidence of moderate chronic L5-S1 radiculopathy on the right and the left. *Id*. at 428. In their follow-up consultation on July 23, 2012, Dr. Blair noted the EMG study was "significant for moderate chronic L5-S1 radiculopathy on the right and left." *Id*. at 431. Dr. Blair discussed Claimant's continuing treatment options in detail. He noted that although Claimant's MRI showed no continuing impingement, that he "certainly has continued neurologic symptomatology attributable to his spine." The etiology was difficult to diagnose absent further testing, thus Dr. Blair recommended a post-myelogram CT scan to further delineate the nature of Claimant's problem. *Id*.

43. Meanwhile, Surety arranged for Claimant to undergo an independent medical examination (IME) with Brian Tallerico, D.O., an orthopedic surgeon with Objective Medical Assessments (OMAC), on August 10, 2012. Ex. 75:1683-1691. Dr. Tallerico concluded that Claimant's condition was related to the industrial accident but deferred assessing his stability and assignment of a PPI rating until after CT myelogram testing took place. *Id*. at 1690-1691.

44. With approval from Surety, Ex. 10:432-433, the CT myelogram testing took place at Portneuf Medical Center on August 30, 2012. *Id*. at 434-437. The imaging showed postoperative changes at L5-S1, but no significant continued neurological impingement. Ex. 10:438. Nevertheless, Claimant remained "markedly symptomatic with pain radiating to bilateral lower extremities," according to Dr. Blair. Dr. Blair opined that a trial of pain management would be advisable and prescribed Lyrica and Feldene. *Id*.

45. In a follow-up consultation on September 13, 2012, Claimant reported that he did not react well to the prescribed medication. Dr. Blair noted in pertinent part as follows: "He has failed conservative therapy. I believe his symptoms are coming from postoperative changes in the lumbar spine as well as degenerative disc disease in his lumbar spine." Dr. Blair recommended another course of epidural steroid injections. *Id*. at 439.

46. On September 19, 2012, Dr. Tallerico provided an addendum report to his IME of August 10, 2012, following review of Claimant's CT myelogram imaging. Ex. 75:1692-1694. Dr. Tallerico concluded in pertinent part as follows:

> After review of this study, I find no anatomic orthopedic explanation for the examinee's ongoing complaints. Therefore, I can state with reasonable certainty no further treatment and certainly no further surgical intervention is indicated. Given that, I would recommend that the examinee be considered fixed and stable related to the industrial injury of December 23, 2011.

Id. at 1693. In addition to determining Claimant to be at MMI, Dr. Tallerico assigned him a WPI of nine percent as a result of his industrial injury. *Id*. He further observed that Claimant's "CT/myelogram was essentially negative by his postoperative without any evidence to support his ongoing lower extremity complaints or his subjective bowel and bladder complaints." *Id*. at 1694. For permanent restrictions, Dr. Tallerico assigned no pushing, pulling, lifting or carrying

greater than 70 pounds and no repetitive pushing, pulling, lifting or carrying greater than 50 pounds. Ex. 75:1694; Tr., 103:23-104:3.

47. Based upon Dr. Tallerico's IME opinion, Surety discontinued further medical benefits to Claimant. Tr., 104:13-15.

48. Claimant received temporary disability benefits from the date of injury until Dr. Tallerico delivered his IME in September 2012. Claimant also received payment of the 9% WPI rating as found by Dr. Tallerico. *Id*. at 32:25-33:4.

49. Dr. Blair continued to believe that epidural steroid injections would be beneficial for Claimant's pain treatment, however "an IME was obtained which deems him at MMI… I do not believe Mr. Cornwall has reached MMI. I believe an epidural steroid injection is reasonable." Ex. 10:442. Meanwhile, Dr. Blair prescribed narcotic pain medications to treat Claimant's pain issues. *Id*. at 443.

50. After Surety stopped paying Claimant's medical expenses, he sought another source of insurance coverage. First, he applied to Bannock County Indigency Services, but that agency denied his application. He next applied to the PCIP, a program authorized under the Affordable Care Act, which approved his application for insurance on January 22, 2013. Tr., 106:14-107:13; Ex. 10:458-459.

51. With insurance coverage in place, Claimant sought additional medical treatment for his lower back complaints. He presented to Dr. Blair on February 7, 2013 for discussion of other treatment options. Imaging reviewed by Dr. Blair indicated moderate disc space collapse at the L5-S1 level, with the S2 level only partially fused with a remnant disc. Dr. Blair noted that Claimant remained "markedly symptomatic" and had "failed multiple attempts at conservative

therapy including epidural steroid injections[1] and narcotic pain medication." Claimant was "interested in surgical treatment" in the form of a 360 degree fusion with fusion cage and pedicle screws rotation, and iliac crest bone craft at the L5, S1 level. Dr. Blair discussed the risks and benefits of the surgery, including the possibility that despite surgical intervention, he might remain markedly symptomatic. Claimant wished to proceed with surgery. Ex. 10:461.

52. Claimant returned to consult with Dr. Blair on March 7, 2013. Dr. Blair conducted a detailed informed consent with Claimant. Claimant wished to proceed with the surgery, which was scheduled for April 16, 2013 at Portneuf Medical Center. *Id*. at 462-469.

53. Attorneys for Defendants informed Dr. Tallerico of Claimant's desire for fusion surgery and the plan by Dr. Blair to provide it to him. In a letter dated April 1, 2013, Dr. Tallerico stated his opposition to such surgery, as follows: "I respectfully disagree with Dr. Blair's assessment that Mr. Cornwall is a good surgical candidate. This is a rather young individual to undergo a lumbar interbody fusion, especially within the workers compensation arena. I am doubtful that if Mr. Cornwall would undergo such a procedure that he would have a favorable outcome given the circumstances noted above and in my initial IME." Ex. 75:1695-1696.

54. Defendants' counsel provided Dr. Tallerico with additional medical records, including records of Claimant's mental health treatment, treatment for addiction/alcoholism, and records related to his suicide attempt. Based upon these additional records, Dr. Tallerico opined again on April 11, 2013, that he did "not believe surgery is indicated. It is obvious that this individual presents quite the clinical challenge. In my opinion, given his significant psychiatric history alone, he would be a very poor candidate for this type of process. This is magnified by

[1] Claimant had bilateral injections on March 15, 2012, prior to his diskectomy. It does not appear he ever had the ESI injections recommended by Dr. Blair prior to his fusion. See Ex. 10.

the fact that it would be in the workers' compensation arena." Even if it were not a workers' compensation case and a "failure to thrive," Dr. Tallerico "still would not recommend a 360-degree lumbar fusion in this young troubled individual." Given Claimant's history of opioid dependence with a subsequent overdose and suicide attempt, Dr. Tallerico stated that it "would be a very bad decision to proceed with such a procedure in this individual." Ex. 75:1700.

55. Drew W. McRoberts, M.D., performed the L5, S1 anterior lumbar fusion surgery on Claimant at Portneuf Medical Center on April 16, 2013, with Dr. Blair assisting. Ex. 10:470-471. The indications stated for the procedure were a "27-year-old male with degenerative disc disease of L5-S1 requiring anterior lumbar fusion." Claimant tolerated the procedure well and there were no complications. *Id*.

56. Dr. Blair responded to Dr. Tallerico's opinion that Claimant was a poor surgical candidate for the L5, S1 fusion in a letter to Claimant's counsel dated April 25, 2013. Dr. Blair noted in pertinent part as follows:

> I have reviewed Dr. Tallerico's opinions and I would respectfully disagree with his continued conclusion that Mr. Cornwall is a poor surgical candidate. Mr. Cornwall has undergone multiple nonoperative treatments and remains markedly symptomatic. He has a diagnosis of internal disc derangement at the L5-S1 level with foraminal stenosis. *Although surgery of this nature has a mediocre success rate, this was discussed in detail with Mr. Cornwall and Mr. Cornwall decided to proceed with surgical intervention despite this*. Although Mr. Cornwall is young, I do not believe he is too young for surgical intervention of this form. In particular, given the fact that he is young, surgical intervention will hopefully increase his ability to perform work related activities, allowing him a life of meaningful employment rather than disability. (Emphasis added.)

Ex. 10:497. Dr. Blair further strongly disagreed with Dr. Tallerico that merely because Claimant is in the worker's compensation "arena" does not disqualify him as a candidate for surgery. *Id*. Dr. Blair also stated that he was unaware of Claimant's prior history of narcotic overdose, and had not reviewed any medical records to that effect, but rather was solely informed of that fact

because of Dr. Tallerico's note. He stated that he was unaware of any literature that showed that past narcotic abuse was a contraindication to surgical treatment of low back problems. Ex. 10:498.

57. At Claimant's two-week follow-up examination on May 1, 2013, Dr. Blair observed as follows: "Overall he is doing fairly well postoperatively. He states, however, his preoperative pain symptoms, as well as urinary symptoms, are unchanged from preoperatively." Dr. Blair's plan was to begin abdominal strengthening exercises, followed by back strengthening after four weeks. Ex. 10:472. Dr. Blair ordered additional physical therapy for Claimant. *Id*. at 473.

58. At hearing, Claimant stated that the L5, S1 fusion surgery provided him with pain relief, as follows: "Yes. That relieved all the pressure in my back, the pinching of the spinal cord from the disc that was removed… It never resolved the leg pain. That's why I have the spinal cord stimulator." Tr., 108:7-9; 14-15. Claimant also experienced relief from the symptoms of frequent or urgent urination that he had been experiencing since the industrial accident. *Id*. at 109:2-15.

59. Although she did not specifically testify regarding the lumbar fusion surgery, Claimant's former wife Rhonda Cornwall observed generally that each of Claimant's medical procedures helped him with his pain, as follows:

> Q. Has the medical treatment that Tony [Claimant] has received from Dr. Blair … helped Tony?
> A. Yes.
> Q. Can you describe how?
> A. It prolonged his ability. Because of it he has been able to keep going, keep moving with each one. I noticed, like, he is able to function through his pain.
> Q. That's improved – those treatments, have they improved the quality of his life?
> A. Yes.

> Q. Did he ever have a medical procedure where you thought, well, that didn't do anything for him, or, that was a total – we shouldn't have done that one, or have they all provided some kind of help to him?
> A. They've all provided some kind of relief.

Tr., 186:5-21.

60. At a May 29, 2013 follow-up consultation, Dr. Blair noted that Claimant "notes significant improvement from his preoperative status." Dr. Blair indicated that he would reevaluate Claimant's status in six weeks. Ex. 10:474. At the July 10, 2013 follow-up consultation, Claimant continued to report "significant improvement in his pre-operative status. He is left with some left lower extremity weakness. In addition, he notes continued lower extremity dysethesias. He notes his strength is improved from pre-op and urinary symptoms are improved from pre-op." *Id*. at 475.

61. Although his examination was unchanged from previous post-operative examinations, Claimant reported that his symptoms had not improved in the August 8, 2013 follow-up consultation with Dr. Blair. Dr. Blair noted as follows: Claimant "continues to remain markedly symptomatic.[2] In particular, he continues to have 'nerve pain' into the lower extremities. He states that this is essentially unchanged from previous pre-symptoms. They are fairly severe." Dr. Blair planned an MRI to rule out the possibility of continued neurological impingement, then a CT scan to evaluate hardware placement in the fusion and a possible EMG nerve conduction study to rule out peripheral neuropathy. *Id*. at 476. Claimant continued to be restricted from work. *Id*. at 477.

[2] Dr. Blair's use of the descriptive "continues" with respect to symptoms is strange in light of the fact that on the two previous examinations, Claimant had reported overall improvement in his symptoms. Ex. 10:474-475.

62. At hearing, Claimant recalled that while the fusion surgery did improve the pressure on his spine and urination symptoms, it did not relieve his radicular symptoms of pain and numbness in his legs, which never went away. Tr., 109:16-20.

63. An August 15, 2013 MRI of Claimant's lumbar spine revealed no remarkable acute findings. At the L5-S1 level some metallic artifact was seen within the disc space as well as anteriorly into L5. Ex. 10:480. At the August 20, 2013 follow-up consultation, Dr. Blair noted that the MRI showed postoperative changes but no neurologic impingement. Claimant had just been given a TENS unit trial but there were no results yet. *Id*. at 482. An August 29, 2013, CT scan of the lumbar spine showed postoperative changes at L5, S1 with evidence of posterior an interbody solid bony fusion but no hardware abnormalities. *Id*. at 483-484. A September 9, 2013 EMG study revealed no evidence of lumbar radiculopathy or peripheral neuropathy. *Id*. at 495.

64. At a September 4, 2013 follow-up consultation, Dr. Blair noted that Claimant stated "the vast majority of his symptoms have been ongoing prior to surgery." Dr. Blair did not believe that the pedal screws placed during the fusion surgery were the cause of his symptoms. Dr. Blair prescribed a long-lasting narcotic. *Id*. at 485. Dr. Blair diagnosed Claimant with post-laminectomy syndrome. *Id*. at 485.

65. On September 12, 2013, Dr. Blair noted in pertinent part as follows: "EMG within normal limits. At this time, work-up includes MRI, CT scan, and EMG shows no surgically treatable lesion. I believe a trial of spinal cord stimulator would be reasonable and we will refer patient for such." Ex. 10:496.

66. Dr. Blair referred Claimant to Holly Zoe, M.D., of Zoe Interventional Pain Management Center in Pocatello, for a possible SCS trial. Dr. Zoe diagnosed Claimant with postlaminectomy syndrome lumbar region, and discussed the benefits and disadvantages of a

SCS. Claimant chose to first try more conservative therapy, epidural steroid injections, which took place on November 13, 2013. Ex. 13:617; 624. After minimal benefit from the steroid injections, Dr. Zoe administered a medial branch block at L5, S1 on December 4, 2013. Ex. 13:633.

67. After several courses of steroid injections and medial branch blocks with limited to no beneficial pain relief effect, and following a psychological evaluation to test appropriateness of receiving SCS therapy, Claimant received implantation of a SCS during his treatment with Dr. Zoe on March 4, 2014. *Id*. at 712-714.

68. Claimant returned to consult with Dr. Blair on September 14, 2014. Dr. Blair noted that Claimant had been undergoing pain management with Dr. Zoe, including the SCS "with excellent relief of the symptoms." Claimant had been able to reduce his use of narcotic pain medication because the SCS had been working so well to relieve his pain. Nevertheless, recently before the September 2014 consultation with Dr. Blair, the SCS stopped functioning adequately and Claimant's pain symptoms returned, including weakness in his legs. Diagnostics on the SCS revealed that a number of the leads had failed. Ex. 10:502-503.

69. Dr. Blair referred Claimant to Ryan Hope, M.D., of Idaho Neurosurgery and Spine, for review and possible revision of his SCS. Ex. 16:884. Testing on November 20, 2014 of the SCS unit showed that only two of sixteen contacts had normal impedance. Ex. 16:893. Claimant chose to proceed with the revision of his SCS with a paddle lead; the revision procedure occurred on January 27, 2015. *Id*. at 894.

70. In response to a request for an impairment rating from Claimant's counsel, Dr. Blair opined that Claimant was at MMI in a letter dated February 11, 2015. Ex. 10:499. Dr. Blair placed Claimant under the Lumbar Spine Regional Grid – motion segment lesion – Class 2

with a default impairment of 12%. With various modifiers, Dr. Blair gave Claimant a final 13% WPI rating, 100% of which was attributable to the industrial accident. *Id*.

71. Dr. Blair found that Claimant "has significant physical restrictions due to the work related injury." Ex. 10:499. He thus assigned the following detailed work restrictions, which he deemed were 100% attributable to the industrial injury:

> Sitting for 15 minutes in a working position at a desk or table without reclining before alternating postures by walking for about 15 minutes. 3 hours total cumulative sitting during an 8 hour work day, not including 15 minutes spent walking about. After standing or walking about for the maximum continuous period, this patient needs to alternate postures by lying down or reclining in a supine position for 15 minutes. This patient needs to rest for some period of time during an 8 hour work day in addition to a morning break, a lunch period and an afternoon break scheduled at approximately 2 hour intervals to relieve pain arising from a documented medical impairment. The total cumulative resting period needed during an 8 hour work day is 2 hours. No sustained 8 hrs lifting and carrying; 1-5 lbs > 1/3 – 2/3 of day; 6-10 lbs > 2/3 of day; 11-20 lbs up to 1/3 of day; 21-50 lbs up to 1/3 of day. Postures of Neck: forward flexion, backward flexion, rotation right, rotation left, up to 1/3 of day. Repetitive use of hands: reaching bilaterally > 2/3 of day. Handling bilaterally > 2/3 of day. Fingering bilaterally > 2/3 day.

Ex. 10:499-500.

72. Following the assignment of an impairment rating by Dr. Blair, Claimant continued to receive pain management/palliative care. On February 16, 2016, Claimant came under the care of Phillip R. McCowin, M.D. Ex. 18:990. Dr. McCowin observed that Claimant presented "with severe disabling low back pain." Dr. McCowin noted Claimant's history of surgical procedures and implantation of an SCS. *Id*. at 991. Claimant had "[s]table control of radicular complaints following the decompression and fusion but significant mechanical back pain that appears to be from the SI [sacroiliac] joints more on the left than on the right." *Id*. Dr. McCowin proposed an SI joint fusion as a plan of treatment. *Id*. First, however,

Dr. McCowin administered steroid injections into the SI joints on September 16, 2016. *Id*. at 995.

73. Dr. McCowin performed a left SI joint fusion on October 27, 2016. Ex. 18:997. On January 7, 2017, Claimant reported that his left SI joint paint was "completely resolved." *Id*. at 1003. On January 12, 2017, Dr. McCowin performed a right SI joint fusion on Claimant. Ex. 18:1006. At a February 22, 2017 follow-up, Claimant reported "dramatically less pain than preoperatively." Claimant had been able to reduce his morphine intake. *Id*. at 1009.

74. At the request of Defendants Employer and Surety, Timothy E. Doerr, M.D., completed a comprehensive records review concerning Claimant's medical care related to the industrial injury on November 18, 2016. Ex. 76. Dr. Doerr opined that it was medically more probable than not that Claimant sustained a disc herniation at L5-S1. *Id*. at 1716. He further deemed "appropriate treatment" the therapies that Claimant received immediately following the industrial accident to treat the disc herniation, including oral medications, activity modifications, physical therapy, an L5-S1 epidural steroid injection, and ultimately, the L5-S1 bilateral laminectomy/discectomy. *Id*. at 1716.

75. Dr. Doerr agreed with Dr. Tallerico's conclusions that a variety of factors, including Claimant's psychiatric history, workers' compensation claim status, and lack of objective findings supported a determination that Claimant was not a good candidate for an L5, S1 fusion surgery. He noted in pertinent part as follows:

> Dr. Tallerico's opinion on 04/11/13 that an L5-S1 fusion in this patient would be very unpredictable and highly unlikely to portend a good outcome was quite prophetic. Indeed, despite a successful lumbar fusion at L5-S1, the patient did not have a good outcome. In summary, it is my opinion that based upon that the L5-S1 anterior-posterior fusion performed on 04/16/13 was not indicated as a result of the patient's 12/23/11 industrial injury, on a medically more probable than not basis. Similarly, the need for all treatments rendered after the patient was deemed

> at maximum medical improvement by Dr. Tallerico on 09/19/12 were medically, more probable than not, unrelated to the patient's 12/23/11 injury."

