BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

PAUL HACKMAN, Claimant, v. CHS, INC., Employer, and OLD REPUBLIC INSURANCE COMPANY, Surety, Defendants.	**IC 2016-029879** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **Filed 8/13/2018**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee John C. Hummel, who conducted an emergency hearing in Pocatello on February 22, 2018. Patrick N. George and Fred J. Lewis represented Claimant Paul Hackman, who appeared in person. Jamie K. Moon represented Defendant Employer, CHS, Inc., and Defendant Surety, Old Republic Insurance Company. The parties presented oral and documentary evidence, took post-hearing depositions, and submitted briefs. The matter came under advisement on July 3, 2018. The undersigned Commissioners have chosen not to adopt the Referee's recommendation in order to give different treatment to the issue of Claimant's entitlement to temporary disability benefits, and hereby issue their own findings of fact, conclusions of law, and order.

ISSUES

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

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

   a. Medical care; and

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

2. Whether Claimant has engaged in unsanitary or unreasonable practices that tend to imperil or retard his recovery, pursuant to Idaho Code § 72-435; and

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

INTRODUCTION

Claimant was injured in an industrial accident while working as a truck driver for Employer on June 30, 2016. He was attempting to open a defective valve on his truck to unload propane by swinging a hammer to loosen the valve. In the process of wresting the valve open, he injured his back. After an independent medical examination (IME) by Lynn Stromberg, M.D., who approved treatment, Claimant received a discectomy procedure at L4-L5 performed by Steven Hansen, M.D. Both doctors and Surety knew Claimant was a pack-a-day smoker prior to the procedure. Although the surgery was without complications, Claimant continued to have symptoms. Dr. Hansen recommended surgery at the L5-S1 level and, depending upon the results of that surgery, a second surgery to implant a spinal cord stimulator. Surety then scheduled Claimant for an IME with another doctor, Matthew Drake, M.D. Dr. Drake determined that all surgical treatment for Claimant's back, including the first surgery, was not industrially-related. Surety denied further treatment and benefits. Claimant then filed a motion for an emergency hearing. At a telephone conference, the parties agreed to resolve their difference based upon an apparent stipulation that an MRI and surgery would be covered. Surety then raised an issue

concerning Claimant's smoking; while it approved an MRI, Surety refused to approve further back surgery unless Claimant ceased smoking. Claimant filed another motion for an emergency hearing, which the Referee granted.

CONTENTIONS OF THE PARTIES

Claimant alleges that his physician's request for additional lumbar surgery is reasonable. He further alleges that Defendant agreed to additional surgery and then unreasonably denied it based upon the smoking issue. Claimant further alleges that Dr. Drake is a hand surgeon who was lesser qualified to render an opinion on the reasonableness of his treatment. He also argues that his smoking habit is not a legitimate basis upon which to deny him lumbar surgery. Claimant argues that he is entitled not only to the requested surgical treatment and related care, but also continued temporary disability benefits and attorney fees for unreasonable delay and denial of medical treatment.

Defendants acknowledge Claimant is otherwise entitled to further lumbar surgery but argue that it is not compensable as long as he continues to smoke. They claim that it is medically unreasonable for a patient who smokes to undergo a significant spinal orthopedic procedure due to risk of an inferior surgical outcome, higher rate of a surgical infection, longer recovery time, and a higher rate of the need for additional surgeries. They allege that Dr. Drake's opinion on these matters is reasonable and entitled to greater weight. Further, they argue that Claimant's own surgeon agrees that Claimant's smoking is problematic. With regard to temporary disability benefits, Defendants argue that Claimant is medically stable unless he undergoes surgery, thus he is not entitled to further temporary disability benefits. Finally, Defendants argue that they have reasonably adjusted Claimant's claim, particularly with regard to the reasonableness of his proposed surgery and the smoking issue, and thus they are not liable for attorney fees.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant taken at hearing and at his deposition held on February 8, 2018;

2. Joint Exhibits 1 through 35, admitted at the hearing.

3. The deposition transcripts of the following witnesses:

    a. Stephen Hansen, M.D., taken on February 8, 2018; and

    b. Matthew Drake, M.D., taken on March 12, 2018.

FINDINGS OF FACT

1. **Claimant's Background**. Claimant was born on December 30, 1954. Claimant Dep., 11:21-22. He graduated from Idaho Falls High School in 1973. Tr., 84:13-16. He did not pursue any formal education beyond high school. *Id*. at 17-19.

2. After high school, Claimant pursued a trucking career. His 40-year working career was in the trucking and construction industries, apart from the farm work he performed growing up and working in a potato warehouse immediately after high school. Claimant operated many different kinds of commercial vehicles including long-distance trucks, loaders, asphalt trucks, and construction machinery. *Id*. at 118:22-119:17; Claimant Dep., 23:5-16; Ex. 5:15.

3. Claimant began smoking when he was a sophomore in high school. He quit a handful of times since then. He used various methods to quit smoking, such as Nicorette gum, nicotine patches, and Chantix, but always resumed smoking. Tr., 120:9-121:10.

4. **Prior Medical History**. Prior to the industrial accident, Claimant sought treatment by a chiropractor for minor back complaints, elbow problems, and similar issues. He never had a significant injury to his back or hip prior to the industrial accident. Prior to the

operation he received after the industrial accident, Claimant had not had any surgeries. He broke a bone in his wrist in 2007 and dislocated his elbow in the 1990s; neither accident was work-related. Claimant also received long-term treatment for anxiety and depression with an SSRI anti-depressant prescription. Tr., 117:3-118:11; Claimant Dep., 24:3-22, 26:7-10; Ex. 5:17; Ex. 17:243.

5. In 2015 and 2016, prior to the industrial accident, Claimant sought chiropractic treatment at the Bowman Chiropractic Clinic in Soda Springs. Wesley A. Bowman, DC, examined him and performed spinal adjustments for his complaints of "pain, soreness, tenderness and stiffness" in his lower thoracic, lumbar, left sacroiliac, left pelvic, right sacroiliac, and right pelvic regions. These chiropractic visits occurred on July 6, 2015, and on February 9, February 16, and June 6, 2016. Dr. Bowman diagnosed Claimant with lumbar subluxation, lumbar radiculopathy, pelvic subluxation, and sciatica. Ex. 14:166-170.

6. **Subject Employment**. Employer hired Claimant as a truck driver on February 20, 2015. Ex. 1:1. His duties included driving, loading, and unloading a propane truck. Ex. 5:15.

7. **Industrial Accident**. On June 30, 2016, Claimant was attempting to release a large, defective gate valve on a propane truck at a propane storage facility in Granger, Wyoming. He attempted for twenty minutes to open the valve, which was stuck. Claimant leaned over and twisted the valve, which was two feet inside the trailer, by attempting to "muscle" it. When the valve suddenly became unstuck, he felt the energy transfer to his body and an immediate and sharp pain in his back, left hip, and left leg. Claimant's pain was severe enough that he had trouble walking after the accident. Tr., 87:15- 91:8; Claimant Dep., 27:9-30:25; Ex. 1:1; Ex. 2:2; Ex. 5:13.

8. Employer filed a first report of injury for Claimant's industrial accident on November 1, 2016. The report states that Employer was first notified of the accident on November 1, 2016. Ex. 1:1. Claimant states that he informed Employer of the accident on the date that it occurred, June 30, 2016. Ex. 2:2.

9. **Medical Care and Post-Accident Events**. Claimant sought chiropractic care with Dr. Bowman following the industrial accident. He had chiropractic visits on July 1, July 6, July 18, and August 10, 2016. Curiously, Dr. Bowman's chart notes make no mention of the fact that Claimant had an accident on June 30, 2016. Rather, Dr. Bowman noted the same diagnoses as on prior visits with treatment of Claimant's lower thoracic, lumbar, left sacroiliac, and right sacroiliac regions with chiropractic adjustments. At the last visit on August 10, 2016, Dr. Bowman noted that Claimant was showing improvement and that he was "reporting less discomfort" and was showing "improved function." Ex. 14:171-174.

10. The first medical report to allude to an injury related to Claimant's industrial accident occurred on July 18, 2016. Nicolette Hampton, NP, examined Claimant at the office of his general practice medical provider, Intermountain Medical Clinic. Claimant was at the clinic for a refill of Citolopram, an SSRI medication. NP Hampton noted that Claimant "dislocated his hip 3 weeks ago. He has an appointment with Dr. Bowman his chiropractor later today for an adjustment. Pt. drives a truck for a living so his pain has been really bad with sitting." Ex. 17:254.

