BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

MARIA G. BECERRA, Claimant, v. CHOBANI GLOBAL HOLDINGS, INC., Employer, and SENTRY CASUALTY COMPANY, Surety, Defendants.	**IC 2013-030449** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** Filed February 23, 2018

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee John Hummel, who conducted a hearing in Boise, Idaho, on November 10, 2016. Claimant was represented at hearing by Dennis Petersen, of Idaho Falls. Alan Gardner, of Boise, represented Chobani Global Holdings, Inc., ("Employer"), and Sentry Casualty Company, ("Surety"), Defendants. Oral and documentary evidence was admitted. Post-hearing depositions were taken. The parties submitted post-hearing briefs. Claimant did not submit a reply brief. The matter came under advisement on July 14, 2017. Due to a backlog of cases, the parties agreed to have the matter re-assigned to the Commissioners.

ISSUES

The issues the parties agreed to have decided are:

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

    a. Medical care;

    b. Permanent partial impairment (PPI); and

    c. Disability in excess of impairment (PPD);

2. Whether Claimant may change her treating physician to Michael Spackman, M.D., pursuant to Idaho Code § 72-432(4).

3. Whether the Commission should retain jurisdiction beyond the Statute of Limitations.

CONTENTIONS OF THE PARTIES

Claimant argues that she remains symptomatic from her undisputed November 18, 2013 work injury, when she injured her back while bending to lift boxes. Claimant requires a change of physician to Michael Spackman, M.D., for ongoing epidural steroid injections and pain medication. She requests that the Commission retain jurisdiction to address her ongoing need for medical treatment. If Claimant is stable, she is entitled to 44% permanent physical disability (PPD), inclusive of her 3% permanent physical impairment (PPI), without apportionment. Claimant requests that the Commission adopt the expert opinions of Drs. Spackman, Bates, and Mr. Porter.

Defendants argue that Claimant's minor and temporary lumbar strain has resolved, and she is not entitled to additional medical benefits, a change of physician, or retention of jurisdiction. Claimant's desired medical care of epidural steroid injections and ongoing pain

[1] Claimant waived the issue of Idaho Code § 72-804 attorney fees at hearing, and withdrew the temporary total disability/temporary partial (TTD/TPD) in her post-hearing brief. Tr., 5:22-6:5; C's Brief at 23.

medication treatment has proven ineffective, unreasonable, and unlikely to address her physical complaints. The Commission should adopt the expert testimony of Drs. Hajjar and Collins. Claimant's present symptoms are not causally related to the subject work accident, but rather to her 2008 work injury and her undisputed degenerative disc disease, such that if any impairment is awarded, it should be apportioned to her preexisting condition. Instead, Claimant has insisted on pursuing ineffective treatment outside the chain-of-referral, and beyond the point of medical stability. The Commission should find Claimant medically stable and not entitled to additional benefits.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. Claimant's testimony, taken at hearing and deposition;
2. Testimony of Randie Mendez, taken at hearing;
3. Claimant's Exhibits A-JJ, admitted at hearing;
4. Defendants' Exhibits 1-30, admitted at hearing
5. Post-hearing Deposition of Michael Hajjar, M.D.;
6. Post-hearing Deposition of James Bates, M.D.;
7. Post-hearing Deposition of Michael Spackman, M.D.;
8. Post-hearing Deposition of Delyn Porter, M.A.; and,
9. Post-hearing Deposition of Nancy Collins, Ph.D.

OBJECTIONS

All objections preserved in the post-hearing depositions are overruled, with the exception of Defendants' objection to Dr. Spackman's testimony pertaining to events which occurred after the hearing. The objection is SUSTAINED. In addition, Dr. Spackman provided medical care to Claimant, and he was referred to as Claimant's treating physician. The Commission did not

interpret this "treating physician" reference as a legal conclusion for purposes of the chain-of-referral analysis.

FINDINGS OF FACT

1. **Background.** Claimant was 32 years old at the time of hearing, married, and residing in Buhl, Idaho with her four children. Claimant came to the United States from Mexico when she was two years old, and gained citizenship in 2011. She grew up in the Magic Valley area, attended high school, and ended her schooling a few credits shy of her diploma. In 2006, Claimant obtained an "HSE" or high school equivalency certificate.

2. Claimant worked in customer service at a convenience store deli department and a local grocery store. Thereafter, Claimant worked for a pipe fitting company, where her job duty was cutting and packaging lines of pipe. Claimant then started as a custodian for Shoshone School District. In 2008, Claimant injured her back on the job, when she was thrown to the floor by a floor stripping machine. Claimant had physical therapy at Jerome Physical Therapy and St. Luke's Idaho Elks Rehabilitation Services. (Ex. 3.) Brian Johns, M.D., treated Claimant for her back injury, which he assessed as low back pain with sacroiliac dysfunction. Dr. Johns released Claimant back to work on November 3, 2008, without impairment or restrictions. Claimant returned to work and resumed her job assignments, and even trained for her commercial driver's license to drive routes for school district. Claimant was promoted to an English-as-a-second-language (ESL) para-professional, and acted as a "migrant liaison." Claimant briefly left the school district to work for the South Central Public Health, assisting with the Women, Infants, and Children (WIC) program, but returned to the school district after about six months. In December 2012, she started working for Employer on their production line, which was uneventful prior to the subject accident. Thereafter, Claimant was intermittently off-work due to

her industrial accident and her pregnancy. The parties disputed why Claimant did not successfully return to work after the industrial accident. Claimant presently works part-time (32-34 hours per week) as a receptionist for a medical office, earning $10 an hour.

3. Claimant's co-morbidities include morbid obesity and degenerative joint disease. In May 2012, Claimant reported back pain to Christian Oakley, M.D., in the context of an evaluation for gastric bypass procedure to assist with weight management. On May 30, 2012, Claimant had a gastric sleeve procedure, and her weight significantly decreased from 255 pounds to 187 pounds by March 5, 2013. After the subject industrial accident, Claimant approached Robert Korn, M.D., on November 6, 2015, for a revision laparoscopic sleeve gastrectomy, hoping for additional weight loss. Robert Korn, M.D., supported the revision surgery, noting the negative impact of weight distribution on Claimant's low back.

