BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

MICHELLE STROPE, Claimant, v. KOOTENAI MEDICAL CENTER, INC., Employer, and LIBERTY NORTHWEST INSURANCE CORPORATION, Surety, Defendants.	**IC 2011-003968** **FURTHER ORDER ON MOTION FOR RECONSIDERATION AND/OR REHEARING** Filed January 27, 2017

Hearing on this matter was held on December 1, 2015. The case was decided on evidence adduced at hearing and via post-hearing deposition as anticipated by J.R.P. 10. Referee Taylor submitted proposed Findings of Fact, Conclusions of Law and Order, which were adopted by the Commission by Order dated June 22, 2016. The Commission found, inter alia, that Claimant failed to demonstrate entitlement to further medical treatment related to the subject accident. In connection with the so ruling, the Commission found that Dr. Dirks' records and testimony were insufficient to demonstrate that Claimant's time-of-hearing complaints were causally related to the subject accident versus unrelated conditions/events. Dr. Dirks' opinions were not based on an understanding of Claimant's pre- and post-injury medical history. He conceded that he could not render an opinion on the relationship between Claimant's time-of-hearing complaints and the subject accident without a follow-up MRI evaluation.

Claimant filed a timely motion for reconsideration pursuant to Idaho Code § 72-718.

In support of her motion Claimant argued that the Commission either ignored or misapprehended certain evidence of record in concluding that Claimant had failed to meet her burden of proof. The Commission treated those arguments in its September 9, 2016 Order on Motion for Reconsideration and/or Rehearing, and will not revisit that discussion. However, in further support of her motion for reconsideration, Claimant alerted the Commission to the fact that the recommended lumbar spine MRI was obtained on February 24, 2016. Along with a copy of the radiologist's interpretation of that study, Claimant provided the Commission with certain additional medical records generated by Dr. Dirks, suggesting that Dr. Dirks is of the view that the February 24, 2016 MRI supports the conclusion that Claimant currently has a lumbosacral spine condition that is responsible for her ongoing complaints, that this lumbosacral spine condition is the result of the subject accident, and that this condition requires further medical/surgical treatment. The Commission deemed this new evidence of sufficient importance to warrant reopening the record for the purpose of allowing the parties to adduce such medical evidence as they deemed necessary to fully address the question of what the February 24, 2016 MRI adds to answering the question of whether or not Claimant is entitled to further medical care referable to the subject accident. The parties were specifically cautioned that they should not take the Commission's September 9, 2016 Order as an invitation to ask the Commission to revisit previously considered evidence or argument, much less as an invitation to offer additional evidence which could have been timely adduced at hearing. Following the Commission's September 9, 2016 Order Claimant submitted additional medical evidence and argument on or about December 8, 2016. Defendants submitted additional evidence and argument on the same date.

In support of her motion for reconsideration, Claimant offered exhibits A-B attached to the July 12, 2016 Affidavit of Starr Kelso, as well as certain additional records attached to and referenced in Claimant's December 8, 2016 submission as Exhibits 1 through 17. The Commission admits into evidence Exhibit B to counsel's affidavit, and Exhibits 1, 2, and 10 to counsel's December 8, 2016 filing. As developed in more detail *infra*, the balance of the documents offered by Claimant are not admitted.

As part of its December 8, 2016 filing, Defendants submitted Defendants' Exhibits 1 through 3. Defendants' Exhibit 1 is a November 1, 2016 letter authored by Jeffrey Larson, M.D. Defendants' Exhibit 2 consists of records generated by Brett Dirks, M.D. since the December 1, 2015 hearing. This Exhibit includes the radiologist's interpretation of the MRI of February 24, 2016. Defendants' Exhibit 3 is a copy of Claimant's request for calendaring dated March 26, 2015. The Commission admits Defendants' Exhibits 1-2 into evidence.

