BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

ERVIN DANE ASH, Claimant, v. TYONEK NATIVE CORP., Employer, and THE FIRST LIBERTY INSURANCE CORP., Surety, Defendants.	**IC 2011-004707** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **Filed December 20, 2018**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Brian Harper, who conducted a hearing in Coeur d'Alene, Idaho, on September 12, 2017. Claimant was represented by Bradley Stoddard, of Coeur d'Alene. Joseph Wager, of Boise, represented Tyonek Native Corp., ("Employer"), and The First Liberty Insurance Corp., ("Surety"), Defendants at hearing.[1] Oral and documentary evidence was admitted. Post-hearing depositions were taken and the parties submitted post-hearing briefs. The matter came under advisement on June 12, 2018. Referee Harper submitted proposed Findings of Fact, Conclusions of Law, and Order to the Commission on September 28, 2018. The Commission has carefully reviewed the proposed

[1] While Mr. Wager was counsel for Defendants at the hearing, by the time a briefing schedule was prepared, Matthew Vook had substituted for Mr. Wager as Defendants' attorney of record; by the time Defendants' brief was filed, David Farney was attorney of record for Defendants; and by the time these Findings of Fact were completed, attorney Judith Atkinson had assumed the role of counsel of record for Defendants.

decision, and though in agreement with the ultimate outcome, elects to issue its own Findings of Fact, Conclusions of Law, and Order to give further treatment to the medical opinions at issue on the question of causation, the evaluation of disability, and consideration of apportionment under Idaho Code § 72-406.

ISSUES

The issues to be decided are whether and to what extent Claimant is entitled to the following benefits:

a. Medical care;

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

c. Permanent Partial Impairment (PPI);

d. Permanent Partial Disability in excess of Impairment (PPD);

e. Total Permanent Disability pursuant to the odd lot doctrine or due to 100% disability; and

f. Attorney fees.

CONTENTIONS OF THE PARTIES

On February 11, 2011, Claimant injured his back while attempting to unload a welder. At the time, Claimant was acting within the course and scope of his employment with Employer. Defendants accepted Claimant's lumbar compression fracture claim and resultant surgery.

Claimant argues he needs a fusion surgery which Defendants refuse to authorize. Claimant is not at MMI, is currently limited to sedentary work, and without surgery is totally and permanently disabled. Claimant is entitled to temporary disability benefits

until he recovers from his proposed fusion. Also, Defendants have underpaid Claimant's PPI benefits. Claimant is entitled to attorney fees.

Defendants argue Claimant reached MMI on April 5, 2012; all medical benefits and temporary disability claims thereafter should be denied. Claimant's argument for additional medical care thereafter is for conditions not causally related to the industrial accident in question. Claimant has been paid the proper measure of PPI benefits. Furthermore, he is not totally and permanently disabled, nor has he suffered a permanent disability greater than impairment. Attorney fees are not appropriate.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. Claimant's testimony, taken at hearing;
2. Claimant's Exhibits (CE) A through OO, admitted at hearing;
3. Defendants' Exhibits (DE) 1 through 7, admitted at hearing;
4. The post-hearing deposition transcript of John McNulty, M.D., taken on November 6, 2017;
5. The post-hearing deposition transcript of Douglas Crum, taken on December 12, 2017;
6. The post-hearing deposition transcript of Jeffrey Larson, M.D., taken on January 30, 2018;
7. The post-hearing deposition transcript of Mary Barros-Bailey, Ph.D., taken on March 6, 2018; and
8. The Idaho Industrial Commission's file on this matter.

CLAIMANT'S MOTIONS TO STRIKE

At the outset, Claimant raised objections to the depositions of Dr. Larson and Dr. Barros-Bailey, moving the Commission to strike and disregard the depositions in their entireties due to an alleged lapse of procedural protocol. Specifically, counsel argued there was no notice of the depositions provided to Claimant, as required by JRP 10 (E) 1, at least ten days prior to hearing. Claimant also objected to the fact Defendants had not moved for an enlargement of time to take the depositions as per JRP 10 (E) 3. Finally, Claimant objected to the depositions because Defendants had not substantively answered discovery requiring them to identify their expert witnesses, list the subject matter on which said expert would testify, provide the substance of the facts and opinions on which the expert would testify, and list the expert's educational background and qualifications. Claimant likewise moved to exclude Dr. Barros-Bailey's CV, offered as an exhibit to the deposition, on the ground it had not been provided in response to discovery.

Defendants responded by noting that JRP 3 requires all motions not made at hearing to be made in writing and provide opposing counsel 14 days to respond, which Claimant failed to do. Also, Claimant's counsel sat quietly at hearing while the depositions in question were discussed on the record, and therefore waived any right he might have had to object. Finally, Defendants' Rule 10 disclosures listed the fact that the above-identified experts would be deposed post hearing.

With regard to Dr. Barros-Bailey's CV, since it was not produced at any point in the discovery process, it is not admitted as an exhibit to her deposition, and will not be reviewed by the undersigned. It should be noted that the Commission is very familiar with Dr. Barros-Bailey's credentials. She is a frequently-used expert and the exclusion of her

CV is not a basis to diminish the weight given to her opinions, as she is a qualified expert on the subject of forensic vocational evaluation. Furthermore, she testified to her qualifications during her deposition.

Claimant's arguments in favor of striking Defendants' post-hearing depositions are not well taken. While it is true that Defendants' then-attorney Mr. Wager did not file a "place holder" Notice of Deposition[2], as is customary, he did file a copy of his Rule 10 disclosures which listed the experts as testifying via post-hearing deposition. Additionally, during the pre-hearing telephone conference with the Referee and counsel for the parties on August 25, 2017, the topic of post-hearing depositions was specifically addressed and defense counsel mentioned that such depositions would take place. At hearing, on the record, Defendants confirmed their intent to depose these experts and Claimant's attorney said nothing in opposition.

Attorneys practicing in Idaho should understand that "gotcha" tactics are discouraged in the workers' compensation setting. Technical objections without supporting prejudice are generally disfavored. It is not the intent of the Judicial Rules of Practice and Procedure to give attorneys a sword to use against unwary, or even sloppy opposing counsel, but to allow all parties the opportunity to move through the litigation process in an orderly fashion without undue surprise or prejudice. As shown below, Claimant was neither unduly surprised nor prejudiced by the actions of Defendants.

Claimant knew these depositions were going to take place well before the hearing, because this was revealed in Defendant's timely JRP 10(C) disclosure. While, JRP 10(E)

[2] A very common practice is for the parties to file a "Notice of Deposition" with no time or date included in the notice, and then work with the deponent and other counsel to arrange for the deposition at a time available to all. This "place holder" notice is used to satisfy the technical requirements of Rule 10 E 1, while acknowledging the reality that arranging a mutually-convenient time to depose experts often takes some doing such that it is not completed by the time of hearing.

specifies that the post hearing depositions of experts may only be taken subject to notice filed with the Commission no later than 10 days prior to hearing, thus lending technical credence to Claimant's position, we conclude that requiring compliance with the rule under these circumstances would elevate form over sensibility.

In addition, Claimant should have objected at the time of hearing when post-hearing depositions were being discussed if he felt Defendants had given inadequate notice. Failure to timely object certainly gave the appearance that Claimant had no issues with Defendants taking the depositions. The situation is analogous to a party failing to object to certain jury instructions, and then subsequently appealing their inclusion. In such circumstances our Supreme Court will not consider such untimely objections. *E.g.*, *Bolognese v. Forte*, 153 Idaho 857, 292 P.3d 248 (2012). The same logic applies to Defendants' failure to move for an extension of time. As was discussed on the record, the Commission understands the often-unrealistic time frame imposed by JRP Rule 10, and using our discretion allows counsel to arrange for depositions outside of such time frame without the need for a motion to extend time. This practice was put on the record at hearing. If Claimant's counsel objected to this practice he should have so noted at the hearing. Defense counsel could then have moved for an extension on the record.

Claimant's motions to strike the depositions of Drs. Larson and Barros-Bailey are denied.[3]

All other objections preserved during the depositions are overruled.

[3] It is understandable if Claimant's counsel was frustrated by Defendants' actions. Claimant's attorney "played by the book" in this matter; he filed Notices of Depositions – complete with dates and times – in a timely fashion prior to hearing, and moved for an extension of time to complete those depositions. Claimant's attorney's actions are commendable and exhibit a standard all attorneys should strive for, but the fact that he did everything right does not provide justification for ambush tactics when opposing counsel's conduct is less-than-ideal, but not prejudicial to Claimant.

FINDINGS OF FACT

1. At the time of hearing Claimant was 67 years old. His expertise is in the field of construction, construction management, welding, and welding inspection. His work experience is global. Claimant's work duties range from sedentary to very heavy in nature, depending on the project. Extensive travel is required.

2. In 2010, Claimant went to work for Employer as a construction director earning $72.12 per hour.

3. While in the course and scope of his employment with Employer on February 11, 2011, Claimant was attempting to remove a welder from the trunk of his car when he slipped on ice, causing him to fall backwards to the ground with the welder on top of him. Claimant felt immediate intense pain in his low back and down his legs.

4. Claimant saw Thomas Nickol, M.D., at Kootenai Medical Center Emergency Room on February 14, 2011 for his continuing back pain and weakness with difficulty walking. Claimant was diagnosed with an acute L1 compression fracture, and acute herniated disks at L3-4 and L4-5. Claimant was referred to Bret Dirks, M.D., a local neurosurgeon, who examined Claimant on February 15, 2011.

5. In his history, Dr. Dirks noted Claimant complained of bilateral leg weakness which "do go out from underneath of him randomly when he has a shooting pain in his lower back." CE R, p. 1. Dr. Dirks interpreted the radiological studies as showing the L1 fracture, stable, and multi-level disk degeneration fairly severe at L3-4, 4-5, and L5-S1. Dr. Dirks felt the compression fracture should heal on its own, but Claimant's sacroiliac pain complaints warranted a series of SI injections. Claimant was also prescribed physical therapy.

6. The SI injections helped Claimant's sacroiliac pain to the point where by April 21, 2011 Dr. Dirks noted that Claimant's sacroiliac pain was much improved and he was weaning off of narcotic pills and his back brace, which had been prescribed earlier in his treatment regimen. Dr. Dirks felt Claimant was fixed and stable, and released Claimant to return on an "as needed" basis.

7. Claimant returned to Dr. Dirks nine weeks later, on June 28, 2011. Claimant was hurting in his lower thoracic and upper lumbar region. X-rays showed the previously-diagnosed compression fracture. Dr. Dirks ordered a vertebroplasty and additional rehabilitation therapy at a chiropractic center.