Ex. 76:1716.[3]

76. At the request of Claimant's counsel, Dr. Blair completed a comprehensive records review, including radiographs, concerning Claimant's treatment following the industrial injury and delivered a report on March, 8, 2017. Ex. 56. Dr. Blair connected all post-injury diagnoses to the industrial accident. *Id*. at 1340-1341. He further found that all of the treatments that Claimant received were reasonable and necessary, attributable to the industrial accident and not the aggravation of a pre-existing condition. *Id*. at 1341-1342. He specifically found that Claimant's SI joint condition was the result of the industrial injury because Claimant underwent a lumbar fusion as a result of the accident, which in turn put stress on his SI joints. *Id*. at 1342. Thus, he found the treatment for the SI joints, including the fusions, reasonable and medically necessary. *Id*. Dr. Blair opined that Claimant would continue to require palliative care attributable to the industrial accident. *Id*. Dr. Blair stated that Claimant's medical treatment and conditions had changed his previous opinion regarding MMI on February 11, 2015. Because Claimant developed severe SI sacroiliac joint dysfunction attributable to his fusion subsequent to February 11, 2015, Dr. Blair opined that Claimant reached MMI on March 1, 2017, subsequent to his recovery from bilateral SI joint fusions. Nevertheless, Dr. Blair considered his 13% WPI

[3] A follow-up records review by Dr. Doerr affirmed his previous opinions and also extended it to include the SI joint fusion surgeries that occurred after his initial records review. Dr. Doerr concluded that the medical evidence documented no "medical evidence to support injuries to the bilateral SI joints as a result of the patient's 12/23/2011 industrial injury. Therefore, the need for the patient's bilateral SI joint fusions was medically more probable than not unrelated to the patient's 12/23/2011 injury. In summary, after reviewing these additional medical records, my opinions remain unchanged from those expressed in my original independent Records Review on 11/18/2016." Ex. 76:1720. On 4/28/2017, an additional records review resulted in Dr. Doerr's opinion that despite Dr. Blair's record review, his opinions were unchanged and all but the original surgery were medically unnecessary. *Id*. at 1722. Defendants asked Dr. Doerr to update his medical opinions four more times between August 11, 2017 and July 16, 2018, but none of the additional medical records that he reviewed changed his opinion that while Claimant's first surgery (laminectomy/discectomy) was related to the industrial injury, subsequent medical treatment including the fusion surgeries were not industrially related and were medically unnecessary. *Id*. at 1723-1733.

rating and work restrictions to be unchanged from February 11, 2015. *Id*. at 1343. Finally, Dr. Blair disagreed with the IMEs of both Dr. Tallerico and Dr. Doerr, particularly on the issue of whether Claimant was a poor candidate for surgery due to his past psychiatric history. Ex. 56:1343-1344.

77. Claimant received a referral from Dr. Blair for a functional capacity examination (FCE) by Superior Physical Therapy Spine & Sports Center in Pocatello. Steve Klitgaard, P.T., conducted the testing. Ex. 51. The first attempt to conduct the FCE on April 10 and 11, 2017 was unsuccessful due to Claimant's self-limiting behaviors. While Claimant cooperated on some tests, he limited some activities prior to objective signs of maximal performance due to his fears and concerns of further injuring his lower back. *Id*. at 1292. P.T. Klitgaard concluded as follows: "Client has the limitations of his perceived abilities and not wanting to push himself due to the fear of reinjuring his low back. His goal was to complete the test to get his case finalized. Unfortunately, because of self-limiting I am unable to determine his true limitations." Ex. 51:1293.

78. Claimant returned for two days of FCE testing on June 13, 2017. Ex. 52. Bart McDonald, P.T., concluded that Claimant "demonstrated cooperative behavior and was willing to work to maximum abilities in all test items. It was obvious by both objective and subjective observations during the exam that the client struggled with many of the test items. However, a maximum effort was given on both day one and day two of the testing." *Id*. at 1302. McDonald listed the following items as potential barriers to return to work for Claimant: one handed ladder climbing; climbing ladders with loads; awkward low level lifting (i.e., lifting the bag off a mower); heavy shoveling; and slight limitations with prolonged or repetitive kneeling or crouching. *Id*. at 1303.

79. McDonald concluded that Claimant's restrictions included the following: waist to floor lifting up to 30 pounds occasionally; front carry up to 50 pounds occasionally; frequent elevated work; occasional crouching and kneeling; frequent stair climbing; frequent walking; frequent sitting; and avoidance of heavy shoveling. *Id*. at 1304-1306.

80. At the request of counsel for Defendants Employer and Surety, Nancy E. Greenwald, M.D., performed an independent medical records review and delivered a report dated July 31, 2017. Ex. 77. Dr. Greenwald reviewed past medical records and Social Security applications to determine whether Claimant suffered from pre-existing impairments. *Id*. at 1734. Dr. Greenwald found that Claimant had the following WPIs related to his pre-existing conditions: 10% attributable to his bipolar and depression with anxiety; and 12% attributable to his fetal alcohol syndrome, alcohol misuse with intoxication, and drug overdose. According to the combined values chart, these pre-existing conditions combined to a 21% WPI. *Id*. at 1735-136.

81. Dr. Greenwald opined that due to his pre-existing conditions, Claimant should be restricted from a multitasking work environment, allowing for repetitive tasks, as well as assignment to a quiet work environment with avoidance of heights. Dr. Greenwald also indicated that Claimant should avoid high stress work environments, avoid risk for injury activities, i.e., working around heavy equipment or dangerous sharp mechanical equipment. *Id*. at 1736.

82. Dr. Greenwald concluded her report with the following observation: "Certainly, with the pre-existing diagnosis of mental health issues … places Mr. Cornwall at a very high risk for alcohol and drug abuse and chronic pain syndrome. These types of patients are at risk for multiple interventions and generally none of them provide 'pain relief.'" *Id*.

83. After reviewing additional medical records, Dr. Greenwald updated her records review IME on June 11, 2018. *Id*. at 1737. Based on the additional records provided, Dr. Greenwald revised her opinion on whether Claimant had an impairment related to his chronic sinusitis, which she had previously rated at 0%. She observed in pertinent part as follows: "In summary from the sinus medical records review, it is clear there is indication that the patient has a pre-existing sinus condition from the fetal alcohol syndrome deformity… Using the AMA *Guide to Evaluation of Permanent Impairment*, 6th Edition, page 267, table 11-6, there is criteria for air passage deficits. Clearly, the patient has obstruction… Default is 19% whole person." Dr. Greenwald also assessed a 1% WPI for Claimant's pre-existing knee arthritis. Ex. 77:1738; 1740.

84. Dr. Greenwald added her impairment rating for Claimant's chronic sinusitis and knee arthritis to her previous impairment ratings, as follows: "Using my prior impairment ratings from the letter of 07/31/17, 19% + 12% + 10% + 1% equals, using the combined values chart, 37% whole person impairment." *Id*. at 1470.

85. Dr. Greenwald confirmed her opinion that based upon Claimant's past psychiatric history, including alcoholism, drug abuse, and suicide attempt involving opiates, he remained a poor candidate for surgical interventions on his lumbar spine and other pain management treatments, and the failure of the interventions he received demonstrated this point. She repeated her opinion that Claimant should be weaned from any opiate pain medications. *Id*.

86. The most recent medical record adduced is dated May 2, 2018 from the Vista Pain Group, Dr. Hope's current practice. Ex. 14:874. Claimant reported he continued to have pain 7/10 in his back, SI joints, and legs, but that his pain was stable with morphine three times a day, Lyrica twice a day, and Flexeril three times a day.

87. **Social Security Disability Applications**. Claimant first applied for SSD benefits after graduating from high school in 2003, at the urging of his older sister. Tr., 85:10-24. The Social Security Administration (SSA) denied his application, which was based upon his fetal alcohol syndrome and related developmental disabilities. *Id*. at 86:8-12. Claimant did not appeal the determination or request reconsideration. *Id*.

88. Although he was unsure about the details in his hearing testimony, Claimant apparently applied a second time for SSD following his 2005 suicide overdose attempt. *Id*. at 86:18-88:8. Claimant based his application this time on his mental health status following the suicide attempt. Tr. at 86:18-88:8. The SSA denied the application and he did not appeal the determination or request reconsideration. *Id*.

89. Claimant applied for SSD a third time in 2012 after he was unable to work following the industrial accident and the aggravation that occurred on February 4, 2012. Ex. 6. He based this application solely upon his lumbar back injury sustained in the industrial accident. *Id*. The SSA denied Claimant's SSD application at the initial determination and redetermination stages, Ex. 6, but ultimately awarded Claimant SSD benefits on September 27, 2013 following a hearing by an SSA administrative law judge (ALJ). Ex. 6:129.

90. The ALJ found in pertinent part as follows: "[T]he severity of the claimant's back impairment meets the criteria set forth under [the Social Security Act]. The claimant is not able to ambulate effectively because his left leg collapses. Because the claimant is found disabled based on his physical impairments alone, his mental impairments are not considered further. The claimant has been under a disability as defined in the Social Security Act since February 4, 2012, the amended alleged onset date of disability…" Ex. 6:128.

91. **Vocational Assessments**. *Nancy Jean Collins, Ph.D.* Claimant retained Nancy Jean Collins, Ph.D., to evaluate his employability and level of potential disability. Dr. Collins earned a doctorate in adult education with an emphasis in vocational rehabilitation from the University of Idaho in 1994. Ex. 59:1349. She has provided expert vocational testimony in Industrial Commission workers' compensation cases as well as personal injury and employment cases. *Id*. at 1358-1361. She practices her profession in Boise, Idaho, as a vocational rehabilitation counselor and vocational consultant. Collins Dep., 5:13-16. The Commission is well acquainted with the qualifications of Dr. Collins and she is qualified to provide expert vocational testimony in this matter.

92. Dr. Collins prepared her original report and delivered it on May 7, 2015. Ex. 60. Records that Dr. Collins reviewed for the evaluation include the following: pre-injury and post-injury medical records for Claimant, including IMEs of Doctors Tallerico, Doerr, and Greenwald; vocational records (*Occupational Employment Quarterly 2014*,[4] Department of Labor job listings, and O*NET); Claimant's tax records; discovery exchanged between the parties; SSD documents for Claimant; and Industrial Commission Rehabilitation Division notes. Ex. 60:1363. Dr. Collins also conducted a diagnostic interview of Claimant in May 2015. Collins Dep., 15:8-12.

93. Factors considered in the employability evaluation of Dr. Collins included the following: physical capacity; acquired vocational skills; skills acquisition potential; labor market; education; age; and psychological functioning. Ex 60:1370.

94. Dr. Collins accepted the physical limitations specified by Dr. Blair on February 11, 2015. *Id*. at 1371. She noted in pertinent part as follows: "When considering

[4] Dr. Collins clarified that she reviewed the *Occupational Employment Quarterly 2014* for the Pocatello area. Collins Dep., 14:12-13.

subjective complaints, a thorough review of the records can indentify those complaints are consistent with a diagnosis [of Dr. Blair]. There was nothing in the records that pointed to malingering, secondary gain or functional overlay. Mr. Cornwall's subjective complaints are consistent with the physical restrictions outlined by Dr. Blair." *Id*.

95. With regard to educational background, Dr. Collins noted that although Claimant graduated from high school, he required special education classes and acknowledged he would not have graduated without the assistance of his wife. Testing found he was unable to do simple subtraction or simple multiplication problems correctly. Claimant's wife took care of all family finances. Because of his limited cognitive skills, adaptability to new and different situations was difficult for Claimant. *Id*. at 1373.

96. Dr. Collins found that Claimant's vocational history was consistent with his cognitive limitations and education. He worked primarily in maintenance jobs. His work history includes jobs that would be considered medium to heavy work. He performed unskilled labor for his entire working career. Ex. 60:1373-1384.

97. With regard to his current abilities, Dr. Collins observed in pertinent part as follows: "He is now so limited by his positional restrictions that he would not be able to perform work at any of the strength categories listed above [sedentary, light work, medium work, heavy work, very heavy work] on an unlimited basis." *Id*. at 1374. Dr. Collins concluded regarding Claimant's physical abilities as follows:

> In my opinion, Mr. Cornwall's restrictions are so severe that he will not meet the requirements of any unskilled or semi-skilled jobs. His work tolerance is so restricted that even with a sympathetic employer he would not be able to work more than a few hours a day. Accommodations would require less than full-time work, extra rest periods, and adjustments in starting and ending times and a place to recline."

Id. at 1375.

98. Concerning earning capacity, Dr. Collins concluded as follows: "Mr. Cornwall was not a high wage earner, but he was able to perform unskilled work on a full-time basis and he had a good work history. His restrictions will not allow him to return to any regularly available work, therefore he does not have an earning capacity." *Id*.

99. Dr. Collins stated that all of her opinions were formulated within a reasonable degree of certainty. After briefly listing Claimant's work restrictions, she concluded as follows:

> In addition to these severe restrictions and chronic pain, Mr. Cornwall has a limited education, cognitive limitations, learning disabilities and no transferable skills. It is highly unlikely he would be successful in a training program. While there might be some part-time work available with a sympathetic employer, he is so injured that he cannot perform services other than those which are so limited in quality, dependability or quantity, that a reasonable stable market does not exist.

Ex. 60:1376.

100. After delivering her original report on May 15, 2015, counsel for Claimant requested that Dr. Collins update her opinion on Claimant's employability four times (6/23/16, 3/1/17, 1/9/18, and 3/23/18) as the case progressed and additional medical or other records became available. *See*, Ex. 61-64. On each occasion, Dr. Collins adhered to her initial conclusion that Claimant was totally and permanently disabled, and that nothing in the additional records provided changed her opinion but in fact supported it. *Id*.

101. In a final updated opinion delivered on March 23, 2018, Dr. Collins adhered to her previous opinions that Claimant is totally and permanently disabled. Ex. 64. Claimant's counsel asked her to review the vocational report of Delyn Porter, Employer/Surety's expert. *Id.* at 1381.

102. Dr. Collins began her addendum report of March 23, 2018 by reiterating that Claimant was "enrolled in special education classes throughout his schooling. He has borderline intelligence and is unable to do simple subtraction or multiplication." These and other severe

cognitive deficits must be considered significant vocational factors in Claimant's case, according to Dr. Collins. *Id*.

103. Dr. Collins then proceeded to consider each of the jobs that Mr. Porter identified as within Claimant's capabilities: telephone service agent, production line worker, courtesy lube technician, production associate with Deseret Industries, custodian, dishwasher, cabinet builder, assistant cook, and cook. *Id*. at 1382. She notes in pertinent part as follows: "If Dr. Tallerico's opinion is assumed, Mr. Cornwall could perform a limited number of these jobs. If Dr. Doerr's opinion is assumed, none of these jobs are appropriate because of the need for position changes." She further concluded that if Dr. Blair's restrictions are assumed, Claimant "could not perform any of these jobs." Ex. 64:1382-1383.

104. Dr. Collins criticizes Mr. Porter's opinions for failing to take into account Claimant's chronic pain, need for position changes or additional breaks, and the fact that he had not worked for six years. Ex. 65:1383.

105. Dr. Collins concluded her addendum report by opining that Claimant is "not competitively employable." She opined that Claimant "is realistically totally disabled by his chronic pain, need for frequent position changes, and need to take breaks during a work day. He was injured six years ago and he has been unemployed and receiving pain management during this time. His subjective complaints have been consistent throughout and his treating physicians feel his pain is significant." *Id*.

106. Prior to her deposition, Dr. Collins reviewed the hearing transcript. Collins Dep., 14:23-25.

107. In her deposition testimony, Dr. Collins observed that it was significant that the SSA determined that Claimant was disabled in September 2013. She noted in pertinent part as

follows: “It is significant in that Social Security does fairly comprehensive evaluations to establish disability. They look at different things than the Workers’ Compensation Disability Analysts look at, but a lot of the same factors. The thing that was real significant in his getting Social Security Disability is it is very age-related. You have to be really significantly disabled to get Social Security Disability in your 20s.” *Id*. at 31:4-12.

108. The fact that Claimant applied for SSD twice before his industrial injury did not make any difference to Dr. Collins. She observed as follows: “Well, I mean, it does go to the fact that he and other people recognized that he had some sort of disability to begin with.” Collins Dep., 31:23-25.

109. Dr. Collins explained how Claimant’s time-of-injury job was unskilled labor as follows: “If he had been doing it by himself without a manager, it would have probably been considered a semi-skilled job, but he really – what he explained is that the manager of the parks or his supervisor would say, ‘This is what you’re going to do today and how to do it.’ He said he would have had trouble without that help.” *Id*. at 33:11-17.

110. Dr. Collins classified the jobs in Claimant’s work history as “medium to heavy because they did require standing, walking – obviously all of his jobs did – fairly significant lifting, bending, twisting, stooping – all of those.” *Id*. at 34:14-17. Claimant’s time-of-injury job was medium to heavy. *Id*. at 19. Furthermore, Claimant did not have any transferable skills. *Id*. at 35:5-6.

111. According to Dr. Collins, pre-injury, Claimant had access to a “fairly limited labor market,” thus he “may have had access to 10 percent of the labor market.” *Id*. at 36:16-22. Post-injury, Claimant’s restrictions prevented him from doing the medium to heavy jobs that he had previously performed, thus depriving him of access to these jobs, so the injury “totaled him,”

i.e., made him totally and permanently disabled. *Id*. at 36:23-37:11. "I just couldn't think of any job he could do with his background and abilities that would allow him to change positions every 15 minutes, take additional breaks during the day." *Id*. at 37:13-16. Based upon all these factors, Dr. Collins determined, according to a more probable than not standard, that Claimant was totally and permanently disabled. *Id*. at 37:24-38:6.

112. Dr. Collins was comfortable with the more severe restrictions specified by Dr. Blair than stated in the later FCE, because "they were more consistent with the subjective complaints over the last three or four years." Collins Dep., 41:23-24.

113. Concluding her direct testimony, Dr. Collins summarized her analysis of Claimant's disability as follows:

> If Mr. Cornwall were to go out and look for work, he would have to have really significant accommodations. He would have to have sit/stand work to begin with, a job with no multitasking, he would have to have a certain way of presenting new information, a quiet work area, avoidance of heights, some adaptive technology, extra rest periods, adjustment in work hours, and frequent absences.
> That's just – you know, those are the kinds of things you look at when you're looking at total disability. You know, is an employer realistically going to hire this person? Can they provide reasonable accommodations? In this case, I just didn't feel that was reasonable at all.
> Q. Okay, is Mr. Cornwall totally and permanently disabled?
> A. In my opinion, he is.

Id. at 51:19-52:10

114. On cross examination, Dr. Collins responded to a question as to whether Claimant was capable of doing custodial work, as follows: "I can't think of an employer in the world who would hire a custodian who needed to lay down or sit. There's no sitting in custodial work. You don't sit and dust or sit and mop. That would not be reasonable." *Id*. at 67:11-14.

115. When asked whether she saw a basis for ISIF liability based upon Claimant's pre-existing limitations, Dr. Collins responded as follows:

> You know, I think the issue for this gentleman that would not bring in the Special Indemnity Fund is that his restrictions are so significant for his back injury, that they disable him in and of themselves. I don't see there's a combination factor.
> Q. But in your own evaluation, you point out that some of the jobs he could not do because they required multitasking; correct?
> A. Correct. Yes.
> Q. And the multitasking was definitely something that preexisted the work accident?
> A. Correct.
> Q. So isn't there some way to at least make an argument that prior condition does combine with his back injury to make him totally and permanently disabled?
> A. I think you could make the argument.

Collins Dep., 68:21-69:15.

116. *Delyn D. Porter, M.A., CRC, CIWCS.* Defendants Employer and Surety retained Delyn D. Porter, M.A., CRC, CIWCS, to evaluate Claimant's employability and level of potential disability. Ex. 78. He delivered a report dated January 8, 2018. *Id*. at 1744.