In connection with the numerous exhibits offered by Claimant which the Commission has declined to admit, many consist of evidence that could have been adduced at the original hearing, and are therefore inadmissible at this time pursuant to J.R.P. 10. Other of the Exhibits (notably those generated in connection with obtaining Dr. Seely's response) are irrelevant to the one issue before the Commission. While the Commission has admitted Dr. Seely's November 16, 2016 response to Counsel's inquiries that response is not particularly informative, because it does nothing to disclose the foundation for Dr. Seely's opinion that the need for the February 24, 2016 MRI is causally related to the subject accident. The response does not reveal what medical records Dr. Seely reviewed in arriving at this opinion. The evidence of record does not reflect that Dr. Seely possessed or reviewed the records of other providers generated in connection with Claimant's back injury. How he came to the conclusion that the need for the MRI is related to

the original accident is unclear. However, Dr. Seely's original recommendation for the study is found in his chart note of September 28, 2011, and we surmise that since Claimant had recent L5-S1 surgery (June 2011) Dr. Seely concluded that further work-up was reasonably related to that procedure.

Most of the other exhibits are offered to discredit the opinions of Dr. Larson. Claimant has demonstrated to the satisfaction of the Commission that Dr. Larson refused all entreaties to meet with Claimant's counsel, or to make Nurse Practitioner Moore available for interview. Nurse practitioner Moore was eventually allowed to respond to several questions posed by counsel. We also note that Dr. Larson did provide written response to a number of questions posed by Defendants. Claimant's counsel argues that Dr. Larson's refractory attitude towards Claimant's counsel demonstrates bias against Claimant and in favor of Defendants. We find this evidence and these arguments unpersuasive; other equally plausible explanations for Dr. Larson's reluctance to engage counsel could be entertained.

We decline to admit Nurse Practitioner Moore's November 29, 2016 response to counsel's inquiries. The questions posed to Nurse Practitioner Moore were intended to clarify certain aspects of Nurse Practitioner Moore's December 17, 2012 chart note. (*See* Claimants' exhibit H at 177). That note reflects that Claimant presented with complaints of left leg pain and tingling of two months duration, which Claimant associated with some home maintenance activities. The note further reflects that Claimant had L5-S1 surgery on June 6, 2011, and acknowledged prior low back problems. The questions posed to Nurse Practitioner Moore were intended to demonstrate that Nurse Practitioner Moore was aware of records generated in connection with Claimant's first L5-S1 surgery in 2010. This, it is argued, tends to denigrate the Commission's observation that there is no indication Nurse Practitioner Moore was aware of the

2010 surgery. (*See* June 13, 2016 Decision at paragraph 35). It is not clear to the Commission what Nurse Practitioner Moore's responses demonstrate, but they don't undermine her observations that Claimant reported a recent onset of lower extremity pain which she associated with home repair activities, and that the distribution of these symptoms was consistent with a problem at L3. Regardless, Exhibit 17 to Claimant's December 8, 2016 submission is deemed inadmissible because there is no reason these inquiries could not have been made of Moore in time for the original hearing as required by J.R.P. 10.

Dr. Dirks' lengthy letter of December 7, 2016 will be discussed *infra*.

To set the stage for the discussion of the February 24, 2016 MRI, it may be helpful to set forth the findings of the three studies at issue. Claimant underwent her first MRI evaluation of the lumbar spine on March 17, 2010. That study was performed before Claimant's non-work related L5-S1 micro discectomy in June of 2010. The study was read as follows:

> L2-3: Normal
> L3-4: Broad based disc protrusion is present. This is superimposed on mild ligamentum flavum hypertrophy and minimal facet DJD. The anterior thecal sac is deformed with a concave margin. There is encroachment on the origin of both L3 nerve roots. The L3 nerve roots exit patent foramina bilaterally.
> L4-5: Diffuse minimal annular bulging and central annular fissuring are present, but there is no disc protrusion, central canal or foraminal stenosis. L4 nerve roots exit patent foramina bilaterally.
> L5-S1: Broad based disc protrusion is accompanied by more central component with minor caudad migration posterior to the S1 vertebral body. There is no disc extrusion or free fragment. This contacts the thecal sac in the origin of the left L5 nerve root and causes minimal deviation of the left S1 nerve root origin. The L5 nerve roots exit patent foramina bilaterally. The S1 nerve root does not show deviation. No facet arthropathy.
>
> CONCLUSION:
> 1. Small-moderate disc protrusion at L5-S1 with subtle deviation of the left S1 nerve root origin.
> 2. Mild central canal stenosis at L3-4.