8. On August 2, 2011 Casey Fatz, M.D., radiologist, performed a kyphoplasty (similar procedure to vertebroplasty) to inject bone cement into Claimant's L1 fracture. Claimant did not improve. Three weeks after the procedure, Claimant presented to Dr. Dirks with a history of a recent fall down stairs due to muscle cramps and spasms in his low back. Claimant had difficulty walking fully erect. Claimant's chief complaint through this time frame was falling when he experienced episodes of sharp pain in his low back which led to his legs giving out.

9. A repeat MRI in September 2011 showed mild impingement of the L5 nerve root/ganglion bilaterally due to annular bulging, mild to moderate spinal stenosis at L4-5 with bilateral mild compression of the L5 nerve root. At L3-4 there was mild disk degeneration with mild narrowing impinging on the L4 nerve root bilaterally. Dr. Dirks felt Claimant was not a surgical candidate due to lack of radiating leg symptoms, with his pain centered around the level of the previous compression fracture.

10. At his last visit with Claimant on October 18, 2011, Dr. Dirks summed up

Claimant's condition as one of persistent pain in his mid to lower thoracic spine with no pain into Claimant's legs. Claimant walked hunched over, and complained of increased pain when he twisted, but there was no evidence of acute injuries on MRI. Dr. Dirks felt an independent examination was appropriate, as he had nothing left to provide Claimant.

11. Claimant saw Jeffrey McDonald, M.D., of North Idaho Neurosurgery & Spine on October 24, 2011. Claimant's complaints that day included "neck pain, mid-back discomfort, and lower back pain." CE T, p. 1. Flexion and extension x-rays taken that day showed no instability in Claimant's lumbar spine.

12. Dr. McDonald assessed Claimant's cervical complaints as the most bothersome, consisting of low posterior cervical pain, intrascapular pain, and bilateral upper extremity numbness with episodes of fatigue. Claimant noted his neck and scapular pain (which he described as "lightning bolt") allowed him only two hours' sleep per night.[4] *Id.* at 3.

13. Dr. McDonald felt Claimant's low back pain was multifactorial and presented as bilateral sacroiliitis. Dr. McDonald suggested bilateral SI injections and low back physical therapy. He ordered new diagnostic films.

14. On November 11, 2011, Claimant had a lumbar CT scan performed. It revealed no complications at the site of Claimant's kyphoplasty, bilateral nondisplaced pars defects with mild central canal stenosis with impingement but no compression or displacement of the S1 nerve root, moderate to severe central canal stenosis at L3-4 and 4-5, and mild disk degeneration without stenosis at L2-3. At multiple levels

[4] While Claimant denied at hearing that he had complained of neck pain, the medical statements and treatment, including a cervical spine MRI done in November 2011 strongly suggest Claimant's testimony on this point is inaccurate. However, since no claim is made for cervical complaints, the issue is not explored in depth herein.

of Claimant's lumbar spine moderate to advanced degenerative facet arthrosis was noted.

15. Dr. McDonald saw Claimant in follow up on November 28, 2011. At that visit, Claimant relayed an incident which had happened to him on or about October 30 of that year. Claimant's legs had gone out from under him while he was working for Employer in Ketchikan. Claimant described the event as a stabbing pain through his low back when he twisted, causing him to fall, striking his head on a table. He was diagnosed with an intracranial hemorrhage and was flown to a hospital in Seattle, where he was hospitalized for a couple of days. His head injury resolved without issue.

16. Dr. McDonald diagnosed five issues with Claimant; cervical spondylosis, bilateral sacroiliitis, bilateral L5 pars defect, resolved L1 compression fracture, and intercerebral hemorrhage (apparently resolved) caused by sacroiliitis. Dr. McDonald's main focus was to determine if the pars defect played a role in Claimant's low back complaints, or if the pain was due exclusively to sacroiliitis. To that end, he prescribed injection therapy and physical therapy.

17. Claimant underwent a series of L5-S1 injections on December 7, 2011, January 11, and January 31, 2012.

18. On January 24, 2012, while still in a period of recovery, Claimant underwent an OMAC (Objective Medical Assessments, a company frequently used in recent times to supply IME physicians) panel IME at Surety's request. The panel physicians, James Haynes, M.D., neurologist, and George Harper, M.D., orthopedic surgeon, (OMAC doctors) were asked to determine if Claimant's fall and resultant head injury, cervical spine, and lumbar spine treatment were related to his original industrial accident of February 11, 2011. The OMAC doctors were also asked to recommend a treatment plan

for industrially-related injuries which were not stable. Finally, they were asked to discuss work restrictions and impairment for stable conditions.

19. After an efficient summary of past medical records and treatments, the OMAC doctors performed physical examinations and rendered diagnoses and opinions. They opined that Claimant's sudden falls were related to his L1 compression fracture, which they both felt looked unstable due to a possible "kyphoplasty defect." They went so far as to "raise the possibility of a three-level fusion to stabilize the spine." CE Z, p. 19. They suggested the final determination be made by a tertiary spine specialist. They also felt Claimant would not ever return to his pre-accident state, was limited to sedentary work in his then-current state (but the job would have to take into account the threat of him falling), and Claimant was not stable, and thus not ratable.

20. Dr. McDonald next examined Claimant on February 16, 2012. He also was asked to review the recent IME findings from the OMAC doctors. On that date, Claimant complained of neck and intrascapular pain, and pain at the lumbosacral junction, directly over the L5-S1 level. Claimant had no SI joint pain.

21. Repeat x-rays were taken, showing the healed L1 fracture with no change from the October 2011 films. Dr. McDonald found no evidence of instability or kyphotic deformity across the fracture site.

22. Responding to the IME report and in light of his findings on this visit, Dr. McDonald opined that the L1 fracture was healed and asymptomatic on that date. No further treatment was needed, and specifically Dr. McDonald objected to any suggestion of a fusion at the thoracolumbar junction. He also agreed Claimant's neck complaints were not industrial, although if Claimant's pain did not subside

he would be a candidate for surgery outside of the workers' compensation system.

23. Dr. McDonald noted that Claimant's bilateral L5 pars fractures predated the industrial accident, but did not opine on Claimant's suggestion that the accident made the condition symptomatic. Instead, Dr. McDonald felt the causation issue should be sorted out by other physicians. Regarding the L5-S1 joint segment issues, Dr. McDonald pointed out Claimant had responded "impressively" to the transforaminal epidural steroid injections. Also, Claimant's sacroiliitis appeared to be asymptomatic after injections, and Dr. McDonald felt no further treatment was needed. Finally, the doctor opined that if Claimant's L5-S1 pain continued to be intolerable he would be a candidate for an L5-S1 fusion. Dr. McDonald was unsure if the surgery would be related to Claimant's industrial accident, and felt the causation question should be fleshed out through the IME process.

24. On that same date, Dr. McDonald responded to questions raised by Surety. Therein, he agreed Claimant's neck complaints were not related to the work accident. He disagreed with any suggestion that the site of Claimant's kyphoplasty may be unstable and in need of further treatment, up to and including thoracolumbar fusion surgery. Dr. McDonald noted that Claimant was asymptomatic at that level at his most recent examination, and x-rays confirmed stability in that area. He recommended against any further treatment at the L1 fracture site. Claimant's sacroiliitis had also resolved; no further treatment for that condition was needed.

25. Dr. McDonald's main concern was Claimant's symptomatic L5-S1, the site of his bilateral pars defects. While Claimant responded well to injections at this site, with 60% improvement in his low back pain, and 100% relief of his leg pain,

Claimant could nevertheless require an L5-S1 fusion if the pain remained intractable. Dr. McDonald sought causation clarification through the IME process, but noted that Claimant, by history, did not have this pain before his industrial accident, and has been symptomatic since.

26. Surety sent Claimant for an IME with Jeffrey Larson, M.D., a neurological surgeon, on March 22, 2012. Dr. Larson reviewed medical records and films, reviewed a lumbar MRI taken that day, took a history from Claimant, and prepared written answers to Surety's questions.

27. Curiously, in his history to Dr. Larson (and at hearing) Claimant denied ever suffering from neck pain in spite of an abundance of medical records documenting his treatment therefore, dating back to well before the industrial accident in question.[5] This denial came after Claimant was informed by Dr. McDonald that the neck issues would not be covered by workers' compensation.

28. The only issue Dr. Larson correlated to the work accident was Claimant's L1 compression fracture, which was fully healed. He felt Claimant's low back complaints were unrelated, and stemmed from facet spondylosis at L4-5 and spondylolysis at L5. Dr. Larson stated those conditions were chronic and required no treatment. Claimant's spine was stable throughout with no radicular symptoms.

29. Dr. Larson declared Claimant at MMI and felt he could return to work without restrictions. Claimant's healed compression fracture warranted a 7% PPI rating with no apportionment related to his preexisting degenerative disk disease, spondylosis, and spondylolysis. The work accident caused no permanent aggravation of any of those

[5] This assertion is puzzling, although it does not impact Claimant's overall credibility, which the Referee found to be adequate.

conditions in Dr. Larson's opinion.

30. Claimant returned to Dr. McDonald on April 5, 2012. The doctor explained to Claimant that after reviewing Dr. Larson's IME report in detail he (Dr. McDonald) agreed with Dr. Larson's findings and conclusions. While Dr. McDonald acknowledged that Claimant had ongoing low back issues which could benefit from further care, such care would fall outside of workers' compensation as Claimant's ongoing condition was not industrially related. Dr. McDonald agreed with Dr. Larson that the only injury caused by the work accident was the L1 compression fracture which was stable.

31. Dr. McDonald felt Claimant suffered from instability at L5-S1, L4-5, and L3-4. His suggested options for treating the non-industrial instability included fusion surgery from L3 to S1, or conservative care of physical therapy and injections. Claimant elected continued physical therapy at that time.

32. Dr. McDonald continued to treat Claimant for ongoing pain complaints at the site of his L5-S1 pars defects through the calendar year 2012 with injections and home exercise. The injections provided substantial, but temporary relief.

33. On May 16, 2013, Claimant presented to Dr. McDonald with complaints of mid-back complaints; his low back was not hurting at that time. Dr. McDonald felt Claimant's thoracolumbar discomfort was "related to degenerative changes of a musculoskeletal nature" – "his spine was aging." CE T, p. 58. Dr. McDonald had no treatment suggestions for Claimant's current complaints. He noted Claimant had obtained relief from his low back complaints with periodic injections and prescribed narcotics, but his chronic mid-back pain was due to aging and would be best managed by Claimant's primary care provider. Since Claimant was taking no narcotics at the time

of this visit, Dr. McDonald suggested it would be appropriate to transition Claimant's care back to his family doctor. Should Claimant again have L5-S1 complaints, Dr. McDonald would provide care for those complaints on an as-needed basis.

34. On August 11, 2014, Claimant presented to the emergency room at Kootenai Medical Center after having fallen down a flight of stairs two days earlier. He had a contusion around his left eye socket, and low back pain. Claimant also had slight neck pain and bruises on his arms and legs without tenderness except his lumbosacral spine. Claimant indicated his legs had "given out" causing him to fall. Claimant related this incident to his previous industrial injury, noting he had fallen several times since that accident. He was treated with pain medication.