117. Mr. Porter is a self-employed vocational expert with offices for practice in Blackfoot, Idaho. Porter Dep., 5:1-6. He has practiced as Porter Vocational Services since December 2010. *Id*. at 7-9. He holds a master's degree in rehabilitation counseling from Western Washington University and is a certified rehabilitation counselor (CRC). He has also been certified through the Idaho Industrial Commission's Workers' Compensation certification course *Id*. at 6:2-11. He is a past field consultant for both the Idaho Division of Vocational Rehabilitation and the Idaho Industrial Commission. *Id*. at 7:1-13. Mr. Porter has appeared as a vocational expert in past Industrial Commission cases. His qualifications are well known to the Commission and he is qualified to render a vocational opinion in this case.

118. Mr. Porter reviewed all relevant pre-injury and post-injury medical records in this case. Ex. 78:1744-1745. He also reviewed additional information and resources as follows: Idaho Department of Labor records; pertinent SSD records; statement of earnings from the SSA; educational records for Claimant; Claimant's tax returns 2009 – 2012; vocational reports of

Nancy Collins, Ph.D.; workers' compensation – first report of injury; Claimant's resume; pleadings in workers' compensation case; AMA *Guides to the Evaluation of Permanent Impairment,* 6th Ed.; Dictionary of Occupational Titles; O*NET; Idaho Career Information System (eCIS); Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles (SCODRDOT); New guide for Occupational Exploration; The Revised Handbook for Analyzing Jobs; Rehabilitation Consultant's Handbook, 4th Ed.; The Henry J. Kaiser Family Foundation; Occupational Outlook Handbook; SkillTRAN; and U.S. Department of Labor Bureau of Labor Statistics. Ex. 78:1745-1746.

119. In a section of the report entitled "Family/Social History," Mr. Porter noted that Claimant reported that he was born with fetal alcohol syndrome and had a history of mental health issues prior to the industrial injury, that included a suicide attempt and hospitalizations. He noted that Claimant graduated from high school. *Id*. at 1782.

120. At the time of the interview with Mr. Porter, Claimant was living with his elderly father and helped care for him by taking care of household chores, including laundry, dishes, preparing meals, cleaning, etc. Claimant undertook these tasks in "short shifts." *Id*. Claimant reported that he felt totally and permanently disabled and unable to work. *Id*.

121. Mr. Porter listed the same employment history for Claimant noted elsewhere in the record with the exception that he had also worked part-time as a newspaper bundle hauler for the Idaho State Journal for approximately six years. *Id*. at 1783.

122. The interview that Mr. Porter conducted with Claimant was significant for the following observations:

> Mr. Cornwall was noted to have difficulty with long-term memory. Despite these deficits, the information he shared during the intake interview correlated closely with the vocational and medical records reviewed as part of this evaluation report.

> Mr. Cornwall acknowledged a significant pre-existing non-industrial medical history. A review of the medical records finds ongoing difficulties and cognitive deficits dating back to well before his 2011 industrial accident. He was involved in special education classes throughout his years of schooling due to cognitive deficits and learning disabilities.

Id. at 1784.

123. Claimant reported to Mr. Porter significant and numerous limitations to his post-injury capacity, including limitations and deficits in the following areas: standing, walking, sitting, lifting/carrying, pushing/pulling, kneeling, bending/stooping, twisting, forward reaching, overhead reaching, climbing, gripping, fine-finger handling, chronic pain feeling, sleeping, driving, and activities of daily living. Ex. 78:1784-1785.

124. The following occupational titles were found by Mr. Porter to be relevant to Claimant's work history: groundskeeper, industrial/commercial; construction worker II; newspaper delivery driver; sorter-pricer (nonprofit); stock clerk (retail trade); material handler (any industry); and sales attendant (retail trade). *Id*. at 1786-1790.

125. For a transferable skills analysis, Mr. Porter found that Claimant's work history showed that he had worked in jobs classified as unskilled to semi-skilled (over 3 months up to and including 6 months of vocational preparation). He found that Claimant was still capable of working in occupations from unskilled to semi-skilled. *Id.* at 1790.

126. For the physical strength category, Mr. Porter explained that physical strength was divided between the exertional (lifting, pulling) and positional (standing, sitting, walking, twisting, kneeling, bending, etc.). *Id*. at 1791. For a worker to have the ability to perform a category of strength work, he or she must have both the exertional and positional abilities demanded by that category. *Id*. The strength work categories are as follows: sedentary work, light work, medium work, heavy work, and very heavy work. *Id*.

127. Mr. Porter reviewed the physical restrictions and impairments assigned by various physicians in Claimant's case. He noted that restrictions imposed by Dr. Greenwald were not exertional or positional but rather mental in nature. He noted that the restrictions placed by Dr. Tallerico placed Claimant in a medium work strength category, which Dr. Doerr agreed with, while the more significant restrictions of Dr. Blair placed Claimant in the below sedentary work capacity post injury. Ex. 78:1791-1794. Meanwhile, results of the FCE that Claimant underwent would place him in the light-medium work capacity category post-injury. *Id*. at 1794-1796. Mr. Porter noted that Dr. Doerr determined that the FCE restrictions were the most appropriate. *Id*. at 1797.

128. Mr. Porter concluded that according to the opinion of Dr. Tallerico, Claimant was capable of returning to his time of injury position with Employer. *Id*. at 1799. Based upon the medical opinion of Dr. Blair, Claimant was unable to return to time of injury position with Employer. *Id*. at 1800. Meanwhile, based upon the medical opinion of Dr. Doerr, Claimant was unable to return to his time of injury employment, however Dr. Doerr apportions 1/3 of the need for restrictions to the industrial accident and 2/3 of the need for permanent work restrictions to nonindustrial factors. *Id*. He further observed that the "assigned restrictions from Dr. Blair remain markedly more restrictive than the objective restrictions identified in the FCE report." *Id*. at 1803.

129. Claimant "reasonably had access to, and was competitive for, approximately 11% of the total jobs in his assigned labor market area" on a pre-injury basis, according to Mr. Porter. *Id*. Based upon the medical opinions of Dr. Tallerico, Claimant would be capable of performing sedentary, light, and medium physical demand work categories, post-injury, thus he continued to be competitive for 7% of the jobs in his labor market, resulting in 34.6% loss of labor market

access. *Id*. at 1803-1804. If the permanent work restrictions identified in the FCE and as adopted by Dr. Doerr were used, Claimant would continue to have access to 4.5% of the total jobs in his assigned labor market area, resulting in a 59.1% labor market loss post-injury. *Id*. at 1804. Using the restrictions from Dr. Blair, Claimant would continue to have access to approximately 2.75% of the total jobs in his labor market area, resulting in a post-injury labor market loss of 75%. Ex. 78:1804.

130. For wage earning capacity, Mr. Porter determined that Claimant had a pre-injury wage earning capacity of $11.89 per hour. Ex. 78:1805. Based upon the restrictions assigned by Dr. Tallerico, Claimant would have been able to return to his time-of-injury employment, with no loss of wage earning capacity. *Id*. If the opinions of Dr. Blair and Dr. Doerr and the findings of the FCE are applied, Claimant would have a post-injury wage earning capacity of $9.76 per hour, thus sustaining an 18% wage earning capacity loss. *Id*. at 1806.

131. Mr. Porter searched open job listings in the Pocatello area at the time of his report, and determined that the following jobs met his physical capacity as outlined in the FCE report: telephone service agent, production line worker, courtesy lube technician, Deseret Industries production associate, building custodian, dishwasher, cabinet builder, and assistant cook. *Id*. at 1808-1813.

132. In concluding his report, Mr. Porter noted that Dr. Greenwald assigned Claimant a combined WPI of 21% for pre-existing impairments prior to the industrial injury.[5] He had also received a 13% WPI as a result of the industrial injury.[6] *Id*. at 1814. Because Claimant had been successfully employed at his time-of-injury employment from 2004 to 2012, Mr. Porter

[5] Mr. Porter apparently failed to take into account that Dr. Greenwald later amended her impairment rating for pre-existing impairments to a combined 37%. *See*, Ex. 77:1470.

[6] 13% was Dr. Blair's opinion. Dr. Tallerico and Dr. Doerr assigned a 9% WPI.

determined that Claimant's pre-existing impairments "did not constitute a hindrance or obstacle to obtaining employment." *Id*. at 1815.

133. Mr. Porter further concluded in pertinent part as follows regarding whether Claimant is totally and permanently disabled: "Given the fact that his calculated labor market loss ranges from 36.4% to 75% depending upon which medical opinions are considered, it is obvious to this evaluator that Mr. Cornwall continues to possess some post injury work capacity and labor market access and would not meet the criteria for 100% loss of labor market access." Ex. 78:1815.

134. As for *Odd-Lot* Doctrine status, Mr. Porter found that the first two prongs of the criteria are inapplicable to Claimant based upon "his lack of effort in attempting or unsuccessfully working other jobs" after the injury. *Id*. Thus the only way for Claimant to establish total and permanent disability through *Odd-Lot* Doctrine is by establishing that efforts to find suitable work would be futile. *Id*. at 1816. Mr. Porter determined, based upon a post-injury job market access of 25% to 64%, that it would not be futile for Claimant to find suitable employment. *Id*. Thus, Claimant was not totally and permanent disabled. *Id*.

135. Based upon the medical opinions of Dr. Tallerico, Claimant would have a 27.2% permanent partial disability, inclusive of the 9% whole person impairment assigned by Dr. Tallerico. *Id*. Using the "objective" results of the FCE and Dr. Doerr, Claimant would have a 38.6% permanent partial disability, inclusive of impairment. Using the medical opinions of Dr. Doerr, Claimant would have a permanent partial disability of 46.5%, inclusive of the 13% WPI assigned by Dr. Blair. *Id*. at 1817.

136. In his deposition, Mr. Porter noted that Claimant did not undertake any thorough job search following his industrial injury through the present. Porter Dep., 17:12-18:4.

137. Agreeing that Claimant was severely limited in his employment opportunities before he suffered the industrial accident, Mr. Porter observed as follows: "He [Claimant] was primarily qualified for entry-level types of jobs. And when you look at his work history, most of it involved unskilled or semi-skilled work at its highest. He didn't have any work experience in skilled employment." Porter Dep., 19:23-20:2.

138. Regarding the vocational report of Dr. Collins, Mr. Porter observed in pertinent part as follows: "I see that she came up with a total and permanent disability, but I don't see how it was calculated." *Id*. at 33:21-24. Porter agreed that Dr. Collins simply concluded that there were no jobs available to Claimant in his job market. *Id*. at 34:6-8.

139. Mr. Porter admits that he did not receive or review copies of the supplemental vocational reports prepared by Dr. Collins. *Id*. at 38:13-22.

140. In commenting on the fact that Claimant assisted his father with household chores while he lived with him, Mr. Porter did not ask any follow-up questions of Claimant to determine how much he did versus his father's contribution. *Id*. at 40:17-21.

141. Mr. Porter agreed to the following facts: Claimant has never worked in an office environment. *Id*. at 41:17-19. He has never done work where one of his primary responsibilities was to answer or talk on the phone. *Id*. at 20-23. Claimant has never performed mechanical work, fixing engines and vehicles and small motors. *Id*. at 41:24-42:2.

142. Mr. Porter agreed that during his years of doing vocational work, it is not uncommon for physicians to assign more severe work restrictions than an FCE, as occurred with Dr. Blair. *Id*. at 42:3-10. Nevertheless, he adhered to his position that the FCE restrictions were "more objective." *Id*. at 20-21.

143. Under cross examination at his deposition, Mr. Porter admitted that Claimant could not now perform any of the previous jobs that he had performed, including the time-of-injury job and previous positions (siding installer, floor clerk/stock clerk at Deseret Industries, newspaper bundler/hauler), if FCE restrictions were considered. Porter Dep., 49:5-50:8.

144. Counsel for Claimant questioned Mr. Porter extensively about the jobs that he had listed in his report that he believed Claimant was capable of performing, such as telephone service agent, resulting in admissions that undercut the reliability of his vocational report. *Id*. at 50:9-63:9.

145. For telephone service agent, Mr. Porter listed the qualifications as having good communications skills and good computer skills, among others. *Id*. at 51:1-4. He admitted, however, that Mr. Porter only had "basic computer skills, but again with minimal training, I have had a lot of people who have worked [telephone] centers. It doesn't take much for them to develop the computer skills to be able to do that." *Id*. at 7-11. Counsel then queried as follows:

> Q. Were those individuals people who were in special education classes throughout their schooling?
> A. Some of them, yes.
> Q. And did any of those people have fetal alcohol syndrome?
> A. No.
> Q. Or symptoms from fetal alcohol syndrome?
> A. Not that I remember, no.
> Q. What was your understanding of Mr. Cornwall's communication skills?
> A. My observation was he communicated with me very well during the intake interview. He spoke clearly. I was able to understand him. He communicated better probably than I am today.[7]
> Q. Okay. That's interesting to me because that's never been my experience with him and I've sat in on that interview and I don't remember that the same way. But that's your testimony?

[7] At hearing, Rhonda Cornwall testified in pertinent part as follows: "Q. Tony's reading and writing skills, his communication skills, how does he do there? A. Good as my fourth grader. Q. And tell us what you mean by that. Give us some examples. A. When he reads things, he has a hard time understanding. He doesn't remember what he's read. He tries to sound out words. You know, sometimes, it's not correct." Tr., 172:8-16. The observations of Ms. Cornwall are more in line with those of the Referee in observing Claimant's communication skills at the hearing.

A. Yes.

Id. at 51:12-52:6.

146. With regard to the job of production line associate that Mr. Porter identified as appropriate for Claimant, he did not screen whether the employer would allow Claimant to take breaks as needed or lift less (20 pound restriction.) Porter Dep., 53:25-54:8.

147. Concerning the position of courtesy lube technician (oil changer), Mr. Porter stated that such workers would be able to take a break as needed "depending upon the work flow," but he admitted that if they're busy they cannot. *Id*. at 54:9-11. And they may be required to lift up to 55 pound gallon drums of oil occasionally. *Id*. at 14-19.

148. For the position of dishwasher, Mr. Porter agreed that, depending upon the setup of the kitchen, the job would require "standing in awkward positions for prolonged periods of time" as well as require the worker to remain in that position doing dishes for longer than fifteen to twenty minutes at a time. *Id*. at 55:17-56:1. That job would only allow Claimant to take breaks as needed if the workflow allowed, according to Mr. Porter. *Id*. at 56:8-13. Asked whether dishwasher jobs were difficult for people with low back injuries, Mr. Porter responded as follows:

> Q. Is it your experience that – for people you've interviewed vocationally with low back injury, that the dishwashing job is probably the one that's the most uncomfortable and difficult for them?
> A. It is.
> Q. Did you take that into consideration when you listed this as a job he [Claimant] could do?
> A. I did not. It was an entry-level job that was very routine is what I identified as I put it in there.

Id. at 14-23.

149. Asked whether he took into account all of the restrictions specified in the FCE in determining that certain jobs were appropriate for Claimant, Mr. Porter replied that he primarily

looked at "Dr. Tallerico's restrictions and went from there." *Id*. at 57:3-4. But when reminded that his report stated the jobs in the Pocatello area were reviewed for the "noted physical demand capacities in the FCE report," Mr. Porter admitted as follows: "I stand corrected." Porter Dep., 57:10-18.

150. When asked whether the cabinet builder position that he identified in Pocatello as appropriate for Claimant involved heavy lifting, Mr. Porter replied "Not necessarily." *Id*. at 58:6-8.

151. The following exchange in Mr. Porter's cross examination is particularly instructive:

> Q. Did you contact any of these employers to find out whether they would accommodate Mr. Cornwall's restrictions as stated in this FCE?
> A. No.
> Q. Did you consider, in arriving at any of your opinions, the fact that Mr. Cornwall would need a quiet area to work?
> A. No.
> Q. Isn't that one of the restrictions or accommodations that Dr. Greenwald identified?
> A. It was.
> Q. Why didn't you consider that?
> A. *An oversight on my part*.
> Q. If you would have considered that, how would it have changed your opinions regarding Mr. Cornwall's disability in light of Mr. – Dr. Blair's work restrictions, physical restrictions?
> A. It would increase the disability a little bit, but it still – in my mind, you still don't get to total perm.
> Q. Well, what if you combine it with the need for breaks as needed. In other words, earlier you said if you consider breaks as needed, I think it would increase by 10 percent. Now let's overlay the quiet work area.
> A. That's probably going –
> Q. Total perm?
> A. I still don't think it gets you to total perm. I think it increases your disability again. Probably another 10 percent, maybe.
> Q. So we're getting closer to total perm even based on your opinions?
> A. Yes.
> Q. But you haven't gone back and done the actual evaluation to determine that, correct?
> A. No.

Q. How about the avoidance of heights, did you consider that?
A. I did not.
Q. Oversight again?
A. I'm assuming, yeah.

Porter Dep., 58:7-60:22 (emphasis added).

152. Mr. Porter admitted that he did not include consideration of Dr. Greenwald's identified work restrictions in his report. *Id*. at 60:25-62:21. If they were included, Mr. Porter admits that it would put Claimant closer to total and permanent disability, as follows:

Q. So if you now overlay these additional things from Dr. Greenwald, these additional work restrictions from Dr. Greenwald, are we getting – aren't we at total disability?
A. I think you get closer, but you're still not there in my opinion.
Q. But you haven't done the evaluation?
A. Correct.
Q. If you went back and did the evaluation, could you give the Commission a more accurate answer as to whether my client is totally and permanently disabled?
A. Correct.

Id. at 62:22-63:9.

153. **Medical Testimony**. *Benjamin Blair, M.D.* Claimant took the deposition of Dr. Blair on November 13, 2018. Blair Dep., 1:5. Dr. Blair is an orthopedic surgeon with offices for practice in Pocatello, Idaho and is licensed to practice medicine in Idaho. *Id*. at 5:13-18.

154. Dr. Blair is a graduate of Albany Medical College in Albany, New York. He completed his surgical internship at New York University in New York. He completed his orthopedic residency at the Hospital for Joint Disease in New York. He also completed a spine fellowship year at the University of California, San Diego. *Id*. at 6:5-11. He became board certified in orthopedic surgery in 1998 and is currently so certified. *Id*. at 12-17. He has practiced orthopedic medicine in the Pocatello area for approximately 22 years. *Id*. at 7:12-14. He specializes in surgery of the spine, including neck, mid-back and low back. *Id*. at 15-19. He has hospital privileges at Portneuf Medical Center in Pocatello. *Id*. at 8:9-13.

155. Dr. Blair has provided expert medical testimony in past Industrial Commission cases and the Commission is well acquainted with his credentials. Dr. Blair is qualified to provide expert medical testimony in this case.

156. Dr. Blair treated Claimant as a patient since 2012. Blair Dep., 5:23. To render medical opinions as an expert in this case, he also reviewed relevant medical records, including those generated prior to the industrial accident and those generated after it. He also reviewed other documents, including the FCE completed concerning Claimant. *Id*. at 9:10-10:1. He relied upon those documents as well as his own experience in treating Claimant in rendering medical opinions on what treatment was reasonable and necessary and whether the conditions were industrially related. *Id*. at 5-13. Dr. Blair also responded and commented on the other medical opinions offered in this case. *Id*. at 14-16. He also provided opinions on Claimant's impairment and permanent physical restrictions, which included an original report and a supplemental report after Claimant received additional medical treatment. *Id*. at 11:21-12:3. He included his medical opinions in a series of five reports that have already been summarized above. *Id*. at 10:17-13:18.

157. Dr. Blair concluded that the cause of Claimant's internal disc derangement at L5,S1 was a "combination of the initial injury to the L5,S1 with the herniated disc and then the subsequent surgery that he had to L5,S1." *Id*. at 23:5-8.