Claimant's Exhibit E at 87.

Following the subject accident, Claimant underwent MRI evaluation of the lumbar spine on February 28, 2011. Notably, the radiologist who read that study did not have the opportunity to compare it against the previous study of March 17, 2010. The February 28, 2011 MRI was read as follows:

> L2-3: There is no significant central canal or neural foraminal narrowing at this level.
> L3-4: Broad-based posterior disk protrusion at this level with posterior annular tearing flattens the ventral surface of the thecal sac resulting in moderate central canal and moderate bilateral lateral recess narrowing without significant neural foraminal narrowing.
> L4-5: Broad-based posterior disk protrusion at this level with posterior annular tearing results in mild central canal and mild bilateral lateral recess narrowing. There is also mild bilateral neural foraminal narrowing at this level.
> L5-S1: Prior laminotomy at this level. Circumferential disk bulge at this level persists combine with facet arthrosis resulting in mild left-sided neural foraminal narrowing.
>
> IMPRESSION:
> 1. Postoperative changes at L5-S1 without evidence of recurrent disk herniation at this level.
> 2. Broad-based posterior disk protrusions at L3-4 and L4-5 are present. There is moderate central canal and bilateral lateral recess narrowing at L3-4 as discussed above.
> 3. No severe central canal or neural foraminal stenosis is identified.

Claimant's Exhibit E at 93-94.

Finally, on February 24, 2016, Claimant underwent her third lumbosacral MRI. That study was read as follows:

> L2-L3: Moderate disk desiccation, posterior broad-based this protrusion, effaces the ventral thecal sac producing mild to moderate canal stenosis. Moderate posterior facet degenerative changes with mild to moderate bilateral neural foramina narrowing right greater than left.
> L3-L4: Mild to moderate disk desiccation, posterior broad-based disk osteophyte complex, extends into the bilateral foraminal spaces right greater than left. There is moderate to marked canal stenosis, moderate posterior facet degenerative changes with ligamentum flavum hypertrophy. There is moderate left and right neural foramina narrowing, right greater than left. Potential minimal contact bilateral L3 nerve roots.

L4-L5: Mild to moderate disk desiccation, posterior broad-based disk osteophyte complex, effaces ventral thecal sac, produces moderate canal stenosis. Mild to moderate posterior facet degenerative changes, moderate to marked bilateral neural foramina narrowing, potential contact bilateral L4 nerve roots.
L5-S1: Marked disk desiccation, mild to moderate Modic type I endplate change, no canal stenosis. Mild to moderate posterior facet degenerative changes with moderate to marked left, moderate right neural foramina narrowing. Potential contact left L5 nerve root.
Remaining upper sacral canal is unremarkable.

IMPRESSION:
1. Status post left L5 hemilaminotomy, multilevel lower lumbar spine spondylosis, with multilevel chronic posterior fact hypertrophic degenerative changes, no abnormal lumbar cord signal or suspicious marrow lesion. Pertinent degenerative levels below.
2. L2-L3: Mild to moderate degenerative canal stenosis, mild to moderate degenerative bilateral neural foramina narrowing without apparent nerve root contact.
3. L3-L4: Moderate to marked degenerative canal stenosis, posterior broad-based disk osteophyte complex, moderate degenerative bilateral neural foramina narrowing right greater left, may contribute to a bilateral L3 radiculopathy.
4. L4-L5: Moderate degenerative canal stenosis, moderate to marked degenerative bilateral neural foramina narrowing, may contribute to a bilateral L4 radiculopathy.
5. L5-S1: Moderate to marked degenerative bilateral neural foramina narrowing, left greater than right, may contribute to a left L5 radiculopathy.
6. Milder or no significant degenerative changes at the remaining lumbar spine, lower thoracic levels.