> Her activity profile is excellent with some limitations imposed by lower back degenerative joint disease which is now currently requiring therapy with steroid injections and is limiting her mobility to some degree. She seeks revision of the laparoscopic sleeve gastrectomy to obtain adequate weight loss which is medically necessary given the degenerative joint disease of her back currently imposing limitations on mobility and requiring steroid injection therapy.
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> DE 23, 1.

4. Dr. Korn's notes do not explain whether, or to what extent, Claimant's industrial accident affected her degenerative joint disease. Presently, Claimant gets quarterly Botox injections with Dr. Hammond for migraines, and is prescribed anti-depressants and a muscle relaxant.

5. **Industrial Accident.** Employer hired Claimant in 2012 as a machine operator, responsible for packaging of product, accuracy of labels on the product, and keeping cardboard boxes on the production line. On November 8, 2013, Claimant injured her lower back while bending to pick up boxes for the production line. She promptly reported pain through her waist

and radiating down her left leg, and sought medical care with Dr. Johns of Occupational Health. Dr. Johns ordered chiropractic treatment and imposed work restrictions. Claimant was newly pregnant at the time of this industrial accident, and her pregnancy soon introduced its own complications to Claimant's ability to work. Based on feedback from Claimant's obstetrician, Claimant's treatment plan discontinued chiropractic care, discouraged narcotic medication, and recommended physical therapy. Claimant disliked these changes, particularly the physical therapy. While Claimant testified that her pregnancy and payment issues ended her course of physical therapy, the St. Luke's Magic Valley Outpatient Rehab notes state that "the patient canceled all subsequent appointments" after her initial evaluation. Ex. D: 18. On December 9, 2013, Dr. Johns diagnosed sacroiliac (SI) dysfunction, but released Claimant to full-duty work.

6. Later that same day, Claimant escaped from a house fire with her young children. Fortunately, she and her family were safe, but her house was a complete loss. The house fire coincided with a flare in Claimant's complaints, and she returned to physical therapy on December 10, 2013. Dr. Johns reinstituted modified work restrictions. By December 30, 2013, Claimant's obstetrician took her off-work for the remainder of her pregnancy and maternity leave. Claimant testified that Dr. Johns was in mutual agreement with her obstetrician about taking Claimant off-work. Dr. Johns continued to follow Claimant's progress, although the treatment of Claimant's high-risk pregnancy took precedence. Claimant reported problems with mobility, pain down her thigh, and continued taking pain medication. Claimant disputed the portions of the medical record relating her pregnancy's impact on her ability to perform her essential job functions, such as the potential need for intravenous fluids and lifting restrictions related to her pregnancy. Claimant's baby was born in April of 2014, and Dr. Johns resumed more active care of Claimant. He recommended an MRI evaluation, which occurred on May 15,

2014, and showed SI joint dysfunction. Dr. Johns referred Claimant to Dr. Jensen to address these findings.

7. On May 22, 2014, Dr. Jensen evaluated Claimant, and recommended a part-time return to work and physical therapy. Claimant did not fully implement these recommendations before her May 28, 2014 tubal ligation surgery, and carpal tunnel release surgeries with Tyler Wayment, M.D., on June 19, 2014 and July 8, 2014. After extensive back-and-forth between Claimant, Employer, and her medical providers, Dr. Johns released Claimant to the light-duty work of washing "booties," the protective coverings worn at the plant. She lasted two weeks in this assignment, before she resumed (unsuccessfully) her machine operator duties. Per Claimant, she approached Employer with her abilities, but they encouraged her to pursue short-term disability rather than accommodate her restrictions. Tr., 71-72. Per Employer, it was difficult to find an appropriate work assignment for Claimant, because Claimant wanted restrictions that exceeded those of her physician. Employer sent Claimant home on July 23, 2014, due to the safety risks associated with narcotic medication. Claimant complained to Dr. Jensen and Employer of undesirable side effects from her medication, specifically drowsiness and dizziness. Thereafter, Claimant had various unexcused absences that Claimant insists were due to medication side effects or medical appointments.

8. Dr. Jensen continued to treat Claimant regularly throughout July and August, eventually referring her for IME evaluation with Michael Hajjar, M.D., discussed below. After the evaluation's conclusion, Claimant reported to Dr. Jensen that Dr. Hajjar recommended epidural steroid injections. Dr. Hajjar disputed Claimant's report, and Dr. Jensen did not provide the injections; Claimant's assertions were not corroborated by the contemporaneous medical

notes. By August 19, 2014, Dr. Jensen noted that he had nothing more to offer the patient, and discharged the Claimant from his care.

9. On September 3, 2014, Dr. Hajjar performed an IME evaluation of Claimant. Dr. Hajjar evaluated Claimant again on October 19, 2016. He also reviewed the medical records and testified via post-hearing deposition on March 8, 2017. Dr. Hajjar is a board-certified neurosurgeon in the Boise area, and qualified to render an expert medical opinion. Dr. Hajjar concluded that Claimant had reached medical stability, and required no further medical treatment and no permanent restrictions. When considering Claimant's present symptoms and causation, Dr. Hajjar places great significance on Claimant's 2008 injury, because a previous back injury is a significant predictor of future back problems. He identified several reasons to dispute a casual relationship between the subject accident and Claimant's present condition. First, the 2014 MRI shows subtle, degenerative changes, likely casually related to the progression of a degenerative condition—not the acute subject accident. Second, Claimant's symptomatology shift (from left to ride side) and the nature of her complaints (back pain greater than leg pain) do not indicate a discrete structural injury that one would expect from the subject accident. Given this physical evidence indicating the progression of a degenerative condition, Dr. Hajjar opined that the November 2013 injury was a temporary aggravation of the preexisting degenerative condition and that Claimant was medically stable with a 2% whole person PPI rating. He apportioned 50% of this rating to Claimant's preexisting degenerative disc disease. Dr. Hajjar did not assign any restrictions related to the 2013 injury, as Claimant's physical examination was normal with no abnormal reflexes, normal neurological presentation, and only slight limitations in movement.