158. Dr. Blair disagreed with Dr. Tallerico's conclusions that Claimant was a poor surgical candidate because of evidence of past opiate abuse and because he was a patient in the workers' compensation realm. In Dr. Blair's opinion, a patient who has had a past history of opiate abuse has no less chance of a successful outcome in surgery, and the fact that Claimant came to treatment as a workers' compensation claimant should not disqualify him from treatment. *Id*. at 32:14-34:3.

159. Based upon the FCE, Dr. Blair assigned Claimant a 13% WPI rating and permanent restrictions, as follows:

> So no lifting more than 10 pounds frequently, 20 pounds occasionally, and 30 pounds rarely; minimal crouching, kneeling; occasional stair climbing; no ladder climbing; no heavy shuffling; no sitting greater than 15 minutes without changing position; no walking greater than 15 minutes or standing greater than 15 minutes without a change in position; request some period of time for a break for an 8-hour day, a morning break, a lunch period, and afternoon break scheduled at approximately 2-hour intervals.

Blair Dep., 42:16-43:1.

160. Dr. Blair's diagnosis of Claimant based upon his review of medical records and his treatment of Claimant was as follows:

> So a herniated disc at L5,S1. He was status posed [sic] where he had a laminectomy – a lumbar discectomy at L5,S1. He had internal disc derangement at L5,S1. He had undergone a lumbar fusion at L5,S1. He had post laminectomy syndrome in the low back. He had sacroiliac joint dysfunction on the left side. He had a left sacroiliac joint fusion. He had sacroiliac joint dysfunction on the right side, and he had a right sacroiliac joint fusion.

Id. at 43:16-23.

161. Dr. Blair opined that all of the above conditions were the "result of the workplace accident and then subsequent surgeries he had," without apportionment to any other causes such as pre-existing or subsequent conditions. *Id*. at 44:2-8. Furthermore, Dr. Blair opined that all of the medical treatment that Claimant had received subsequent to the industrial accident was medically necessary and attributable to the industrial accident, and not the result of a pre-existing condition. *Id*. at 44:9-45:6.

162. Specifically with regard to the SI joint fusions performed by Dr. McCowin, Dr. Blair attributed that treatment to the industrial accident because they were necessitated by the fusion performed at L5,S1, which was attributable to the industrial accident. He explained as follows; "[W]hen you do a fusion, you take the motion out of a joint and so the body has to make

up for motion either above or below or usually both. The joint below L5,S1 are the sacroiliac joints. Those are the next two joints on the right or the left, and so they become more mobile and that's actually not very normal for a sacroiliac joint, and that causes increased wear and tear." Blair Dep., 45:7-46:3.

163. At the time of his deposition, Dr. Blair did not recommend any further treatment as a result of the industrial accident. *Id*. at 46:4-7.

164. Dr. Blair disagrees with the opinions of both Dr. Tallerico and Dr. Doerr, because they concluded "that everything following the lumbar discectomy was not work related, and therefore everything past that was also not work related." *Id*. at 46:23-47:23.

165. On April 25, 2017, in addition to giving Claimant permanent restrictions, he also gave him an updated permanent impairment rating of 13% WPI. The impairment rating was the same as the previous rating because the *Guides* do not recognize any impairment rating for sacroiliac joint fusions. *Id*. at 48:22-49:4.

166. Dr. Blair found that Claimant was a "good, compliant, well-motivated" patient. *Id*. at 49:8-11. He did not observe any drug-seeking behaviors exhibited by Claimant. *Id*. at 12-14.

167. Although he opined that the medical treatment that Claimant received since the industrial accident was necessary, Dr. Blair declined to unequivocally state that the treatment had "helped" Claimant, as follows:

> Q. Did you feel the medical treatment you provided him helped him?
> A. I guess you would have say how – how you defined helped?
> Q. Yeah I think what you are getting at is –
> A. He's still symptomatic; he still hurts. It still interferes with his function. I mean, whether he is better overall, I think you actually have to ask him. He is still not doing well.
> Q. Still needs treatment?
> A. Yes.

Blair Dep., 49:15-25.

168. On cross examination, counsel for Employer and Surety challenged Dr. Blair on the fact that he is serving in a dual capacity, as both treating physician and medical expert witness. He dismissed the suggestion that it was a problem as follows:

> Q. Do you think there is any problem taking on both roles in a case like this?
> A. No, I don't think so.
> Q. I mean, do you think that you might lose some objectivity because of your relationship with Mr. Cornwall?
> A. I think I gain and lose objectivity; so I think it probably cancels out to be the same. Again, more experience with Mr. Cornwall gives me more in-depth insight to his problems and having been involved. Again, as I said, I'm his advocate so in that way I'm definitely less impartial than someone who is an IME.

Id. at 57:19-58:6

169. Dr. Blair acknowledged that the MRI following Claimant's first surgery, the discectomy at L5,S1, showed no reoccurrence of any herniation. He explained why the radiologist did not say anything about disc derangement in the report because "desiccation and narrowing," which was identified, and which is the drying out the disc and narrowing, is synonymous with disc derangement. *Id*. at 58:13-59:8.

170. Dr. Blair agreed that the SI joint fusions were due to the lumbar fusion, thus "if the fusion is not related to the work injury, the SI fusion would also not be related." *Id*. at 61:13-23.

171. Dr. Blair agreed that he informed Claimant that the lumbar fusion surgery had a "mediocre success rate." *Id*. at 71:2-8. He did not specifically inform Claimant that a lumbar fusion may later require an SI joint fusion. *Id*. at 9-21.

172. Admitting that Claimant did not return to a level of function that he was before the surgery, Dr. Blair agreed that the lumbar fusion surgery did not increase his ability to

perform work-related activities. “He’s never returned to the level function that he was before the surgery.” Blair Dep., 71:22-72:13.

173. The indications for performing a lumbar fusion surgery, according to Dr. Blair, are “[o]ngoing symptoms for greater than six months, failure of conservative therapy, and then diagnosis of either instability or internal disc derangement.” *Id*. at 76:23-77:8.

174. Dr. Blair saw internal disc derangement at L5,S1 on the MRI prior to the lumbar fusion surgery. *Id*. at 77:9-15. He also saw evidence of disc derangement at L2-3, but did not perform a fusion at that level. He did not operate at that level, however, because the EMG nerve conduction study isolated L5,S1 as the source of the problem, and also the film said mild desiccation at L2-3. *Id*. at 77:16-78:6.

175. Challenged on the fact that lumbar fusion at L5,S1 was not a successful surgical solution, Dr. Blair replied as follows: “Well, first, hindsight is 20/20. So at the time I think it was a very reasonable decision to perform a fusion. And again, I don’t know. I would have to ask him [Claimant] if he improved with the fusion to know if it was worthwhile or not.” *Id*. at 82:18-22.

176. Dr. Blair concluded his deposition by stating that nothing in the cross examination has changed any of the opinions that he has expressed about Claimant and his treatment. *Id*. at 92:17-20.

177. *Brian D. Tallerico, D.O.* Counsel for Defendants Employer and Surety took the deposition of Dr. Tallerico on November 30, 2018. Dr. Tallerico is a board-certified orthopedic surgeon. He received a medical degree from Midwestern University, Chicago College of Osteopathic Medicine in 1997. Thereafter he completed an internship in Chicago and a residency in orthopedic surgery at Ohio University in Columbus, Ohio in 2002. Tallerico Dep., 5:7-6:18.

178. At the time of deposition, Dr. Tallerico was practicing orthopedic surgical medicine at the Auburn Community Hospital in New York. He also performs IMEs by contract with OMAC. Tallerico Dep., 7:12-22.

179. Dr. Tallerico performs on average between ten and fifteen IMEs per month. *Id*. at 8:17-23. He estimated that he spent 90% to 95% of his work time on surgical practice with 5% to 10% spent on forensic medicine, i.e., IMEs. *Id*. at 11:2-19. Defendants primarily contracted with him to perform IMEs; he estimates that claimants contracted with him on one out of every ten or fifteen cases. *Id*. at 11:20-24. OMAC is associated primarily with sureties and insurance carriers. *Id*. at 11:25-12:3.

180. Dr. Tallerico has testified in past Industrial Commission cases. His qualifications are well known to the Commission. He is qualified to provide expert medical testimony in this matter.

181. Dr. Tallerico examined Claimant for the IME on August 10, 2012. Prior to the examination, he received Claimant's medical records and diagnostic reviews. *Id*. at 14:15-18. Dr. Tallerico documented the records and studies that he reviewed in his report, which is contained in the record as Exhibit 75. *Id*. at 14:15-15:3.

182. Postoperative X-rays taken after Claimant's L5,S1 discectomy procedure showed no instability (one vertebrae sliding forward on another). *Id*. at 16:8-20.

183. In his first report, Dr. Tallerico's principal conclusion was as follows:

> I felt that he [Claimant] did have a lumbar sprain/strain injury with a herniated disc in L5,S1 related to the industrial injury in status post discectomy and laminectomy. Then I documented evidence of chronic L5,S1 radiculopathy bilaterally related as well but with unusual and discordant physical examination.
> Q. What did you mean by that?
> A. Well, on his physical exam, he didn't have classic findings of lumbar radiculopathy.

Q. And it appears like in a later addendum from you after you reviewed a postoperative MRI, you even changed that opinion, correct?
A. I believe so.
Q. And if you could explain ultimately what you had – what opinion you had regarding the evidence of chronic L5,S1 radiculopathy?
A. Right. So after I got the follow-up imaging, I amended my diagnosis to – and made it subjective complaints of chronic radiculopathy in the bilateral lower extremities without supportive objective findings.
Q. And that was based upon the CT myelogram?
A. Correct.

Tallerico Dep., 17:10-18:8

184. Dr. Tallerico also stated his opinion that the discectomy/laminectomy at L5,S1 that Dr. Blair had performed was industrially-related. *Id*. at 18:15-18.

185. In the next report of September 19, 2012, after reviewing the CT myelogram that Dr. Blair ordered, Dr. Tallerico found that Claimant was at MMI and gave him a 9% WPI based upon the *Guides*, 6th Ed. He further assigned physical restrictions of no pushing, pulling, lifting or carrying of greater than 70 pounds, and no repetitive activities in excess of 50 pounds. As no further surgery was proposed at this time, Dr. Tallerico did not address that topic. *Id*. at 25:21-27:25.

186. In his next addendum report authored April 1, 2013, Dr. Tallerico weighed in on whether Claimant was a good candidate for a surgical fusion at L5,S1. He "respectfully disagreed" with Dr. Blair that Claimant was such a good surgical candidate. His reasoning was as follows:

> Well, I felt that first – first, he was a rather young individual. That's reason No. 1. He also had some past medical history that was concerning. And that was probably – that was actually the next one so I'll hold off on that one. It was a workers' compensation case, which has a poor outcome with lumbar fusion, 50 percent, which isn't a great result for any type of surgery. I just felt that he would not have a favorable outcome given the circumstances.

Tallerico Dep., 28:10-24. Furthermore, Dr. Tallerico felt that the indications for an L5,S1 fusion, instability of the segment together with bilateral neuroforaminal stenosis or central canal stenosis to a severe degree related to the instability of the segment, were not present. He did not see any evidence of that on Claimant's imaging. Tallerico Dep., 29:1-19. Due to a lack of objective findings of recurrent disc herniation, the surgery was not warranted, in Dr. Tallerico's opinion. *Id*. at 30:5-14.

187. Dr. Tallerico critiqued Dr. Blair's use of the term "severe disc derangement," because from his reading of the imaging studies "it did not appear that there was any significant disc narrowing or collapse." In Dr. Tallerico's estimation, pain complaints alone were not an appropriate indication for surgery. "Typically you try not to operate on subjective complaints." *Id*. at 30:15-31:11.

188. In addition to a lack of objective medical findings, Dr. Tallerico found that Claimant was not a good surgical candidate for an L5,S1 fusion because of his prior medical history, as follows:

> Well, his medical history, basically his psychosocial issues and his mental illness was of grave concern, I believe, when, considering such an operation. I mean there are many spine surgeons that get a psychiatric consult on every single spine fusion they perform just as checking the box, much like getting medical clearance.

Id. at 32:20-33:1. Inquiring into a patient's potential drug abuse or opioid dependence would be an important prerequisite to surgery, and Dr. Tallerico did not see that Dr. Blair did so. *Id*. at 33:2-14.

189. Dr. Tallerico further disagreed with Dr. Blair that Claimant had undergone "multiple nonoperative treatments" prior to the fusion. "The only treatments I'm aware of is I believe some [physical] therapy and then a single injection that made him worse." Tallerico Dep., 34:12-35:4.

190. Dr. Tallerico observed that the use of the term "disc derangement" by Dr. Blair was too vague, so much so that "a lot of insurance companies won't even approve MRIs if you just write internal derangement of the joint." He observed that Claimant's L5,S1 level, simply by virtue of having been status post-surgical, warranted the "generic" term of disc derangement, as follows: "So that's not inaccurate saying he has internal disc derangement because he operated on that disc. So it's automatically going to have abnormalities and be an abnormal disc. It was operated on. Part of it was removed." *Id*. at 35:5-19.

191. Dr. Tallerico did not specifically question Dr. Blair's expertise or medical decision making, however in this case he concluded "that it was a questionable judgment call to proceed with the [fusion] surgery." *Id*. at 42:23-43:2.

192. While acknowledging that he had the advantage of having reviewed the full medical record concerning Claimant before issuing his opinion on fusion surgery, Dr. Tallerico admitted that Dr. Blair as the treating physician had the advantage of meeting with Claimant on multiple occasions and taking multiple histories and conducting physical exams each time. *Id*. at 43:8-25.

193. Dr. Tallerico acknowledged that Dr. Blair had more experience in performing low back fusion surgeries and spine surgeries in general. Dr. Tallerico, however, stopped performing spine surgeries in 2013 or 2014. Tallerico Dep., 45:15-46:5.

194. Dr. Tallerico observed generally concerning the L5,S1 fusion surgery, when asked to comment on whether Dr. Blair performed an "unnecessary, frivolous surgery," as follows: "I have the benefit of seeing it all from a distance, after the fact sometimes and formulating an opinion. And, you know, I think just at the end of the day, I just – I was prophetic about it. It seems that I just didn't feel it was a good idea for this guy to have that surgery. That

was just my opinion. I think it's supported by the lack of objective evidence for the indications." Tallerico Dep., 55:20-22; 56:9-16.

195. Dr. Tallerico admitted that he had performed surgeries on patients who had histories of mental health conditions, alcoholism, drug abuse/dependency, and workers' compensation claims. *Id*. at 57:11-25. Nevertheless, he put these factors into context when considering Claimant's candidacy for the lumbar fusion surgery, as follows:

> So taking as a whole, again, having the benefit of me seeing the whole picture as far as prior history – suicide attempt, drug abuse, overdose, alcohol, workers' comp, lack of objective findings, imaging studies and whatever disagreement we have about physical exam findings – taking that as a big picture, it makes it – in my opinion, it contraindicates to having this type of surgery.

Id. at 58:14-21.

196. Dr. Tallerico requires all surgical patients in his own practice to disclose whether they have abused opioids in the past. Furthermore, his policy is to provide opioid pain medication for only up to six weeks following surgery. He believes that "musculoskeletal pain is better treated chronically with anti-inflammatories rather than opioids… The tide is definitely changing… I think it's just always a good idea to wean everybody off [of opioid medications]." *Id*. at 59:18-61:13.

197. Dr. Tallerico reiterated his position on objective findings as a required indication for surgery, as follows:

> Q. Is disc desiccation, in the absence of any objective findings of neurological impingement or instability in the lumbar spine, an indication for lumbar fusion surgery?
> A. Absolutely not.

Id. at 70:6-10.

198. With regard to the SI joints, Dr. Tallerico noted that he never reviewed any medical records in which the industrial accident was mentioned as having impacted the SI joints,

nor did Claimant mention the SI joints in his examination by Dr. Tallerico. Furthermore, Claimant did not demonstrate any symptoms of SI joint pain or problems in Dr. Tallerico's examination. Tallerico Dep., 74:18-75:6.

199. *Timothy E. Doerr, M.D.* Defendants Employer and Surety took Dr. Doerr's deposition on November 16, 2018. Doerr Dep., 2:4-5. Dr. Doerr is a board-certified orthopedic surgeon with a fellowship in spine. *Id*. at 5:24-6:1. He has practiced orthopedic surgery in Boise since 1997 under Orthopaedic Associates. *Id*. at 6:7-14. He graduated from the University of California at Davis Medical School in 1991. Thereafter, he completed a general surgery internship with the University of Colorado in 1992, his orthopedic residency at the University of Colorado in 1996, and a spine fellowship at the same institution in 1997. *Id*. at 6:24-7:4.

200. 90% of Dr. Doerr's work is devoted to medical practice, while 10% consists of performing independent medical examinations (IMEs). *Id*. at 8:1-12. He performs 100% of his IMEs for sureties. *Id*. at 66:7-8.

201. Dr. Doerr has testified as a medical expert in past Industrial Commission cases. Doerr Dep., 6:15-19. The Commission is aware of his credentials. He is qualified to testify as an expert medical witness in this case.

202. Defendants Employer and Surety retained Dr. Doerr to perform an independent records review of Claimant's case. He did not examine or meet Claimant in person. *Id*. at 9:11-10:3. His report is contained in the record as Ex. 76. *Id*. at 10:9.

203. Dr. Doerr reviewed medical records for Claimant that both predated and postdated the industrial injury. *Id*. at 11:4-7. He also reviewed all relevant diagnostic films. *Id*. at 12. He did not examine Claimant but stated that it was unnecessary to do so because when he "received the records the [fusion] surgery had already been performed. So a physical examination on my

part post-operatively would not give me any additional information with regard to whether surgery was indicated over and above what was documented in the medical records." Doerr Dep., 12:21-13:1.

204. Based upon his records review, Dr. Doerr opined that the condition Claimant had as a result of the industrial accident following the incident was "an L5,S1 central disc protrusion with back and leg pain. And some degree of neurologic impingement. And the neurologic impingement was relatively mild." *Id*. at 13:13-17. Dr. Doerr agreed that the initial conservative treatment and the laminectomy/discectomy, as well as follow-up care, that Claimant received to treat his industrially-related condition was appropriate. *Id*. at 13:24-14:4.

205. Dr. Doerr agreed with Dr. Tallerico's opinion that fusion surgery at L5,S1 was not indicated, as follows:

> Dr. Tallerico's opinion, and I agree with this, was that based upon the patient's examination where the light touch and pinprick sensation was altered, and it didn't follow nerve distribution, as well as alcoholism, bipolar disorder, anxiety, depression, drug and alcohol abuse, and prior suicide attempt – and subsequently opioid dependency – actually, the opioid dependency – pre-existing opioid dependency dated back to the patient's early 20s. He was a very, very poor candidate for a fusion. Dr. Tallerico identified that before the fusion. And I agree with that. And the patient had a fusion. The fusion was successful radiographically. The spine fused. And he had a poor outcome.

Id. at 14:24-15:12.

206. Dr. Doerr further opined that there was no indication on Claimant's pre-fusion MRI that would warrant such a surgery. While there was disc desiccation and disc narrowing, as was to be expected after a discectomy and naturally as the patient ages, there was no neurologic impingement. The disc desiccation and narrowing by themselves were not an indication for a fusion surgery. *Id*. at 16:2-14. The EMG study showed an expected finding of moderate chronic

radiculopathy bilateral in both legs, but again was not an indication for fusion surgery. Doerr Dep., 16:18-17:5.

207. Dr. Doerr interpreted Dr. Blair's use of the term "severe disc derangement" as a generic term for disc degeneration or desiccation and disc space narrowing, again, an insufficient indication for fusion surgery. "If we operated on everybody with disc derangement by the time people were in their fifties almost everyone would have a fusion." *Id*. at 17:6-21. Furthermore, there were no indications on Claimant's imaging studies that he "had instability related to his L5,S1 surgical level or any other levels prior to subsequent to his initial surgery." *Id*. at 18:20-25.