11. Andrew Thayne, M.D., with Intermountain Medical Clinic, examined Claimant on August 15, 2016 at an urgent care visit. He noted that Claimant was in the clinic for evaluation of "low back pain and L sciatica for almost 2 months. Started end of June with very hard twisting of large valve. Seemed to really wrench his low back. Ever since has had LBP [low

back pain] and L sciatica with shooting pains down lateral L leg and L foot usually numb. Followed by chiropractor and just no better." Dr. Thayne recommended a lumbar spine MRI and referral to a spine specialist. Ex. 17:256-257.

12. Dr. Thayne ordered MRI imaging of Claimant's lumbar spine. The imaging took place on August 18, 2016 at the Portneuf Medical Center. While noting mild degenerative changes throughout Claimant's lumbar spine, the MRI report, as dictated by David Cameron, M.D., found the following: "1. Large disc extrusion at L4-5 with associated facet arthropathy results in severe spinal stenosis and nerve root encroachment. 2. Disc extrusion at L5-S1 with left facet arthropathy results in left neural foraminal narrowing with contact the left L5 and S1 nerve roots as described." Ex. 16:229-230.

13. Anthony Joseph, M.D, an orthopedic specialist, evaluated Claimant on October 4, 2016. Claimant presented with low back pain and radiculopathy. The history that Dr. Joseph took included the fact that Claimant smoked a pack of cigarettes per day. Dr. Joseph's diagnosis was spinal stenosis, lumbar region and sciatica, left side. He performed a left-sided transforaminal epidural steroid injection into Claimant's L4-5 interspace. Ex. 18:260-264. Claimant followed-up with Dr. Joseph on October 25, 2016. Dr. Joseph noted that Claimant had relief from his lumbar pain and radiculopathy from the epidural steroid injection. His pain decreased from a 9 to a 5 level. Claimant still had a sensation in his left foot "like his sock is balled up under his foot." Symptoms were worse with activity. Dr. Joseph performed additional transforaminal epidural steroid injections into Claimant's left L4-5 level and L5-S1 level. He also prescribed Lyrica. *Id*. at 278-281.

14. On November 1, 2016, Surety received notification of Claimant's injury and Surety's adjuster Gayle Warner began investigating the claim. Tr., 19:9-24. Warner and Surety

were aware of Claimant's smoking habit from "the beginning of the investigation" when Warner interviewed Claimant. One of the standard questions that Warner asked injured workers was whether they smoked. Tr., 77:11-25.

15. Claimant next presented to Dr. Joseph on November 15, 2016 with his workers' compensation adjuster to determine his next steps in treatment. Dr. Joseph noted "marked improvement of his symptoms following epidural steroid injections." They discussed continuing Lyrica, however Dr. Joseph did not feel further steroid injections were indicated at that time. He released Claimant to full duty, and would consider him at maximum medical improvement (MMI) if symptoms continued to improve. Ex. 18:282-285.

16. On December 20, 2016, Claimant reported to Dr. Joseph that his symptoms were worse and aggravated by physical activity; he ultimately did not believe that the steroid injections had helped. Dr. Joseph performed additional transforaminal epidural steroid injections, Left S1 interspace and left L5-S1 level. *Id*. at 287-289.

17. At request of Surety, Lynn Stromberg, M.D., an orthopedic surgeon with Western Spine Institute in Idaho Falls, performed an IME of Claimant on February 9, 2017. Dr. Stromberg held board certifications by the American Board of Orthopedic Surgeons and the American Academy of Disability Evaluating Physicians. He reviewed Claimant's medical history, including his treatment by Dr. Bowman and Dr. Joseph. He reviewed the MRI of Claimant's lumbar spine from August 18, 2016. He also obtained new X-rays of Claimant's lumbar spine on February 9, 2017. Dr. Stromberg noted Claimant's pack a day cigarette habit. He further noted that the MRI showed "a large extruded herniation." Dr. Stromberg opined in pertinent part as follows: "At this point, there is little chance that the symptoms are going to resolve without further intervention. I find that the reported work incident was the direct

causative event relating to the lumbar disc herniation." Dr. Stromberg recommended that Claimant undergo a lumbar decompression and discectomy procedure at L4-5. Ex. 12:136-140.

18. After receiving a copy of the IME from Dr. Stromberg, Ms. Warner notified Claimant in writing that the Surety had approved surgery as recommended. Tr., 54:2-55:1.

19. Upon referral from Dr. Joseph, Stephen Hansen, M.D., an orthopedic surgeon with Idaho Sports and Spine in Pocatello, evaluated Claimant for lumbar surgery on February 24, 2017. Dr. Hansen took Claimant's medical history and noted that Claimant "blew his L4-5 disc out. He was in such miserable pain. This occurred in June of 2016. He has been miserable since then." Dr. Hansen recorded Claimant's status as a "current every day smoker." He reviewed Claimant's MRI, which demonstrated "a large disc extrusion centrally, eccentric to the left, with large inferior migration from L4-5." Noting that Claimant had failed conservative care, including steroid injections and chiropractic treatment, Dr. Hansen concluded that Claimant "needs surgery … a discectomy at L4-5 on the left." Ex. 15:175-180.

20. Claimant returned to Dr. Hansen for pre-surgery consent and review on March 13, 2017. Dr. Hansen noted that Claimant elected to proceed with the surgery after being informed of risks and benefits. Dr. Hansen also noted that Claimant had been unable to work since December 30, 2016, due to pain and weakness. He took Claimant off work beginning December 31, 2016 through May 1, 2017, at which time he could be released to light duty. *Id*. at 181-187.

21. Dr. Hansen performed the lumbar surgery on Claimant at Portneuf Medical Center in Pocatello as an outpatient procedure on March 15, 2017. The specific procedures performed were as follows: a hemilaminotomy L4-L5 on the left with discectomy at L4-L5; and foraminotomies L4-L5 and L5-S1. Dr. Hansen noted that he decompressed the L4 nerve

completely in the foramen on the left; the L4-L5 and L5 nerve was completely decompressed from its takeoff all the way distally into the foramen where it was completely decompressed as well. In performing the discectomy, Dr. Hansen ensured that "there was no significant compression all the way from the central aspect of the spinal canal distal to the pedicle. The L5 nerve was completely decompressed without any evidence of ongoing nerve compression or residual disc herniation." Claimant tolerated the procedure well and Dr. Hansen discharged him from the hospital. Ex. 19:343-344.

22. Dr. Hansen and his associates at Idaho Sports and Spine followed Claimant for his post-operative care with office visits on March 27, April 18, May 8, June 6, and August 8, 2017. On April 18, 2017, Claimant was still reporting some pain in his posterior left leg and weakness in left foot. Dr. Hansen decided to obtain another lumbar MRI, as Claimant's "symptoms are not appreciably better." The MRI, performed on May 4, 2017, showed some narrowing of the L5/S1 foramen. Dr. Hansen recommended a steroidal injection of the left S1 nerve root, which he performed on June 6, 2017, with no complications. Dr. Hansen observed that if no improvement occurred, Claimant might need surgery to address the stenosis at the L5-S1 on the left, which had not been approved at the time of his last surgery. He observed further that Claimant "certainly seems to be experiencing S1 nerve pain, however since his surgery to decompress his left L5 nerve." On August 8, 2017, Claimant reported no improvement from the injection. Dr. Hansen noted that he would like to obtain an MRI with and without contrast of the lumbar spine "to assess the extent of recurrent disc extrusion and epidural fibrosis." He anticipated recommending decompression on the left at L5-S1, and possibly residual compression at L4-5. Ex. 15:188-213.

23. There is no indication in Dr. Hansen's post-surgical notes that Claimant suffered any surgical wound infection or similar perioperative complications. There is no record that

Dr. Hansen was required to perform a secondary operation to irrigate and disinfect any wound infection. Ex. 15:188-213.

24. Ms. Warner observed that Claimant did not recover well from his surgery, based on the medical records and his continuing pain complaints. After receiving Dr. Hansen's recommendation for another MRI, she arranged for an IME with Matthew Drake, M.D. Tr., 55:5-56:16.

25. Dr. Drake performed an IME of Claimant under the auspices of an IME vendor, OMAC (Objective Medical Assessments) based in Seattle, Washington. Ex. 13:141. The IME took place in Pocatello on August 24, 2017. Prior to the examination, Dr. Drake reviewed relevant medical records, including chiropractic records, Dr. Joseph's records, MRIs, X-rays, Dr. Stromberg's IME, and Dr. Hansen's records, including the operative report. He also took Claimant's medical history and examined him. Claimant told Dr. Drake that the lumbar surgery "was of no benefit whatsoever" and that he had ongoing symptoms including low back pain, trouble lifting and bending, and left lower extremity numbness and tingling. Dr. Drake noted that Claimant smoked a pack of cigarettes per day. During the examination, Dr. Drake observed that Claimant had "somewhat of an antalgic gait favoring the right side." He observed no other abnormal physical findings. Ex. 13:141-149.

