BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

STEVEN H. McCONNELL, Claimant, v. AUTOZONE, Employer, And NEW HAMPSHIRE INS. CO., Surety, Defendants.	**IC 2012-013368** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **Filed October 8, 2021**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Industrial Commission assigned this matter to Referee Alan Taylor. A hearing on bifurcated issues was held on April 14, 2017. Claimant's exhibits 1 through 20 and Defendants' exhibits 1 through 11 were admitted. The Commission concluded Claimant's condition at that time was caused by a compensable industrial accident on May 20, 2012 and found compensable a sacroiliac fusion surgery which had been performed on March 3, 2017.

Referee Taylor conducted a second hearing in Boise on November 21, 2019. Brian Storer represented Claimant. Scott Wigle represented Defendants. The parties presented testimonial evidence and documentary evidence. Claimant's exhibits 27 through 36 and Defendants' exhibits 37 through 67 were admitted. The post-hearing deposition period was prolonged by the pandemic. Referee Alan Taylor retired, and the parties agreed this matter should be decided by Referee Douglas Donohue without need for additional hearing. The parties submitted briefs. The case came under advisement on February 19, 2021, and is ready for decision.

ISSUES

The issues to be decided as amended at hearing are:

1. Whether the condition for which Claimant currently seeks benefits was caused by the industrial accident;

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

3. Whether and to what extent Claimant is entitled to:

   a. Medical care,
   b. Temporary partial or temporary total disability,
   c. Permanent partial impairment,
   d. Permanent partial disability, and
   e. Attorney fees; and

4. Whether apportionment for a pre-existing condition is appropriate under Idaho Code §72-406.

CONTENTIONS OF THE PARTIES

Claimant Contends

Claimant contends he injured his left sacroiliac joint which, after considerable delay, required fusion surgery. The delay compromised full recovery. Claimant dramatically improved after the surgery. However, over time, symptoms returned to near pre-surgery levels. A piriformis syndrome and radicular pain arose as consequences of the injury and the delayed surgery. Subsequent medical treatment included a spinal cord stimulator without complete success at ameliorating his pain. Claimant is entitled to past and future medical care, including continued palliative medication to ameliorate his pain for the rest of his life.

Claimant is entitled to temporary disability benefits from the date of the accident to the date of medical stability. This date is no earlier than Dr. Faciszewski's IME of January 10, 2017. The MMI date is likely July 23, 2018, when Dr. Bates evaluated PPI.

Claimant is an odd-lot worker. His SI joint injury was the sole basis for approval of Social Security disability benefits. Defendants unreasonably relied upon Dr. Friedman's biased opinion, and attorney fees should be awarded. Defendants' continued denial of post-surgical medical care on that basis—contrary to the Commission Findings on October 16, 2017—is unreasonable.

Claimant alleges Defendants' attorneys are lying about Claimant's drug dependence and its relevance.

Defendants Contend

Defendants acknowledge and accept the accident of May 20, 2012. However, they contend that Claimant continued working without time loss for several months for Employer and a subsequent employer. He also managed his own self-employment, an engine repair shop. On December 20, 2015, Claimant was found to be at maximum medical improvement and rated at 1% whole-person PPI. In 2018 Dr. Bates confirmed MMI and rated Claimant at 3% PPI.

Any subsequent medical care is merely palliative. Worse, Claimant's continuing loss of function is due to this palliative care, to large doses of opioids prescribed over a long period of time by pain management physician Dr. Marsh. Medical records report that Claimant blamed his continuing loss of function on these medications. But Claimant has been noncompliant with Dr. Marsh's pain management plan which attempted to reduce Claimant's opioid intake. He has twice been hospitalized for overdose. Further, this reported loss of function did not prevent Claimant from working as an employee or for himself. Similarly, the spinal cord stimulator—paid for by Medicaid—was merely palliative and has exacerbated rather than ameliorated Claimant's loss of function. Claimant's opioid addiction is the major cause of his continuing difficulties.

At the first hearing, conducted just six weeks after Claimant's SI joint surgery, Claimant testified that his SI joint fusion was a "miracle." Following the *Sprague* doctrine, compensability

of the surgery was based, in part, on the supposed success of that surgery. At the 2019 hearing Claimant testified that it was a "failure." The fusion is objectively fixed and stable, thus, not a failure. Also, as Claimant has blamed his loss of function on his medications, any "disability" is not permanent and can be ameliorated by weaning Claimant off the opioids.

All temporary disability due Claimant has been paid. He seeks TTD benefits for times which he was working, for subsequent non-compensable injuries, and for times after he has been declared medically stable.

Claimant has minimal permanent disability and is not an odd-lot worker. Apportionment is appropriate under Idaho Code § 72-406 because much of Claimant's alleged disability is a result of his opioid medication and Claimant had a longstanding problem with medication before the accident.