208. Dr. Tallerico's physical examination of Claimant had revealed that his light touch and pinprick examinations revealed varying results with no dermatomal pattern. Nevertheless, Dr. Doerr could find nothing in Dr. Blair's records to show that he conducted similar sensory exams despite Claimant's subjective complaints of pain and paresthesias. *Id*. at 19:14-20:10.

209. In Dr. Doerr's opinion, the CT myelogram did not offer any further evidence that would be a supporting indication for the fusion surgery. "No. It revealed that there was no neurologic impingement. Basically confirming the disc degeneration of the disc, but it didn't add anything over the MRI." *Id*. at 21:7-9.

210. Summing up the objective findings, Dr. Doerr observed that there was no nerve impingement, no disc instability, and only mild to moderate disc desiccation and narrowing, and that none of these were indications for surgery. *Id*. at 21:10-19.

211. Dr. Doerr commented on whether it was advisable to perform the L5,S1 fusion, as follows:

> Q. In Dr. Blair's post-hearing deposition he stated that in hindsight it may not have been the best option to perform the surgery. You would agree with that?
> A. Yes.

Q. In fact, Dr. Tallerico had authored an opinion basically indicating that Mr. Cornwall was not a good surgical candidate prior to the surgery.
A. Correct.
Q. And you agree with Dr. Tallerico's evaluation?
A. I do.

Doerr Dep., 25:12-22.

212. Noting that the L5,S1 fusion surgery did not improve Claimant's symptoms, Dr. Doerr observed he "did not see any time frame or time interval where he [Claimant] had improvement between his fusion and June of 2018." *Id*. at 26:1-14.

213. For all of the foregoing reasons, Dr. Doerr did "not believe that the L5,S1 fusion was indicated as a result of the 12-23-11 industrial injury." *Id*. at 19-22. The decision to perform the fusion was not reasonable and not related to the work injury. *Id*. at 26:25-27:2. He also agreed that the treatment Claimant has received since the fusion was not indicated. *Id*. at 26:21-24.

214. As to the SCS that Claimant received after L5,S1 fusion surgery, Dr. Doerr did not find that procedure was reasonable either. He clarified his answer as follows: "The indications for a spinal cord stimulator are very similar to the indications for a fusion. It is a clinically-based decision utilizing a patient's history of any factors of poor outcomes. Which would be the same as a fusion." *Id*. at 27:11-19.

215. Dr. Doerr agreed with Dr. Blair that SI joint fusions are "somewhat controversial." He defined when an SI joint fusion is indicated as follows:

> The only absolute indication for an SI joint fusion is traumatic AC joint disruption, which is associated with major pelvic injuries such as motor vehicle accidents, crush injuries, where the SI joint is grossly unstable and the pelvis is unstable. The other indication for an SI joint fusion is if somebody has a spinal deformity that is so severe that it requires a fusion.

Id. at 28:1-8.

216. Dr. Doerr further agreed with Dr. Blair that to the extent that it is found that L5,S1 level fusion was not indicated, then the SI joint fusions would similarly be not indicated. In his opinion, the SI joint fusions were not related to the work injury. Doerr Dep., 29:11-18; 22-24.

217. Noting that the FCE did not include a sitting or walking restrictions, Dr. Doerr did not agree with the 15 minute walking restriction and 15 minute sitting restriction of Dr. Blair. Admitting that he did not examine Claimant himself, he believed that the FCE limitations were the "most appropriate and the most reliable." *Id*. at 30:3-31:14.

218. Dr. Doerr apportioned Claimant's condition in thirds as follows: "One is the industrial related L5-S1 discectomy. One is the L5-S1 fusion. One is for the SI joint fusions. And I believe they all equally contribute to the need for restrictions. So I apportioned one third each." *Id*. at 31:15-24.

219. Upon cross examination, Dr. Doerr admitted that he himself had performed a fusion on a workers' compensation patient, on a patient with a history of alcoholism, and a patient with a history of depression. But he denied having ever performed such a procedure on a patient that had a prior suicide attempt or opioid abuse. He explained that any "history of opioid abuse is an absolute contraindication in my practice for a fusion." *Id*. at 35:10-36:7.

220. Dr. Doerr noted that Claimant "never came off of his narcotics is my recollection. But all of the narcotics he was given were being prescribed. So he certainly had an opioid dependency with a history of opioid abuse in the past. All those are, in my practice, absolute contraindications for a fusion." *Id*. at 37:4-8.

221. Explaining his standard of care for prescribing narcotics, Dr. Doerr stated as follows: "I don't prescribe narcotic medications for generally more than two to four weeks post-

op. If somebody is still taking narcotics at six weeks post-op we put them on a taper. I never prescribe narcotics, except on a very, very rare occasions, 12 weeks post-op. Never." Doerr Dep., 38:8-13.

222. When challenged whether his standard of care was higher than most other surgeons, Dr. Doerr replied as follows: "That is the standard of care now. It has always been my standard of care." *Id*. at 16-17. Dr. Doerr received training that spinal patients are at a very high risk for opioid dependency, so this has been his standard of care since 1997. *Id*. at 39:1-5.

223. Dr. Doerr disagreed that evidence of chronic L5,S1 radiculopathy was the basis for performing a fusion. "Chronic L5,S1 radiculopathy is not an indication for fusion. Never is an indication for a fusion… That has no bearing on a need for a fusion. And that would be malpractice to fuse somebody for a chronic L5,S1 radiculopathy. This is not an indication for a fusion." *Id*. at 45:1-3; 6-9.

224. With regard to Dr. Tallerico's opinions on MMI and subsequent surgeries, Dr. Doerr observed in pertinent part as follows: "Dr. Tallerico rendered his opinion in foresight. He saw the patient after his first surgery. And his opinion, which was very prophetic, was that there is nothing else that is going to make you better. Therefore, you're at maximum medical improvement. And the patient elected, my understanding, outside of his workers' compensation claim, to undergo all of these procedures. And Dr. Tallerico's opinion was borne out based upon the poor outcomes from subsequent surgery." *Id*. at 53:1-10.

225. Dr. Doerr admitted that it is the physician who issues permanent physical restrictions and not the physical therapist. *Id*. at 55:3-7.

226. *Phillip McCowin, M.D.* Claimant took the deposition of Dr. McCowin on November 28, 2018. McCowin Dep., 2:1-4.

227. Dr. McCowin is an orthopedic surgeon who practices in Idaho Falls with the clinic Summit Orthopaedics. He is licensed to practice medicine in Idaho and has done so since 1991. McCowin Dep., 5:14-23. He is familiar with Claimant because he was his treating physician. *Id*. at 6:1-3.

228. A 1986 graduate of George Washington University Medical School, Dr. McCowin underwent his residency training at that school also. *Id*. at 10-17. He is board certified in orthopedic surgery medicine. *Id*. at 20-24.

229. Dr. McCowin describes his medicine practice as follows: "I'm a general orthopedist with a specialty interest in spine surgery." *Id*. at 7:20-21. He has hospital privileges at Mountain View Hospital. *Id*. at 8:13-14.

230. Dr. McCowin has testified before as a medical expert in workers' compensation cases before the Commission. *Id*. at 8:15-16. He has also performed IMEs. *Id*. at 18-19.

231. Dr. McCowin's experience and education with SI joint fusions goes back to the 1990s, when the technology and understanding of SI joint pathology were not very good, thus surgery outcomes were often not good. *Id*. at 18:18-19:2. Later, new devices were developed in the mid-2000s that made the surgeries more successful. Dr. McCowin has attended "five or six different laboratory sessions, cadaver sessions and clinical sessions and performed between 50 and 100 SI fusion procedures." McCowin Dep., 19:3-24.

232. The qualifications of Dr. McCowin are well known to the Commission. Although he testified as a treating physician and not as an expert in this case, he is qualified to testify in this matter.

233. Claimant first saw Dr. McCowin in an office visit on February 16, 2016. His complaints were disabling low back pain with occasional numbness and tingling in the left leg.

He had previously had lumbar spine surgery and placement of an SCS. McCowin Dep., 10:14-11:5. Based upon his physical examination of Claimant, history, and other information, including diagnostic films, Dr. McCowin diagnosed Claimant with SI joint mediated pain and dysfunction, worse on the left side than on the right side. *Id*. at 12:24-13:5. Dr. McCowin thought that Claimant would be a good candidate for an SI joint fusion. *Id*. at 13:14-16. He first sent Claimant to a physical therapist to assist both therapeutically and diagnostically. *Id*. at 17-25.

234. After more testing and a diagnostic SI joint injection, *Id*. at 16:1-9, Dr. McCowin confirmed that Claimant had left SI joint dysfunction. *Id*. at 18:11-12. He performed a left SI joint fusion surgery on Claimant on October 27, 2016. *Id*. at 16-18. The surgery was without complications. *Id*. at 22:3-5. Claimant's left-sided SI joint pain completely resolved. *Id*. at 9-10.

235. Dr. McCowin found Claimant to be a good candidate for an SI joint fusion on the left side based upon the two primary indications, findings on the physical examination and the results of injections of the joints. *Id*. at 20:18-21:13. He did not initially fuse both joints because his experience was that if the more symptomatic joint was fused first, the mechanics improved enough in the pelvis that fusion of the other joint might be unnecessary. *Id*. at 14-24.

236. Follow-up on January 4, 2017 with Claimant found that he "related that the pain in his left side had completely resolved." *Id*. at 24:5-9. This suggested to Dr. McCowin that the surgery had been successful. *Id*. at 13-14. Nevertheless, Claimant continued to have complaints about right-sided SI joint pain. *Id*. at 17. Dr. McCowin proceeded to perform a right-sided SI joint fusion on Claimant on January 12, 2017. *Id*. at 26:16-17. The procedure was without complications. *Id*. at 19-20.

237. The last visit that Dr. McCowin had with Claimant was on February 22, 2017. Claimant was fully weight bearing and had minimal pain at that point. Imaging showed that the

fusions were successful and apparently healing well. The SI joint fusion on the right "appeared to be successful. This operation is primarily for pain control and his pain complaints were reduced." McCowin Dep., 27:25-28:15.

238. Dr. McCowin disagreed with Dr. Doerr's opinion that the SI joint "is an extremely stable joint." He also disagreed that the only indications for an SI joint fusion surgery were either trauma or congenital problems. "That's a completely different animal than *an elective SI joint fusion*." *Id*. at 31:6-12 (emphasis added).

239. Dr. McCowin also critiqued Dr. Doerr for not having examined Claimant and "he doesn't appear to have any basis as an expert in SI joint fusion based on his testimony compared to review of current literature." *Id*. at 34:21-25.

240. Dr. McCowin offered the following assessment of the causal connection between Claimant's SI joint condition and the industrial injury, as follows:

> Q. One of the things that I'd like to know is whether you can causally relate the need for the SI joint fusions to the either the fusion performed by Dr. Blair previous to your surgery or the original – and/or the original injury on December 23, 2011?
> A. Because I was not able to examine the patient or get a history prior to the original surgical intervention, I can only give an opinion based on his history. And his history, to me, was that his symptoms started at the time of the injury[8] and it persisted through the fusion.

Id. at 35:12-22.

241. On cross examination, however, Dr. McCowin admitted that he had not stated any opinions about SI joint dysfunction causation in his medical records, as follows:

> Q. And would you agree that in your medical records you haven't stated any opinions regarding the cause of the SI joint dysfunction?
> A. I could not see any reference to causation in my records.

[8] In fact, there is no basis in the medical record from which to conclude that Claimant experienced any SI joint symptoms in the period following the industrial injury. The earliest that these symptoms appear in the record are following the implantation of the SCS.

McCowin Dep., 43:24-44:3.

242. *Bart McDonald, MPT*. Claimant took the deposition of Mr. McDonald on November 13, 2018. McDonald Dep., 2:1-5. He is a physical therapist. *Id*. at 5:25. At all relevant times, he owned and operated an outpatient physical therapy practice under the trade name Superior Physical Therapy (formerly Aspen Physical Therapy) in Idaho Falls and Pocatello for individuals with work-related injuries as well as general orthopedics. *Id*. at 6:1-12; 8:14-9:2. He is licensed as a physical therapist in Idaho. *Id*. at 10:15-16.

243. Mr. McDonald received a bachelor of science from Brigham Young University in 1995 and a master's degree in physical therapy from Emory University in Atlanta in 2000. He holds several different specialty certifications in physical therapy, including one with WorkWell, a company that has a specialty program for functional capacity examinations (FCEs). He also performs electromyography in nerve conduction for which he received a certification from Hands-On Diagnostic. *Id*. at 6:23-7:13.

244. Having performed FCEs since 2000, Mr. McDonald performs approximately one to two FCEs per month. The therapists in his practice also perform FCEs. *Id*. at 7:14-23.

245. WorkWell specializes in training physical therapists to perform FCEs and to be able to interpret the data, write the reports, and perform other tasks associated with FCEs in a standardized format. *Id*. at 9:3-11.

246. Mr. McDonald has previously testified as an expert witness in other cases, which were one or two during the past five years. He has previously testified in post-hearing depositions for the Industrial Commission. *Id*. at 53:23-54:9.

247. Mr. McDonald defines the purpose of an FCE as follows:

> So the goal of the FCE is to determine the function of the individual through objective measures and be able to then, if desired by either the employer or the individual or the physician ordering the test, make job-related recommendations as to whether the critical demands from the individual's job match their performance as being able to – as demonstrating during the functional capacity examination.

McDonald Dep., 10:25-26:8.

248. McDonald conducted an FCE for Claimant. *Id*. at 10:20-22. He completed the two-day FEC on June 13, 2017, and the report is contained in the record as Exhibit 52. *Id*. at 14:20-24.[9]

249. Mr. McDonald performed a physical examination of Claimant to begin the FCE. *Id*. at 17:24-18:1. After the physical examination, he moved on to the real testing of the FCE. *Id*. at 22:17-19.

250. Based upon his training, experience, and education, Mr. McDonald assessed that Claimant gave his best effort and performed consistently during the FCE. *Id*. at 41:13-22.

251. Upon the completion of the FCE, Mr. McDonald provided his FCE report to Dr. Blair, who requested it. Dr. Blair used the information obtained in the FCE to formulate permanent physical restrictions for Claimant. *Id*. at 46:23-47:10.

252. Based upon the FCE, Mr. McDonald did not believe that Claimant could push, pull, lift, or carry greater than 70 pounds. *Id*. at 47:14-17. Furthermore, he did not believe that Claimant could safely lift, push, or pull repetitively greater than 50 pounds. *Id*. at 47:18-20.

253. Claimant was able to do the elevated work with some limitation in the FCE. He was able to perform the standing work with no limitation. Furthermore, although he had some

[9] A prior FCE conducted by Steve Klitgaard of McDonald's practice on April 10 and 11, 2017 was invalid due to Claimant's lack of giving "full maximum effort," which is why the FCE was repeated with Mr. McDonald. McDonald Dep., 14:6-9; 15:4-14.

limitation on the walking test, he was able to perform the stairs and sitting tests without limitation. McDonald Dep., 51:20-52:11.

254. In preparing his FCE, Mr. McDonald did not receive a job description for Claimant's time-of-injury employment. *Id*. at 59:7-11.

255. In preparing his FCE report, Mr. McDonald did not rely upon Mr. Klitgaard's report. *Id*. at 62:6-10.

256. *Nancy E. Greenwald, M.D.* Defendants Employer and Surety took Dr. Greenwald's deposition on November 16, 2018. Greenwald Dep., 2:1-4.

257. Dr. Greenwald is a board certified physician with specialties in physical medicine rehabilitation (physiatry) and brain injury medicine. *Id*. at 5:21-6:5. At all relevant times since 1997, she practiced medicine in Boise at her clinic, Idaho Physical Medicine & Rehabilitation. *Id*. at 6:6-11.

258. After having received a dual program medical degree from Dartmouth College and Brown University, Dr. Greenwald served an internship at Rogers William Hospital in Providence, Rhode Island. She then completed her residency at the University of Michigan Physical Medicine & Rehabilitation Program. Greenwald Dep., 7:2-13. She also served a brain injury fellowship. *Id*. at 8:2-5.

259. Counsel for Defendants Employer and Surety retained Dr. Greenwald to perform a records review and answer a set of specific questions related to possible past impairments. Her series of reports (dated July 31, 2017; June 11, 2018; and June 28, 2018) are contained in the record as Exhibit 77. She did not meet with Claimant but rather strictly performed a records review. She reviewed both pre-accident and post-accident medical records as part of her review. *Id*. at 8:9-9:19; 10:3-5.

260. Dr. Greenwald explained the reason for why it was not necessary for her to meet with Claimant to perform her review in pertinent part as follows: "From the records that I was given, as well Mr. Bauman's questions, it appears they wanted me to focus more on his [Claimant's] pre-existing conditions and how they might affect him as far as impairments. So for that reason it is pre-existing to his injury records. So it was felt it wasn't necessary to examine him." Greenwald Dep., 10:8-13. Defendants Employer and Surety asked Dr. Greenwald to opine regarding some pre-existing conditions that Claimant had and whether they constituted impairments. *Id*. at 10:18-22.

261. Based upon her education, experience and training, as well as the records that she reviewed, Dr. Greenwald opined that Claimant has conditions unrelated to his December 2011 work injury that resulted in impairments. *Id*. at 10:23-11:2. She used the 6th Edition of the *Guides* to reach her conclusions. *Id*. at 11:9-10.

262. First, Dr. Greenwald found that Claimant had a heart murmur that did not appear to impact him functionally, therefore she provided no ratable impairment for it. This condition was not discussed in the medical records much past 2004. *Id*. at 11:8-13. Tobacco use and pulmonary issues, including a pulmonary embolism, were also of note in Claimant's records, however Dr. Greenwald did not assign those conditions any permanent impairment. Similarly, she did not assign any permanent impairment to the cellulitis Claimant had in his leg in 2006, which was an isolated incident and did not affect him permanently. Additionally, he had a foreign body in left eye with a small corneal abrasion but no permanent loss of sight, thus no permanent impairment. *Id*. at 11:13-12:2.

263. In reviewing Claimant's mental health conditions, Dr. Greenwald found that they included conditions that constituted collectively a permanent impairment. Claimant had the pre-

injury diagnoses of bipolar disorder and depression with anxiety. "This actually was well documented. There were multiple notes. So at that point I felt that this seemed to be a… chronic diagnosis." She noted that Claimant had an arrest in 2007 and a suicide attempt in 2008 related to his mental health issues. Thus, she placed Claimant in a "moderate symptoms class," which "defaults to 10 percent of whole person impairment." Greenwald Dep., 12:3-11.

264. Claimant's diagnosis of fetal alcohol syndrome, together with his own history of alcohol abuse with intoxication and addiction issues, including a drug overdose, left Claimant with exposure to a "significant anoxic[10] brain injury." Dr. Greenwald placed this condition in a class two, which is a moderate amount of abnormalities with memory loss condition. She listed that as a 12 percent WPI. *Id*. at 12:12-23.

265. At the time of the July 13, 2017 report, Dr. Greenwald did not assign any impairment to Claimant's sinusitis condition because she felt she needed more information on it. *Id*. at 12:24-13:4.

266. Dr. Greenwald was able to review additional medical records for her June 11, 2018 addendum report. These records showed that Claimant's sinusitis merited rating for a permanent impairment as a class two, which defaults to a 19 percent WPI. Greenwald Dep., 13:10-16.