26. Dr. Drake diagnosed Claimant with a lumbar strain, resolved, related to the industrial accident, and lumbar spine degenerative disc disease with L4-5 and L5-S1 disc herniation, preexisting, and not related to the industrial accident. He opined that Claimant "clearly had pre-existing lumbar degenerative disease and was seeking care for this prior to the date of accident of June 30, 2016." He further opined that the MRI of August 16, 2016 showed no evidence of post-traumatic findings, but rather only degenerative findings. Dr. Drake

determined that Claimant was at MMI as of the date of examination, with no applicable work restrictions and no ratable impairment related to the industrial accident. He further concluded that surgical intervention to decompress the S1 level would not be medically necessary, and that medical care to date, including the previous surgery, had not been reasonable or necessary to address a lumbar strain. Finally, in response to a specific question from Surety, Dr. Drake opined that Claimant's pack a day cigarette habit was "associated with inferior surgical results." Ex. 13:150-153.

27. In response to Dr. Drake's report, Ms. Warner sent Claimant a change of status notice discontinuing further medical and time loss benefits. Tr., 58:5-10. That decision was based entirely upon Dr. Drake's IME report. *Id*. at 11-14. Due to Surety's decision, Claimant did not receive further temporary disability benefits after September 6, 2017. Tr., 102:13-15.

28. Dr. Hansen reviewed Dr. Drake's IME and responded to its findings in a letter to Claimant's attorney on October 9, 2017, a copy of which was shared with Surety and Ms. Warner by their legal counsel. Ex. 15:215-217; Tr., 45:18-21. Dr. Hansen criticized Dr. Drake's IME for documenting Claimant's "4/5 weakness of the left EHL and TA muscles" and lumbar radiculopathy, yet "failing to list that obvious diagnosis in his IME." Dr. Hansen further criticized Dr. Drake for claiming that Claimant had a preexisting 4/5 weakness in his left EHL and TA before the industrial accident, when there was no evidence for this. Furthermore, he disputed Dr. Drake's diagnosis of lumbar strain and his conclusion that it was resolved. Dr. Hansen acknowledged that Claimant had "obvious degenerative changes" in his lumbar spine that existed prior to the industrial accident. Nevertheless, even if there were abnormalities of the L4-5 disc prior to June 30, 2016, thereafter Claimant "clearly developed worsening symptoms and signs, including significant pain and weakness, all consistent with an L4-5 disc extrusion on

the left that causes lumbar radiculopathy." Dr. Hansen opined that it was a "100% probability" that but for the industrial accident, Claimant would not have needed the lumbar surgery. Dr. Hansen noted that Claimant's continued symptoms after the surgery could be due in part to the fact that surgery was delayed seven and a half months after the injury, and that older patients, those who smoke, and those with generally poorer health "typically should have surgical decompression earlier rather than later in order to avoid permanent neurological damage, including persistent pain and weakness." Thus, if Claimant had been treated with surgery earlier, Dr. Hansen opined that he would have had a better outcome. Dr. Hansen concluded that Claimant was still not at MMI, because treatment of his S1 nerve through decompression and/or a spinal cord stimulator could provide him further relief from his symptoms. Ex. 15:215-217.

29. On November 9, 2017, Claimant through counsel filed a Request for an Emergency Hearing, with supporting documentation. The motion sought an emergency hearing on the issues of whether Claimant was entitled to the medical treatment recommended by Dr. Hansen, including lumbar decompression surgery at S1 and a spinal cord stimulator, related temporary disability benefits and attorney fees. On November 28, 2017, Defendants through counsel filed a Response to Claimant's Request for Emergency Hearing, with supporting documentation. The Response denied that an emergency hearing was necessary and asserted that Surety had a reasonable basis to deny further benefits to Claimant.

30. On November 20, 2017, counsel for Defendants, Mark Peterson, wrote an email to counsel for Claimant, Patrick N. George, that stated in pertinent part as follows:

> I am unable to reach the adjuster and may or may not be able to this week. The adjuster [Ms. Warner] reached out to Dr. Hansen's office regarding an authorization for treatment and I do not know that she has heard back from him. *I can verify that the MRI is obviously approved and if a surgery is recommended intend that it would be approved as well.* Presumably, the doctor will want to

> review the MRI results before definitively recommending surgery and exactly what that surgery would entail.

Ex. 31:525 [emphasis added].

31. After having disallowed benefits to Claimant following Dr. Drake's IME, Surety, through Ms. Warner, approved additional doctor visits with Dr. Hansen and the MRI for which Dr. Hansen had requested approval. Tr., 58:22-59:1. Ms. Warner explained that she had only approved additional visits with Dr. Hansen and the MRI to explore whether surgery was necessary; she did not pre-approve surgery, despite her legal counsel's representation in the November 20, 2017 email. She recalled in pertinent part as follows:

> My understanding at the time what I was going to approve was the lumbar spine MRI to see what the findings were and then we would address any issues after that once we had the MRI report.
>
> Q. (BY MR. GEORGE) How do you get around the line that says "The MRI is obviously approved and if surgery is recommended, intend that it would be approved as well" as shown in Exhibit 31, Bates 525?
>
> A. I'm sorry I don't have a response to that. Only because my understanding was that I had agreed with – to approve Dr. Hansen's request for the lumbar spine MRI. I've never in my career approved the surgery before we have the findings, if that's what is being done.
>
> Q. Well, Mark is your attorney, right?
>
> A. Correct.

Tr., 34:17-35:7.

32. Dr. Hansen met with Claimant on November 29, 2017 to discuss surgical treatment options. Claimant reported having continued lower back pain bilaterally and radiating into his left posterior leg. He rated his pain level at 8. Dr. Hansen reviewed an MRI (with and without contrast) of Claimant's lumbar spine taken on the same date, November 29, 2017. The MRI showed Claimant's previous discectomy at L4-5 on the left with hemilaminotomy at the

same level. There was no evidence of recurrent disc extrusion; nevertheless there was significant lateral recess stenosis at L5-S1 on the left, with disc osteophyte complex centrally causing some lateral recess compression. Dr. Hansen recommended decompression on the left at L5-S1, however because he also believed that Claimant's residual lateral calf and dorsal foot pain were from his L5 radiculitis, he also recommended a spinal cord stimulator. Dr. Hansen recommended proceeding with the decompression surgery first and then, after Claimant recovered, performing the spinal cord stimulator implant if his symptoms continued. Ex. 33:539-543.

33. Dr. Hansen wrote a letter to Surety on November 29, 2017, that stated as follows: "I am writing this letter for my patient Paul Hackman. Paul is currently unable to work. With his signs and symptoms, he has not been able to work since before his surgery of March 15, 2017. I have restricted his duties since then." Ex. 30:521.

34. Counsel for Defendants wrote to counsel for Claimant on November 29, 2017. He observed that "the adjuster confirmed with me that she has not received any request for authorization of treatment that has been denied. She was recently contacted by Dr. Hansen's office regarding the scheduled MRI and approved it consistent with prior communications to you. She has not been previously asked for authorization of any medical treatment from Dr. Hansen that was not approved." Ex. 21:500.

35. The Referee held a telephone conference with counsel for the parties on November 30, 2017 to discuss the request for an emergency hearing. At the telephone conference both counsel represented the matter had been resolved on the issue of medical treatment, thus an emergency hearing was unnecessary. Counsel for Claimant advised the Referee that "we have the medical portion worked out." The only remaining unresolved issue was temporary disability benefits, which counsel stated that they were still working out. Counsel for Defendants agreed

with Claimant's counsel representation concerning settlement negotiations. The Referee then issued an Order Denying Claimant's Motion for Emergency Hearing on December 1, 2017.

36. In an email dated December 14, 2017, counsel for Defendants advised Claimant's counsel that he had spoken with the adjuster and stated "she has not received a request for authorization from Dr. Hansen requesting surgery." Counsel asked Claimant's counsel to forward a written request from Dr. Hansen to him so that he could follow up with the adjuster. Ex. 22:501.

37. On December 15, 2017, counsel for Defendants sent letter questionnaire to both Dr. Hansen and Dr. Drake regarding "potential surgical recommendations" for Claimant to undergo a decompression and hemilaminotomy at L5-S1. The questionnaire noted that Claimant is a "current every day smoker" and "smokes one pack of cigarettes on daily basis." The questionnaire asked whether it was medically reasonable for Claimant to undergo the proposed surgery while he remains an active smoker, whether the physicians agreed that ongoing nicotine use can have a negative impact on recovery and effectiveness of the proposed surgery, and similar questions, all related to the topic of nicotine/tobacco use. Ex. 13:159-161; Ex. 26:513-515.