10. Dr. Hajjar strongly disputes that Claimant requires additional medical treatment related to her industrial accident. Physical medical strategies, such as the physical therapy

recommended by Dr. Bates would be reasonable, if Claimant is to have additional care. He discourages additional epidural steroid injections, reasoning that epidural steroid injections are unreasonable, and are only effective at treating nerve root symptoms, which Claimant does not have. Claimant's disinterest in additional physical therapy does not persuade Dr. Hajjar to endorse epidural steroid injections.

11. Based on Dr. Hajjar's 2014 IME, Defendants declined to provide further medical care for Claimant. On November 11, 2014, Dr. Manos of the Spine Institute of Idaho examined Claimant. Although Dr. Manos' chart notes indicate that counsel might have referred her, Claimant testified that she self-referred to Dr. Manos, based on a friend's recommendation. Ex. Y. Dr. Manos assessed lumbar strain, and gave a 15-pound lifting and a 4-hour (part-time) restriction. Like the previous physicians, Dr. Manos recommended physical therapy. PA Kalyn Baisley managed Claimant's subsequent visits, and even helped Claimant with short-term disability paper work. On December 10, 2014, PA Baisley documented that Claimant had not started the recommended physical therapy, and continued her hydrocodone and tramadol prescriptions. She cleared Claimant to operate machinery and work in the lab, with the understanding that Dr. Manos' restrictions would be re-visited in eight weeks. On February 27, 2015, Claimant returned to the Spine Institute for evaluation. Claimant's examination was normal, notwithstanding Claimant's subjective complaints of low back pain, bilateral hip pain, and occasional left leg pain with numbness and tingling. Dr. Manos and PA Baisley did not consider Claimant to be a surgical candidate and referred Claimant to Michael Spackman, M.D., for conservative care. Thereafter, Dr. Spackman treated Claimant with epidural steroid injections. Spackman Dep., at 17:13-21; 18:11-14. Per Claimant, the injections give brief relief, with her pain returning approximately two and a half months after each injection.

Notwithstanding that the epidural steroid injections provide only a temporary respite, Claimant is pleased with them, because she feels like they make "an everyday difference" on her activity level, and decrease her pain. Tr., 77.

12. Dr. Spackman testified via deposition on February 17, 2017. He practices physical medicine and rehabilitation, and is qualified to give an expert medical opinion. Dr. Spackman opined that Claimant requires ongoing injections and occasional pain medication to manage her symptoms from the industrial accident. He first examined Claimant on March 26, 2015. The physical examination was unremarkable, but showed some discomfort and slow movements:

> I typically do a full examination on my patients when they come in. So at that point she didn't express any kind of specific distress—well—or she was in no distress at that point. She was a little overweight, normal affect, oriented, no specific head issues, no specific neck issues, eyes, ears, nose, throat, mouth were all normal. Cardiovascular she didn't have any edema, she had normal pulses, she was breathing easily. Her belly was soft, nontender. She didn't have a rash on her skin. She was able to arise from her chair without any problems. She was able to get off and on the table without difficulty. She was able to walk on her toes and her heels. She had a nonantalgic gait. She didn't have any device she was walking with. She had a normal station.
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> I wrote down here that her motions were slower and deliberate, meaning that even though she was able to do these, it wasn't done easily. It was obviously that, you know, she seemed stiff/uncomfortable while doing that.
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> She did have reduced lumbar range of motion to 60 degrees flexion, otherwise, it was normal. She had a positive straight leg raise.
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> Spackman Dep., 12:4-13:1.

Claimant showed normal range of motion in her hip, with some tenderness in her sacroiliac joints and over her sciatic notch, which Dr. Spackman described as the place where the sciatic nerve runs through the buttocks. *Id*. at 14: 33-15:13. Aside from this sciatic irritation, "the rest of her lower extremity had good range of motion, no other issues. Her strength was normal, her

reflexes were normal, her sensation was normal." *Id*. at 14:14-17. Dr. Spackman diagnosed degeneration of the lumbar intervertebral disc, opiod dependence and lumbar radiculopathy. He continued her prescription Tramadol and Robaxin, a muscle relaxer, but encouraged her to avoid narcotic medication. *Id.* at 16:19-17:5. Dr. Spackman placed permanent restrictions of "light restrictions as normally and customarily described with occasional bending and twisting." Ex. Y; Spackman Depo., 38:13-21. Although Dr. Spackman acknowledged that Claimant has a degenerative back condition and conceded that one might apportion her present condition "at least partially," to this preexisting degenerative condition, he doubted that he or anybody could assign an accurate percentage. *Id*. at 35:13-23. Given the onset of symptoms following the subject accident, Dr. Spackman did not apportion any of Claimant's condition to a pre-existing condition.

13. James Bates, M.D., practices physical medicine and rehabilitation, and is qualified to give an expert medical opinion. He evaluated Claimant on March 1, 2016, reviewed medical records, and testified via deposition on January 17, 2017. Dr. Bates found Claimant to be showing normal responses in motor strength, major muscle groups, lower extremities, and the reflexes and sensory exam, with moderate range of motion restrictions for the subject accident, which he described as back pain/strain with components of pelvic or sacroiliac joint involvement. Bates Dep., 8-9. Yet, due to the pelvic or sacroiliac joint pain he observed on his physical exam, Dr. Bates deferred finding Claimant stable. *Id.* at 10-11. He thought Claimant might benefit from specialized physical therapy for soft tissue pain, and corticosteroid injections for Claimant's SI joints. *Id*. Dr. Bates recommended temporary restrictions of frequent position changes from sitting, standing, or walking, maximum lifting of 30 pounds, occasional bending, stooping, and squatting, and no twisting while lifting. *Id*.