267. Dr. Greenwald also assigned a 1% WPI for patella femoral arthritis (knee arthritis). *Id*. at 13:18-22.

268. Adding up the pre-existing impairments that Dr. Greenwald found in her reports – 19% WPI (sinusitis) + 12% WPI (anoxia/brain injury from fetal alcohol syndrome, alcoholism and related conditions) + 10% WPI (mental health conditions) + 1% WPI (patella femoral

[10] Anoxic means a "lack of oxygen." Greenwald Dep., 26:7.

arthritis) – and applying the combined values chart from the *Guides*, she found that Claimant had a total 37% WPI attributable to pre-existing conditions. Greenwald Dep., 13:16-14:2.

269. Dr. Greenwald assigned permanent work restrictions based upon Claimant's pre-existing impairments that affected his ability to work. Claimant would need to work in an environment that avoids multi-tasking, allow for repetitive tasks for better learning, and a quiet work environment or ear protection would be beneficial. Claimant should avoid stressful activities and avoid high risk activities, for example working around heavy equipment or dangerous sharp mechanical equipment. *Id*. at 17:13-24.

270. When asked her opinion on Claimant's lumbar fusion surgery, Dr. Greenwald explained in pertinent part as follows: "I'm a rehab physician. So we are all about mobility. And there is a time and place for fusions. I think in America we tend to overfuse people. So I actually disagree [with Claimant's fusion]. I was not a fan of him going into that particular fusion." *Id*. at 24:7-11.

271. **Claimant's Condition at Time of Hearing.** At the time of hearing, Claimant was still seeing Dr. Ryan Hope for pain management. Dr. Hope helped Claimant with adjustment of his SCS and prescribed pain medication for him, including narcotic pain medication. Claimant does not believe he could do without pain medication, stating as follows: "No. Not without my pain management program I'm on. It enables me to do what I do on a daily basis." At times his pain medication makes him feel tired or groggy. In general, after a full day, Claimant feels exhausted. No medical provider has told him that they felt he has ever abused prescription medication. He follows all physician directions as to the use of medications. Occasionally, he has been able to reduce his use of pain medication, but then his "pain just goes up and down," so his prescriber authorizes a higher dosage. Tr., 114:24-116:8.

272. On average weekly, Claimant has lower back and leg pain that is severe enough that he cannot get out of bed. Tr., 116:20-117:4.

273. Claimant's pain level often affects his ability to sleep. Claimant states in pertinent part as follows: "I have chronic pain, so I always feel pain. I have to use my spinal cord stimulator to help aid the pain to go to sleep. I wake up in pain. Sometimes I have to go to sleep in pain, and I wake up wondering, how did I go to sleep? I'm in pain." *Id*. at 117:5-13.

274. Claimant suffers headaches on a weekly basis that he attributes to his lumbar spine condition. *Id*. at 117:14-24. More infrequently, the headaches will get so bad that he has to lay on the couch and "it hurt to see." On a few occasions he has gone to the emergency room to "get shots." *Id*. at 118:2-12.

275. During the day, Claimant often experiences back pain that makes him adjust activities or stop what he is doing. "I have to constantly shift the way I'm sitting. Stand too long, sit too long… If I stand too long or sit too long. I have to move just right, or it can aggravate the daily pain that I deal with on a daily basis." He can sit for fifteen to twenty minutes comfortably before his pain becomes a problem for him and then he either needs to shift around or stand up to get comfortable. *Id*. at 118:21-22: 119:14-16; 120:16-25.

276. On a more infrequent basis, perhaps monthly, Claimant will cancel his plans for the day due to the severity of pain. "At least once or twice a month I'll have to miss out on an activity that my family's doing. Or if they have to go somewhere, I just can't do it." *Id*. at 119:8-11.

277. Claimant can ride comfortably in a car on short trips through town; "grocery store is the max." *Id*. at 120:1-4.

278. Claimant has frequency or urgency to go issues with his bladder that he attributes to his back condition. Tr., 120:9-15.

279. Claimant requires a significant amount of help from his children to accomplish tasks of daily living around his household. “They’ve all had to basically do everything.” For example, in doing laundry, Claimant can put clothes in and out of the washer and dryer; his children bring it up and down stairs because that’s what bothers his back. *Id*. at 122:14-25. The children also mow the lawn and shovel snow, and undertake repairs with directions from Claimant. *Id*. 123:4-13.

280. Claimant no longer enjoys, is capable of, or is able to participate to a full extent in previous pastimes like hunting and fishing. “Hunting. I can’t do it. I used to run up and down the mountains all day long.” He can still shoot a deer if it is close to the camp but he cannot participate in any of the activities like dressing the deer or transporting it. As for fishing, Claimant confines that activity to a nearby pond to which he can drive. *Id*. at 123:14-124:13.

281. Above the location where Claimant had his lumbar spine fused at L5,S1, he experiences a constant, dull ache that escalates if he aggravates it, for example by trying to do too much. This same pain has never really gone away until after the industrial accident. He did not have such pain prior to December 23, 2011. *Id*. at 125:1-17.

282. The following extended exchange in cross examination addresses Claimant’s condition immediately after the injury and at hearing:

> Q. And do you agree that your back condition is really no better today than it was after your accident?
> A. With all the surgeries that I had that have helped tremendously on a lot of things I am able to do, I can do for my family. It’s just a thing I’ll have the rest of my life. I don’t know whether I’m answering your question.
> Q. Do you feel like your back condition is any better today than it was after your accident?

A. Yes, I'm walking. I am thankful for my doctors and the medicine and pain management I'm on. I am able to function with it.
Q. Are you still taking the same amount of pain medications that you were after the accident?
A. Yes.
Q. That's the morphine, Lyrica and the ---
A. Flexeril. I think that's what they call it.
Q. And you take those three times every day?
A. Yes.

Tr., 141:3-21.

283. Claimant has not worked since February 2012, nor has he applied for any jobs since then. *Id*. at 144:1-7.

284. Claimant is capable of driving short distances. *Id*. 145:8-11. He has a smart phone he is able to use. *Id*. at 145:12-16. He is capable of working on a computer to perform simple tasks, including searching the internet and using Facebook. His children assisted him with Facebook. *Id*. at 145:17-22.

285. Claimant does not feel capable of working at a call center because of the "multitasking." He feels that the anxiety of working in such an atmosphere would be too much. "In my opinion, I barely function as a parent, like I'm there – it would take me, like, two days to do the dishes." *Id*. at 145:23-146:8.

286. Claimant agrees that his problems of anxiety and working around larger groups of people predated his industrial accident. *Id*. at 146:14-18.

287. Claimant also does not feel capable of working in a retail job because of his "mobility… reliability, pain complaints." *Id*. at 146:19-25.

288. Claimant states that his limitations have always been the same since the 2011 accident. "Yeah. *They've always been the same*, and some days are worse than others." *Id*. at 148:6-9 (emphasis added).

289. Claimant does not feel that he could work any eight-hour per day job while on his pain medications. Tr.,158:17-20.

290. Other activities of daily living that Claimant is still capable of performing include the following: wiping counters, helping with the dishes, occasionally folding laundry, and light cooking (noodles, macaroni and cheese, etc.). He cannot vacuum, mop, or sweep, which are chores his children perform. Similarly, his children perform lawn mowing and snow shoveling for him. *Id*. at 159:3-160:15.

291. Rhonda Cornwall observed that due to Claimant's injuries sustained in the industrial accident, the family has "to rely on other people a lot to help, and I am not able to get as much help around the home, or with my kids sometimes." *Id*. at 183:25-184:2. Claimant could not help Ms. Cornwall with changing the oil in her car or brakes anymore, he could help very little with housework, and he could not do as many activities with the children like taking them places. Without Claimant's ability to help fully, they had "to call my mom or neighbors to help out… because he can't function some days. It's really hard." *Id*. at 184:8-19.

292. Ms. Cornwall observed that Claimant struggled with pain on a daily basis, as follows:

> The looks on his face. He often will shake, just sitting there, because of the pain. Trying to do certain things, he'll stop, because – I'm not sure what happened, he'll kind of jerk and not be able to move for a second, through pain. He'll tell me sometimes that he hurts, not able to get up in the morning.

Id. at 185:18-23.

293. Claimant appeared to be physically uncomfortable at multiple times during the hearing; he either stood or sat down, or changed positions while sitting. He did not necessarily do so every 15 to 20 minutes as he indicated he was advised by doctors' restrictions to do so.

294. **Claimant's Credibility.** Claimant and Rhonda Cornwall testified credibly during the hearing. Claimant's recollection of dates (such as dates of treatment or Social Security applications) was at times unreliable; wherever those recollections conflict with the written record, the written record is relied upon for a more accurate historical account.

295. Claimant's testimony that he was capable of working at the time of his first Social Security application conflicted with the representations he made on the application. Nevertheless, from the full context of his testimony it does not appear that Claimant had an appreciable understanding that he was making a material misrepresentation on the application; rather, he was merely applying because his sister insisted that he do so.

DISCUSSION AND FURTHER FINDINGS

296. 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 that it serves leave no room for narrow, technical construction. *Ogden v. Thompson*, 128 Idaho 87, 88, 910 P.2d 759, 760 (1996). 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).

297. **Compensability; Causation; Medical Benefits.** Claimant bears the burden of proving that the condition for which compensation is sought is causally related to an industrial accident. *Callantine v. Blue Ribbon Supply*, 103 Idaho 734, 734, 653 P.2d 455, 455 (1982). There must be medical testimony supporting the claim for compensation to a reasonable degree of medical probability; a claimant is required to establish a probable, not merely a possible, connection between cause and effect to support his contention. *Dean v. Dravo Corporation*, 95 Idaho 958, 560-61, 511 P.2d 1334, 1336-37 (1973).

298. No special formula is necessary when medical opinion evidence plainly and unequivocally conveys a doctor's conviction that the events of an industrial accident and injury are causally related. *Paulson v. Idaho Forest Industries, Inc.*, 99 Idaho 896, 901, 591 P.2d 143, 148 (1979). The Industrial Commission, as the fact finder, is free to determine the weight to be given to the testimony of a medical expert. *Rivas v. K.C. Loggin*g, 134 Idaho 603, 608, 7 P.3d 212, 217 (2000). "When deciding the weight to be given an expert opinion, the Commission can certainly consider whether the expert's reasoning and methodology has been sufficiently disclosed and whether or not the opinion takes into consideration all relevant facts." *Eacret v. Clearwater Forest Industries,* 136 Idaho 733, 737, 40 P.3d 91, 95 (2002).

299. An employer is required to provide reasonable medical care for a reasonable time. Idaho Code § 72-432(1). A reasonable time includes the period of recovery, but may or may not extend to merely palliative care thereafter, depending upon the totality of facts and circumstances. *Harris v. Independent School District No. 1*, 154 Idaho 917, 929, 303 P.3d 604, 615 (2013).

300. It is for the physician, not the Commission, to decide whether the treatment is required; the only review the Commission is entitled to make is whether the treatment was reasonable. *Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 722, 779 P.2d 395, 397 (1989). What constitutes reasonable medical care is to be determined by a totality of the circumstances approach. *Chavez v. Stokes*, 158 Idaho 793, 798, 353 P.3d 414, 419 (2015). The reasonableness of a doctor's determination that treatment is indicated should be measured at the time the doctor prescribes treatment, not by 'armchair doctoring' afterwards with the benefit of hindsight. *Id.*

301. Idaho recognizes the "compensable consequences" doctrine, which provides that when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury likewise arises out of the employment, unless it is the result of an independent intervening cause attributable to the claimant's own intentional conduct. Lex K. Larson, Larson Workers' Compensation § 10.01 (Matthew Bender, Rev. Ed.) The Industrial Commission has recognized the compensable consequences doctrine in prior cases. *Castaneda v. Idaho Home Health, Inc.*, 1999 IIC 0538 (July 1999); *Martinez v. Minidoka Memorial Hospital*, 1999 IIC 0262 (February 1999); *Offer v. Clearwater Forest Industries*, 2000 IIC 0956 (October 2000).

302. *Injury Resulting from December 23, 2011 Accident*. There is no dispute that Claimant suffered an identifiable injury from the industrial accident on December 23, 2011. Dr. Blair diagnosed a herniated disc at L5,S1. Ex. 10:368. Dr. Tallerico agreed that Claimant's condition following the incident was related to the industrial accident. Ex. 75:1690-1691. Dr. Doerr opined that Claimant sustained a disc herniation at L5,S1 that was related to the industrial accident. Ex. 76:1716. Thus, there is unanimous and undisputed medical evidence in the record supporting the fact that Claimant sustained an injury to his L5,S1 disc as a result of the industrial accident. None of the parties dispute this.

303. *Discectomy/Laminectomy at L5,S1 and Related Treatment*. Similarly, the medical authorities on both sides of this case agree that the discectomy/laminectomy performed by Dr. Blair, together with related preoperative and postoperative treatments, were reasonable, necessary and causally related to the industrial accident. Dr. Blair opined that this surgery was "the result of the workplace accident." Blair Dep., 44:2-8. The Surety pre-approved the surgery. Dr. Tallerico agreed the surgery was industrially related, reasonable, and necessary. Tallerico

Dep., 18:15-18. Dr. Doerr also agreed that the discectomy/laminectomy at L5,S1 and related care were industrially related and appropriate. Doerr Dep., 13:24-14:4. Thus, there is undisputed medical evidence in the record supporting the compensability of the discectomy/laminectomy, together with the related preoperative and postoperative medical care that Claimant received that was related to it, up until the time that that Dr. Tallerico declared Claimant at MMI.

304. *Fusion at L5,S1 and Related Treatment*. After Claimant underwent the discectomy/laminectomy at L5,S1 and follow-up care, Dr. Blair proposed further surgical intervention in the form of a fusion at the same spine level. This is where the medical authorities and the parties disagree, with Dr. Blair contending that the surgery was industrially related, necessary and reasonable, and Dr. Tallerico and Dr. Doerr opining that the surgery was not industrially-related and unreasonable. For the reasons discussed below, the weight of the evidence supports a finding that L5,S1 fusion surgery and related care was not compensable and that the opinions of Dr. Tallerico and Dr. Doerr should be given more weight on this issue.

305. On June 25, 2012, Dr. Blair ordered a postoperative MRI with contrast following the discectomy/laminectomy at L5,S1 that show postoperative changes but no "evidence of recurrent or new disc herniations." Ex. 10:418-419. This was the first intimation that Claimant's case lacked objective findings for further surgery, nevertheless Dr. Blair advocated for a fusion surgery at L5,S1 based upon "internal disc derangement," failure of conservative therapy, and the persistence of Claimant's subjective pain complaints. Ex. 10:421.

306. On September 19, 2012, Dr. Tallerico found Claimant at a MMI and concluded that "no further treatment and certainly no further surgical intervention is indicated." Ex. 75:1693. Similarly, Dr. Doerr in his records review agreed with Dr. Tallerico that Claimant was not a good candidate for an L5,S1 fusion surgery, noting that the outcome of such a surgery

"would be very unpredictable and highly unlikely to portend a good outcome" and that Dr. Tallerico's opinion prior to the surgery was "quite prophetic." Ex. 18:1716.

307. In defending his decision to take Claimant to a fusion surgery at L5,S1, Dr. Blair made a rather telling admission on April 25, 2013, as follows: "Although surgery of this nature has a *mediocre success rate*, this was discussed in detail with Mr. Cornwall and Mr. Cornwall decided to proceed with surgical intervention despite this." (Emphasis added.) Ex. 10:497. If the treating physician refers to the "mediocre success rate" of the surgical procedure in question, it is difficult to find that the surgery was reasonable. While the physical condition of the disc resulting in a diagnosis of internal disc derangement may have been arguably sufficient to causally connect the condition to industrial accident, nevertheless that fact does not make the subsequent fusion surgery reasonable.

308. Dr. Blair appeared to abdicate responsibility for the surgery, portraying it as an elective procedure that Claimant chose despite having been informed that the chances of a successful outcome were not good. When confronted at his deposition whether the surgery "helped" Claimant, Dr. Blair essentially demurred by not answering the question and suggesting that it was a question that should be answered by Claimant. Blair Dep., 49:15-25. Nevertheless, this dispute is not about whether Claimant reasonably chose elective surgery but whether Dr. Blair acted reasonably in proposing necessary surgery to his patient and then performing it. Under the circumstances admitted by Dr. Blair, it is difficult to find that he even "required" the surgery in question as a necessary step to treating Claimant's lumbar spine condition.

309. Similar to his opinion that a fusion surgery had a mediocre success rate, in Dr. Blair's own interpretation of imaging studies, including a post-laminectomy/discectomy MRI and CAT scan, he found that the imaging showed that Claimant "had a bad disc at L5,S1 but his

nerves were not pinched." Blair Dep., 24:17-25. This result informed Dr. Blair that "there was *no easy surgical solution* to improve his [Claimant's] symptoms" (emphasis added). *Id*., at 25:20-23. Certainly no surgeon is able to guarantee the results of a surgical procedure, nevertheless Dr. Blair's own language in describing Claimant's condition prior to the L5,S1 fusion does not inspire confidence that he himself believed that the surgery was properly indicated.

310. Dr. Tallerico, meanwhile, highlighted the lack of objective findings supporting a fusion surgery in opining that such a surgery would not be reasonable. There was no recurrent disc herniation following the discectomy/laminectomy surgery at L5,S1. Tallerico Dep., 30:5-14.

311. Dr. Tallerico was particularly critical, and rightly so, of Dr. Blair's reliance upon a diagnosis of "severe disc derangement" as a basis to proceed with a fusion surgery, that it was terminology so vague that many insurance companies would not approve treatment if the indication were disc derangement. He noted that this "generic" term is accurate in the sense that Claimant did not have a normal disc because it had been operated upon; automatically it is going to have abnormalities virtually by fact having been the subject of a previous operation. Tallerico Dep., 35:5-19.

312. Moreover, there is evidence of pre-existing conditions and other medical factors in the record, highlighted by both Dr. Tallerico and Dr. Doerr and either ignored or discounted by Dr. Blair, that made Claimant an unsuitable candidate for fusion surgery. In particular, Claimant's extensive psychiatric history and the evidence of his abuse of narcotic prescription medication associated with his overdose suicide attempt, which Dr. Blair admitted he was unaware of until he read about it in Dr. Tallerico's report, Ex. 10:498, together with his fetal alcohol syndrome, alcoholism, young age (twenties), and status as a workers' compensation

claimant, added to the overall unreasonableness of performing lumbar fusion surgery upon Claimant, particularly given the lack of objective findings to support the surgery.[11]

313. As. Dr. Greenwald noted in her deposition testimony, when faced with a patient with such a complex medical history, "it is highly unlikely that there is going to be one particular treatment [such as fusion surgery] that is going to get rid of the pain. It is kind of chasing the dog's tail. Because it is much more complex than just fixing one physical abnormality." Greenwald Dep., 22:1-14.

314. Finally, while hindsight may be twenty/twenty, the final factor weighing against the reasonableness of Claimant's L5,S1 lumbar fusion surgery is that while it was technically successful in that it produced the required fusion of the spinal level operated upon, the results of the surgery were ultimately unsuccessful. It did not improve his overall function and Claimant continued to complain of significant pain symptoms that were unabated from his pre-surgical condition. Nevertheless, Dr. Blair advocated for surgery for which he informed Claimant there was a "mediocre success rate," which turns out to have been the case here.

315. In summary, although Claimant's severe disc derangement may have been causally connected to the industrial injury by virtue of the fact that it was the result of the previous surgery that was causally connected to the accident, based upon all the facts and circumstances detailed above, the lumbar fusion surgery at L5,S1 and related care were not medically reasonable, and thus, not compensable.