38. Ms. Warner recalled that the purpose of sending the letter questionnaires was "centered around the effect of his [Claimant's] continued smoking, not whether the surgery was required." Tr., 63:16-17. She recalled further as follows: "We were just trying to gather enough information so we could make a timely and appropriate response." *Id.* at 23-25.

39. On December 20, 2017, Dr. Hansen sent a letter outlining his request for approval of surgical procedures, addressed to Ms. Warner with Surety. The letter stated in pertinent part that its purpose was "to formally request an outpatient hemilaminotomy at L5-S1 on the left for

Paul Hackman, as discussed in my office note dated 11/29/17. I would prefer to do this surgery as soon as possible. It is possible, although unlikely, that this would be his only necessary surgery. However, based on the delay in his first surgery, to decompress his left L5 nerve, he has ongoing neuropathy that would potentially benefit from a second surgery, an implantation of a spinal cord stimulator." Ex. 29:520.

40. On December 26, 2017, Dr. Drake provided his response to the letter questionnaire of December 15, 2017 sent by Defendants' counsel. In his response, Dr. Drake opined that it was not medically reasonable for Claimant to undergo decompression at L5-S1 and L4-5, to the extent that he remains an active smoker. He explained that "smoking is a modifiable pre-operative risk factor shown to be associated with disappointing surgical results and surgical site infections." Dr. Drake attached abstracts for two clinical studies regarding tobacco use and surgical outcomes, which he asserted supported his opinion, as follows: *Prognostic Factors for Satisfaction After Decompression Surgery for Lumbar Spinal Stenosis*, Paulsen, Bouknaitir, Fruensgaard, Carreon, and Anderson (June 1, 2017); and *Risk Factors for Acute Surgical Site Infections after Lumbar Surgery: a Retrospective Study*, Lai, Song, Guo, Bi, Liu, Yu, Zhu, Dai, and Zhang (July 19, 2017). Ex. 13:159-164.

41. Surety determined that it would not authorize Dr. Hansen's recommended lumbar surgeries for Claimant while he continued to smoke, per Dr. Drake's opinion as expressed in his December 26, 2017 response to the tobacco questionnaire. As of the date of hearing, Claimant's surgery remained unapproved by Surety. Ms. Warner explained Surety's reason for not authorizing the surgeries as follows:

> Q. [BY MR. GEORGE] Have you approved either one of those surgeries [outpatient hemilaminotomy at L5 to S1 on the left and spinal cord stimulator implantation] as of today?

A. No.

Q. So the fact that you were waiting for a request from Dr. Hansen – or the fact that you testified that you were waiting for a request from Dr. Hansen isn't true, is it?

A. No. That is true. We were waiting for the request to respond.

Q. Then why haven't you approved the surgeries?

A. Because we obtained an independent medical by Dr. Matthew Drake. He diagnosed Mr. Hackman with a back strain from the incident turning the valve in June 2016. And he also sent some echo literature that indicating undergoing another procedure while smoking would not be beneficial to him.

Tr., 37:17-38:8.

Q. (BY MS. MOON) Ms. Warner, what was your understanding of claimant's medical stability based on Dr. Drake's opinion?

A. He advised that he would remain at medical stability unless or, I guess, until he had the recommended L5-S1 surgery.

Q. Okay. So in response to this, what did you do with regard to the outstanding surgical recommendation?

A. I don't believe we sent a form denying it, but I know we have not approved it.

Q. Okay. And what is the basis for the surety's decision not to –

A. Because of the smoking.

Q. Is it also based on Dr. Drake's medical opinion?

A. Because he continues to smoke, yeah. Considerably, yes.

Q. Okay. Ms. Warner, claimant was smoking at the time of the first surgery, correct – back in March 2017?

A. Correct.

Q. So why did you approve the first surgery when he was smoking and not the outstanding surgery right now?

> A. Well, because I'm not a doctor. We typically rely on the doctor's practice. A lot of doctors won't do surgery unless a nicotine test is negative prior to surgery. And because it didn't appear to be an issue at the time based on Dr. Hansen's information, we went ahead and approved it.
>
> The second surgery we didn't – part of it because he had a poor recovery from the first one, which you can infer was because of the smoking, and then the second one was just based on Dr. Drake's report.

Tr., 66:3-67:17.

42. Claimant informed Employer that he was retiring on December 30, 2017, his 62nd birthday; thereafter, he applied for Social Security benefits in January 2018. *Id*. at 70:4-7; 107:7-16; 113:8-19.

43. Dr. Hansen examined Claimant again on January 4, 2018. Dr. Hansen noted that Claimant was "quite miserable and frustrated" due to his continued pain and weakness symptomatology. He offered Claimant help with smoking assistance but he declined. Dr. Hansen concluded that Claimant "still has sensory and motor changes consistent with radiculopathy on the left at L5." Dr. Hansen's recommendation continued to be a decompression on the left at L5-S1, and that Claimant would also likely benefit from a spinal cord stimulator for his residual lateral calf and dorsal foot pain, with the decompression to be performed first, followed by the spinal cord stimulator implantation depending upon the results of the first surgery. Claimant elected to undergo surgery. Ex. 33:544-550.

44. On January 10, 2018, Claimant filed an amended request for an emergency hearing. Defendants filed a response to the request on January 16, 2018. On January 17, 2018, the Referee held a telephone conference with counsel for the parties to discuss the issues raised by the amended request. The Referee took the matter under advisement pending receipt of additional medical documentation, which was a response by Dr. Hansen to the tobacco use impact questionnaire propounded by Defendants' counsel on December 15, 2017.

45. On January 19, 2018, Dr. Hansen responded to the questionnaire from Defendants' counsel.[1] Dr. Hansen affirmed that it was medically reasonable for Claimant to undergo a decompression surgery at L5-S1, despite his smoking. Dr. Hansen further stated that ongoing nicotine use may or may not have a negative impact on Claimant's recovery from surgery, but there was no accurate way to quantify any potential adverse affect smoking may have. In Dr. Hansen's experience, there were patients who smoked considerably more than Claimant who did well with compression surgeries with no adverse effects. He further noted that a fusion surgery was not contemplated for Claimant, and that there was clear medical evidence that smoking adversely affects the success of fusion surgeries. In Dr. Hansen's opinion, there was no medical consensus that smoking adversely affects the outcomes of disectomies or simple decompression procedures. He observed that the preponderance of medical literature demonstrates that smoking does not cause a higher failure rate from decompressions and discectomies. In Dr. Hansen's opinion, the critical issue was the amount of time that transpired between his injury and approval for surgery. Delay in approval for surgery was responsible for Claimant's ongoing pain. Dr. Hansen recommended decompression regardless of whether Claimant quit smoking. Nevertheless, he still considered quitting smoking "optimal" for Claimant, but Claimant's failure to quit smoking would not result in an inferior clinical result. Dr. Hansen continued to recommend decompression at L5-S1 on the left, with a hemilaminotomy at L5-S1, followed by the implantation of a spinal cord stimulator. Ex. 27:516-518.

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[1] At the January 17, 2018, telephone conference, counsel for Claimant explained the month-long delay in Dr. Hansen's response was due, in part, to the fact that his father had passed away in the interim. Additionally, the time period coincided with the Christmas and New Year holidays Dr. Hansen confirmed that his father was in the process of dying and receiving hospice care during the time period in question. Hansen Dep., 19:8-13.

46. Claimant's counsel filed a supplemental submission containing Dr. Hansen's January 19, 2018 letter. Defendants filed a supplemental response on January 29, 2018. On February 1, 2018, the Referee issued an order granting Claimant's amended request for an emergency hearing and scheduled the hearing for February 22, 2018.

47. **Claimant's Condition at Hearing**. With regard to whether he would return to work, Claimant stated in pertinent part as follows: "I would if I could, but currently I feel like I'm at 35, 40 percent back to normal … I have no quality of life. I'm not going to be able to do the things I wanted to do and – in my retirement years. I'm not going to be able to work. I'm going to be on pain medicine the rest of my life." Claimant still smoked at the time of hearing but was attempting to reduce or quit and had reduced his smoking to approximately a half pack of cigarettes per day. Tr., 103:18-104:10.

48. As of the date of hearing, Claimant had paid for pain prescriptions for his condition out of his own pocket that had not been reimbursed by Surety. *Id*. at 102:16-25; Ex. 32:529-531 (Claimant's Walgreens prescriptions for Morphine and Gabapentin, totaling $303.19).

49. **Credibility**. The Commission has no basis to challenge the Referee's findings that Claimant testified credibly at hearing. Defendants do not question Claimant's credibility.

50. The testimony of Ms. Warner, Surety's adjuster, while rendered credibly on its face, raised troubling implications regarding the sequence of events leading to Surety's denial of Dr. Hansen's surgical recommendations and the reasons for doing so. These concerns rendered her testimony unreliable. The specific details of this problematic testimony will be explored further in the discussion below concerning an award of attorney fees. The Commission has no basis to challenge the Referee's findings on Ms. Warner's credibility.