14. Like Dr. Hajjar, Dr. Bates disagrees with Dr. Spackman's recommendation for epidural steroid injections every two to three months with occasional pain medications. Dr. Bates explained that epidural injections are more appropriate for *radicular* pain, not for the centralized pain in the gluteal region described by Claimant. *Id*. at 14. Although he would not endorse an ongoing regime of epidural steroid injections, Dr. Bates testified that one or two epidural injections, Claimant's right L5 transforaminal injection on June 17, 2015 and the bilateral on September 15, 2015, were reasonable treatment as a trial. *Id*. at 33.

15. Claimant did not have the physical therapy Dr. Bates recommended, prompting Dr. Bates to adjust his temporary restrictions, discussed above, to permanent restrictions. He issued a 3% permanent physical impairment rating, without apportionment, based on the *AMA Guides to the Evaluation of Permanent Impairments, Sixth Edition*. *Id*. at 17-18.

16. **Vocational Testimony.** Delyn Porter, Claimant's vocational expert, testified regarding Claimant's permanent partial disability. Mr. Porter has the requisite credentials and experience to testify as a vocational expert. After meeting with Claimant on February 4, 2016, and reviewing medical records, Mr. Porter calculated loss of labor market access for each doctor's set of restrictions using three approaches. For his first approach (hereinafter, "IDOL approach"), Mr. Porter reviewed current job openings at the Idaho Department of Labor (IDOL) within a 50-mile radius of Buhl, Idaho, and identified jobs that Claimant could perform before and after her industrial accident. Porter Dep., 46:2-47:17. With the IDOL approach, he reasoned that Claimant could access 22.5% of the labor market *before* her industrial accident. For his second approach (hereinafter *Employment and Wage Report* approach), Mr. Porter analyzed Claimant's loss of access using the *Employment and Wage Release Report for the South Central Idaho Labor Market*, resulting in a pre-injury labor market access of 17.3%, only slightly lower

than the first approach. *Id.* at 50:2-23. Mr. Porter's third approach (hereinafter "SkillTran approach") is based on *SkillTran,* a computerized system that identifies available jobs using the *Dictionary of Occupational Titles* (DOT).

17. Using Dr. Hajjar's restrictions (or lack thereof), Claimant would have the same work access that she had prior to the injury, and she would be able to continue to do the time-of-injury job. *Id*. at 37:2-6.

18. Under Dr. Spackman's restrictions (notably, the occasional bending and twisting), Claimant would be unable to return to her time-of-injury job or work as a school attendant, stock clerk, kitchen helper, convenience store clerk, deli worker, production laborer, a janitor, or as a grocery store cashier/clerk. *Id*. at 7-13; 38:12-39; 39: 5-24; 39:25-40: 41:7. She would continue to be capable of working as a paraprofessional, ESL instructor, bus driver, clinical assistant, and telemarketer. *Id*. at 41:25-42:24; Ex. HH. Claimant's most appropriate vocational option post-accident is the job she secured as a "paraprofessional," because the physical demands are compatible with the restrictions from all the physicians who testified. *Id*. at 41:12-22. Applying the IDOL approach, Claimant's labor market access drops from 22.5% to 15.1%, for a 32.9% loss of labor market access. *Id*. at 48:4-10. The *Employment and Wage Report* approach shows Claimant's labor market access decreasing from 17.3% to 12.1%, for a 30.1% loss of access. *Id.* The *SkillTran* approach results in a 15.8% loss of access. *Id.*

19. Under Dr. Bates' restrictions, Claimant cannot return to work as a convenience store clerk; deli worker; kitchen helper; production laborer; janitor, and grocery store cashier or clerk. Ex. HH, 42. Dr. Bates' lifting restrictions would not prevent Claimant from returning to her time-of-injury job; however, the positional restrictions would. *Id*. at 42:14-20. As with Dr. Spackman's restrictions, Claimant could still access work as a paraprofessional, ESL

instructor, bus driver, clinical assistant, and telemarketer. Using the IDOL approach, Claimant's labor market access plummets from 22.5% to 8.1%, or a 64% loss of labor market access. Similarly, the *Employment and Wage Report* approach shows a drastic decrease from 17.3% to 6.9%, or a 60.2% loss of labor market access. *Id*. at 48:19-23. Under the *SkillTran* approach, Claimant has lost 47% of labor market access. *Id*. at 55:18-56:6. Mr. Porter pointed out that *SkillTran* is only capable of analyzing generic reaching and positional changes, which is less reliable considering Claimant's restrictions from Dr. Bates. *Id*. at 56: 11-22.

20. Mr. Porter's wage loss calculations were based on a pre-injury wage of $15 per hour. Mr. Porter increased Claimant's reported pre-injury wage of $14.42 to match the Social Security Itemized Statement of Earnings, and to reflect that she had earned approximately $31,000 the year prior to the subject industrial accident. *Id*. at 57:5-23. Mr. Porter used the *Idaho Department of Labor's Occupational Employment & Wage Release Report (2015)* to identify median earnings for categories of jobs, and calculated that Claimant's post-injury wage earning capacity drops to $10.91 per hour, or a loss of 27.3%. *Id*. at 58:1-17; 59:11-19. The *SkillTran Pre- and Post-Injury Wage Earning Capacity Reports* curiously show an increase in Claimant's post-injury wage earning capacity, notwithstanding the additional restrictions. *Id*. at 60:20-61:9. Mr. Porter emphasized that *SkillTran* is not readily adaptable to an individual's specific restrictions. *Id*. at 70:14-71:18. At maximum, *SkillTran* program showed a 1.6% loss of wage earning capacity. *Id*. at 61:10-19.