Comment: The following findings are so common in adults without low back pain that while we report their presence, they must be interpreted with caution and in the context of the clinical situation. (Reference Jarvik et al, Spine 2001)
Prevalence of findings in patients without low back pain:
Disk degeneration (any evidence): 92%
Disk desiccation/T2 signal loss: 83%
Disk height loss: 56%
Disk bulge: 64%
Disk protrusion: 32%
Annular tear/high intensity zone: 38%

Defendants' Exhibit 2.

Again, the radiologist who read the February 24, 2016 films did not have the opportunity to compare them against either of the prior studies.

The radiology reports leave the Commission unable to determine whether Claimant requires surgery, and if so, whether the need for low back surgery is referable to the subject accident. It was for this reason we allowed the parties to adduce additional proof on the issue. What has been provided is not especially helpful in assisting the Commission in understanding what the February 24, 2016 MRI does or does not signify. We accept that the L5-S1 space is problematic, and may warrant surgical intervention. However, we are no closer to understanding whether that level continues to be problematic because of the subject accident versus pre-existing conditions, subsequent events or the natural progression of Claimant's lumbosacral spine disease.

However, lesions at L3-L5 are now thought by Dr. Dirks to be the direct result of the accident. Recall that Nurse Practitioner Moore thought that Claimant's exam was consistent with a problem at L3. Dr. Dirks stated in his note of November 10, 2015 that Claimant's findings correlated with an L4-L5 radiculopathy. However, until Dr. Dirks' letter of December 7, 2016, no one had suggested that Claimant's work accident caused anything other than a direct injury to the L5-S1 disc space. At this late date in the proceedings, Dr. Dirks now proposes:

> I have reviewed and compared Ms. Strope's three MRIs which were obtained on March 17, 2010, February 28, 2011 and February 24, 2016. On May 11, 2011, Dr. Larson stated that he felt the "most dominate finding" on Ms. Strope's February 28, 2011 MRI, was a recurrent disc herniation on the left at L5-S1. He felt that there was "no significant nerve root impingement" at L3-4 and L4-5 as shown on the February 28th MRI.
>
> Based upon my comparison of Ms. Strope's March 2010 and February 2011 MRIs, and Dr. Larson's operative report, which states that he removed a free fragment of disc from beneath the S1 nerve root, I agree that Ms. Strope's February 2011 MRI showed a recurrent disc herniation on the left at L5-S1. While there may not actually be a disagreement between Dr. Larson and me, our apparent disagreement is based upon our opinion as to what is, and is not "significant". In my opinion, the February 2011 MRI shows that the disk protrusions at L3-4 and L4-5 had progressed beyond what was shown on her March 2010 MRI, as a result of her January 2011 industrial accident. In my

> opinion, after her January 13, 2011 industrial accident, Ms. Strope's low back pain and left lower extremity pain on May 11th was not only related to the L5-S1 area but it was also related to progression of the protrusions at the L3-4 and L4-5 in the mid-lumbar region. If I had been treating Ms. Strope at that time, I would have not only addressed the fragment of disk at L5-S1 but I would have also addressed the L3-4 and L4-5 disk protrusions that had progressed as a result of the January 2011 accident.

Claimant's Exhibit 2.