DISCUSSION AND FURTHER FINDINGS

51. The provisions of the Idaho Workers' Compensation Law should be liberally construed in favor of the employee. *Haldiman v. American Fine Foods*, 117 Idaho 955, 956, 793 P.2d 187, 188 (1990) (retraining benefits statute liberally construed to permit payment of travel-related retraining expenses rather than requiring claimant to pay them from his subsistence-level temporary disability benefits). 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) (substantial evidence supported Commission's finding that the industrial accidents did not cause claimant's breathing problems, where medical evidence was conflicting).

52. **Medical Benefits**. Idaho Code § 72-432(1) provides in pertinent part as follows: "The employer shall provide for an injured employee such reasonable … medicines … as may be reasonably required by the employee's physician … immediately after an injury … and for a reasonable time thereafter." Claimant bears the burden of proving that medical expenses are due to an industrial injury and must produce medical testimony that supports a claim for compensation to a reasonable degree of medical probability. *Langley v. State of Idaho, Industrial Special Indemnity Fund*, 126 Idaho 781, 785, 890 P.2d 732, 736 (1995) (medical testimony failed to demonstrate an industrial cause of damage to claimant's knee). A physician, not the Commission, must determine whether medical treatment is required; the Commission's role is to determine whether, based upon the totality of the circumstances, the medical treatment determined required by a physician is reasonable. *Chavez v. Stokes*, 158 Idaho 793, 798, 353 P.3d 414, 419 (2015) (bill for medical helicopter transport of claimant following his finger injury was reasonable medical care).

53. Defendants do not raise causation as a defense to Claimant's entitlement to the additional lumbar surgeries recommended by Dr. Hansen. Rather, they concentrate their argument against approving medical benefits solely on the reasonableness of providing the surgeries to Claimant because he is a habitual tobacco smoker (and the corresponding issue of an "unsafe/unsanitary practice"). They summarize their argument in pertinent part as follows: "It is critical to remember that the sole basis that this dispute exists and the resources for this hearing is being expended is that Claimant continues to make the voluntary choice every day to smoke cigarettes despite medical professionals telling him he should not do so. Indeed, if he were to have stopped engaging in this harmful conduct, there is no question that the surgery would have been authorized and completed at this point." Defendants' Post-Hearing Response Brief at 13.[2]

54. Dr. Hansen's medical opinion is that a surgical decompression of Claimant's L5-S1 nerve, followed by spinal cord stimulator implantation, are medically required. To determine whether such medical treatment is reasonable, the deposition of testimony of Dr. Hansen and Dr. Drake will be discussed below.

55. *Dr. Hansen*. Defendants took the deposition of Dr. Hansen on February 8, 2018. Dr. Hansen was an orthopedic spine surgeon who practiced medicine for thirteen years prior to the deposition. His entire practice consisted of orthopedic spine surgery. Hansen Dep., 4:18-24. He held a certification from the American Board of Orthopedic Surgery. *Id*. at 5:2-4. He was a 1999 medical graduate of the University of Illinois. He completed an orthopedic surgical residency in Omaha in a joint program of Creighton University and the University of Nebraska

[2] Defendants' position on causation at hearing is a complete reversal from their position after they obtained Dr. Drake's IME in August 2017. Based upon Dr. Drake's opinion at that time that Claimant had suffered a mere "back strain" as a result of the industrial accident, Defendants cut off both medical and income benefits to him.

Medical Center. He completed his training with a spine fellowship at the University of Indiana in Indianapolis. *Id*. at 5:6-23.

56. Dr. Hansen noted in regard to smoking in general as follows: "[S]moking is something that we document at every patient visit in my office, and we always encourage to stop smoking. I think it's important for patients to stop smoking, regardless of what health care I recommend and so I just explain that to them." Hansen Dep., 8:18-23.

57. Regarding his opinion that there was no consensus in the medical literature that smoking adversely affects the outcomes of a discectomy or simple decompression, Dr. Hansen stated that he was not relying on a single study or group of research papers. Rather, he explained in pertinent part as follows: "It was my overall impression through my training and experience as a surgeon, of meetings where I've attended where people have discussed literature, review articles I've read." *Id*. at 24:2-9.

58. To prepare for his deposition, Dr. Hansen reviewed specific articles in the medical literature concerning the impact of smoking on orthopedic surgical outcomes. One was *Patient Characteristics of Smokers Undergoing Lumbar Spine Surgery: an Analysis from the Quality Outcome Database*, published in the Journal of Neurosurgery Spine in December 2017. This article examined a large database of 7,547 patients with the data gathered retrospectively. The review examined whether the patients smoked or not as the focus of inquiry. It found that smoking "did not have any bearing on the effectiveness of decompression surgery." *Id*. at 9:25-10:13; 11:6-12:2.

59. A second article Dr. Hansen reviewed was entitled *The Effects of Smoking and Smoking Cessation on Spine Surgery: A Systematic Review of the Literature*. This was also a review article that looked at "a lot of the literature." Dr. Hansen noted that "most of the high

quality literature on smoking deals with fusions not on fusions with decompressions, but their conclusion was there is – the jury is out on smoking on whether – what its effects are on surgical outcomes, but that surgical outcomes in smokers undergoing surgeries seem to be worse than those of nonsmokers." *Id*. at 10:16-18; 12:7-18.

60. Dr. Hansen classified both review articles that he read as level four studies according to the seven levels of evidence in medical literature. Hansen Dep., 15:9-24.

61. Dr. Hansen explained his opinion that the potential risk of smoking to surgical outcomes is "theoretical and based on biological principles" in pertinent part as follows: "So all living structures require a blood supply to maintain life. Nicotine causes vasoconstriction, which means that structures have less of a blood supply. The blood supply is suboptimal if nicotine is present … And so any substance such as nicotine that inhibits the blood supply is a problem …" *Id*. at 25:15-19; 26:5-6. Thus, Dr. Hansen agreed that this biological principle suggests that there would be a theoretical higher risk of an adverse impact on the outcome of a decompression in an active smoker, including higher infection and re-operation rates; as well as other associated risks, such as bronchial spasm upon awakening from surgery. *Id*. at 26:8-30:5.

62. Nevertheless, as a general matter, Dr. Hansen found no consensus in the medical literature regarding the impact of smoking on surgical outcomes in decompressions, thus the exact likelihood that nicotine could negatively impact results in such surgeries is currently unknown. *Id*. at 33:13-25. With regard to spinal fusion surgeries, he observed as follows: "We have very good evidence in the medical literature that smoking decreases fusion rates … Because of the blood supply issue." *Id*. at 49:6-10. He distinguished compression surgery patients because "a smoker going to a fusion is almost predestined to fail, whereas someone who has got a nerve

compression from a disc herniation isn't destined to fail if they continue to smoke. They can still have a really good outcome." *Id*. at 49:15-19.

63. Dr. Hansen believed that Claimant would be better off with surgery, despite the fact that he still habitually consumed tobacco. He summarized his approach as follows

> I think that it would be better for Paul to stop smoking now for a lot of reasons, but in weighing the clinical decision on the timing of his surgery, you have to take into consideration a lot of other things. He's in a lot of pain. And in my opinion if – if we delay his surgery based on the theoretical possibility that if he stopped smoking for three months he might have a slightly better neurological outcome than if he had surgery now, I think that is less of an issue and less important than the fact that he's suffering, and he's in a lot of pain. And I honestly think we can help him with surgery.

Hansen Dep., 36:20-37:6.

64. Dr. Hansen reiterated his opinion that simply performing the L5-S1 decompression surgery would not solve Claimant's problem, because "the real operation that would help him would be the spinal cord stimulator." Dr. Hansen recommended the decompression surgery to occur first because Claimant "does have some current compression on his MRI scan" and when Dr. Hansen performed a steroid injection on his S1 nerve, "he did respond favorably." Thus, Dr. Hansen was following typical orthopedic protocol in performing all necessary decompression surgery first before turning to the therapy of a spinal cord stimulator. *Id*. at 37:7-38:14. The L5-S1 decompression surgery would not cure Claimant of his pain, but would result in less pain, assuming no complications and Claimant heals well. Then the spinal cord stimulator implantation would likely result in even less pain, giving him a better chance to reduce his narcotic pain reliance and resume normal activities of daily living. *Id*. at 43:17-44:2.

65. Dr. Hansen agreed that there was no further neurological risk to Claimant in waiting to perform surgery if he were required to quit smoking for a minimum of three months.

Nevertheless, he put the consequences of delaying surgery for Claimant in the following perspective: “You are putting a miserable guy who is suffering in a tailspin where he has no hope and no chance to improve his current situation of being in a lot of pain.” Hansen Dep., 46:12-23.