EVIDENCE CONSIDERED

The record in the instant case included the following:

1. The legal file in this matter (including testimony, exhibits, briefs, and the decision from the 2017 hearing);

2. Oral testimony taken at the 2019 hearing of Claimant, his wife Janice, neighbor and business partner Mike White, and Claimant's bookkeeper Emily Call;

3. Exhibits 27 through 67, admitted at hearing (lower-numbered exhibits were the subject of an earlier hearing as explained above), EXCEPT that Exhibit 29, page 25 is a drug screen report for "Steve McMullen" with a different birthdate than Claimant; Exhibit 29, page 56 is a portion of a psychological report clearly unrelated to Claimant; this latter page is duplicated at Exhibit 51, page 2367. These few pages receive no weight; and

4. Deposition testimony after the second hearing of treating physician Daniel

Marsh, M.D., of IME physician Robert Friedman, M.D., and of vocational experts Nancy Collins, Ph.D., and Douglas Crum.

All objections raised in post-hearing depositions are OVERRULED.

At the first hearing, Defendants' Motion to Compel certain tax records was pending, but not pertinent to the bifurcated issues then at hand. Defendants represented that Claimant's counsel had indicated that these documents would be produced and, relying on that indication, did not seek resolution from Referee Taylor at that time. In Defendants' brief following the 2019 hearing, Defendants represented that Claimant did not at any time produce the tax records sought. Also, the Motion to Compel included a recording, taken by cell phone, by Claimant at an examination by Dr. Friedman. At the first hearing, Claimant's counsel represented they would attempt to retrieve and produce it. This recording was not produced either.

The undersigned Commissioners have chosen not to adopt Referee Donohue's recommendation and hereby issue their own findings of fact, conclusions of law, and order.

FINDINGS OF FACT

1. A hearing was held on April 14, 2017. Findings of Fact and Conclusions of Law were issued with an Order on October 16, 2017. These Findings, Conclusions, and Order are affirmed and incorporated by reference.

2. Claimant was employed by Employer part-time, for about five years. His employment continued after the industrial accident. 2019 Hearing Tr., p. 18.

3. Claimant was also self-employed, providing mechanic services from a shop on his residential property both before and after the industrial accident. *Id.* at 18-19. The business was named "Steve's Small Engine Repair" and later "McConnell Auto Solutions." The business grew, and Claimant moved the business from his residential property to a separate business location. *Id.*

at 25.

Summary and Additional Findings on Medical Care: Accident to First Hearing

4. On January 31, 2013, Timothy Doerr, M.D., opined Claimant was medically stable from the industrial injury. He opined Claimant suffered continuing symptoms from pre-existing spinal cord abnormalities. He opined Claimant could return to work without permanent impairment and without restrictions related to his industrial injury. Defendants' Ex. 39, p. 2115.

5. On December 31, 2013, and January 2, 2014, Dr. R. R., M.D. (handwritten signature illegible), opined Claimant was unable to return to work for Employer. He opined Claimant had restrictions including light duty without lifting and requiring frequent position changes which Employer would not accommodate. He opined Claimant's pain was related to his SI joint and that Claimant was not yet medically stable. *Id.* at 2117-18.

6. In November 2014, a pain management consult recommended an opiate withdrawal program and complete discontinuance of Opana and Tramadol with a limit of four hydrocodone per day until weaning was complete. Defendants' Ex. 43, p. 2212.

7. Between the industrial accident and the date of the first hearing Claimant saw several physicians for conditions unrelated to the industrial accident. These records often acknowledge an accident, a preexisting degenerative condition, and/or Claimant's pain medication regimen. These records are generally unremarkable, except that Claimant often underreported the amount of narcotics he was taking—in number of different prescription medications, in medication strength in milligrams, and/or in number of pills taken per day.

8. On December 30, 2015, Robert Friedman, M.D., reviewed records and examined Claimant. Defendants' Ex. 47, pp. 2293-2300. He opined the recommended SI joint fusion, if performed, would "have no effect on the patient's pain." *Id.* at 2298. Moreover, he noted the

medical records did not support SI joint involvement before September 2013 and therefore opined any SI joint involvement was unrelated to the industrial accident. *Id.* He noted that Dr. Peter Reedy, M.D., had found Claimant's examination to be normal as of August 28, 2012. *Id.* at 2299. He opined Claimant was medically stable when he conducted his IME. *Id.* at 2298. He concurred with Dr. Doerr that Claimant was likely medically stable as of January 13, 2013, and "certainly" by the October 9, 2013 date when Dr. Montalbano examined Claimant and opined him to be medically stable. *Id.* at 2299. Dr. Friedman rated permanent impairment arising from the industrial accident at 1% of the lower extremity. *Id.* He opined Claimant could return to work without restrictions. *Id.* He opined that opioids and benzodiazepines "are not medically necessary or indicated." *Id.*

9. On March 3, 2017, Shane Andrew, D.O., performed the left SI joint fusion surgery. Dr. Andrew described it as a successful surgery without complications. In a follow-up note thirteen days later, Dr. Andrew opined the fixation of hardware and surgical site looked excellent. Defendants' Ex. 50, pp. 2315, 2330.