21. In summary, Mr. Porter's analysis gives no PPD under Dr. Hajjar's opinion. Using Dr. Spackman's restrictions and the IDOL approach, Claimant has 30.1% PPD, inclusive of impairment. With the *Employment and Wage Report* approach, Claimant has 28.7% PPD, inclusive of impairment. The *SkillTran* approach gives 8.7% PPD, inclusive of impairment.

Under Dr. Bates' restrictions, and the various approaches described above, Claimant's PPD, inclusive of impairment, is either 45.65% (IDOL approach), 43.75% (*Employment and Wage Report* approach), or 24.3% (*SkillTran* approach). *Id.* at 69:1-20.

22. Defendants criticized Mr. Porter's report, arguing that it derives its positional restrictions from Claimant's subjective opinions, i.e., Claimant's belief that she could walk only 30 minutes to one hour maximum, inflated the wage loss calculations by including overtime, and the three approaches to disability added more confusion than clarity. *Id*. at 75: 2-9. Mr. Porter defended his opinion by explaining that Dr. Bates' positional restrictions (change from sitting to standing to walking every 30 minutes) support his interpretation, but conceded the possibility that the wages might have included overtime. *Id*. at 75:2-12; 19-21.

23. Nancy Collins, PhD, Defendants' vocational expert, also testified regarding Claimant's permanent partial disability. Dr. Collins has the requisite credentials and experience to testify as a vocational expert. Like Mr. Porter, Dr. Collins interviewed the Claimant, reviewed relevant records, and calculated disability under each set of physician-imposed restrictions. Dr. Collins' methodology uses a process developed by the rehabilitation experts Boyd and Toppino and *SkillTran*. Collins Dep., 8:4-10, 22. Thereafter, Dr. Collins does a second analysis focusing on Claimant's labor market and actual job numbers. *Id*. Claimant presented well to Dr. Collins and Claimant's work history showed that she could develop new or expand skill sets, such as when she started work as a janitor for a school district, and advanced to a paraprofessional position. Dr. Collins reviewed Mr. Porter's report, and utilized the *Occupational Employment Quarterly for Twin Falls* and the *Idaho Occupational and Employment Wage Survey for Twin Falls* (2016). Dr. Collins opined that Claimant has multiple employment options. Claimant has performed sedentary work, has office skills, is bilingual

(Spanish/English), and has the ability to successfully train on-the-job. *Id*. at 30:25- 31:17. Dr. Collins categorized Claimant's work history as sedentary and light, with some at the medium-duty level. With a medium-duty restriction, Claimant's loss of access is 3%. Ex. D at 27: 7-8. With a light-duty restriction, Claimant's loss of access is 28%. *Id*. With additional positional restrictions from Dr. Bates, Claimant's loss of access is 38%. *Id*.

24. Claimant earned $14.42 per hour in her time-of-injury job. With Dr Hajjar's opinion, Claimant has no restrictions related to her industrial accident, and no loss of earning capacity. DE 27, 8. Dr. Collins opined that Claimant could realistically earn between $12 and $13 per hour, post-injury. Collins Dep., 32:13-33:7. Therefore her loss of earning capacity is 14%. DE 27, 9. Overall, Dr. Collins recommended 0% PPD under Dr. Hajjar's restrictions; 3% PPD under Dr. Manos' restrictions, because Claimant could return to *many* production jobs; 14% PPD under Dr. Spackman's restrictions because she could perform *some* production jobs; and, 26% PPD under Dr. Bates' restrictions.

25. **Claimant's Credibility.** Defendants argue that Claimant is not entirely credible and that her subjective symptom reports are not reliable. With respect to her relevant medical conditions, Dr. Hajjar displayed some skepticism that Claimant's pain complaints were valid. When Defendants pressed Claimant during cross-examination to explain inconsistencies in the medical record and her testimony, Claimant defensively insisted that the medical record was inaccurate. Claimant denied having physical restrictions related to her pregnancy, denied having degenerative joint disease, and denied reporting complaints of back pain related to her obesity to her physician, notwithstanding the gastric surgery she had to facilitate weight loss. The medical record shows a March 22, 2008 visit where Claimant is described by a family member as having "attention seeking behavior before" where she "faked episodes of pain when

there was emotional conflict at home." Ex. 2, 1. However, this unflattering description of Claimant comes from a layperson, not a medical professional, and does not equate to a clinically valid diagnosis of magnification of symptoms. The parties agreed to re-assign this matter from the Referee to the Commissioners to expedite its completion. The Commission did not hold a new hearing, and cannot make a finding on Claimant's observational credibility. However, having compared Claimant's substantive testimony to other evidence of record, the Commission found instances where Claimant's answers to Defendants were nonresponsive, and her wholesale denials of the accuracy of the medical record were implausible. Tr., 90-95. The Commission recognizes that it could not have been easy for Claimant to revisit the distressing loss of her stillborn child, complications of her high-risk pregnancy, her weight struggles and the complete loss of her home by fire—including her escape with her young children. There is nothing in the records that alludes to malingering, secondary gain, or functional overlay. Nevertheless, where Claimant's testimony conflicts with the medical testimony, Claimant's testimony will be allocated less weight.

26. Defendants hired a private investigator for surveillance of Claimant. The investigator started on October 6, 2016, and took surveillance films on October 11, 2016 through October 12, 2016. DE, 29. The surveillance films showed the Claimant entering and exiting her vehicle without difficulty, operating her vehicle, cleaning her car windshield with one hand, pumping gas, carrying a bag over her shoulder, grocery shopping with pushing a shopping cart, lifting items into the cart, and loading bags into her vehicle. *Id*. Claimant appeared to be moving comfortably at a moderate pace in the film, but was not shown doing any strenuous activity. *Id.* The surveillance report did not influence the expert medical testimony.

27. Randie Mendez, assistant safety manager for Chobani, testified at hearing. As safety manager for Chobani, Randie Mendez assists with all workers' compensation claims and Employer's return-to-work program. The brief testimony verified Claimant's light-duty work duties, and Employer's concern about Claimant's dizziness.