66. *Dr. Drake*. Defendants deposed Dr. Drake on March 12, 2018. At the time of deposition, Dr. Drake practiced medicine in Bethesda, Maryland. Drake Dep., 4:21-24. He graduated with a medical degree from Johns Hopkins University in 2004, then he completed his orthopedic surgery residency at Tripler Army Medical Center in Honolulu, Hawaii, in 2009. After his residency, Dr. Drake completed a hand surgery fellowship from 2009 to 2010. He was an active duty military orthopedic surgeon, board certified in both orthopedic surgery and hand surgery. Drake Dep., 5:5-23. 80% of his current practice is devoted to treating patients, with the remaining 20% devoted to forensic orthopedic work, such as IMEs, utilization reviews, and disability reviews. *Id*. at 6:20-7:5.

67. Dr. Drake’s sole experience with treating the spine occurred during his residency when he had a rotation in spinal surgery. *Id*. at 8:11-20. His role in spinal surgeries during his residency rotation was to aid and assist in those surgeries, with his last surgical role happening in 2009. Dr. Drake was not been a primary surgeon performing fusions, discectomies, laminectomies, or hemilaminectomies during his post-residency/fellowship practice of medicine. *Id*. at 43:22-45:1.

68. The last time Dr. Drake denied a patient a surgery based upon a smoking habit was two to three years prior to his deposition. *Id*. at 51:24-52:6. It was uncommon for him to deny surgery to a patient on this basis because his practice was exclusively in upper extremity surgery, “and a lot of them are tissue surgeries with low infection rates, so smoking status is not as important as it is in spinal surgery.” *Id*. at 6-12.

69. Although Dr. Drake was licensed to practice medicine in seven states, including Idaho, the only state where he actually currently practices medicine is Maryland. He maintained licensure in the other states, including Idaho, solely for the purpose of conducting IMEs and other forms of forensic medicine. *Id*. at 42:5-43:18. He performed approximately 20 or 30 IMES for OMAC each month. Drake Dep., 47:2-3. No claimants had retained Dr. Drake to perform IMEs in Idaho; he performed his IMEs exclusively for defendants. *Id*. at 48:21-23.

70. Dr. Drake relied primarily upon the two studies that he attached to response to Surety's tobacco questionnaire (referenced above) to conclude that smoking was a substantial risk factor for Claimant having a poor outcome, including infection, in undergoing lumbar decompression surgery. He graded both studies as level three to four out of the seven classification levels of medical evidence. The first study tracked 2,500 patients who had lumbar decompression surgery to address spinal stenosis. He found that the study concluded that "smoking is a predictor of dissatisfaction after the surgery. Meaning that if someone is an active smoker, the lumbar decompression surgery is much less likely to be beneficial to them." *Id*. at 17:22-18:1. The second study tracked risk factors for developing an infection after lumbar surgery in all types of spinal surgery, including fusions and decompressions. He concluded that it showed that the "infection rate is significantly higher in people that are smoking at the time of their procedure." *Id*. at 21:8-10.

71. Dr. Drake applied the findings of these studies to Claimant as follows: "They apply directly. He's already had one surgery on his spine, which has failed to relieve his symptoms, and now a second one is being proposed. So his current situation actually is quite nice to show why the literature is what it is. Spinal surgery in smokers doesn't go very well." *Id*. at 27:5-10. Dr. Drake concluded as follows: "The bottom line is that his [Claimant's] smoking

status makes him at risk for number one, the procedure not being that effective, meaning that he won't feel that he got much out of it. And number two, it sets him up for potential wound problem after surgery." *Id.* at 35:25-36:5. In Dr. Drake's opinion, Claimant's smoking is a "practice that tends to impair or retard his recovery from the L5 hemilaminotomy." Drake Dep., 37:15-19.

72. *Weighing the Medical Evidence*. The medical opinion of Dr. Hansen is entitled to more weight than that of Dr. Drake on the issue of whether it is unreasonable for Claimant to undergo further lumbar surgery while he continues to smoke, as discussed below.

73. Dr. Drake was the author of an IME opinion dated August 24, 2017 that concluded that further treatment of Claimant was not reasonable because there was a lack of a causal connection between the industrial accident and Claimant's lumbar condition and radiculopathy, which he diagnosed as a mere back strain. Nevertheless, the weight of the medical evidence, comprised of the opinions of both Dr. Stromberg, Defendants' first IME physician, and Dr. Hansen, Claimant's treating surgeon, found that Claimant's condition was industrially-related. Dr. Hansen convincingly criticized Dr. Drake's causation analysis in his letter of October 9, 2017, the reasoning of which does not need to be repeated here.

74. Dr. Hansen's critique of Dr. Drake's causation analysis appears to have been enough to cause Surety to authorize further treatment, at least in the form of an MRI and additional visits with Dr. Hansen. And by the time of hearing and post-hearing briefs, Defendants had completely abandoned Dr. Drake's causation analysis as an argument against coverage of Claimant's medical treatment. Dr. Drake's discredited causation analysis, therefore, does not inspire confidence in his supplementary opinion on whether Claimant's smoking should prevent him from receiving further lumbar surgery.

75. The fact that Dr. Drake has not practiced spinal orthopedic medicine is relevant to the weight given to his opinion. Dr. Drake's subspecialty was hand surgery and he practiced orthopedic medicine exclusively on the upper extremities of patients. He never took the lead on a spinal surgery and the last time that he assisted or aided in such a surgery was during a rotation in his residency, prior to his practice. Thus, Dr. Drake was opining in an area of medicine and on a body part for which his expertise was confined to medical school instruction and a brief surgery rotation during his residency. While he may have been a board certified orthopedic surgeon, in this matter he was less qualified to provide a fully-informed opinion than Dr. Hansen.

76. In contrast, Dr. Hansen is a board certified orthopedic surgeon whose practice is devoted to spinal surgeries of all kinds, including fusions and decompressions. It is reasonable to give more weight to the opinion of Claimant's treating surgeon who regularly practiced in the area the applicable area of medicine.

77. Dr. Drake's opinion on the surgical consequences of smoking brooked no ambiguity or nuance. His certainty that Claimant's status as a habitual smoker would risk a poor surgical outcome, based upon two studies of middle weight evidence, does not enhance the trustworthiness of his opinion. With his own patients for whom he performed surgeries of the upper extremity, Dr. Drake found little occasion to deny surgery due to smoking; he acknowledged that medical literature did not justify such a measure based upon adverse consequences such as higher infection rates. Nevertheless, Dr. Drake would not acknowledge a similar nuance with spinal fusion surgeries, in which the consequences of smoking were well documented, and spinal decompressions/discectomies, where the risk of smoking was not as well documented.

78. Dr. Hansen acknowledged that there is some medical evidence that continued smoking by spinal surgery patients, including those receiving decompressions, risked poor outcomes. Nevertheless, his review of the literature, combined with his experience as a surgeon, informed his opinion that there was less risk for smokers undergoing decompression and discectomy procedures. Dr. Hansen made a good case that the risk was much higher in fusion patients, whose fusions would likely fail because of the critical blood supply issue. Dr. Drake, however, predicted the same dire outcomes for decompression patients, which does not even make sense from a biological perspective. (If the purpose of a decompression surgery is to relieve the "pressure" on a nerve, this would appear to be beneficial to the blood supply, not make further demands upon it as in a fusion surgery.)

79. Dr. Drake applied reductive reasoning to Claimant's case, calling it a perfect example of the studies which suggest poor outcomes, because Claimant had a "poor" outcome from his first decompression surgery, i.e., he was not satisfied with the result due to continued pain, weakness, and neuropathy symptoms. Nevertheless, there is no direct evidence in the record that Claimant's smoking caused a "poor" result from his first decompression surgery. This is a mere inference that both Dr. Drake and Ms. Warner drew, based upon their overall concerns about the health impacts of smoking on spinal surgery patients.

80. A plausible explanation for Claimant's continued symptomatology following his first surgery was the one that Dr. Hansen posited – that the seven month plus delay between Claimant's industrial injury and his first surgery resulted in sufficient nerve damage that could not be remedied, thus Claimant would continue to have symptomatology in any event without further medical intervention.

81. Dr. Drake, in his eagerness to demonstrate that Claimant's "poor" surgery result was proof that his smoking was the cause, nevertheless conveniently ignored the fact that Claimant suffered no post-surgical infection, a risk of smoking that Dr. Drake spent considerable time in his deposition discussing. Nonetheless, the fact that Claimant suffered no such complications is not proof that smoking has no such consequence, no more than the fact that if he had suffered a post-surgical complication such as an infection would be proof that smoking was the cause. The reality is that Claimant has multiple risk factors for poor surgical results, including his age, body mass index, and the delay in performing the original surgery, in addition to smoking. Spinal surgeries are complex procedures and their outcomes, good or bad, cannot always be neatly explained nor can they be guaranteed.