316. *Spinal Cord Stimulator*. Following his fusion surgery at L5,S1, Claimant continued to be highly symptomatic with pain symptoms, particularly in his legs. Dr. Blair then

[11] Dr. Blair testified he was not sure whether he received Dr. Tallerico's letter detailing Claimant's psychiatric history prior to performing the fusion. However, Dr. Blair had this information from Claimant's referral from Pocatello Family Medicine, which references his history of "depression, chronic back pain, suicide attempt… fetal alcoholic syndrome, heart mumer [sic] as a child, pt. overdosed on oxycotin, alcohol, and tylenol, anxiety." Ex. 10:352.

referred him to Dr. Zoe for implantation of an SCS. There is no testimony from either Dr. Zoe or Dr. Hope, who implanted the replacement SCS when the one implanted by Dr. Zoe had its contacts fail, that positively relates the SCS to the industrial accident. Nevertheless, Dr. Blair opined that the SCS was a treatment that was reasonable and necessary and causally related to the industrial accident. Ex. 56:1342.

317. Whether both the original and replacement SCSs were compensable is a closer question than the fusion surgery. An SCS may be implanted solely for palliative purposes and not with the intention of restoring physical function, thus it is a medical treatment that may be considered reasonable and necessary past the date of MMI if it is for valid palliative purposes.

318. Claimant has stated his belief that the SCS helped relieve his pain. While his first SCS essentially stopped functioning due failure of a majority of its leads, following implantation of his second SCS, Claimant reported improvement in some pain symptoms, although he still had "pain through his mid-back, lower back and right thigh." Ex. 16:898. Nevertheless, at hearing he admitted that he was taking the same amount of narcotic pain medication that he was taking after the industrial accident. Tr., 141:3-21. Furthermore, on a functional basis, Claimant admitted that he was no better off in terms of his limitations at hearing as immediately after the industrial accident, stating as follows: "Yeah. They've always been the same, and some days are worse than others." Tr., 148:6-9. Rhonda Cornwall acknowledged at hearing that Claimant still struggled with significant pain on a daily basis. *Id*. at 185:9-15.

319. Dr. Doerr provided definitive testimony opining against the reasonableness of the SCS and related treatment, observing that the clinical indications for a fusion were very similar to that of a SCS. "It is a clinically-based decision utilizing a patient's history of any factors of poor outcomes. Which would be the same as a fusion." Doerr Dep., 27:11-19. Thus, the same

pre-existing conditions and factors that made Claimant a poor candidate for the lumbar fusion surgery – fetal alcohol syndrome, depression/anxiety, alcoholism (albeit recovered), and opioid overdose suicide attempt – similarly disqualified him for implantation of a SCS.

320. Furthermore, by the time that SCS implantation was performed, it should have been apparent that Claimant was opioid dependent. As Dr. Greenwald observed, it was unlikely that a patient with such a complex medical history would obtain significant pain relief, let alone restoration of physical function, from any particular treatment course, Greenwald Dep., 21:17-22, which would include an SCS to the same extent as the lumbar fusion surgery.

321. In summary, Dr. Doerr's opinion on the appropriateness of the SCS treatment is more credible than the testimony of Dr. Blair on this issue. The SCS implantation and related treatment was not reasonable and thus not compensable.

322. *SI Joint Fusions*. The treatment Claimant received related to fusion of his SI joints is not as close a call. First, there is no competent medical evidence in the record that causally relates these procedures and related treatments to the industrial accident. As. Dr. Tallerico noted, there were no medical records in which the industrial accident was mentioned as having impacted the SI joints. Tallerico Dep., 74:18-75:6.

323. Dr. Blair provided a rationale for causation with the SI joints by asserting that the fusions were necessary because performing the L5,S1 lumbar fusion surgery, which he viewed as necessary and related, shifted stress on the SI joints, the next level below. Blair Dep., 45:7-46:3. Nevertheless, Dr. Blair admitted on cross examination in his deposition that because the necessity for the SI joint fusions was due to the lumbar spine fusion, that "if the fusion is not related to the work injury, the SI joint fusion would also not be related." Blair Dep., 61:13-23.

324. Meanwhile, Dr. Doerr opined that the SI joint fusions were not related to the work injury and also pointed out that to the extent that it is found that the L5,S1 level fusion was not indicated, then the SI joint fusions would similarly not be indicated. Doerr Dep., 29:11-18; 22-24.

325. In summary, the opinions of Dr. Tallerico and Dr. Doerr are more credible than the opinion of Dr. Blair on the compensability of the SI joint fusions. Those procedures and the related health care are not causally related to the industrial accident and were not reasonably indicated medical procedures. Thus, this medical care is not compensable.

326. *Pain Management*. Claimant has treated his pain with narcotic and non-narcotic medications almost continually since his industrial injury. *Rish v. The Home Depot*, 161 Idaho 702, 390 P.3d 428 (2017), is the seminal case regarding the reasonableness of palliative care, including narcotic pain management. In *Rish*, the Claimant treated her pain with narcotics for years after her industrial injury, but she did not regain any function and the narcotics only temporarily reduced her pain. The Court vacated the Commission's finding that her pain management treatment was unreasonable. The Court observed that related palliative care can be reasonable even if it does not restore function, is ineffective, or "results in addiction or dependency, which, in turn, requires additional treatment." *Id*. at 161 Idaho, 702, 706, 390 P.3d, 428, 432.

327. Claimant's pain was caused by the industrial accident. No expert testified, and no medical records reveal, that Claimant was malingering, abusing his medications, displaying opiod seeking behaviors, or that his pain is attributable to a cause other than his industrial accident. By all accounts, Claimant's pain is genuine and debilitating; it started on the date of the accident and continued until the date of hearing. Claimant takes his medications as prescribed,

testified that they help him on a daily basis, that he would be more limited without them, and his medications, even his narcotics, were reasonably[12] prescribed at the time he began them.

328. However, the deposed experts opined that Claimant is now opiod dependent and that the standard of care regarding opioids is different in 2019 than it was even in 2011 and 2012. The weight of the medical opinion evidence is that such long-term, indiscriminate treatment of pain with narcotic medications is counterproductive and contraindicated, as especially the opinions of Dr. Tallerico and Dr. Doerr disclose.[13] Further, although not dispositive, Claimant testified he is in the same amount of pain now as he was after the accident and is functionally limited in the same ways now as he was after the accident.

329. Claimant's opiod dependency is a compensable consequence of Claimant's injury. Claimant's continued use of narcotics is unreasonable, but Claimant's need for non-narcotic palliative care and treatment for opiod dependency is reasonable and related to the accident.

330. *Summary – Compensability of Medical Care*. This decision has found that all medical treatments that followed the discectomy/laminectomy surgery and its reasonable recovery period were not causally related to the industrial accident and/or not medically reasonable. Therefore, Claimant's request for reimbursement of medical expenses related to

[12] Per *Chavez, supra*, whether or not treatment is reasonable depends on what the physician knows at the time the physician administers treatment, not with the benefit of hindsight. Both Drs. Tallerico and Doerr testified that the standard of care regarding narcotics, specifically opioids, has changed since the mid-2010s. Dr. Doerr testified: "[I]n 2011 through 2014 physician prescribing of opioids was very liberal. No pharmacy in this state would fill that number of narcotic prescriptions in 2018…If somebody is still taking narcotics at six weeks postop we put them on a taper. I never prescribe narcotics, except on very, very rare occasions, 12 weeks postop. Never…*That is the standard of care now.*" Doerr Dep., 37:17-20; 38:10-13; 38:16. (emphasis supplied).

[13] At least one member of the Court in *Rish, supra*, agreed. W. Jones cautioned in his concurrence:

> I write in order to emphasize that this Court has vacated, and not reversed, the Commission's conclusion that the continued prescription of opioids to Rish was unreasonable. Opioids are highly addictive and can cause significant harm to a patient over time. While palliative care can, and often does, reasonably include the temporary prescription of opioids for pain relief, an indefinite prescription of opioids may cause more harm than good. It is proper for the Commission to consider whether a claimant was suffering from opioid addiction at the time opioids were prescribed in determining whether said prescription was reasonable.

these treatments must be denied. However, Claimant's opiod dependency is a compensable consequence of his industrial injury; Claimant is entitled to treatment for this condition and to any reasonable palliative care to treat his pain.

331. **Temporary Disability Benefits**. Disability, for purposes of determining total or partial temporary disability income benefits, means a decrease in wage-earning capacity due to injury or occupational disease, as such capacity is affected by the medical factor of physical impairment, and by pertinent nonmedical factors as provided for in Idaho Code § 72-430. Idaho Code § 72-102(11). Temporary partial and total disability entitlement is evaluated according to statute. Idaho Code § 72-408. It is payable throughout the period of recovery to the date of MMI. *Jarvis v. Rexburg Nursing Center*, 136 Idaho 579, 38 P.3d 617 (2001).

332. This decision has found above that none of the medical treatments that Claimant elected to receive outside of the workers' compensation system following the compensable discectomy/laminectomy surgery at L5,S1 were industrially related or reasonable, thus not compensable. It is reasonable to find that Claimant was medically stable as of the date that Dr. Tallerico found him to be so, September 19, 2012.

333. Surety has already paid all temporary disability benefits to the date of medical stability as found by Dr. Tallerico. Claimant is entitled to no further temporary disability benefits.

334. **Permanent Partial Impairment (PPI)**. "Permanent impairment" is any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved and which abnormality or loss, medically, is considered stable or non-progressive at the time of evaluation. Idaho Code § 72-422. "Evaluation (rating) of permanent impairment" is a medical appraisal of the nature and extent of the injury or disease as it affects an injured employee's

personal efficiency in the activities of daily living, such as self-care, communication, normal living postures, ambulation, traveling, and non-specialized activities of bodily members. Idaho Code § 72-424. When determining impairment, the opinions of physicians are advisory only. The Commission is the ultimate evaluator of impairment. *Waters v. All Phase Construction*, 156 Idaho 259, 262, 322 P.3d 992, 995 (2014).

335. There are two competing impairment ratings in the record, the 13% WPI found by Dr. Blair, Claimant's treating physician, and the 9% WPI found by Dr. Tallerico, the Defendant Employer and Surety's IME physician. Both impairment ratings are within a reasonable range of appraisal of the nature and extent of Claimant's permanent injury sustained as result of the industrial accident.

336. For the reasons explained below, the permanent work restrictions assigned by Dr. Blair are entitled to greater weight in this decision. Accordingly, Dr. Blair's 13% WPI is similarly entitled to greater weight. Furthermore, Dr. Blair's 13% WPI is more nuanced, applying modifiers in the *Guides* that Dr. Tallerico did not consider in applying the median 9% WPI.

337. Claimant is entitled to a 13% WPI, as found by Dr. Blair.

338. **Apportionment under Idaho Code § 72-406**. If the permanent disability is less than total, it may be apportioned by any pre-existing conditions that led to the disability, as provided by Idaho Code § 72-406. Nevertheless, as discussed below, Claimant is totally and permanently disabled, thus apportionment does not apply.

339. **Disability.** "Permanent disability" or "under a permanent disability" results when the actual or presumed ability to engage in gainful activity is reduced or absent because of permanent impairment and no fundamental or marked change in the future can be reasonably

expected. Idaho Code § 72-423. "Evaluation (rating) of permanent disability" is an appraisal of the injured employee's present and probable future ability to engage in gainful activity as it is affected by the medical factor of permanent impairment and by pertinent nonmedical factors provided in Idaho Code § 72-430. Idaho Code § 72-425.

340. The test for determining whether Claimant has suffered a permanent disability greater than permanent impairment is "whether the physical impairment, taken in conjunction with nonmedical factors, has reduced Claimant's capacity for gainful employment." *Graybill v. Swift & Company*, 115 Idaho 293, 294, 766 P.2d 763, 764 (1988). In sum, the focus of a determination of permanent disability is on Claimant's ability to engage in gainful activity. *Sund v. Gambrel*, 127 Idaho 3, 7, 896 P.2d 329, 333 (1995).

341. Permanent disability is a question of fact, in which the Commission considers all relevant medical and nonmedical factors and evaluates the advisory opinions of vocational experts. *See, Eacret v. Clearwater Forest Industries*, 136 Idaho 733, 40 P.3d 91 (2002); *Boley v. State of Idaho, Industrial Special Indemnity Fund*, 130 Idaho 278, 939 P.2d 854 (1997). The burden of establishing permanent disability is upon Claimant. *Seese v. Ideal of Idaho, Inc*., 110 Idaho 32, 714 P.2d 1 (1986).

342. Total permanent disability may be established using either the 100% method or the *Odd-Lot* Doctrine. Under the 100% method, Claimant must prove his medical impairment and non-medical factors combine to equal a 100% disability. Under the *Odd-Lot* Doctrine, Claimant must show he was so injured that he can perform no services other than those which are so limited in quality, dependability, or quantity that a reasonably stable market for them does not exist, absent business boom, the sympathy of the employer, temporary good luck, or a

superhuman effort on Claimant's part. *See, e.g. Carey v. Clearwater County Road Dept.*, 107 Idaho 109, 112, 686 P.2d 54, 57 (1984).

343. Claimant has the burden of proving *Odd-Lot* status. *Dumaw v. J. L. Norton Logging*, 118 Idaho 150, 153, 795 P.2d 312, 315 (1990). He may establish total permanent disability under the *Odd-Lot* Doctrine in any one of three ways: (1) by showing that he has attempted other types of employment without success; (2) by showing that he or vocational counselors or employment agencies on his behalf have searched for other work and other work is not available; or (3) by showing that any efforts to find suitable work would be futile. *Lethrud v. Industrial Special Indemnity Fund*, 126 Idaho 560, 563, 887 P.2d 1067, 1070 (1995).

344. *Weighing the Vocational Evidence*. At the time of hearing, Claimant had not worked in any capacity for approximately six years, since February 2012. Tr., 144:1-7. This contrasts starkly with his working career, in which he began working upon graduation from high school in 2003 and worked continuously until February 2012.

345. Claimant was also the recipient of SSD benefits pursuant to an award dated September 27, 2013, two years after his industrial injury. Ex. 6:129. While SSD determinations are in no way binding upon the Commission in workers' compensation cases, Dr. Collins correctly observed that the SSA award was significant as follows: "The thing that was real significant in his getting Social Security Disability, it is very age-related. You have to be really significantly disabled to get Social Security Disability in your 20s." Collins Dep., 31:4-12.

346. The record as a whole demonstrates, therefore, that the industrial accident in December 2011 seriously undermined Claimant's ability to carry on any gainful occupation, because his ability to work suffered significantly following the accident, he has been unable to

return to work since, and the SSA, applying its strict standards, has acknowledged his inability to work.

347. This finding is strengthened by the permanent work restrictions that Dr. Blair assigned to Claimant as a result of the industrial accident. While Dr. Tallerico, Dr. Doerr, and the FCE assessed less-severe restrictions than those of Dr. Blair, it is reasonable to find that Dr. Blair's permanent work restrictions are entitled to the most weight in this decision. Although this decision has not accepted Dr. Blair's opinions on the compensability of Claimant's post-discectomy/laminectomy medical treatments, nevertheless his judgment on permanent work restrictions is credible and supported by the record. As Claimant's treating physician from 2012 through 2018, Dr. Blair was in a good position to assess Claimant's physical abilities by following him throughout this time period. In contrast, Dr. Tallerico examined Claimant on only one occasion and Dr. Doerr never examined Claimant but rather performed only records reviews.

348. Dr. Blair's restrictions included lifting no more than 10 pounds frequently, 20 pounds occasionally, and 30 pounds rarely, with minimal crouching, kneeling; occasional stair climbing; no ladder climbing; no sitting greater than 15 minutes without changing position; no standing greater than 15 minutes without a change in position; no walking greater than 15 minutes without a change in position; and taking frequent breaks. Blair Dep., 42:16-43:1.

349. As Dr. Collins observed, Dr. Blair's restrictions "were more consistent with the subjective complaints" that Claimant expressed in the years following the industrial accident. Collins Dep., 41:23-24. These restrictions certainly disqualified Claimant from performing the unskilled, medium/heavy work that he had been performing as a custodian for Employer. Furthermore, the restrictions are so severe that Claimant cannot meet the requirements of any unskilled or semi-skilled job, and his work tolerance is so limited that even with a sympathetic

employer, he would not be able to work more than a few hours per day, as Dr. Collins noted. Ex. 60:1375.

350. Claimant has few, if any, transferable work skills. His longest and most significant work experience was in a maintenance/custodian position for Employer and its predecessor. This job matched his cognitive limitations and educational attainment. Including this position, he performed exclusively unskilled or semiskilled labor for his entire working career. It is doubtful that Claimant, with his significant developmental disabilities, could undergo retraining or adapt to performing more skilled occupations, such as telephone work.

351. The evidence demonstrates that Claimant is "not competitively employable," Ex. 64:1383, and is "realistically totally disabled," as Dr. Collins observed. *Id*. Both vocational experts, Mr. Porter and Dr. Collins, estimated that Claimant had a very limited pre-injury access to his job market, 11% per Mr. Collins and 10% per Dr. Collins, due to his pre-existing cognitive limitations. Due to his severe pain and work restrictions Claimant cannot return to his time-of-injury employment or any similar unskilled or semiskilled labor, and due to his cognitive deficits he is restricted from performing any employment at a higher skill level. It is important to note that Claimant struggled in a fairly simple labor position at Dairy Queen, albeit one that required him to follow steps for food preparation and counting change. He also struggled to perform work for the siding company, especially when tasks required measuring.

352. In contrast to the opinion of Dr. Collins, the opinion of Mr. Porter was that Claimant is not totally and permanently disabled, but rather that he sustained a permanent partial disability short of total. Ex. 78.1815. Nevertheless, his opinion was discredited when he admitted during his deposition that Claimant could not now perform any of the previous jobs he had performed, but which his report indicated that he was capable of performing, using the FCE

restrictions. Porter Dep., 49:5-50:8. Furthermore, many if not most of the job positions that Mr. Porter had determined Claimant could perform, such as telephone service agent, cabinet builder, and dishwasher, were ones that he was forced to admit that Claimant could probably not perform. *Id*. at 51:12-52:6. Finally, Mr. Porter admitted that it was an "oversight" on his part to not consider the restrictions stated in the FCE or the restrictions identified by Dr. Greenwald, and that if he did so, his analysis might come closer to finding that Claimant was totally and permanently disabled. He also admitted that if he revised his analysis by more fully considering these factors, it might give the Commission a more accurate answer to whether Claimant is totally and permanently disabled. *Id*. at 62:22-63:9.

353. Given that the analysis of Mr. Porter has some serious flaws that he admitted to during deposition, the analysis of Dr. Collins is entitled to more weight and credibility. Dr. Collins found that Claimant was disabled using the 100% method, because prior to his industrial injury, he had access to a fairly limited labor market of approximately 10%, and the industrial accident essentially "totaled him" by preventing him from performing the medium to heavy jobs that he had previously performed. Collins Dep., 36:23-37:11. Dr. Collins simply could not think of "any job he could do with his background and abilities that would allow him to change positions every 15 minutes, take additional breaks during the day." *Id*. at 37:13-16. Thus, Claimant was totally and permanently disabled. *Id*. at 37:24-38:6. The analysis of Dr. Collins is well-reasoned and entitled to greater weight.

354. Finally, even if Claimant were not permanently and totally disabled according to the 100% method, it is reasonable to find that he would also qualify under the *Odd-Lot* Doctrine under the standard set by *Lethrud*, 126 Idaho at 563, 887 P.2d at 1070. Claimant cannot qualify under the first two prongs of the *Lethrud* test because he did not attempt other types of

employment without success, nor did he or vocational counselors or employment agencies on his behalf search for other work and other work was not available. Nevertheless, under the totality of the circumstances, it is reasonable to find that any efforts to search for suitable work on Claimant's behalf would be futile. The record, considered as a whole, demonstrates that following the industrial accident, Claimant became a profoundly disabled person for whom reasonable employability was foreclosed. Claimant could not return to his time-of-injury employment, and the evidence supports a finding that this was essentially a job provided by a sympathetic employer (a family relation was in management).