DISCUSSION

28. **Additional Medical Benefits.** Claimant alleges that she suffered a permanent injury to her low back on November 8, 2013, for which she still requires medical treatment. Defendants contend that, at most, Claimant suffered a temporary injury and that she is not entitled to further care. We first turn to the issue of the extent and degree of Claimant's work produced injury, and then to her need for medical treatment.

29. "Causation is an issue whenever entitlement to benefits is at question." *Gomez v. Dura Mark, Inc.*, 152 Idaho 597, 601, 272 P.3d 569, 573 (2012). *Serrano v. Four Seasons Framing*, 157 Idaho 309, 317, 336 P.3d 242, 250 (2014).

30. The Commission has three causation opinions from Drs. Hajjar, Spackman, and Bates. Dr. Hajjar emphatically denies a causal relationship between Claimant's industrial accident and any treatment after his September 2014 date of medical stability. He cites to Claimant's longstanding degenerative spine condition, confirmed by Claimant's September 2014 MRI, without any evidence of an acute problem that one would expect from the described industrial accident. Hajjar Dep., 10:18-11:9. Dr. Spackman insists that there is a causal relationship between Claimant's industrial accident and ongoing treatment, and cites to Claimant's new symptoms after the industrial accident. Spackman Dep., 35:13-23; 36:14-37:8. Dr. Spackman diagnosed Claimant with lumbosacral spondylosis with radiculopathy based on his physical examination, but did not address why Drs. Bates and Hajjar did not find

radiculopathy symptoms. *Id.* at 34:19-21. Dr. Bates opines that a causal relationship between Claimant's industrial accident, and *some* of the medical treatment Claimant received after September 2014. He largely agrees with Dr. Hajjar's lumbar spine assessment (sprain/strain), but believes that the industrial accident produced additional pain generators in the sacral region or the soft tissue components of that region that warranted investigation and treatment. Bates Dep., 21:16-25. Dr. Bates verified components of pelvic or sacroiliac joint involvement during his physical examination of Claimant, and noted that the soft tissue damage would not be expected to appear on an MRI. *Id*. Dr. Bates did not find evidence of radiculopathy. Therefore, Dr. Bates finds a casual relationship between the industrial accident and *most* of the medical treatment she independently pursued up to May 4, 2016; Claimant's epidural steroid injections being the exception. Due to Claimant's MRI findings and his evaluation, Dr. Bates could only endorse *two* epidural steroid injections as causally related; this is only because the treatment was appropriate to investigate the nature and extent of Claimant's injury, not because he recommended the same for treating Claimant's symptoms. At his March 1, 2016 evaluation, Dr. Bates considered Claimant unstable, and recommended physical therapy, which Claimant did not pursue or request at this hearing. By May 4, 2016, Dr. Bates found Claimant medically stable without the physical therapy program, and gave Claimant an impairment rating and restrictions.

31. After considering the evidence, the opinion of Defendants' IME physician, Dr. Hajjar, carries less weight, for the reasons discussed below. Dr. Hajjar would have the Commission attribute the entirety of Claimant's condition to her degenerative condition alone or the 2008 industrial accident, even though Claimant was released without impairment or restrictions, and there were new symptoms of pain originating after the industrial accident, as

described and confirmed by Drs. Spackman and Bates. The Commission cannot exclude the industrial accident's traumatic impact as it caused additional symptomatology. While the Commission agrees that Claimant's spine was not in pristine condition prior to her relatively minor industrial accident, that fact alone does not bar Claimant from workers' compensation recovery. "An employer takes an employee as it finds him or her; a preexisting infirmity does not eliminate the opportunity for a workers' compensation claim provided the employment aggravated or accelerated the injury for which compensation is sought." *Spivy v. Novartis Seed, Inc.*, 137 Idaho 29, 34, 43 P3d. 788, 793 (2002) (claimant's preexisting arthritis was not a bar to recovery when she injured her shoulder removing defective seeds from a conveyor belt in employer's processing plant).

32. Here, Claimant suffered an identifiable injury in the industrial accident that produced painful symptoms and required medical treatment. Drs. Spackman and Dr. Bates cited to Claimant's onset of symptoms in formulating their opinions, and Claimant's previous industrial accident did not result in any permanent restrictions or modification of her daily activities. She was able to perform her job for Employer without incident or medical intervention prior to the accident. Dr. Bates persuasively explained that the accident caused a lumbar spine sprain/strain, and additional pain generators in the sacral region or the soft tissue components of that region. Bates Dep., 21:16-25. Dr. Bates' physical exam verified these components of pelvic or sacroiliac joint involvement during his physical examination of Claimant, but not radiculopathy. *Id.* Dr. Spackman also supports causation for an injury beyond a temporary aggravation, but his opinion did not effectively rebut Dr. Hajjar's criticisms or demonstrate a thorough understanding of Claimant's past history. Dr. Spackman's opinion did not persuasively address why his diagnosis of radiculopathy should be adopted when two other

physicians did not find radiculopathy. Dr. Bates' opinion effectively addresses the issues raised by Dr. Hajjar, namely Claimant's preexisting degenerative condition, shows a good understanding of Claimant's medical history, and has objective support from his examination and findings. For these reasons, the Commission finds Dr. Bates' opinion persuasive. The industrial accident caused a lumbar sprain/strain with components of soft tissue damage and pain in the pelvic or sacroiliac region.

33. The next issue is whether Claimant is entitled to additional medical benefits for the condition that has been deemed compensable. Idaho Code § 72-432(1) requires an employer to provide 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 or manifestation of an occupational disease, and for a reasonable time thereafter. It is for the physician to determine what care is required, and for the Commission to determine whether the required care is reasonable. In *Chavez v. Stokes*, 158 Idaho 793, 353 P.3d 414 (2015), the Idaho Supreme Court overruled in part *Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989), regarding the determination of reasonable medical treatment, stating:

> This Court's review of the Commission's determination of the reasonableness of the claimant's medical treatment pursuant to Idaho Code section 72–432(1) is a question of fact to be supported by substantial and competent evidence.
>
> ….
>
> [T]he central holding of Sprague, which remains valid, is simply: "It is for the physician, not the Commission, to decide whether the treatment is required. The only review the Commission is entitled to make of the physician's decision is whether the treatment was reasonable." 116 Idaho at 722, 779 P.2d at 397. The Commission's review of the reasonableness of medical treatment should employ a totality of the circumstances approach.