82. Finally, Dr. Hansen made a convincing argument that reducing every conceivable "preventable" risk such as smoking to a poor surgical outcome is not the only factor to consider when determining the reasonableness of performing additional lumbar surgeries on Claimant. Yes, first do no harm, but that is not the only duty. The ultimate duty of the physician is to alleviate a patient's suffering, if at all possible. Dr. Hansen seemed more appropriately focused on that objective, and that is more reasonable than Dr. Drake's harm reduction preoccupation.

83. For all the foregoing reasons, Dr. Hansen's proposed surgeries, including decompression at L5-S1 and spinal cord stimulator implantation, constitute reasonable medical treatment.

84. Claimant is also entitled to reimbursement of the unreimbursed prescriptions he paid for from his own pocket that were outstanding at the time of hearing.

85. **Injurious Practices**. Defendants argue that Claimant's continued smoking habit constitutes an injurious practice that warrants the suspension of his workers' compensation

benefits, including the proposed surgery, while he continues to engage in it. *See*, Defendants' Post-Hearing Response Brief at 15. Defendants argue that "there is no dispute" that smoking constitutes an injurious practice as contemplated by Idaho Code § 72-435. *Id*.

86. Idaho Code § 72-435 states as follows:

> **Injurious practices – Suspension or reduction of compensation.** If an injured employee persists in unsanitary or unreasonable practices which tend to imperil or retard his recovery the commission *may* order the compensation of such employee to be suspended or reduced.

[Emphasis added.]

87. Defendants rely upon the fact that Dr. Hansen acknowledged that there are potential harmful surgical outcomes associated with smoking for their argument that it is "undisputable" that Claimant's smoking is an injurious practice contemplated by the statute. Nevertheless, as discussed above, the fact of Claimant's smoking *per se* does not render Dr. Hansen's recommendation for further lumbar surgery unreasonable. Claimant's smoking is only one factor to consider. His well being in the reduction of his pain is, under the totality of the circumstances, more important than the risk presented by his smoking.

88. The "injurious practices" provision in Idaho Code § 72-435 is not frequently litigated. There is not a single Idaho Supreme Court case interpreting the provision. There were only 19 Commission cases referencing it between 1984 and 2015. The single case cited by Defendants, *Osterhoudt v. Quality Truss & Lumber, Inc*, 2005 IIC 0645 (9/26/2005), involved a claimant who received a spinal fusion surgery covered by the surety. There was a dispute in the medical evidence, with claimant's treating surgeon opposed to a re-fusion surgery because he did not agree that the fusion had failed, while a third opinion by an orthopedic surgeon found that claimant's fusion was a "probable nonunion." *Osterhoudt*, 2005 IIC 0645.11. The IME physician, Dr. Montalbano recommended a re-fusion surgery but opined that it should not go

forward until Claimant quit smoking. *Id.* at 14. The referee agreed that claimant's surgical re-fusion should be suspended until he ceased smoking, as follows: "Dr. Montalbano attributed Claimant's pseudoarthrosis to his smoking. The Referee finds the diagnostic and surgical procedures recommended by Dr. Montalbano will not benefit Claimant until such time he ceases to smoke. Thus, the Referee concludes these procedures are suspended until such time Claimant stops smoking." *Osterhoudt*, 2005 IIC 0645.18.

89. *Osterhoudt* is distinguishable from the present case. It involved a fusion surgery, which Dr. Hansen pointed out that the medical literature clearly associates with poor outcomes due to smoking, such as a nonunion. This is not a fusion surgery case but a decompression surgery, together with spinal cord stimulator implantation. Dr. Hansen's credible opinion is that the risks associated with decompression and smoking are not as clearly presented as they are in fusions and that Claimant may have a good result despite his smoking.

90. Two other Commission cases addressed smoking and the injurious practices statute. In *Pillsbury v. Haras Incorporated*, 1990 IIC 0874 (11/21/1990), defendants argued that claimant was not entitled to permanent physical impairment benefits because they alleged that her impairment had been extended or increased because she was a smoker. The referee disagreed, finding that claimant's smoking was an addiction and a nonmedical factor relevant to disability, not an unsanitary or unreasonable practice within the meaning of Idaho Code § 72-435. *Id.* at 5. In *Casner v. Woodgrain Mouldings, Inc.*, 1992 IIC 0134 (2/21/1992), claimant's physician requested her to quit smoking, but she did not. The evidence did not support a finding that Claimant's smoking was directly related to her recovery but that the doctor's request may have been made simply for her "general well being," thus the referee did not reduce claimant's benefits due to her smoking. *Id.* at 12.

91. From the above discussion, it may be reasonably concluded that the Commission has not held that smoking constitutes an injurious practice *per se* pursuant to Idaho Code § 72-435, as Defendants appear to invite the Commission to conclude in this case. Rather, the Commission's approach to smoking has been to determine, under all the facts and circumstances of each case, whether it constitutes such a detriment to the injured worker's recovery that the strict remedy of withholding benefits must be applied.

92. Under all the facts and circumstances, and particularly taking the opinion of Dr. Hansen, Claimant's treating physician, into account, Claimant's benefits should not be suspended or reduced.

93. For the foregoing reasons, the proposed surgeries shall not be withheld or suspended due to Claimant's smoking pursuant to Idaho Code § 72-435.

94. **Temporary Disability**. Idaho Code §72-408 defines an injured worker's right to temporary total or temporary partial disability benefits during a period of recovery. That section provides in pertinent part:

> 72-408. INCOME BENEFITS FOR TOTAL AND PARTIAL DISABILITY. Income benefits for total and partial disability during the period of recovery, and thereafter in cases of total and permanent disability, shall be paid to the disabled employee subject to deduction on account of waiting period and subject to the maximum and minimum limits set forth in section 72-409, Idaho Code, as follows:
> (1) For a period not to exceed a period of fifty-two (52) weeks, an amount equal to sixty-seven per cent (67%) of his average weekly wage and thereafter an amount equal to sixty-seven per cent (67%) of the currently applicable average weekly state wage

The term "disability" as used in Idaho Code §72-408 is defined as follows:

> (11) "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 in section 72-430, Idaho Code.

Therefore, during a period of recovery from an injury or occupational disease, temporary disability shall be paid for loss of earning capacity associated with the work accident. Once established, the entitlement to temporary disability may be curtailed only upon demonstration that Claimant has been released to light-duty work and that (1) his former employer has made an offer of work consistent with his restrictions and which is likely to continue, or (2) that employment is generally available to Claimant consistent with his light-duty restrictions within his labor market. (See *Malueg v. Pierson Enterprises*, 111 Idaho 789, 727 P.2d 1217 (1986). Here, Surety discontinued temporary disability benefits on or about September 6, 2017 in reliance on the results of Dr. Drake's August 24, 2017 IME. As developed *infra*, Dr. Drake opined that Claimant suffered only a lumbar strain as a consequence of the subject accident and that he was at a point of maximum medical improvement from this injury as of the date of the IME. Based on this opinion, Surety issued a notice of change of status discontinuing further medical and time loss benefits.

95. Of course, Surety has since abandoned this causation defense, and concedes that Claimant is yet in a period of recovery from the effects of the work accident and requires further medical/surgical treatment. The remaining defense to providing Claimant the medical/surgical treatment he requires is that his refusal to abandon smoking makes him a poor surgical risk, and constitutes an injurious practice under Idaho Code §72-435. As explained above, we reject these remaining defenses to the provision of medical treatment proposed by Dr. Hansen.

96. From the foregoing, we conclude that Claimant is still in a period of recovery since he has not been provided the medical treatment which we have found reasonable. For his part, Dr. Hansen indicated in his letter of November 29, 2017 that Claimant is "currently" unable to work and that this restriction has been in place since before the March 15, 2017 surgery.

Nothing in the record establishes a change in Dr. Hansen's opinions concerning Claimant's current functional ability. In light of Dr. Hansen's recommendation that Claimant is unable to work, we do not reach the question of whether Claimant's TTD benefits are subject to curtailment per *Malueg, supra*. *Malueg* applies only in those cases where claimant has been released to light-duty work.

97. Based on these facts we conclude that Claimant has been in a period of recovery since his TTD benefits were curtailed by Surety on September 6, 2017. The evidence demonstrates that he has suffered a decrease in wage earning capacity as the result of the subject accident and that he is entitled to benefits pursuant to Idaho Code § 72-408 until such time as he is declared medically stable. We note Claimant's December 30, 2017 retirement, but do not find that this impacts his entitlement to temporary disability benefits pursuant to Idaho Code § 72-408. First, such benefits are payable based on a loss of wage earning capacity related to the industrial accident and this is demonstrated by the evidence, retirement or no. Second, the evidence establishes that Claimant's decision to retire was not made independent of his industrial accident. He testified that he would work if he could, but that his persistent pain/discomfort has left him unable to work. Tr., 103/18-104/10.