Therefore, per Dr. Dirks' review of the three studies referenced above, there is a significant interval change at L3-L4 and L4-L5, between the dates of the pre-injury MRI and the first post-injury MRI, suggesting, to Dr. Dirks, that the subject accident caused injury not only at L5-S1, but also at L3-L4 and L4-L5. Dr. Dirks believes that Dr. Larson should have included L3-L5 in the original surgery, and Dr. Dirks now proposes that three-level surgery should at last be done, all for the purpose of addressing multi-level accident-caused lesions. The surgery would be a big one, eventually resulting in fusion from L3 through S1. In this regard, it is notable that when three-level spinal surgery was originally proposed by Dr. Dirks, he stated that in order to address the work-caused lesion at L5-S1, it was necessary for him to address other lumbar issues at L3-L4 and L4-L5.

> As documented in the radiologist's report, and my personal review of the MRI, Ms. Strope has neuroforaminal narrowing, greater on the left, that is causing her to suffer a left L5 radiculopathy. This radiculopathy is at the site of her June 6, 2011 surgery and it is clearly the result of the fact that her surgery did not resolve the injury she suffered at work on January 13, 2011. I am recommending surgery to correct this condition and in order to do so, I will have to address her other lumbar issues at L3-L4 and L4-L5.
>
> (Dr. Dirks' July 12, 2016 letter.)

This is somewhat different than saying what Dr. Dirks now asserts, i.e., that the reason to do surgery at L3 through L5 is because the accident caused injury at all those levels which warrants surgical revision at this time.

The first thing that might be said about this, and other of Dr. Dirks' opinions, is that it comes too late in the game.

In connection with rendering his original opinions Dr. Dirks could have reviewed the 2010 and 2011 MRI evaluations and could have expressed this new opinion in timely fashion. He did not, and one reason for refusing to entertain the opinion quoted above is that opinions concerning comparison of the 2010 and 2011 studies were not adduced in connection with the original hearing in conformance with J.R.P. 10. Claimant will not now be heard to retroactively establish a foundation for Dr. Dirks' opinion when this could have been done prior to the original hearing.

It is also notable, however, that Dr. Dirks' opinion concerning the 2010 and 2011 MRI studies is not shared by Dr. Ludwig. Dr. Ludwig also undertook a comparison of these studies, and concluded that there was no significant interval change at L3-L4 and L4-L5 between the pre-injury and post-injury studies. (*See* Defendants' Exhibit F at 122). The evidence of record, i.e. the evidence that was timely offered in accordance with J.R.P. 10, fails to prove that the subject accident caused any injury other than at L5-S1. Even were we to consider Dr. Dirks' December 7, 2016 opinion, we are unable to say that it should be elevated above the similar comparison performed by Dr. Ludwig.

Further, in its original decision, the Commission criticized Dr. Dirks' opinion for not being based on a thorough and complete understanding of the record. At the invitation of Claimant, Dr. Dirks has now tried to cure that deficiency in his December 7, 2016 letter, a letter which outlines facts supporting Dr. Dirks' opinions, facts which he had not considered at the time of his deposition. Dr. Dirks' December 7, 2016 parsing of the chiropractic, and other records in response to counsel's first three questions will not be considered by the Commission.

Next, we must consider what little evidence the parties have provided us concerning whether the February 24, 2016 MRI sheds any light on whether Claimant suffers from an ongoing accident-related problem at the L5-S1 level which requires surgical intervention. Dr. Dirks states that the radiologist who reviewed the February 24, 2016 MRI came to the conclusion that Claimant's L5-S1 level was contributing to her left radiculopathy. (*See* December 7, 2016 Dirks letter at 2). First, the report on the February 24, 2016 MRI, authored by Dr. Tryon, does not support Dr. Dirks' assertion. Dr. Tryon only said that the degenerative changes at L5-S1 may contribute to a left L5 radiculopathy. Second, there is nothing in Dr. Tryon's report, or in Dr. Dirks' December 7, 2016 letter which would allow the Commission to come to any conclusion concerning whether the marked degenerative changes at L5-S1 noted by Dr. Tryon are referable to the subject accident. Even if it be accepted that Claimant requires surgery at the L5-S1 level, the February 24, 2016 MRI does not appear to be a "smoking gun" that illustrates that the need for treatment is referable to the accident versus documented subsequent events or normal progression of lumbar spine degeneration.