Chavez, 158 Idaho at 797-798, 353 P.3d at 418-419.

Recently in *Rish v. The Home Depot, Inc.*, 161 Idaho 702, 390 P.3d 428 (2017), the Idaho Supreme Court examined the reasonability of purely palliative medical care. The Court reaffirmed the "totality of the circumstances approach" for evaluating whether or not medical care is reasonable under IC § 72-432(1) *Hall v. Fenice Corp.*, 082517 IDWC, IC 2013-016822

34. As to reasonableness, Dr. Spackman is the only physician endorsing ongoing epidural steroid injection treatment and occasional pain medication to manage Claimant's symptoms as reasonable care, based on his identification of radicular symptoms in Claimant. Drs. Hajjar and Bates reject Dr. Spackman's recommendations as not constituting reasonable treatment.

35. Dr. Hajjar articulated several objections to the proposed course of epidural steroid injection treatments, i.e., epidural steroid injections as more effective at treating nerve root symptoms, such as leg pain, rather than Claimant's reported symptoms; his opinion that physical medicine strategies, such as the physical therapy recommended by Dr. Bates, are more effective treatment, and that Claimant's physical examination was normal with Claimant moving freely, no abnormal reflexes, normal neurological presentation, and only slight limitations when moving. Dr. Hajjar opined that the proposed care will be ineffective at alleviating both her low back industrial injury *and* her long-term chronic degenerative condition. Per Dr. Hajjar, "Suboptimal care (epidural steroid injection) that is against doctor's advice is probably bad medicine." Tr., 26:14-16.

> I tend to agree with Dr. Bates in the simple fact that they are doing the same things over and over again with no end point and with no tangible benefit other than to get to the next injection. Therefore, the benefit of this for the patient is debatable. Dr. Bates recommends physical medicine strategies and physical therapy to be utilized, but Ms. Becerra does not want to proceed with this, as she believes it flares her up. Therefore, given this disconnect, Dr. Bates has recommended that patient is at medical stability and maximum medical

> improvement. Even though I disagree with other aspects of Dr. Bates' reports, I agree with this conclusion, that the best option for Ms. Becerra given her diagnosis of multilevel degenerative disk disease without any other neurological manifestation, the test option for this is clearly physical medicine and physical therapy and not injections. Injections do not work well for this diagnosis. The medication does not get into the disk space and for a four level problem, I am not sure exactly what injections on a long-term basis are aiming to achieve.
>
> Ex. 14, at 9-10.

36. Dr. Bates agrees with Dr. Hajjar that ongoing epidural steroid injections are not indicated for Claimant's condition and is not reasonable treatment in Claimant's case. Dr. Bates explained that these injections are not appropriate for the Claimant's reported symptoms, which are not radicular, and that Claimant would be better served with physical therapy, which Claimant is uninterested in pursuing. Bates Dep., 14. Nevertheless, Dr. Bates testified that one or two epidural injections, Claimant's right L5 transforaminal injection on June 17, 2015 and the bilateral on September 15, 2015, were reasonable treatment as a trial to investigate Claimant's problems. *Id*.

37. Given the voluminous medical objections, the Commission is not inclined to find ongoing epidural steroid injections reasonable. Drs. Hajjar and Bates have persuasively testified that ongoing epidural steroid injections are not reasonable treatment for Claimant's industrial accident, and that Claimant is medically stable. Claimant is entitled to the epidural injections she received on June 17, 2015 and September 15, 2015, but nothing further.

38. **Change of Physician Request.** Having failed to prove her entitlement to additional medical care in the form of ongoing epidural steroid injections and pain medications with Dr. Spackman, Claimant has not shown she is entitled to a change of physician to Dr. Spackman.

39. **Permanent Partial Impairment (PPI).** The next issue is the extent of Claimant's permanent impairment. "Permanent impairment" is any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved and which abnormality or loss, medically, is considered stable or nonprogressive at the time of evaluation. Idaho Code § 72-422. "Evaluation (rating) of permanent impairment" is a medical appraisal of the nature and extent of the injury or disease as it affects an injured employee's personal efficiency in the activities of daily living, such as self-care, communication, normal living postures, ambulation, traveling, and nonspecialized activities of bodily members. Idaho Code § 72-424. When determining impairment, the opinions of physicians are advisory only. The Commission is the ultimate evaluator of impairment. *Waters v. All Phase Construction*, 156 Idaho 259, 262, 322 P.3d 992, 995 (2014).

40. Dr. Bates recommends a 3% whole person PPI rating, without apportionment, based on the *AMA Guides to the Evaluation of Permanent Impairments, Sixth Edition*. Bates Dep., at 17-18. Dr. Bates' rating is considered Class I, which is the highest level of impairment for a strain type injury. Ex. 15, at 9. Dr. Bates also imposed permanent restrictions of frequent position changes from sitting, standing, or walking, maximum lifting of 30 pounds, occasional bending, stooping, and squatting, and no twisting while lifting. *Id*.

41. Dr. Hajjar proposed a 2% whole person PPI rating, with 50% apportioned between the subject accident and the remaining 50% to Claimant's preexisting degenerative disc disease and the June 16, 2008 accident. Dr. Hajjar categorized Claimant into Class 0, although he acknowledged it was debatable. Dr. Hajjar would not attribute any restrictions or limitations to the subject industrial accident.