98. In summary, we conclude that Claimant is entitled to temporary disability benefits payable per Idaho Code § 72-408 from September 6, 2017 until such time as he is found to be medically stable.

99. **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.

100. The decision that grounds exist for awarding attorney fees is a factual determination that rests with the Commission. *Troutner v. Traffic Control Company*, 97 Idaho 525, 528, 547 P.2d 1130, 1133 (1976) (surety did not unreasonably delay determination of employee's claim, thus was not liable for attorney fees). Statutory attorney fees pursuant to Idaho Code § 72-804 are awardable if the employer/surety: (a) contested a claim without a reasonable ground; (b) neglected or refused to pay the compensation within a reasonable time after receipt of a written claim; or (c) discontinued payment of compensation without reasonable grounds. *Anderson v. Harpers, Inc.*, 143 Idaho 193, 200, 141 P.3d 1062, 1069 (2006) (Commission's award of attorney fees upheld due to unreasonable denial and delay of benefits).

101. There are several grounds upon which an award of attorney fees pursuant to Idaho Code § 72-804 is proper. First, this claim was accepted and Claimant's first lumbar decompression surgery was approved based upon an independent medical opinion commissioned by Defendants from Dr. Stromberg, an Idaho spinal orthopedic surgeon, that his lumbar condition was industrially related and the required treatment was a decompression surgery. After Claimant received that surgery but was still symptomatic, his treating physician, Dr. Hansen, indicated that the next steps would be further decompression surgery at L5-S1, followed by a spinal cord stimulator implantation. Rather than returning to Dr. Stromberg to determine the reasonableness of this treatment, Defendants retained the services of Dr. Drake, who supplied an

opinion that not only was further lumbar surgery unreasonable, but the first surgery was also unreasonable and Claimant's condition was not industrially-related.

102. It was not reasonable for Defendants to rely upon Dr. Drake's opinion in this regard by cutting off benefits on September 6, 2017. Although a board certified orthopedic surgeon, Dr. Drake's specialty was hand surgery and he had never performed spinal surgery except as an assistant during his clinical rotation during his residency. Defendants appear to have understood their error in relying upon Dr. Drake's questionable causation opinion because they seem to have forgotten it altogether at hearing and in post-hearing briefing.

103. Second, Defendants never gave Dr. Hansen an adequate opportunity to respond to Dr. Drake's IME and cut off benefits before he had a chance to respond. When Dr. Hansen did forcefully respond, providing a strong critique of Dr. Drake's causation analysis, in October 2017, Defendants begrudgingly agreed to reconsider, but only after Claimant filed a request for an emergency hearing.

104. Third, Counsel for the parties represented to the Referee at the November 30, 2017 telephone conference that the parties had the "medical portion worked out." Counsel for Defendants also assured Claimant's counsel in an email message on November 20, 2017, that "of course" the MRI was approved and there was an "intention" that the surgery would similarly be approved, provided that a positive recommendation was received for it from Claimant's surgeon.

105. Surety's adjuster, Ms. Warner, however, disavowed the representations of her legal counsel to both the Referee and opposing counsel. It is possible that she and her legal counsel were not communicating effectively about this matter, although that is unlikely. Regardless, the situation as it developed amounted to a bait and switch. Defendants temporarily delayed an order for an emergency hearing by assuring that Claimant would receive the medical

treatment that his physician required. This extended, however, only to additional doctor's visits and a new MRI. Defendants also delayed the matter by insisting, bureaucratically, that Dr. Hansen had not properly or formally "requested" the surgical procedures in question, although they fully understood from summer of 2017 on and certainly with Dr. Hansen's October 20, 2017 letter responding to Dr. Drake's IME what Dr. Hansen's preferred treatment plan was.

106. Ms. Warner asserted at hearing that she was merely waiting for the results of the MRI and a formal request from Dr. Hansen to decide whether to approve the surgery. Then the MRI was performed and Dr. Hansen submitted the required formal letter requesting approval of the surgery on December 20, 2017. Dr. Hansen's letter, sent to the attention of Ms. Warner and Surety, must have crossed in the mail with the tobacco use questionnaires sent by Defendants' counsel on December 15, 2017.

107. Ms. Warner undoubtedly already had tobacco use in mind as a basis to deny Claimant's surgical requests, because she had included it in as an IME question to Dr. Drake back in August 2017, and he had responded that smoking was generally associated with poor surgical results. In any event, Dr. Drake's more prompt response to the tobacco questionnaire in December 2017, indicating that surgery was unreasonable in light of Claimant's smoking, was all that Surety needed to decide to refuse to authorize Claimant's surgeries. Ms. Warner stated that she did not issue any kind of status change notice to Claimant indicating that the surgeries would not be approved, which was likely not improper in light of the fact that the benefits denial notice from September 2017 was still in effect.[3] While Dr. Hansen's response to the questionnaire was significantly delayed, Surety dispensed with the pretense of waiting to see

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[3] In hindsight, it would have been prudent for Claimant to demand that Surety issue a status change notice appropriately reflecting the settlement reached between counsel for the parties.

what he had to say about the matter before communicating that Dr. Hansen's surgical plan would not be approved.

108. The sequence of events, as described above, demonstrated arbitrary and dilatory behavior on the part of Surety in adjusting this claim, beginning with the decision to obtain a second IME from a physician who was not appropriately credentialed to render an informed opinion. Defendants thus unreasonably delayed Claimant's surgical treatment, prolonging his suffering due to the pain associated with his condition. Defendants initially relied upon a questionable causation opinion authored by Dr. Drake in August 2017 to deny further treatment. Once that became untenable, they appeared to enter into a good faith settlement of the matter by agreeing to cover the additional medical treatment, including doctor visits, a new MRI, and the surgeries. Regardless of whether this stipulation accurately represented Surety's intentions towards adjusting the claim, the commitment made by Defendants' counsel should have been honored, as it induced Claimant to rely upon it to his detriment by abandoning his first request for an emergency hearing on November 30, 2017. The Defendants then surfaced the smoking issue in December 2017 to provide a new basis for denial, knowing full well how Dr. Drake would respond because they had already asked him this question as part of his original IME. Again, Defendants undertook this new smoking endeavor without even bothering to wait for Dr. Hansen's opinion on it.

109. For the foregoing reasons, Claimant is entitled to recover attorney fees pursuant to Idaho Code § 72-804.

CONCLUSIONS OF LAW AND ORDER

1. Dr. Hansen's plan of treatment, including lumbar decompression surgery at L5-S1, followed by implantation of a spinal cord stimulator, is reasonable.

2. Claimant is entitled to reimbursement for his prescription costs that were unpaid at the time of hearing.

3. Idaho Code § 72-735 does not require that Claimant's medical treatment be suspended or delayed because Claimant has engaged in an unsanitary or unreasonable practice that tends to imperil his recovery.

4. Claimant is entitled to temporary disability benefits payable per Idaho Code §72-408 from September 6, 2017 until such time as he is found to be medically stable.

5. Claimant is entitled to recover attorney fees from Defendants pursuant to Idaho Code § 72-804 based upon Defendants' unreasonable denial and/or delay of benefits. Unless the parties can agree on an amount for reasonable attorney's fees, Claimant's counsel shall, within twenty-one (21) days of the entry of the Commission's decision, file with the Commission a memorandum of attorney fees incurred in counsel's representation of Claimant in connection with these benefits, and an affidavit in support thereof. The memorandum shall be submitted for the purpose of assisting the Commission in discharging its responsibility to determine reasonable attorney fees and costs in the matter. See *Hogaboom v. Economy Mattress*, 107 Idaho 13, 684 P.2d 900 (1984). Within fourteen (14) days of the filing of the memorandum and affidavit thereof, Defendant may file a memorandum in response to Claimant's memorandum. If Defendant objects to any representation made by Claimant, the objection must be set forth with particularity. Within seven (7) days after Defendant's response, Claimant may file a reply

memorandum. The Commission, upon receipt of the foregoing pleadings, will review the matter and issue an order determining attorney fees and costs.

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

DATED this __13th__ day of August, 2018.

INDUSTRIAL COMMISSION

_______/s/__________________
Thomas E. Limbaugh, Chairman

_______/s/__________________
Thomas P. Baskin, Commissioner

_______/s/__________________
Aaron White, Commissioner

ATTEST:

_________/s/____________________
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __13th__ day of ____August________, 2018, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** was served by regular United States Mail upon each of the following:

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RACINE OLSON
PO BOX 1391
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~~sjw~~ el

_/s/_______________________________