35. Claimant asked to have his workers' compensation file reopened. Surety arranged for Claimant to be seen by Dr. Larson for a repeat IME on August 26, 2014. At that time Claimant related the recent fall to Dr. Larson, and also noted he could no longer walk more than about a block due to low back and right lower extremity pain, whereas two years previously he had been walking five miles.

36. Dr. Larson reviewed CT scans taken during Claimant's recent ER visit, described above. The scans showed facet spondylosis at L3-4, L4-5, and L5-S1; the most prominent levels were L4-5 and L5-S1. Claimant also had right L5 spondylolysis. Dr. Larson interpreted the imaging as showing chronic degenerative findings with no instability at L5-S1. However, Claimant's complaints with walking and lower extremity weakness correlated with neurogenic claudication.[6] Available imaging did not show significant stenosis to explain the claudication, so Dr. Larson felt new imaging would be

[6] The term neurogenic claudication will be elaborated upon hereinafter.

appropriate to try and confirm or rule out the neurogenic claudication. In any event, Dr. Larson felt Claimant's condition was not due to his industrial injury, but rather "was a natural progression of degenerative spondylosis of the lumbar spine." DE 5, p. 44.

37. Dr. Larson's opinions on PPI (7%), date of MMI (February 11, 2011), and work restrictions (none industrially related) did not change from his previous report.

38. This second IME report was sent to Dr. McDonald for his review and concurrence. Dr. McDonald agreed with Dr. Larson's report.

39. After Surety clarified that the MRI suggested by Dr. Larson to rule out or confirm neurogenic claudication would not be related to the industrial accident, it did not obtain any additional diagnostic studies.

40. Claimant returned to his primary care provider, Anthony Peters, D.O., for further care and maintenance of his medications. On October 10, 2014, Claimant obtained a lumbar MRI which showed severe central stenosis at L4-5, increased from 2011, but stable from the recent CT scan in August. Claimant was diagnosed with chronic but stable back pain. Claimant was maintained on Norco for pain.

41. Dr. Peters referred Claimant to John Schuster, M.D., an orthopedic surgeon in Spokane. Dr. Schuster first saw Claimant in mid December 2014. X-rays taken that day showed moderate stenosis at L3-4 and severe stenosis with grade 1 anterolisthesis at L4-5. The initial plan was for Claimant to undergo a two level discectomy and fusion due to his worsening symptoms in his low back and legs.

42. For reasons not self-evident in the record neither of Claimant's private

insurance companies (Blue Cross and Medicare) would authorize surgery.[7] However, in Dr. McNulty's deposition, discussed below, there is mention that Claimant tested positive for nicotine prior to surgery. Dr. Shuster's pre-operative form indicated nicotine use constituted an absolute bar to fusion surgery. Claimant consistently in all medical records denied the use of nicotine, claiming he stopped smoking in 1990 and used no other form of nicotine. *E.g.,* CE L, p. 2, under smoking/tobacco history. In Dr. Barros-Bailey's report she mentions Claimant told her the surgery was not authorized due to the ongoing workers' compensation claim. However, it could be that the insurance companies would not authorize surgery for reasons unrelated to either Claimant's nicotine use or workers' compensation issues.

43. On March 11, 2015, Claimant saw John McNulty, M.D., an orthopedic surgeon in north Idaho, for an independent evaluation at the request of his counsel, who also supplied Dr. McNulty with a 17 page introduction letter summarizing medical treatment and requesting opinions. Dr. McNulty further summarized the medical records provided him, took a history from and examined Claimant, and prepared a report. He was deposed post hearing.

44. At the time of examination by Dr. McNulty, by history, Claimant was experiencing no pain at the site of his compression fracture. Claimant spoke of pain to his posterior right thigh which at times extended to his ankle. His right leg would also

[7] It appears not all records from Dr. Schuster were made part of the record, as the office visit records jump from December 19, 2014 to October 26, 2015, with only a list of medications dated September 30, 2015 in between. Furthermore the October 2015 office note is odd in that it states under "Plan: options fusion? Unlikely there is a surgical solution with what I know at this point[.] you need to get the claims resolved. [A]t this point, neither will pay for anything…" "**No follow up appointment needed**" (Emphasis in original.) CE L, p. 13. There is an MRI and bone scan report dated December 21, 2015 ordered by Dr. Schuster at the October 26 visit, but no corresponding follow up office note. The next and final office note is dated April 28, 2016, when again surgery is discussed in detail as an option, along with several non-surgical options. It notes on the bottom of the page that the next appointment will be on the day of surgery. *Id* at 20. This is the last note from Dr. Schuster.

at times develop sudden weakness, causing him to fall. Claimant related multiple falls since the accident. His pain was not typically disabling, but aggravated by lifting and walking. Walking more than a quarter mile or lifting more than 30 pounds flared his low back and right leg pain. He had trouble sleeping at night. Claimant felt his symptoms had worsened during the past year.

45. Claimant indicated he was taking few pain pills, and working as a program director for a renewable energy company (which since went out of business) at the time of the examination. Dr. McNulty observed that Claimant could sit with minimal discomfort but moved slowly. Claimant's spine was minimally tender over L5-S1 and the SI joints. Orthopedic testing was largely unremarkable.

46. Dr. McNulty diagnosed multilevel spinal stenosis with neurogenic claudication, and noted Claimant's repaired L1 compression fracture. The fracture was stable; Dr. McNulty assigned a 12% whole person PPI for the compression fracture. Dr. McNulty felt Claimant was not at MMI with regard to his low back, and believed Claimant would benefit from an L5-S1 fusion surgery. Dr. McNulty also opined that Claimant's falls since the industrial accident accelerated his spinal deterioration.

47. Dr. McNulty felt the primary need for surgery would be directly attributable to Claimant's work-related injury on 2/11/2011 and not natural progression of degenerative spondylosis.

48. Dr. McNulty also placed 20 pound (rarely) lifting, and sedentary job duty restrictions for Claimant. He would not be able to return to his time-of-injury job.

49. At Claimant's counsel's request, Dr. McNulty re-examined Claimant on June 14, 2017. By the time of this examination Claimant was 67 years old.

50. Dr. McNulty reviewed additional medical records provided him by counsel. Therein he noted that Claimant's fusion surgery was cancelled due to a positive nicotine test. Claimant was wearing a back brace. His history detailed a worsening condition, with falls coming at approximately three times monthly, greater lower extremity pain bilaterally, trouble negotiating stairs (down more difficult than up), and lessened daily activity with greater trouble sleeping at night. Claimant's physical examination was consistent with a progressively worsening condition. Dr. McNulty added L3-4 and L4-5 spondylolisthesis to his diagnosis based on the additional radiographs he reviewed. He still felt Claimant was a surgical candidate, but expanded his fusion recommendation to include both L3-4 and L4-5. Claimant was not at MMI, but without further treatment, Dr. McNulty raised Claimant's PPI rating to 19% whole person due to the spinal stenosis. Claimant should be limited to sedentary work.

DISCUSSION AND FURTHER FINDINGS

51. Claimant has the burden of proving, by a preponderance of the evidence, all facts essential to recovery to his claims. He carries the burden of proving that the condition for which compensation is sought is causally related to an industrial accident. *Duncan v. Navajo Trucking*, 134 Idaho 202, 203, 998 P.2d 1115, 1116 (2000). The proof required is "a reasonable degree of medical probability" that Claimant's condition was caused by an industrial accident. *Anderson v. Harper's Inc.*, 143 Idaho 193, 196, 141 P.3d 1062, 1065 (2006). To prove that a causal relationship is medically probable requires Claimant to demonstrate that there is more medical evidence for the proposition than against it. *Jensen v. City of Pocatello*, 135 Idaho 406, 18 P.3d 211 (2000). In determining causation,

it is the role of the Commission to determine the weight and credibility, and to resolve conflicting interpretations, of testimony.

52. Defendants do not dispute the fact that Claimant suffered a compensable accident on February 11, 2011, injuring his back while attempting to unload a welder. Defendants accepted Claimant's lumbar compression fracture claim and resultant surgery, paid temporary disability and at least some PPI benefits.

53. The first issue for resolution involves Claimant's claim for additional medical treatment. In this regard several possibilities exist. Claimant's industrial accident may have created a condition which requires surgical intervention. Alternatively, Claimant may be in need of surgery for a degenerative condition unrelated to the industrial accident. Finally, Claimant may not need surgery. Medical opinions exist in this case supporting all three of the above postulates.

MMI and Medical Care Benefits

54. Idaho Code § 72-432(1) mandates that an employer shall provide for an injured employee such reasonable medical, surgical or other attendance or treatment, nurse and hospital service, medicines, crutches, and apparatus, as may be reasonably required by the employee's physician or needed immediately after an injury, and for a reasonable time thereafter. If the employer fails to provide the same, the injured employee may do so at the expense of the employer. An employer is only obligated to provide medical treatment necessitated by the industrial accident, and is not responsible for medical treatment not related to the industrial accident. *Williamson v. Whitman Corp./Pet, Inc.*, 130 Idaho 602, 944 P.2d 1365 (1997).

55. Idaho Code § 72-422 does not contemplate that a claimant must regain his pre-accident state to be considered medically stable, but only that his persisting condition is

not likely to progress significantly toward resolution within the foreseeable future. The persisting condition must be related to a compensable industrial accident. *Snider v. Empro Employer Solutions, LLC* 2013 IIC 0072.1, 0072.9 (Nov 2013).

56. Claimant argues he is not at maximum medical improvement (MMI), or medical stability, and needs a fusion surgery due to sequelae from the industrial accident. Defendants argue Claimant long ago reached MMI regarding his work injury, and any continuing low back issues are non-industrial.

57. In support of his position Claimant relies on the opinions of Dr. McNulty. Claimant also points out he did not have a history of low back problems, and was not subject to random and repeated falling episodes before the work accident.

Dr. McNulty Deposition

58. Dr. McNulty was deposed on November 6, 2017. At his deposition Dr. McNulty acknowledged the MRI taken three days post accident showed moderate central spinal stenosis at L3-4 and L4-5 "secondary to a combination of congenitally short pedicles, degenerative disk disease, hypertrophy of the ligamentum flavum and facet arthropathy" which were "predisposing congenital findings" but not at that time an operative condition, nor symptomatic prior to the accident in question. McNulty Depo. p. 13. He also acknowledged Claimant suffered from mild to moderate L4-5 neuroforaminal narrowing due to degenerative disk disease, as well as a right L5 pars defect without spondylolisthesis. Dr. McNulty explained that spondylolisthesis is an abnormal movement or instability of the vertebral bodies, and a pars defect is a congenital defect in the posterior part of the spine. Dr. McNulty also felt that annular tears at L4-5 and L5-S1 were likely related to Claimant's industrial accident.