42. Here, the expert opinions are similar in their methodology, but sharply diverge on the treatment of Claimant's degenerative disc disease. The Commission is not inclined to attribute any impairment or restrictions to Claimant's 2008 industrial accident after the fact, instead finding that the contemporaneous evaluation of the Claimant's condition in 2008, which did not give any impairment or restrictions, is more persuasive than Dr. Hajjar's report in 2014 and reviewed in 2016. While the experts agree that Claimant's degenerative disc disease pre-existed the accident, Dr. Bates would not apportion for this condition because he reasoned that the low back was previously asymptomatic. The medical record supports that Claimant's low back did cause her some concerns prior to the industrial accident, but these never resulted in additional restrictions, limitations, or permanent modification of the Claimant's activities of daily living. The Claimant has proven she suffers permanent physical impairment of 3% of the whole person, and is entitled to Dr. Bates' restrictions.

43. **Permanent Disability. "**Permanent disability" or "under a permanent disability" results when the actual or presumed ability to engage in gainful activity is reduced or absent because of permanent impairment and no fundamental or marked change in the future can be reasonably expected. Idaho Code § 72-423. "Evaluation (rating) of permanent disability" is an appraisal of the injured employee's present and probable future ability to engage in gainful activity as it is affected by the medical factor of permanent impairment and by pertinent nonmedical factors provided in Idaho Code § 72-430. Idaho Code § 72-425.

44. 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). In sum, the focus of a

determination of permanent disability is on the claimant's ability to engage in gainful activity. *Sund v. Gambrel*, 127 Idaho 3, 7, 896 P.2d 329, 333 (1995).

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

46. Mr. Porter provided several thoughtful approaches to Claimant's disability. He opined that under Dr. Bates' restrictions, Claimant's disability, inclusive of impairment, is either 45.65% (IDOL approach), 43.75% (*Employment and Wage Report* approach), or 24.3% (*SkillTran* approach). Porter Dep., 69:1-20. Mr. Porter detailed how he reached these recommendations in his report, and he explained the limitations of the *SkillTran* software that could undervalue a claimant's disability. Dr. Collins relied on *SkillTran* software, and recommended 26% PPD under Dr. Bates' restrictions.

47. Mr. Porter pointed out that *SkillTran* is incapable of identifying distinctions between reaching restrictions, i.e., overhead versus reaching chest height to waist height versus reaching below waist, etc., and the program does not allow you to input positional changes every 30 minutes. Porter Dep., 56:11-22. Because Dr. Bates gave Claimant positional restrictions, the Commission finds Mr. Porter's criticisms of *SkillTran* to be instructive, and his loss of labor market access to be persuasive. Claimant has shown a 44% loss of her labor market access.

48. As a component of the total disability recommendation, Mr. Porter's wage loss analysis is based on a pre-injury wage of $15 per hour, which exceeds Claimant's pre-injury

wages, and reasoned that her Claimant's post-injury wage earning capacity drops to $10.91 per hour, or a loss of 27.3%. Porter Dep., 58:1-17; 59:11-19. This approach overstates Claimant's wage loss, and as a result, slightly inflates the Claimant's disability. Dr. Collins opined that Claimant was earning $14.42 per hour in her time-of-injury job, and that she could realistically earn between $12 and $13 per hour, post-injury, resulting in a loss of wage earning capacity of 14%. Collins Dep., 32:13-33:7; Ex. 27, 9. Claimant has demonstrated resourcefulness and the ability to learn on the job, the Commission anticipates she will be able to restore most of her time-of-injury wages. Dr. Collins' loss of wage earning capacity is more persuasive.

49. Having considered all of the vocational experts' permanent disability ratings, the Commission finds that Claimant has proven her entitlement to 29% PPD, inclusive of impairment.

50. **Apportionment.** In cases of permanent disability less than total, if the degree or duration of disability is increased or prolonged because of a preexisting physical impairment, the employer shall be liable only for the additional disability from the industrial injury. Idaho Code § 72-406.

51. Dr. Hajjar's opinion on apportionment was persuasively challenged by Dr. Bates. The Commission is not persuaded that Claimant's 2008 industrial accident or the preexisting degenerative disc disease should warrant a preexisting physical impairment for apportionment purposes.

52. **Retention of Jurisdiction**. The final issue is whether the Commission should retain jurisdiction beyond the statute of limitations. The retention of jurisdiction is within the discretion of the Commission. When it is clear that there is a probability that medical factors will produce additional impairment in the future, it is appropriate for the Commission to retain

jurisdiction. *Horton v. Garrett Freightlines, Inc.*, 106 Idaho 895, 896, 684 P.2d 297, 298 (1984). Where a claimant's medical condition has not stabilized or where a claimant's physical disability is progressive, it is appropriate for the Commission to retain jurisdiction. *Reynolds v. Browning Ferris Industries*, 113 Idaho 965, 969, 751 P.2d 113, 117 (1988). Retention of jurisdiction may be appropriate in cases where there is a probable need for future temporary disability benefits associated with surgery. *Emerson v. Floyd Smith Jr. Trucking*, 1986 IIC 0697 (Dec. 9, 1986).

53. The Commission is persuaded by the medical testimony of Drs. Hajjar and Spackman that Claimant is medically stable, and is not entitled to further medical care. Therefore, there is an insufficient basis to retain jurisdiction of the matter.

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CONCLUSIONS OF LAW AND ORDER

1. Claimant is entitled to the first two epidural injections she received as a trial, but nothing further. Claimant has not shown she is entitled to a change of physician to Dr. Spackman.

2. The Claimant has proven her entitlement to 3% whole person permanent physical impairment (PPI);

3. Claimant has proven her entitlement to 29% permanent physical disability (PPD), without apportionment;

4. Apportionment under Idaho Code § 72-406 does not apply in this matter;

5. Claimant has not shown that the Commission should retain jurisdiction.

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

DATED this _23rd_ day of _February_, 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 23rd day of _February_, 2018, a true and correct copy of the **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** was served by regular United States Mail upon each of the following:

DENNIS PETERSEN
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___/s/_____