Turning to Dr. Larson's letter of November 1, 2016, it appears to have been generated in response to inquiries and additional records submitted by Julie Osler of Surety. The "new records" provided to Dr. Larson are not indentified, but appear to include the 2016 MRI and Dr. Dirks' subsequent surgical recommendation. Dr. Larson does not believe that the treatment proposed by Dr. Dirks is referable to the subject accident. Explaining his reasoning, he stated:

> 3. Does the additional information prove that the claimant needs additional treatment related to the 1/13/2011 injury?
>
> a. No. Her injury resulted in a disc herniation with radiculopathy that was treated with microdiscectomy left L5/S1. Of note she had pre-existing low back problems and had bilateral lumbar discectomy L5/S1 prior to the industrial injury of 1/13/2011. The medical record of 9/7/2011 documented no radiculopathy with an intact neurologic exam. MRI

> review documented pre-existing degenerative disc disease at L3/4, L4/5, and L5/S1. Evaluation of 12/13/2012 done by Holly Moore, N.P.-C. including Ms. Trope's intake form suggests new left L3 radicular symptoms unrelated to the prior L5/S1 disc herniation for which she recommended a new MRI. The symptoms were new and started in the months prior to the evaluation. She did not have the MRI or follow-up. A more recent evaluation by Dr. Dirks documented no radiculopathy but rather he diagnosed bilateral SI joint pain. He arranged for a new MRI which was performed on 2/24/2016 and again documented chronic findings unrelated to the industrial injury. The radiologist noted multilevel degenerative disc disease L2/3, L3/4, L4/5, and L5/S1. There is no residual or recurrent disc herniation. Dr. Dirks' focus then shifts to the chronic MRI findings. The surgery being recommended is based on these chronic findings and not based on objective findings. It is not related to the industrial injury.
>
> 4. Do the findings of the MRI of 2/24/2016 provide a basis to relate the need of the MRI to the industrial injury of 1/13/2011.
>
> a. No. The patient's current subjective complaints are unrelated to the industrial injury.

Defendants' Exhibit 1.

Therefore, per Dr. Larson, the February 24, 2016 MRI only demonstrates chronic findings unrelated to the subject accident. The surgery recommended by Dr. Dirks is related to these chronic findings, not the accident.

On balance, we cannot say that the February 24, 2016 MRI does anything more than support Dr. Dirks' belief that Claimant would benefit from surgical intervention. However, the study, and the analysis related thereto, provides nothing illuminating on the question of whether the need for surgery is referable to the subject accident versus non-work related causes. We find Dr. Larson's opinion persuasive. For these reasons, the Commission declines to revisit the original determination of June 22, 2016 except to order the payment of the expenses associated with the February 24, 2016 MRI. The Commission concludes that this was a reasonable, although ultimately unhelpful, diagnostic expense which should be borne by Defendants.

Defendants are directed to pay the costs of that study to Claimant per *Neel v. Western Construction*, 147 Idaho 146, 206 P.3d 852 (2009).

ORDER

1. Claimant has not shown that her ongoing complaints and the requested medical care are causally related to the industrial accident.

2. Defendants are directed to pay the cost of the February 24, 2016 MRI, pursuant to *Neel v. Western Construction*, 147 Idaho 146, 206 P.3d 852 (2009).

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

DATED this 27th day of January, 2017.

INDUSTRIAL COMMISSION

____/s/_____
Thomas E. Limbaugh, Chairman

____/s/_____
Thomas P. Baskin, Commissioner

____/s/_____
R.D. Maynard, Commissioner

ATTEST:

___/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 27th day of January, 2017, a true and correct copy of the foregoing **FURTHER ORDER ON MOTION FOR RECONSIDERATION AND/OR REHEARING** was served by regular United States Mail upon each of the following:

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ka _____/s/_____