59. Dr. McNulty found it significant that within days after the accident Claimant was complaining of leg weakness and pain, a complaint that persisted and increased over the ensuing years. The doctor felt the complaints were consistent with either spinal stenosis or neurogenic claudication, a condition where spinal compression of the nerves makes one's legs go weak. Neurogenic claudication is a result of spinal stenosis (narrowing of the spinal canal) and instability.

60. Another explanation for Claimant's falling episodes came from Drs. Haynes and Harper, who felt sudden onset of postsurgical pain from Claimant's kyphoplasty led to pain inhibition and leg weakness which triggered his falls.

61. Dr. McNulty noted that Claimant's stenosis progressed with time, until x-rays taken by Dr. Schuster in late April 2016 showed spondylolisthesis (grade1) at L3-4 and (grade 2) at L4-5, which could account for Claimant's ongoing complaints. Dr. Schuster also described "crippling stenosis" evident on an MRI taken at that time. Dr. McNulty felt the industrial accident and subsequent falls (which were also a result of the industrial accident) were responsible for Claimant's progressing stenosis (previously asymptomatic) and instability as noted in 2016.

62. Dr. McNulty felt surgery would more probably than not improve Claimant's low back condition. Dr. McNulty would not be the surgeon doing the surgery.[8]

Dr. Larson's Deposition

63. Defendants rely on the opinions of Dr. Larson to support their position. He was deposed on January 30, 2018.

[8] In deposition Dr. McNulty admitted he has not performed any spinal surgeries since 1994.

64. Dr. Larson examined Claimant in 2012 and 2014. After his 2012 examination, he testified the only industrially-related injury he found was the L1 compression fracture; all other findings were either congenital or degenerative. There was no lumbar instability or radicular pain. Claimant's subjective low back pain complaints were "multifactorial"; some pain was from the compression fracture, but also the muscles and ligaments were strained in the accident as well. Dr. Larson felt no further treatment was necessary for any of Claimant's complaints.

65. Dr. Larson re-examined Claimant in 2014, and again diagnosed chronic multifactorial back pain. He noted disagreement with Dr. McDonald's findings of L5-S1 spondylolisthesis. Dr. Larson's review of CT and MRI films demonstrated to him no movement of the joint on flexion/extension studies. Dr. Larson pointed out that Claimant's complaints during his treatment with Dr. McDonald shifted "from the low back to the mid back to even the neck." Larson Depo., p. 25. Dr. Larson felt this was consistent with a multifactorial low back picture. He also felt some of Claimant's continuing low back pain stemmed from his fixed and stable compression fracture. Dr. Larson pondered whether Claimant's numerous falls since his accident may have also aggravated his chronic degenerative findings.

66. Dr. Larson explained that facet joints consist of a superior facet pointing upward and an inferior facet pointing downward. The inferior facet drops behind the superior facet of the vertebral body below it, like shingles. A pars defect is "an absence" between the inferior and superior facet of one vertebral body, and is a potential weak area. Larson Depo., p. 27. Pars defects are either congenital or occur as a fracture when the spine is stretched or extended. Pars defects can cause low back pain, and Dr. Larson noted Dr. McDonald focused on Claimant's pars defect as a source of his continued low back pain.

67. In 2014, Dr. Larson found three issues with Claimant; low back pain, spondylosis or degenerative bone spurs at L4-5 and L5-S1, and a right L5 spondylolysis (defect or break in the connection between vertebrae) or alternatively neurogenic claudication (stenosis compressing the nerves of the spinal canal), diagnosis of which was subject to additional imaging to confirm or rule out claudication. Each of these findings was unrelated to Claimant's industrial accident. Dr. Larson felt Claimant's possible claudication could explain his leg weakness. He was not sure if Claimant actually had claudication since imaging done prior to the 2014 exam did not show clinically significant stenosis. Also Dr. Larson pointed out that neurogenic claudication affected both legs and Claimant often complained of right leg weakness.

68. Dr. Larson opined that lumbar fusion surgery was not needed, since such surgery would be performed to treat severe stenosis which Dr. Larson did not see on the images provided to him. Furthermore, any fusion surgery would not be related to the industrial accident.

69. On cross examination, Dr. Larson explained that neurogenic claudication symptoms include pain and loss of function standing upright, alleviated by sitting down or bending forward. Occasionally claudication manifests with bilateral leg weakness, but much more often bilateral leg pain. It is not caused by trauma absent a disk herniation with compression of the spinal canal. Falling on one's posterior could cause cauda equina (an acute and sudden compression of the spinal canal) but not neurogenic claudication, which develops slowly. Neurogenic claudication is not generally associated with back pain, only lower extremity pain. Dr. Larson felt Claimant's legs giving out were most likely due to some other cause than neurogenic claudication, since that is not a typical symptom.

Typically with neurogenic claudication standing for extended periods causes both legs to become painful. Leaning forward relieves the pressure on the nerves, and thus provides relief.

70. Dr. Larson had no explanation for Claimant's repeated falls, nor was he aware of all of them.

71. Dr. Larson testified that trauma does not exacerbate spinal stenosis except for instances not relevant to this litigation (trauma creating a space-occupying lesion).

Analysis of Medical Opinions

72. Dr. McNulty's examinations were the most recent, and seemingly included the most comprehensive review of materials. Claimant notes this fact in his argument that Dr. McNulty's opinion should be afforded the most weight. However, while it is important to provide IME physicians with a complete set of medical materials, it is not axiomatic that the doctor who reviews the most records "wins." The strength of the opinions is paramount, and a doctor who reaches an opinion contrary to the weight of the evidence, or by questionable methodology, cannot resurrect his opinion by showing he reviewed all the medical records. Of course, the opinion of a physician who fails to review all the relevant and material medical records is suspect *ab initio.* Dr. Larson's opinions were apparently rendered without either his review, or his understanding of, the more recent medical records. He either did not adequately review or he simply ignored Dr. Shuster's 2016 findings of progressive stenosis. Instead Dr. Larson clung to his belief that Claimant did not suffer from clinically significant lumbar stenosis. However, he did opine that even if Claimant had stenosis sufficient to require surgery, the stenosis would not be the result of the industrial accident.

73. The Referee found Claimant to be generally credible in his testimony. He has testified that he was asymptomatic vis-à-vis his lumbar spine prior to the subject accident, and

the record contains no evidence denigrating this assertion. We also accept that Claimant has experienced significant back pain and other related symptoms since the subject accident. Finally, we conclude that as a consequence of the accident, Claimant suffered an L1 compression fracture. It is Claimant's contention that in addition to the L1 compression fracture, he has suffered injury to lower levels of his lumbar spine either as a direct result of the subject accident, or as a result of several subsequent falls causally related to the original accident. Claimant posits that the subsequent falls occurred because of leg weakness which he claims represents "neurogenic claudication" caused by spinal canal stenosis, which, in turn, is related to the original injury. McNulty Depo., pp. 11-12; CE AA, p. 38.

74. Medical records generated contemporaneous with the subsequent falls tend to demonstrate that these falls occurred because of sudden and unexpected episodes of low back pain, which caused Claimant's legs to give-way. CE R, p. 19; CE T, p. 1; CE T, p. 12; DE 5, p. 49. Claimant's testimony, too, tends to support the proposition that the subsequent falls occurred because of sudden and unexpected jolts of low back pain. Tr., pp. 6-61, 65-66, 68, 69, 73-74.

75. Drs. Haynes and Harper opined that Claimant's subsequent falls are the result of "pain inhibition." In other words, Claimant experienced sudden jolts of pain associated with his compression fracture, and it is this episodic low back pain which is the root cause of Claimant's giving-way sensation in his lower extremities. See CE Z. Dr. McNulty expressed his agreement with the explanation offered by Drs. Haynes and Harper. See McNulty Depo., pp.19-22.

76. On the other hand, Dr. McDonald diagnosed Claimant with bilateral sacroiliitis and opined that it was this condition that was responsible for the sudden pain which caused Claimant's fall in Ketchikan, Alaska. Dr. McNulty expressed his agreement with this theory as well. McNulty Depo., pp. 17-18. Therefore, Dr. McNulty has endorsed at least three

different explanations for Claimant's subsequent falls: neurogenic claudication, pain related to bilateral sacroiliitis, and pain related to the L1 fracture.

77. We conclude that while treating/evaluating physicians have described several mechanisms by which the original injury contributed to causing the subsequent falls, it is clear all agree that the original accident is, in some fashion, responsible for causing the falls described by Claimant. However, having reached this conclusion, it is still necessary to test Claimant's theory that the original accident, and what we accept as causally related subsequent falls, are responsible for causing injury to Claimant's lower lumbar spine such that Surety should be held responsible for the multi-level lumbar fusion sought by Claimant.

78. It is clear that Claimant has multi-level disease of the lower lumbar spine which predates the subject accident of February 11, 2011. These pre-existing conditions are outlined in the reports of Drs. Haynes, Harper, and Larson. Dr. McNulty does not disagree that the multi-level spondylosis identified on post-accident films predated the subject accident. McNulty Depo., p. 25. It is argued by McNulty, that the subject accident and/or the subsequent falls, caused further injury to Claimant's lower lumbar spine such as to cause him to become symptomatic sooner than he otherwise would have. However, as developed below, the Commission concludes that Dr. McNulty's opinion in this regard is fundamentally suspect.

79. When asked to describe the acute injuries which he relates to the subject accident, Dr. McNulty initially identified the L1 compression fracture and annular tears in the intervertebral discs at L4-5 and L5-S1. Dr. McNulty testified that he would agree with the radiologist who interpreted the February 14, 2011 MRI that the aforementioned annular tears are "likely related to the accident." McNulty Depo., pp. 13-14. Dr. Nickol also asserted that Claimant suffered from "acute" herniated discs at L3-5. DE M, p. 2. The problem with Dr.

McNulty's insistence in this regard is that while Dr. Burbank, the radiologist reading the February 14, 2011 study, did describe the L1 fracture as "acute" in origin, he did not use the same descriptor with respect to the annular tears at L4-5 and L5-S1. In their review of the February 2011 CT and MRI, Drs. Haynes and Harper disagreed with Dr. Nickol and opined that those studies do not demonstrate acute disc injuries at the lower lumbar levels. CE Z, p. 5. Moreover, subsequent radiological studies imaging the same levels describe "annular bulging" in lieu of "annular tears." See 9-27-2011 MRI ordered by Dr. Dirks; DE R, p. 21. Nor do any of the films taken subsequent to September 27, 2011 suggest the existence of any acute disc injury in the lower lumbar spine. Because Dr. McNulty's conclusion is based on his erroneous reliance on what he believes Dr. Burbank concluded about the February 14, 2011 MRI, we reject his (Dr. McNulty's) conclusion that the "annular tears" seen on that study are acute in origin.