355. In summary, whether considered under the 100% method or the *Odd-Lot* Doctrine, Claimant is totally and permanently disabled.

356. **ISIF Liability**. Idaho Code § 72-332(1) provides as follows:

> 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.

357. In *Dumaw v. J.L. Norton Logging*, 118 Idaho 150, 795 P.2d 312 (1990), the Idaho Supreme Court specified the following four-part test for determining liability under Idaho Code § 72-332(1): 1.) Whether there was a pre-existing impairment; 2.) Whether the impairment was manifest; 3.) Whether the impairment was a subjective hindrance to employment; and 4.) Whether the impairment in any way combines in causing total permanent disability. *Id*. at 118 Idaho 155, 795 P.2d at 317. The party asserting ISIF liability (in this case, Employer/Surety)

bears the burden of proving all four elements. *Eckhart v. State Industrial Special Indemnity Fund*, 133 Idaho 260, 263, 985 P.2d 685, 688 (1999). *See also, Andrews v. State Industrial Special Indemnity Fund*, 162 Idaho 156, 158, 395 P.3d 375, 377 (2017).

358. There is undisputed evidence and testimony in the record supporting a finding that Claimant had several pre-existing impairments. Defendant Employer and Surety asked Dr. Greenwald to identify whether there were any impairments that predated the industrial accident, to rate the same, and to provide permanent restrictions, if any, related to those impairments. She did so in a report that is contained in Ex. 77. She also provided deposition testimony concerning these pre-existing impairments. There are also medical records admitted as exhibits that confirm that these medical impairments preexisted the industrial accident.

359. Dr. Greenwald found that Claimant had a 10% WPI attributable to his bipolar syndrome and anxiety with depression; 12% WPI attributable to his fetal alcohol syndrome, alcohol abuse with intoxication, and opiate drug overdoes (January 2008); 19% WPI attributable to sinusitis related to fetal alcohol syndrome; and 1% WPI attributable to Claimant's pre-existing knee arthritis. Using the combined value chart, Dr. Greenwald opined that the combined pre-existing impairments constituted a 37% WPI. Ex. 77:1735-1738.

360. The second element for ISIF liability is that the impairment or impairments must not only have preexisted the industrial injury and accident but also must have been "manifest" prior thereto. To be manifest, the impairment must not only be in existence before the industrial accident and injury occurred, but Claimant and/or others must have been aware of the condition. In *Horton v. Garrett Freightlines, Inc.*, 115 Idaho 912, 772 P.2d 119 (1989), the claimant had pre-existing impairments of his left hip, shoulders and back, however those conditions were not "manifest" because they were asymptomatic conditions of which neither the claimant nor

employer was aware of at the time of the industrial accident. Thus, ISIF was not liable. 115 Idaho at 918, 772 P.2d at 125.

361. Here, unlike the scenario in *Horton, Id*., all of Claimant's pre-existing conditions were manifest at the time of the industrial accident and injury. Claimant made his fetal alcohol syndrome the basis of his 2003 SSD application after he graduated from high school. Similarly, Claimant applied again for SSD in or about 2005 on the basis of his mental health conditions and suicide attempt. Claimant sought treatment for his sinusitis on multiple occasions prior to 2012. Finally, Claimant's knee injury had a history that extended back to a knee injury in high school gym class.

362. The third element for ISIF liability is that the pre-existing impairments must have constituted a subjective hindrance to employment. Here there is sufficient evidence of this element in the record. Claimant's combined mental health conditions made him averse to working around large groups of people. Thus his employment with Dairy Queen was problematic. Claimant was well aware of his intellectual disabilities and was conscious of his difficulties while employed by the siding company in terms of measuring. In both positions, Claimant's aversion to working around larger groups of people contributed to his lack of employment success. Thereafter, Claimant sought employment first through a sheltered workshop, Deseret Industries, and then a sympathetic employer, ARC (where a family relative was a manager). Claimant's SSD applications in 2003 and 2005 are evidence of his subjective knowledge that his impairments constituted hindrances to employment. Finally, the fact that both vocational experts in this case attributed very small time-of-injury job markets for Claimant (10% Collins, 11% Porter), reinforces that Claimant's pre-existing limitations had a significant impact on his employability. There is abundant evidence that Claimant's bipolar syndrome with

anxiety and depression (10% WPI) and head injury/anoxic brain injury (12% WPI) constituted subjective hindrances to Claimant's employability. Nancy Collins speculated that an individual with a "cleft palate," like Claimant, might have difficulty making himself understood on the telephone. Collins Dep., 39-40. The medical evidence does not support a finding that Claimant was born with a cleft palate. Regardless, he has never been given an impairment rating for this condition, if extant. He was given an impairment rating for sinusitis, a different condition. However, there is nothing in the record which implicates a restriction for Claimant's sinusitis and nasal obstruction. There is no persuasive evidence that Claimant's sinusitis and knee arthritis constituted subjective hindrances to Claimant's employability.

363. The fourth and final element required for ISIF liability is that the pre-existing impairments must "combine with" the impairment from the industrial accident and injury to render a person totally and permanently disabled. In *Garcia v. J.R. Simplot Company*, 115 Idaho 966, 772 P.2d 173 (1989), ISIF argued that the claimant was totally and permanently disabled from the work accident impairment alone, and that this impairment did not combine with pre-existing impairments to cause the claimant to become disabled. The Court disagreed, holding that the "but for" test for determining whether the impairments combined demonstrated that the claimant was disabled by a combination of pre-existing impairments and the work-related impairment.

364. The test, therefore, is whether Claimant would not have been disabled "but for" the pre-existing condition or conditions. *Id*. at 115 Idaho 970, 772 P.2d at 177. Said differently, to invoke ISIF lability, Employer/Surety must show that it is only in combination with Claimant's pre-existing impairments that his low back injury causes total and permanent disability. In this regard, we first note that neither Dr. Collins, nor Mr. Porter has suggested that

Claimant's sinusitis or left knee arthritis are important to contributing to Claimant's total and permanent disability. There is, however, expert testimony lending support to the proposition that Claimant's cognitive and psychological impairments combine with the work accident to cause total and permanent disability.

365. As noted, Delyn Porter's opinion was based on his adoption of restrictions derived from the FCE, restrictions which are unpersuasive. In formulating his opinions, Mr. Porter also failed to consider the restrictions given by Dr. Greenwald for Claimant's pre-existing impairments. Porter Dep., 59:11-63:9. At the time of his deposition, he acknowledged that Dr. Greenwald's restrictions would diminish Claimant's labor market access beyond the loss caused by the low back injury. However, he conceded that he did not undertake any specific analysis of the impact of these further restrictions on Claimant's ability to engage in gainful activity. Ultimately, his opinions are not particularly helpful in understanding how Claimant's pre-existing impairments combine with the work accident to cause total and permanent disability.

366. Dr. Collins made it clear that in evaluating Claimant's access to the labor market, she considered Claimant's cognitive and psychological problems, even though they were not couched as impairments warranting restrictions until Dr. Greenwald characterized them as such. Collins Dep., 43:5-44:1. When specifically asked to address whether Dr. Greenwald's restrictions are critical to the determination that Claimant is totally and permanently disabled, Dr. Collins stated:

> Q: [By Mr. Gardner] Now, clearly, Mr. Cornwall has some conditions that limited him from employment prior to his accident; correct?
> A: Correct.
> Q: Do you see any basis for liability against the ISIF, based on his prior limitations?
> A: You know, I think the issue for this gentleman that would not bring in the Special Indemnity Fund is that his restrictions are so significant for his back

injury, that these disable him in and of themselves. I don't see that these's a combination factor.
Q: But, in your own evaluation, you point out that some of the jobs he could not do because they required multitasking; correct?
A: Correct. Yes.
Q: And the multitasking was definitely something that preexisted the work accident?
A: Correct.
Q: So isn't there some way to at least make an argument that that prior condition does combine with his back injury to make him totally and permanently disabled?
A: I think you could make the argument. My only concern is that I think his restrictions from the industrial accident are so severe that even if he had been an average IQ worker, it would have been very difficult for him to return to work with his skill level.

Collins Dep., 68:15-69:15, emphasis supplied. Arguably, by these comments Dr. Collins endorses the proposition that Claimant's orthopedic restrictions alone are of such moment as to cause total and permanent disability. However, the quoted excerpt admits the possibility that limited employment opportunities for Claimant would exist absent Claimant's pre-existing impairments. Further, other portions of Dr. Collins' reports/testimony suggest that consideration of Claimant's pre-existing impairments is necessary to support the conclusion that Claimant is totally and permanently disabled. Referring to Mr. Porter's recommendation that Claimant could work as a telephone service agent. Dr. Collins testified:

Q: [By Mr. Ruchti] So he talks about Dr. Blair's restrictions, but then lists jobs that aren't consistent with that - -
A: Correct. So I kind of went through the jobs that I felt would be appropriate for Mr. Cornwall. Telephone Service Agent, this is a semi-skilled and can be a skilled job. It's fast-paced. You have to have good speech. You have to understand computers. You have to have customer services skills, strong communication skills, professional language and grammar, good computer skills. This gentleman would in no way qualify for this work. It typically requires prolonged standing - - I mean sitting - - sorry. A lot of these facilities now will allow for a sit/stand desk, but again, that takes time. He wouldn't make it a day in this job. It requires considerable multitasking, looking at different screens. So it's just not something that Mr. Cornwall ever would have been able to do without an injury.

Collins Dep., 48:1-18. Claimant's inability to multi-task and work in a fast paced environment represent restrictions referable to his pre-existing cognitive and psychological impairments. Elsewhere, Dr. Collins suggested that if Claimant had a better ability to learn or acquire skills, employment opportunities might exist for him:

> Q: [By Mr. Ruchti] Okay. All right. So applying all these concepts we've just described, Mr. Cornwall's situation, what does your analysis tell you? What are your opinions regarding his disability?
> A: Well, this gentleman had access to a fairly limited labor market even before his accident. He was really only going to be competitive for unskilled physical labor kinds of jobs, which is what he had done. So pre-injury, you know, he may have had access to 10 percent of the labor market. Post-injury - - because he couldn't go back and do physical labor kinds of jobs and his positional restrictions were so significant - - he had no experience, education, skill for doing sedentary work. So all the work that he was qualified for required prolonged standing and walking. That was the most significant issue that I found for him. His pain just didn't allow him to sit, stand, walk long enough to perform any kind of work. Even if he had - - you know, even if he had a better ability to learn, skill acquisition would be something you could look at. His positional restrictions were just so significant, it just "totaled him."
> Q: When you say "totaled him," what do you mean?
> A: I just couldn't think of any job he could do with background and his abilities that would allow him to change positions every 15 minutes, take additional breaks during the day. If he were a really skilled worker, an employer might be willing to provide some accommodations because you're offering them something, but this gentleman really could be replaced by anybody.
> Q: Yes.
> A: So providing these kinds of accommodations was just not reasonable.
> Q: So your opinion is that Mr. Cornwall was totally and permanently disabled?
> A: Yes.

Collins Dep., 36:12-31:1. Finally, she clearly articulated her view that Claimant's pre-existing restrictions do combine with Claimant's orthopedic restrictions to leave him totally disabled:

> Q: [By Mr. Ruchti] In your professional opinion, is Mr. Cornwall able to be employed in the job market?
> A: No.
> Q: And you have explained the basis for that opinion already?
> A: Yes.
> Q: Okay. Anything else that needs to be added?

> A: Well - - and we haven't talked about this a lot. If Mr. Cornwall were to go out and look for work, he would have to have really significant accommodations. He would have to have a sit/stand work to begin with, a job with no multitasking, he would have to have a certain way of presenting new information, a quiet work area, avoidance of heights, some adaptive technology, extra rest periods, adjustment in work hours, and frequent absences. That's just - - you know, those are the kinds of things you look at when you're looking at total disability. You know, is an employer realistically going to hire this person? Can they provide reasonable accommodations? In this case, I just didn't feel like that was reasonable at all.
> Q: Okay. Is Mr. Cornwall totally and permanently disabled?
> A: In my opinion, he is.

Collins Dep., 51:11-52:10.

367. Claimant's pre-existing cognitive and psychological restrictions foreclose to him any of the sedentary jobs for which he might be able to compete in light of his orthopedic restrictions. Because Claimant is so cognitively and psychologically impaired, employers will be unlikely to offer accommodations and training that might allow Claimant to return to the workplace. From the foregoing, even though Claimant's work-caused restrictions are profound, he would not be totally and permanently disabled without the additional restrictions stemming from his pre-existing cognitive and psychological impairments.

368. ***Carey* Formula**. Next, the apportionment of Claimant's total disability between Employer/Surety and ISIF must be addressed. The Idaho Supreme Court in *Carey v. Clearwater County Road Department*, 107 Idaho 109, 686 P.2d 54 (1984) held that "the appropriate solution of the problem of apportioning the non-medical factors in an odd-lot case where [ISIF] is involved, is to prorate the non-medical portion of disability between the employer and [ISIF] in proportion to their respective percentages of responsibility for the physical impairment." *Id*. at 107 Idaho 118, 686 P.2d at 63. *See also, Garcia v. J.R. Simplot Company*, 115 Idaho at 971, 772 P.2d at 178.

369. The first step is to define the respective percentages of the applicable pre-existing impairments and accident produced impairments. As noted above, the pre-existing impairments attributable to Claimant's sinusitis and knee arthritis do not apply, because, although they were manifest prior to the industrial accident, they were neither a subjective hindrance, nor did they combine with the impairment from the industrial accident to render Claimant disabled.

370. Claimant's impairment from his relevant pre-existing conditions equals 22% of the whole person (10% for psychological issues and 12% for brain injury). Claimant's accident-related impairment equals 13% of the whole person. Combined, Claimant's impairments equal 35% of the whole person, leaving 65% disability from non-medical factors to apportion between Employer and the ISIF. Employer's responsibility may be calculated as follows per *Carey*: 13/35 x 65% = 24% + 13% = 37% disability. Under *Carey*, Employer is responsible for the payment of 37% disability at the PPD rate (55% of the average state wage). 37% permanent partial disability equates to 185 weeks commencing September 19, 2012, Claimant's date of medical stability, at $359.43 per week.[14] Employer is credited for the 9% PPI rating previously paid. During the 185 weeks following Claimant's date of medical stability, the ISIF shall make such additional payments to Claimant as may be necessary to compensate Claimant for any difference between the PPD rate and the TTD rate to which he is entitled pursuant to the provisions of Idaho Code § 72-408. Subsequent to 185 weeks following Claimant's date of medical stability, ISIF shall be solely responsible for the payment of total and permanent disability benefits as authorized by Idaho Code § 72-408.

[14] The record does not provide a basis to determine what part of Claimant's low back injury is referable to the 2011 vs. 2012 accidents. PPD is payable for the 2011 accident at $355.30 per week, while it is payable for the 2012 accident at $363.55 per week. Absent some other way to ascertain at which rate PPI/PPD should be paid, we determine it is appropriate to assume that both accidents contributed equally to Claimant's disability. Therefore, PPI/PPD is payable at $359.43 per week. ($355.30 + $363.55 = $718.85/2 = $359.43).

371. **Attorney Fees**. Claimant has requested attorney's fees pursuant to Idaho Code § 72-804, which reads as follows:

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

372. There is insufficient evidence to find that Employer/Surety unreasonably contested Claimant's claim for benefits in this matter. As discussed above, Surety had reasonable grounds to discontinue benefits after Dr. Tallerico found Claimant to be at MMI on September 19, 2012. None of the medical treatments for which Claimant sought reimbursement were reasonable; they were properly disallowed. As for the claim for permanent and total disability, all of the parties' arguments were within the boundaries of reasonableness.

CONCLUSIONS OF LAW

1. None of the medical treatments that Claimant elected to receive outside of the workers' compensation system following the compensable discectomy/laminectomy surgery at L5,S1 were industrially related or reasonable, and thus they were not compensable. However, Claimant's opiod dependency is a compensable consequence of his industrial accident. Defendants are liable for treatment of this condition and palliative care.

2. Claimant has a 13% WPI.

3. Apportionment pursuant to Idaho Code § 72-406 is not appropriate.

4. Claimant is permanently and totally disabled.

5. ISIF is liable for a portion of Claimant's permanent disability pursuant to Idaho Code § 72-332(1), based upon pre-existing impairments that were manifest at the time of the industrial accident and that combined with the industrial injury to render Claimant totally and permanently disabled.

6. Employer/Surety is liable for 37% and ISIF is liable for 63% of Claimant's permanent disability benefits. Apportionment pursuant to *Carey v. Clearwater County Road Department*, 107 Idaho 109, 686 P.2d 54 (1984) is thus appropriate as follows: Employer/Surety are responsible to pay Claimant total and permanent disability benefits at the applicable statutory rate for the 185 week period subsequent to September 19, 2012. Employer is credited for the 9% PPI rating previously paid. ISIF will pay the differential between the PPD rate and the TTD rate to which Claimant is entitled to under Idaho Code § 72-408 during the first 185 weeks. Thereafter, ISIF is wholly responsible for the payment of total and permanent disability benefits at the applicable statutory rate.

7. Claimant is not entitled to attorney fees pursuant to Idaho Code § 72-804.

RECOMMENDATION

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

DATED this _____ day of _____, 2019.

INDUSTRIAL COMMISSION

_/s/_____
John C. Hummel, Referee

ATTEST:

_/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __9th____ day of _September_____, 2019, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

JAMES D RUCHTI
RUCHTI & BECK LAW OFFICES
1950 E CLARK ST STE 200
POCATELLO ID 83201

DAVID P GARDNER
HAWLEY TROXELL
412 W CENTER STE 2000
POCATELLO ID 83204

PAUL J AUGUSTINE
AUGUSTINE LAW OFFICES
PO BOX 1521
BOISE ID 83701

sjw __/s/ _____

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

ANTHONY RAY CORNWALL, Claimant, v. SOUTH IDAHO PROPERTIES, L.L.C., Employer, and STAR INSURANCE COMPANY, Surety, and STATE OF IDAHO, INDUSTRIAL SPECIAL INDEMNITY FUND, Defendants.	**IC 2012-000050** **ORDER** September 9, 2019

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

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

1. None of the medical treatments that Claimant elected to receive outside of the workers' compensation system following the compensable discectomy/laminectomy surgery at L5,S1 were industrially related or reasonable, and thus they were not compensable. However, Claimant's opiod dependency is a compensable consequence of his industrial accident. Defendants are liable for treatment of this condition and palliative care.

2. Claimant has a 13% WPI.

3. Apportionment pursuant to Idaho Code § 72-406 is not appropriate.

4. Claimant is permanently and totally disabled.

5. ISIF is liable for a portion of Claimant's permanent disability pursuant to Idaho Code § 72-332(1), based upon preexisting impairments that were manifest at the time of the industrial accident and that combined with the industrial injury to render Claimant totally and permanently disabled.

6. Employer/Surety is liable for 37% and ISIF is liable for 63% of Claimant's permanent disability benefits. Apportionment pursuant to *Carey v. Clearwater County Road Department*, 107 Idaho 109, 686 P.2d 54 (1984) is thus appropriate as follows: Employer/Surety are responsible to pay Claimant total and permanent disability benefits at the applicable statutory rate for the 185 week period subsequent to September 19, 2012. Employer is credited for the 9% PPI rating previously paid. ISIF will pay the differential between the PPD rate and the TTD rate to which Claimant is entitled to under Idaho Code § 72-408 during the first 185 weeks. Thereafter, ISIF is wholly responsible for the payment of total and permanent disability benefits at the applicable statutory rate.

7. Claimant is not entitled to attorney fees pursuant to Idaho Code § 72-804.

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

DATED this ___9th___ 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 __9th__ day of __September_____, 2019, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

JAMES D RUCHTI
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