80. Next, Dr. McNulty originally acknowledged that Claimant's L5 pars defect was "pre-existing for sure" (See McNulty Depo., p. 15) but then reversed himself and concluded that because Dr. McDonald had used the term "fracture" to describe the pars defect it must be acute in origin:

> Q: [By Mr. Stoddard] If I could have you turn down to page 15 of Dr. McDonald's records, one dated November 28, 2011. A letter about [sic] to Theresa Nolan of Liberty Northwest. And subparagraph 1 he writes in part: "He would appear to our review to have clinical sacroiliitis but as well has now been identified as having bilateral L5 pars fractures." What is the significance, if anything, with regard to that statement?
>
> A: And I tried finding where I saw the L5 pars fractures, and I couldn't see that in the record. But a fracture is different than a congenital defect. So if he thinks he's got an L5 pars fracture, the fracture is going to be most likely a recent injury. It may have been related to the fall, imaging subsequent to the fall. But, you know, Mr. Ash is not an [sic] MMI and he's still struggling with pain."

McNulty Depo., p. 18-19. However, it is doubtful that Dr. McDonald ever entertained the notion that Claimant's bilateral L5 pars defects were related to the subject accident. In his chart note of

February 16, 2012, Dr. McDonald noted that Claimant had responded well to a series of L5-S1 transforaminal epidural steroid injections, suggesting that Claimant's bilateral L5 pars defects might be one of Claimant's pain generators. However, Dr. McDonald also clearly stated his conclusion that the bilateral pars defects predated the subject accident:

> Review of the CT scans from February 2011 as well as November 2011 document bilateral L5 pars fractures on both studies. There is no spondylolisthesis associated with this, and the fracture margins themselves are corticated. So clearly the fractures predated the injury itself, but in Mr. Ash's opinion, were therefore made symptomatic by the injury. This needs to be further sorted out through the process of the independent medical evaluation.

CE T, p. 36. Dr. McDonald later agreed with Dr. Larson's conclusion that the pars defects were not aggravated by the subject accident. Therefore, we find Dr. McNulty's reliance on Dr. McDonald's reference to bilateral pars "fractures" misplaced, at least to the extent that Dr. McNulty believes that this is evidence of an accident-produced injury.

81. Dr. McNulty acknowledged that Claimant had pre-existing spondylosis at lower lumbar spine levels. This is a progressive arthritic condition which, in severe cases, can compromise the spinal canal and cause neurogenic claudication. Dr. Shuster's notes and studies from 2016 suggest that Claimant may well now suffer from the progression of his spondylosis such that his spinal canal stenosis is now critical. The question is whether or not the original accident, or the related subsequent falls, contributed to the progression of this underlying condition. Dr. McNulty acknowledged that radiological studies performed immediately following the subject accident demonstrated "moderate" stenosis, but nothing constituting an operative problem. McNulty Depo., p. 13. Dr. McNulty reasoned that this condition was, however, aggravated by the subject fall or the related subsequent falls:

> Q: [By Mr. Stoddard]: So do you have an opinion as to whether the industrial accident of 2/11/11 permanently aggravated his low back at his lumbar spine?

> A: So I guess the way to phrase that was, this is a gentleman who was asymptomatic - - you know, everybody's got a little bit of low back pain. Nobody has no back pain. But no treatment. Working heavy job. He does have some findings of moderate stenosis, which probably most of the population his age is going to have. Totally asymptomatic. He gets a major injury of axio load, flexion injury, compression fracture of the spine, and subsequent falls. Over time he has a permanent aggravation of preexisting asymptomatic MRI findings that have turned into spinal stenosis.

McNulty Depo., pp. 33-34. Though it is concise, this opinion is also conclusory and unsupported by any persuasive objective evidence of physical injury caused to the lower lumbar spine either by the original accident, or by any of the subsequent falls. Dr. McNulty did not describe, except in the vaguest terms, what the subject accident or related falls did to contribute to Claimant's pre-existing spondylosis and spondylolysis. The annular tears referenced by Dr. McNulty as well as the bilateral pars defect are not shown to be artifacts of either the original accident or the subsequent falls. While Dr. McDonald briefly entertained the notion that Claimant's pre-existing pars defects might have been aggravated or worsened as the result of the subject accident, he abandoned this view after review of Dr. Larson's report. To simply say, as Dr. McNulty has, that the accident or the subsequent falls aggravated Claimant's pre-existing condition is insufficient, without more elaboration, to prove Claimant's case.

82. With respect to the subsequent falls, while it might be tempting to conclude that one or more of these incidents caused further damage to Claimant's lumbar spine, there is, again, a lack of objective medical evidence which would support the proposition that one or more of the falls caused such further injury. Claimant suffered many bumps and bruises as the result of the subsequent falls, but we find no persuasive medical evidence tending to show that one or more of the falls caused further damage to Claimant's lumbar spine.

83. We have found persuasive Claimant's testimony that he had no significant low back symptoms on a pre-injury basis, and that he has suffered from significant low back pain since February 2, 2011. As even Dr. McNulty has acknowledged, Claimant's L1 fracture is sufficient to explain the low back pain which precipitated his various post-accident falls. At present, Claimant has clear evidence of severe spinal stenosis at the lower lumbar levels, and this too may explain some part of his current presentation. However, that Claimant's spinal stenosis has progressed since February 2, 2011 does not, in and of itself, establish that the subject accident, or the subsequent related falls, are responsible for contributing that progression. Certainly, Dr. McNulty has proposed this, but his explanation is incomplete and unconvincing. Claimant may have evidence of instability at lower lumbar levels as suggested by Dr. Shuster's 2016 records and studies. However, neither does that fact demonstrate a causal relationship between either the original accident and Claimant's current condition or the subsequent falls and Claimant's current condition. The degenerative processes at work in Claimant's lower lumbar spine are, by definition, progressive in nature. Clearly, Claimant's physical capacity has deteriorated with time, and his complaints have increased in severity and frequency. For example, by late 2011 Claimant was experiencing no lower extremity radicular pain, *See e.g.* CE R, p. 26, but by the time Dr. McNulty examined him in 2015 the doctor noted radicular pain. In 2012 Claimant was walking five miles per day, by 2014 he could not walk a quarter mile, and subsequently claimed he could only walk about a block. Lumbar spinal stenosis was rated as mild to moderate shortly after the accident, but "crippling" by 2016.

84. Between the accident in 2011 and 2015 Claimant traveled for work or prospective jobs over a dozen times to Alaska. He also flew to the United Kingdom, Wales, Minnesota,

British Columbia, Florida, Georgia, Illinois, and Seattle. At hearing, Claimant testified he can no longer tolerate prolonged travel.

85. Claimant was released to full duty work by Dr. McDonald on April 5, 2012, declaring Claimant's compression fracture to be fixed and stable. Dr. McDonald continued to treat Claimant for non-industrial low back issues thereafter.

86. The clear progression of Claimant's condition is not shown by these facts to be more probably than not to be the result of the subject accident. Absent something more than the speculation offered by Dr. McNulty, we are unable to conclude that the accident is responsible for Claimant's current condition and need for surgical treatment.

87. Dr. Larson's report and reasoning may be criticized for his failure to consider the most recent reports and radiological studies generated in connection with Claimant's treatment by Dr. Shuster. However, Dr. Larson acknowledged that Claimant's current complaints may, indeed, be related to neurogenic claudication. See DE 5, p. 44. He recommended further studies to make a current assessment of Claimant's spinal canal stenosis. However, Dr. Larson was unequivocal in his testimony that even if Claimant does have current evidence of neurogenic claudication, the accident is not responsible for causing the condition, since radiological studies taken in the years immediately following the February 11, 2011 accident demonstrated no evidence of acute injury at lower lumbar levels, and no evidence of significant spinal canal compromise.

88. Dr. Larson offered no explanation for why Claimant suffered the post-accident falls he described, although he acknowledged that even a healed L1 fracture can be a source of multi-factorial pain. Larson Depo., p. 24.

89. To summarize, Dr. Larson, though identifying a number of chronic degenerative processes in Claimant's lumbar spine, was not able to identify any condition other than the L1 compression fracture that is linked to the subject accident to a reasonable degree of medical probability.

90. The most persuasive medical evidence fails to establish objective evidence of injury to Claimant's lumbar spine, or aggravation of a pre-existing condition in Claimant's lumbar spine as a consequence of the subject accident. In considering the evidence before us on this question, we also think it important to note that Dr. McDonald, the physician who treated Claimant between October of 2011 and May of 2013, has expressed his agreement with the opinions authored by Dr. Larson. It is Dr. McDonald who authored perhaps the most significant observation concerning the etiology of Claimant's ongoing complaints. In his chart note of May 16, 2013, he explained to Claimant that Claimant had an aging spine, and noted that Claimant was simply struggling with accepting the progression of his longstanding degenerative changes. CE T, p. 58. Both Dr. Larson and Dr. McDonald are of the view that the only permanent injury suffered by Claimant as a result of the subject accident is the L1 fracture, and that Claimant may suffer residual discomfort attributable to that injury. This is not, of course, to say that Claimant's lower lumbar spine is not a pain generator at present, only that the evidence fails to establish a link between the subject accident and Claimant's lower lumbar spine pathology. Dr. McNulty's testimony directed to establishing evidence of an accident-related injury in Claimant's lower lumbar spine is significantly challenged by the inaccurate assumptions that he made, and his failure to articulate with any specificity exactly how the subject accident or the subsequent falls caused further injury to Claimant's lower lumbar spine.

91. Based on the foregoing, we conclude that Claimant has suffered an injury to L1 as a consequence of the subject accident. He reached medical stability with regard to this injury on April 15, 2012. However, Claimant has failed to prove, to a reasonable degree of medical probability, that he has suffered further permanent injury to his lower lumbar spine as a consequence of either the original accident, or what we have found to be related subsequent falls. Having determined that the requisite causal link has not been demonstrated, we conclude that Claimant is not entitled to the surgical treatment he seeks.

Right Shoulder

92. On September 11, 2009, Claimant suffered a work-related accident involving his right shoulder. An MRI of October 6, 2009 demonstrated a small rotator cuff tear with significant tendinopathy, bicipital tendon tear, and advanced degenerative changes of the AC joint. On November 20, 2009, Claimant underwent right shoulder surgery involving a right rotator cuff repair with subacromial decompression, attempted biceps tendon repair, and labral debridement. The biceps tendon repair was aborted due to tendon contracture. In June of 2010, Claimant's right shoulder was rated by Dr. McCullen. He felt Claimant was entitled to a 10% upper extremity impairment for the residual effects of the right shoulder injury. In his June 22, 2010 report, Dr. McCullen was not asked to provide an opinion on Claimant's permanent limitations/restrictions and did not volunteer one. However, he did record Claimant's subjective complaints as of June 22, 2010:

> Aching in the right shoulder. Bothers him when he overdoes it or sleeps on it, on the right side. He has limited motion in the right shoulder. He relates no other residual symptoms.

See DE Q, p. 4. It is not suggested that Claimant suffered any injury to his right shoulder as a direct consequence of the accident of 2/11/2011. However, it is suggested that Claimant's

subsequent falls caused additional injury not only to his lumbar spine, but also to his right shoulder. See Tr., pp. 18-19. At hearing, Claimant endorsed such a causal relationship between his current right shoulder condition and his subsequent falls:

> Q: [By Mr. Stoddard]: Now, I believe in the initial report of Dr. McNulty, in 2015, he gave the opinion that you sustained some additional injury with respect to your right shoulder. Are you aware of that?
>
> A: My right shoulder, yes, was hurting from when I fell on the stairs. I landed on my shoulder, face first on my shoulder.
>
> Q: On your right shoulder?
>
> A: Yeah.
>
> Q: What year was that, to the best of your recollection?
>
> A: Let's see. End of '12 to somewhere in mid '13.
>
> Q: Now, you also did a follow-up examination, did you not, with Dr. Jeff Larson, as well?
>
> A: Yes, I did.
>
> Q: And was that arranged by Liberty?
>
> A: Yes.
>
> Q: In his March 11, 2015 report, Dr. McNulty assigned restrictions he said with respect to your right shoulder of 30 pounds. Are you aware of that?
>
> A: Yes.
>
> Q: And he indicated that you should rarely perform overhead use of your right shoulder, and he further found that your lifting was restricted to 20 pounds rarely and five pounds frequently. Were you aware of those restrictions, as well?
>
> A: Yes. What was the date, may I ask?
>
> Q: March 11, 2015.
>
> A: '15, yes.

Tr., pp. 90-92. Dr. McNulty, too, believes that in the course of one of Claimant's falls, he suffered additional injury to the right shoulder, such that he now has limitations/restrictions vis-à-vis the right shoulder that he did not have before the subject accident:

> Mr. Ash sustained a right shoulder injury on 9/11/2009 with subsequent rotator cuff repair. He did have an impairment rating and was determined to have a 10% upper extremity impairment. I have reviewed that rating and agree with that. Mr. Ash underwent numerous falls after his injury on 2/11/2011 and it appears he injured his right shoulder during 1 of those falls. He has increased right shoulder pain and physical exam findings consistent of at least tendinitis if not possible recurrent rotator cuff tear. However, his shoulder is tolerable by his own admission and I would not recommend any further workup for his right shoulder. I would, however, place a 30-pound maximum lifting restriction with rare overheard use of his right shoulder. I would attribute those restrictions as a result of his 2/11/2011 injury and subsequent falls attributed to that injury.
>
> CE AA, p. 30.

93. For the reasons set forth below, we reject Dr. McNulty's conclusion as largely gratuitous, supported primarily by Claimant's testimony, testimony which was given at hearing, well after Dr. McNulty's report of March 11, 2015.

94. First, in his introductory letter to Dr. McNulty, Claimant's counsel did not suggest that one of the questions before the Commission is whether Claimant suffered additional right shoulder injury as a result of the subsequent falls. Further, Counsel provided a succinct synopsis of Claimant's post-February 2, 2011 medical history, none of which suggests that Claimant suffered further injury to his right shoulder as a consequence of the subsequent falls. On the occasion of his exam of Claimant, Dr. McNulty did not elicit from Claimant any history of current right shoulder complaints or any history of having experienced a change in his right shoulder symptoms following any of his several subsequent falls. Dr. McNulty also had the opportunity to review all of the medical records generated at or around the time of Claimant's

subsequent falls. A review of these medical records is important to understanding whether Dr. McNulty's conclusion is supported by an adequate foundation.

95. Dr. Dirks' chart note of August 23, 2011 reflects that Claimant suffered a fall, "down the stairs" the previous week. In its entirety that note reads as follows:

> Mr. Ash returns today and he is actually doing worse. He fell down the stairs last week because of muscle cramps and spasms. He opened up his elbow and he hurt his right knee and his back is just really bothering him. He has not been able to do is [sic] exercises and walking for the last week or so. He is here today following his vertebroplasty from a month or so.
>
> CE R, p. 19.

96. Dr. McDonald's chart note of November 28, 2011 reflects that some weeks prior to that date, Claimant suffered a falling episode while working in Alaska. In this regard, Dr. McDonald's note provides:

> Mr. Ash returns for review of his new imaging studies. Unfortunately, he had another spell two weeks ago while over in Ketchikan. He stood up and twisted slightly, then experienced the sudden onset of this severe stabbing low back pain, which caused him to drop to his knees. Apparently in the course of this, Mr. Ash must have also struck his head, as he wound up being taken to Harborview Hospital, where a CT scan showed a moderate-sized intracerebral hemorrhage, likely traumatic.

CE T, p. 12. The records of Harborview Medical Clinic generated between October 31, 2011 and November 2, 2011 reflect treatment/evaluation for Claimant's head injury, but make no reference, whatsoever, to any complaints of right shoulder symptomatology. See CE Y, pp. 1-40.

97. On August 11, 2014, Claimant was seen at Kootenai Medical Center by Gordon Luther, M.D., for complaints of low back pain following a fall down "an entire flight of stairs" occurring 48 hours earlier. Dr. Luther took the following history on the occasion of his August 11, 2014 evaluation of Claimant:

> This is a 64-year-old gentlemen who states that about 48 hours prior to this evaluation he fell down an entire flight of stairs, tumbling head over heels. He

> denies being knocked out. He has obvious left orbital area contusion but has not had headaches, and his main complaint is low back pain. He states that he has had multiple falls over the last 4 years, after a back fracture at that time. This is what caused his fall today, was his legs "giving out," that has been a recurrent problem. He plans to see Dr. Larson in a couple of weeks for evaluation of possible surgery to help this issue. He otherwise has no significant past medical history. He does note from this fall several areas on his arms and legs of some contusions but other has not had significant pain in those areas and is able to move all joints without pain.

CE M, p. 18. Claimant did present with various contusions on his arms and legs, but did not express any right shoulder complaint, nor were such complaints elicited on exam:

> He has several areas on his arms and legs of slight erythema or ecchymosis from impact, but there is no area of bony tenderness, other than his lumbosacral spine. The remainder of his hips, pelvis, extremities, and spine are atraumatic and nontender to inspection and palpation.
>
> *Id.*

98. Claimant was seen by Jeffrey Larson, M.D., on August 26, 2014, a little over two weeks following his August 11, 2014 evaluation by Dr. Luther. Dr. Larson's report reflects that he reviewed a copy of Dr. Luther's August 11, 2014 chart note. Dr. Larson's report makes no reference whatsoever to any presenting complaints of right shoulder discomfort. See DE 5, pp. 39-45.

99. Nothing in Dr. McNulty's report of March 11, 2015 reflects that he received a history from Claimant on the occasion of that exam that Claimant developed more severe right shoulder symptoms following one of his falls. As developed above, none of the medical records generated at or around the time of the various falls identified by Claimant reflect any contemporaneous complaints of right shoulder discomfort. Accordingly, the question becomes what is the foundation for Dr. McNulty's conclusion that "it appears [Claimant] injured his right shoulder during one of those falls?" See CE AA, p. 30. We appreciate that at hearing Claimant endorsed Dr. McNulty's conclusion, but this testimony can hardly provide a foundation for Dr.

McNulty's earlier opinion. Moreover, the description given by Claimant at hearing is not consistent with any of the contemporaneous histories of the post-accident falls:

> Q: [By Mr. Stoddard]: Now, I believe in the initial report of Dr. McNulty, in 2015, he gave the opinion that you sustained some additional injury with respect to your right shoulder. Are you aware of that?
>
> A: My right shoulder, yes, was hurting from when I fell on the stairs. I landed on my shoulder, face first on my shoulder.
>
> Q: On your right shoulder?
>
> A: Yeah.
>
> Tr., pp. 90-92.

102. In all, we are unconvinced that there is an adequate foundation supporting Dr. McNulty's conclusion that Claimant's current right shoulder complaints are, in some respect, referable to one or more of his post-accident falls. We conclude that the limitations/restrictions identified by Dr. McNulty vis-à-vis the right shoulder are unconnected to the subject accident.

Temporary Disability Benefits

100. Idaho Code § 72-408 provides for income benefits for total and partial disability during Claimant's period of recovery. The burden is on Claimant to establish through expert medical testimony the extent and duration of the disability in order to recover income benefits for such disability. *Sykes v. C.P. Clare and Company*, 100 Idaho 761, 605 P.2d 939 (1980). Once Claimant reaches medical stability, he is no longer in a period of recovery, and temporary disability benefits cease. *Jarvis v. Rexburg Nursing Center*, 136 Idaho 579, 38 P.3d 617 (2001).

101. As noted above, Claimant reached MMI with regard to his industrial compression fracture on April 5, 2012. Defendants made TTD payments through this period. Work restrictions after this time were due to conditions not found herein to be compensable. As such there are no further TTD benefits due and owing to Claimant.

102. Claimant has failed to prove his entitlement to additional TTD payments beyond those previously paid by Defendants.

Permanent Partial Impairment Benefits

103. Permanent impairment is any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved and a claimant's position is considered medically stable. *Henderson v. McCain Foods,* 142 Idaho 559, 567, 130 P.3d 1097, 1105 (2006). Idaho Code § 72-424 provides that the evaluation of permanent impairment is a medical appraisal of the nature and extent of the injury or disease as it affects an injured employee's personal efficiency in the activities of daily living, such as self-care, communication, normal living postures, ambulation, elevation, traveling, and other activities. The Commission can accept or reject the opinion of a physician regarding impairment. *Clark v. City of Lewisto*n, 133 Idaho 723, 992 P.2d 172 (1999).

104. Dr. McNulty assessed a whole person PPI rating for Claimant's fixed and stable L1 compression fracture at 12% based upon severity of the injury as measured using measurement software. Dr. Larson assessed a 7% WP PPI rating for that same injury. Dr. McNulty also calculated a 19% WP PPI for Claimant's spinal stenosis with claudication.

105. Dr. McNulty's PPI rating for Claimant's spinal stenosis is not compensable, as the stenosis is not causally related to Claimant's industrial injury. As between Dr. McNulty's compression fracture analysis and that of Dr. Larson, the weight of the evidence favors the procedure utilized by Dr. McNulty for calculating the extent of Claimant's residual permanent impairment from his industrial injury.

106. Claimant has proven his entitlement to PPI benefits assessed at 12% whole person. Defendants are entitled to a credit toward such PPI benefit payments in the amount of PPI benefits previously paid to Claimant.

Permanent Partial Disability Benefits

107. Permanent disability results when the actual or presumed ability to engage in gainful activity is reduced or absent because of permanent impairment and no fundamental or marked change in the future can be reasonably expected. Idaho Code § 72-423. Evaluation (rating) of permanent disability is an appraisal of the injured employee's present and probable future ability to engage in gainful activity as it is affected by the medical factor of impairment and by pertinent nonmedical factors provided in Idaho Code § 72-430. Idaho Code § 72-425. Idaho Code § 72-430(1) provides that in determining percentages of permanent disabilities, account should be taken of the nature of the physical disablement, the disfigurement if of a kind likely to handicap the employee in procuring or holding employment, the cumulative effect of multiple injuries, the occupation of the employee, and his or her age at the time of the accident causing the injury, or manifestation of the occupational disease, consideration being given to the diminished ability of the affected employee to compete in an open labor market within a reasonable geographical area considering all the personal and economic circumstances of the employee, and other factors as the Commission may deem relevant. The test for determining whether a claimant has suffered a permanent disability greater than permanent impairment is "whether the physical impairment, taken in conjunction with nonmedical factors, has reduced the claimant's capacity for gainful employment." *Graybill v. Swift & Company*, 115 Idaho 293, 294, 766 P.2d 763, 764 (1988).

108. Per *Brown v. The Home Depot*, 152 Idaho 605, 272 P.3d 577 (2012), Claimant's disability should be assessed as of the date of hearing. Pursuant to Idaho Code § 72-425, a permanent disability rating is a measure of the injured worker's "present and probable future" ability to engage in gainful activity. The Court reasoned that in order to assess an injured worker's "present" ability to engage in gainful activity, it necessarily follows that his labor market, as it exists at the time of hearing, is the labor market which the Commission must consider. However, the Commission is afforded latitude to make its determination based on some other labor market, owing to the particular facts of a given case. In this case, the Commission finds no reason to evaluate Claimant's disability based on some labor market other than Claimant's time-of-hearing labor market. As developed below, however, there is a dispute as to the scope of Claimant's time-of-hearing labor market. Doug Crum conducted his analysis based on his belief that Claimant's labor market is his immediate geographic locale, i.e., Kootenai County. Mary Barros-Bailey based her analysis on the assumption that due to Claimant's work history, education and skills, his labor market is national in scope. These competing opinions are discussed in more detail *infra*.

109. If the degree of disability resulting from an industrial injury is increased because of a pre-existing physical impairment, the Employer is liable only for the disability from the industrial injury. See Idaho Code § 72-406(1); *Page v. McCain Foods, Inc.*, 145 Idaho 302, 179 P.3d 265 (2008). Because of its expertise in such matters, the Commission is allowed some latitude in making judgments on apportionment. *Reiher v. American Fine Foods,* 126 Idaho 58, 878 P.2d 757 (1994). Where apportionment is at issue, a two-step process is envisioned to evaluate how much of an injured worker's disability should be assigned to the subject accident. First, an injured worker's disability should be evaluated in light of all accident-produced and pre-

existing impairments as of the date of evaluation, i.e, the date of hearing. Following this assessment of Claimant's disability, the portion of Claimant's disability fairly referable to the subject accident should be assigned to the Employer. (See *Horton v. Garrett Freightlines, Inc.*, 115 Idaho 912, 772 P.2d 119 (1989); *Page, supra*). Apportionment is always at issue if implicated by the facts, and need not be raised by Defendants as an affirmative defense. As noted by the *Page* Court, since it is a statutory dictate that an employer can only be held responsible for the disability attributable to the industrial accident, Claimant is obligated to produce evidence to persuade the Commission as to the disability referable to the subject accident.

110. Here, it is Claimant's contention that the subject accident is responsible for causing the L1 compression fracture as well as permanently aggravating Claimant's pre-existing lower lumbar spine and right shoulder conditions. It is alleged that these conditions leave Claimant profoundly, if not totally and permanently, disabled. However, the Commission has determined that while the evidence establishes a causal connection between the subject accident and the L1 compression fracture, it fails to persuade us that either the subject accident or the causally-related subsequent falls caused any further injury to Claimant's lower lumbar spine or right shoulder.

111. We have concluded that Claimant's lower lumbar spine conditions are progressive in nature. Those conditions predated the subject accident, but have progressed in the years since the accident. Similarly, Claimant's right shoulder condition is the result of a 2009 industrial accident. The facts of this case are similar to those at issue in *Horton, supra*. In *Horton* it was demonstrated that Claimant suffered a work-related right hip injury in 1974. It was also shown that Claimant suffered from conditions involving left hip, low back, and bilateral shoulders which predated the 1974 accident. These other conditions did not become symptomatic until long

after the 1974 accident. However, in performing the two-step analysis anticipated by Idaho Code § 72-406, the Court ruled that it was appropriate for the Commission to consider Claimant's left hip, low back, and bilateral shoulder conditions because the underlying conditions predated the subject accident. Here, too, Claimant's lower lumbar spine conditions predate the subject accident, even though those conditions became symptomatic only after the subject accident. Per *Horton, supra*, Claimant's disability should be evaluated as of the date of hearing by considering not only the L1 fracture, but also Claimant's right shoulder and his lower lumbar spine conditions.

112. Before proceeding further, it is helpful to reiterate the various opinions that have been rendered concerning the scope and extent of Claimant's restrictions. Drs. McDonald and Larson have proposed that Claimant has no restrictions referable to the subject accident. This is not, of course, the same as an opinion that Claimant has no restrictions. The record provides little to suggest that Drs. McDonald and Larson would not agree that notwithstanding the non-work related nature of Claimant's lower lumbar spine condition, he is nevertheless significantly restricted because of those conditions.

113. Dr. McNulty has opined that viewed in a vacuum, Claimant is entitled to restrictions against lifting more than fifty pounds as a consequence of the L1 compression fracture (CE AA, p. 31). Dr. McNulty would impose somewhat more onerous restrictions for what he contends is the work-related aggravation of Claimant's pre-existing right shoulder condition. For this condition, Dr. McNulty would restrict Claimant from ever lifting more than 30 pounds, with rare overhead use of his right upper extremity (CE AA, p. 30). Finally, with respect to Claimant's lower lumbar spine deficits, Dr. McNulty would impose essentially sedentary work restrictions of lifting no more than 10 pounds rarely, and five pounds frequently.

McNulty Depo., pp. 35-36. Per the Supreme Court's direction, the appropriate approach is to gather these restrictions and consider them in the light of Claimant's relevant non-medical factors outlined at Idaho Code § 72-430, in order to arrive at some gestalt of Claimant's ability to engage in gainful activity. After arriving at this assessment, the Commission is then charged with determining what part of Claimant's disability from all causes should be assigned to the subject accident. This is facilitated by an understanding of the restrictions which apply to the subject accident.

114. That analysis was not accomplished in this case. Neither Mr. Crum nor Dr. Barros-Bailey undertook an initial analysis of Claimant's disability from all causes followed by an analysis of what portion of Claimant's disability should be assigned to what we have defined as the accident-produced injury, i.e., the L1 compression fracture. Where most of the medical debate has been over whether Claimant's lower lumbar spine problems are or are not related to the subject accident, some consideration should have been given by the parties to how disability should be apportioned in the event the lower lumbar spine problems are found by the Commission to be non-work related. Rather, both Mr. Crum and Dr. Barros-Bailey couched their opinions in the following terms: Claimant has such-and-such a disability if the opinions of McNulty/Haynes/Harper are adopted and such-and-such a disability if the opinions of Dr. Larson/McDonald are adopted.

115. However, as developed in more detail, *infra*, it is clear that the sedentary restrictions imposed by Dr. McNulty in his report, and expanded at hearing, are onerous enough to subsume the restrictions referable to the shoulder and the L1 fracture. Therefore, the sedentary restrictions are a reasonable reflection of Claimant's disability from all causes. Crum Depo., pp. 48-49. Both Dr. Barros-Bailey and Mr. Crum attempted to evaluate Claimant's disability based

on the sedentary restrictions imposed by Dr. McNulty. Mr. Crum believed that Claimant is 100% disabled if one accepts the restrictions imposed by Dr. McNulty. Mr. Crum was aware that on a pre-injury basis Claimant's labor market was international in scope. However, in evaluating Claimant's disability, Mr. Crum considered only the Kootenai County labor market; he proposed that with no pre-injury restrictions, Claimant had access to 11.2% of the Kootenai County labor market prior to February 11, 2011. With sedentary restrictions imposed by Drs. Haynes, Harper, and McNulty, Claimant has lost all access to the Kootenai County labor market. Crum Depo., pp. 43-47.

116. Dr. Barros-Bailey proposed that in view of the sedentary restrictions imposed by Dr. McNulty, Claimant has lost 78% access to his time-of-injury labor market. Unlike Mr. Crum, she believed that Claimant had access to an international labor market on both a pre- and post-injury basis. However, the analytical tools available to her forced her to evaluate Claimant's disability based on the national labor market. Barros-Bailey Depo., p. 23. This necessarily understated Claimant's actual labor market. She acknowledged that Claimant's ability to travel is limited. Unlike Mr. Crum, Dr. Barros-Bailey does appear to have considered Claimant's likely wage loss. Her report contains the curious observation that Claimant has "demonstrated a prolonged history of earnings far beyond those he earned at the time of injury." DE 6, p. 77. This is apparently based on her interview of Claimant. Barros-Bailey Depo., pp. 39-40. From this, she concluded that Claimant has suffered no wage loss. Claimant's statement about his post-injury earnings may be based on his 2016 partnership tax return, which shows gross receipts in excess of $250,000. However, as Mr. Crum explained, Claimant's 2016 net partnership income was actually only slightly over $10,000. Claimant's social security earnings statements show that his annual income from 2012 forward is as follows:

2012 - $64,642

2013 - $0

2014 - $63,461

2015 - $99,742

For 2016, Claimant's partnership income was approximately $10,000. However, Claimant also had employment income for 2016 from NASCO. Crum Depo., p. 51. He was so employed from 2013-2016. See CE D. His income from this employment was $100,000 per annum. In 2016, Claimant worked for NASCO until the end of July. Therefore, it might be guessed that he earned a little over $58,000 in 2016 for his NASCO work. It is hard to reconcile Mr. Crum's statement with Claimant's 2016 Idaho tax return showing Claimant's adjusted gross income at $199,826. CE E, p. 83. Mr. Crum did not reference Claimant's 2016 Idaho tax return in his recap of Claimant's earnings (CE J, p. 29), although he did testify that he was aware of the existence of the return. Crum Depo., p. 52. At the end of the day, we are unable to know much more about Claimant's 2016 earnings from employment. He may have earned anywhere between $68,000 to $209,000, based on the evidence of record. Claimant's 2017 income is unknown; as of late April of 2017, Claimant was still working on the Orthios project as a contractor. That work has come to an end due to funding issues.

117. Relying on her belief that Claimant has suffered no wage loss, Dr. Barros-Bailey evidently averaged Claimant's 78% national labor market access loss and 0% wage loss to come up with something in the range of a 39% disability figure. To this she added some consideration for Claimant's age, to arrive at a disability figure of 40-45%. Dr. Barros-Bailey's conclusion concerning wage loss challenges her ultimate opinion on disability, but her assessment of Claimant's labor market access loss nevertheless merits consideration.

118. Per his Social Security earrings record (CE E, p. 1), Claimant's earnings for 2008-2011 (inclusive) were as follows:

2008 - $121,519

2009 - $141,369

2010 - $160,961

2011 - $150,797

Disregarding 2016, Claimant's social security earrings record may support a crude assessment of wage loss of something in the range of 38% ($160,000 vs. $99,000). Employing Dr. Barros-Bailey's model might then yield disability in the range of 63% (78+38=116/2 = 58+5=63).

119. We are somewhat skeptical of Mr. Crum's conclusion that an individual with Claimant's accumulated skills and abilities has no labor market whatsoever. We are also critical of his decision to evaluate Claimant's disability with reference to Kootenai County alone, when Claimant's pre- and post-injury work history reflects employment that is national in scope. Claimant has demonstrated an ability to continue to work in his chosen profession in the years subsequent to February 11, 2011, albeit with significant limitations affecting his ability to do field work, an essential component of many of the jobs he is otherwise qualified to perform. Moreover, while Mr. Crum assumed that Claimant could no longer travel long distances by plane or ground transportation, such restriction has not been imposed by Dr. McNulty. Mr. Crum's attempts to parlay the need to protect Claimant from falls into a restriction against travel by air are not well taken. Crum Depo., pp. 41-43. Also, elsewhere in his testimony Mr. Crum was unwilling to endorse that Claimant has been unable to travel since the subject accident. Crum Depo., p. 33.

120. Claimant's testimony that he has unsuccessfully applied for over 100 jobs in his area of expertise is unchallenged. However, his ability to continue to exploit his highest and best potential is also demonstrated by the record; Claimant has managed to find situations in his chosen field that allow continued employment.

121. Considering Claimant's sedentary restrictions in light of his past work history, educational background, age at hearing, labor market, and other non-medical factors, we conclude that Claimant has suffered loss of access to his time-of-injury labor market of 78%. Our conclusion in this regard is premised on Dr. Barros-Bailey's testimony that while Claimant is limited to sedentary employment which includes restrictions against climbing and other activities associated with field work, he is still able to compete for work locally and nationally in sedentary jobs which exploit his skills. Barros-Bailey Depo., pp. 27-29.

122. We further conclude that Claimant has wage loss in the range of 38%. We accept Dr. Barros-Bailey's conclusion that consideration should also be given to Claimant's age at hearing, to support an assessment of disability of 63%, inclusive of impairment.

123. Having found that Claimant is not 100% disabled, we must nevertheless consider whether he is totally and permanently disabled under the odd-lot doctrine.

124. If a claimant is able to perform only services so limited in quality, quantity, or dependability that no reasonably stable market for those services exists, she is to be considered totally and permanently disabled. Such is the definition of an odd-lot worker. *Reifsteck v. Lantern Motel & Cafe,* 101 Idaho 699, 700, 619 P.2d 1152, 1153 (1980). Taken from, *Fowble v. Snowline Express*, 146 Idaho 70, 190 P.3d 889 (2008). Odd-lot presumption arises upon showing that a claimant has attempted other types of employment without success, by showing that she or vocational counselors or employment agencies on her behalf have searched for other work and

other work is not available, or by showing that any efforts to find suitable work would be futile. *Boley*, *supra.*; *Dehlbom v. ISIF*, 129 Idaho 579, 582, 930 P.2d 1021, 1024 (1997). Once the claimant proves odd-lot status, the burden shifts to the employer to prove that regular and continuous suitable work is available to the claimant.

125. Claimant asserts that he has demonstrated his odd-lot status by applying for work without success and also by demonstrating the futility of further attempts to identify suitable employment. As noted above, Claimant testified that he has applied for at least 100 jobs in his area of expertise, but has received no offers because all the jobs for which he applied require physical abilities beyond those he currently possesses. Tr., p. 37. He evidently continues to look for sedentary managerial positions, but without any success to date. However, Claimant's work searches have in fact been successful, since he has managed to obtain, and perform the duties of, a number of employments since the accident of February 11, 2011. Claimant has been employed as recently as April or March of 2017, and his most recent work as a contractor for Ortheos came to an end only because funding for the project dried up, not because of Claimant's physical inability to perform his contracting work.

126. Claimant's proven ability to obtain employment since 2011 also augers against a conclusion that it would be futile for Claimant to continue his search for employment. In this regard, the Commission is particularly struck by Claimant's acumen and experience in his chosen profession. The Commission appreciates that travel is difficult for Claimant, but we conclude that the evidence fails to persuade that air travel is outside his sedentary restrictions. This suggests that Claimant's post-injury labor market is more in line with the opinion expressed by Dr. Barros-Bailey. Claimant may be more disabled if one limits his post-accident labor market to performing work in Kootenai County. However, we agree with Dr. Barros-Bailey that

Claimant's labor market should not be so limited. Claimant's pre- and post-injury employment demonstrates that he competes for work in the national, if not international, labor market. In reaching this conclusion we do not intend to denigrate Claimant's assertion that air travel is difficult for him. There is, however, no persuasive medical evidence that Claimant is unable to travel by air.

127. For these reasons we conclude that Claimant has failed to demonstrate that he is totally and permanently disabled via the odd-lot doctrine.

128. Having concluded that Claimant suffers disability from all causes at 63%, we must next consider the second step of the Idaho Code § 72-406 analysis, i.e., consideration of Claimant's disability from the subject accident. As noted, Claimant has restrictions against lifting more than 50 pounds as a consequence of the L1 compression fracture, the only condition which we have found to be causally related to the subject accident.

129. Although Mr. Crum was aware of Dr. McNulty's restriction against lifting more than 50 pounds due to the L1 fracture, he undertook no meaningful analysis of Claimant's disability relating to those restrictions.

130. As noted above, Dr. Barros-Bailey concluded that with sedentary restrictions, Claimant's loss of access to his time-of-injury labor market is in the range of 78%. Assuming only light-duty restrictions, his loss of labor market access falls to 7%, and assuming only medium-duty restrictions, she proposed that Claimant has suffered no loss of labor market access. See DE 6, p. 77. In her deposition, she clarified that Claimant's 50 pound lifting restrictions for his L1 fracture falls into the medium range. Barros-Bailey Depo., p. 27. While Dr. Barros-Bailey devoted a good deal of attention to explaining Claimant's labor market access loss caused by sedentary restrictions, she spent little time explaining her opinions about the

impact of light and medium duty restrictions. Presumably, she must have concluded that with only medium-duty restrictions, Claimant retained the physical capacity to perform all of the physical requirements of the jobs in his pre-injury labor market. However, if this was her thought process, her conclusion may be criticized because her own analysis strongly suggests that Claimant's pre-injury skill set included skills that Claimant would be unable to exploit with medium restrictions. DE 6, p. 74. In fact, Claimant's time of injury job required occasional lifting over 100 pounds. CE I, p. 5. Assuming only medium duty restrictions, Dr. Barros-Bailey did not explain how Claimant's inability to perform many of the heavy activities he was accustomed to performing in his work leaves him with no labor market loss.

131. On the other hand, Dr. Barros-Bailey appears to have arrived at her labor market access loss opinion for medium restrictions by considering those restrictions in a vacuum. Of course, those restrictions do not exist in a vacuum. Their impact must be considered in light of the sedentary and light duty restrictions Claimant also has. Claimant's sedentary and light restrictions stem from conditions which we have found to be pre-existing in their genesis and unrelated to Claimant's accident. *Horton, supra*. Claimant's accident produced restrictions do not further limit his ability to engage in gainful activity where his pre-existing restrictions are of even greater magnitude. A Venn diagram of Claimant's pre-existing and accident produced restrictions would consist of a first set containing sedentary restrictions and restrictions against ever lifting over thirty pounds with the right arm, with rare overhead use of the right arm and a second set representing restrictions for the L1 fracture, i.e., the restriction against lifting over fifty pounds. This second set is demonstrated to be merely a subset of the set of Claimant's more expansive pre-existing restrictions. From this, we conclude that Claimant has failed to meet his burden of showing that some portion of his current disability (except for the 12% disability

related to impairment) is causally related to his L1 fracture; the L1 fracture is insignificant when compared to Claimant's pre-existing conditions.

Attorney Fees

132. Claimant asserts entitlement to attorney fees pursuant to Idaho Code § 72-804 which provides:

> 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.

The decision that grounds exist for awarding a claimant attorney fees is a factual determination which rests with the Commission. *Troutner v. Traffic Control Company*, 97 Idaho 525, 528, 547 P.2d 1130, 1133 (1976).

133. In the present case, Defendants paid all benefits due and owing except for some PPI benefits. However, when confronted with a discrepancy between the PPI rating from their IME physician, Dr. Larson, and Claimant's IME doctor, Dr. McNulty, Defendants paid the average of the two figures as mandated by IDAPA 17.02.04.281.03. Defendants' conduct in this regard was reasonable.

134. Claimant has failed to prove a right to attorney fees pursuant to Idaho Code § 72-804.

CONCLUSIONS OF LAW AND ORDER

1. Claimant has proven that his L1 compression fracture is causally related to the subject accident. Claimant is entitled to a 12% PPI rating for this injury, and has restrictions against lifting more than 50 pounds as a consequence of this injury.

2. Claimant has failed to prove that his current lower lumbar spine injuries are referable to the subject accident. As such, Claimant is not entitled to the surgery proposed to treat his lower lumbar spine, or to any other medical treatment for these injuries. Claimant has restrictions against engaging in anything more onerous than sedentary activity as a consequence of his lower lumbar spine condition.

3. Claimant has failed to prove that his pre-existing right shoulder condition was aggravated or worsened as a consequence of the subject accident.

4. Claimant has disability from all causes of 63% of the whole person, inclusive of impairment.

5. Claimant has failed to prove that he is totally and permanently disabled under either the 100% method or the odd-lot doctrine.

6. Claimant has failed to prove that any part of his disability, other than his 12% PPI rating, is referable to the subject accident.

7. Claimant has failed to prove entitlement to an award of attorney fees.

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

DATED this ___20th___ day of ___December___, 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 __20th__ day of ___December___, 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:

BRADLEY STODDARD
PO BOX 896
COEUR D ALENE ID 83816

JUDITH ATKINSON
PO BOX 6358
BOISE ID 83707

_____/s/_____