Dr. Marsh: Medical Care after April 14, 2017

10. Daniel Marsh, M.D., continued to provide primary palliative care through Exodus Pain Clinic. On May 2, 2017, Claimant reported his leg pain had returned. Claimant's Ex. 27, p. 6. He had resumed taking narcotics, Opana 5mg, 12 per day and Oxycodone 20mg, 10 per day. *Id.* Dr. Marsh indicated Claimant experienced a 10-day window of relief in which his sacroiliac fusion left him sufficiently pain free to temporarily discontinue his narcotics. *Id.* However, Dr. Marsh later acknowledged that it had not been shown that Claimant discontinued his use of narcotics at all. 2020 Marsh Dep., p. 40.

11. Dr. Marsh's records include recurring preprinted comments. These preprinted comments also are sometimes inconsistent with immediate comments. For example, more than

one note reports that Claimant's gait was antalgic and not antalgic on the same date. Also, more than one note reports Claimant "[d]enies lost or stolen medication. Denies needing early refills due to overtaking medications. Denies increasing dose without authorization. Denies using medication for purposes other than prescribed/intended." Claimant's Ex. 27, pp. 27, 30. In those very notes Claimant had reported taking more Oxycodone than prescribed by Dr. Marsh. This makes it difficult to sort out Claimant's actual condition on a given visit. Findings hereinbelow are those specifically determined to be relevant to the reporting at the visit on that date.

12. On June 5, 2017, Daniel Marsh's nurse practitioner, Cory Huffine, N.P., noted that Claimant reported a pre-surgical level of pain with any activity. Nurse Huffine continued the narcotics as Dr. Marsh had prescribed. NSAIDs, antidepressants, and antianxiety medications were also prescribed in this battle against Claimant's pain. *Id.* at 8-10.

13. On July 5, 2017, Dr. Marsh noted that Claimant reported that he took 190 of his prescribed 240 Oxycodone pills in the past 30 days. *Id.* at 11. Claimant's reported pain score was rising. *Id.*

14. On August 4, 2017, Dr. Marsh noted that Claimant reported he had variably been reducing his narcotic intake. Dr. Marsh reduced Claimant's Oxycodone strength to 15mg tablets. They discussed forming a plan to gradually reduce and eliminate prescription medications. *Id.* at 13-14.

15. On September 5, 2017, Dr. Marsh noted that Claimant ran out of medication. Dr. Marsh stopped the Opana. He returned the 20mg strength on the Oxycodone but limited Claimant to 2 tablets per week. *Id.* at 15-16.

16. One week later, on September 12, 2017, Claimant returned to request more narcotics. Dr. Marsh prescribed Xtampza, 18 mg at two per day, an Oxycodone-like narcotic with

extended-release properties. He resumed the Oxycodone prescription 20 mg at 2 per day. *Id.* at 17.

17. Three weeks after the extra September visit Claimant again saw Dr. Marsh on October 5, 2017. (Unlike Dr. Marsh's notes in May, July, August, and September which were not signed until they were all signed on the same day in November, Dr. Marsh signed this note promptly the next day.) Dr. Marsh increased the Xtampza to 27 mg at 2 per day. *Id.* at 19.

18. On October 16, 2017, Claimant visited Dr. Marsh to prepare a disability application. Claimant reported that "he cannot work because of his pain medications." *Id.* at 21. He asserted additional self-limiting factors related to sitting, standing, taking breaks, and needing to lie down. Dr. Marsh opined his restrictions consistently with Claimant's self-reported limits. He increased Claimant's Oxycodone to 3 per day. Dr. Marsh signed this note 11 days later. *Id.*; 2020 Marsh Depo, p. 24:10-21; p. 25:7-14.

19. On October 19, 2017, a lumbar MRI showed the SI joint surgery, mild asymmetry of the piriformis muscles, and degenerative changes throughout. Claimant's Ex. 27 at 25; Claimant's Ex. 30, p. 1; Defendants' Ex. 50, p. 2351; 2020 Marsh Dep., pp. 50-51.

20. On November 2, 2017, Claimant reported that he was taking 4 Oxycodone per day and had quit taking Xtampza. Dr. Marsh did a triggerpoint injection of Kenalog and lidocaine in the left PSIS area. This eliminated Claimant's reported pain there. Dr. Marsh signed this note 26 days later just moments after he signed the November 13, 2017 note. Claimant's Ex. 27, p. 23.

21. On November 13, 2017, Claimant reported that he was taking 6 Oxycodone per day. This exceeded the 3-per-day limit Dr. Marsh had prescribed in mid-October. Dr. Marsh prescribed morphine sulfate, 15 mg, 4 per day, and a muscle relaxer. *Id.* at 25.

22. On December 12, 2017, Claimant reported that he had closed his business. Claimant denied needing early refills or taking medication in excess of prescribed amounts. *Id.* at 27-28.

23. On December 20, 2017, Dr. Marsh performed a left cluneal nerve block using lidocaine and celestone. *Id.* at 29.

24. On January 4, 2018, Claimant reported that he was taking 1.5 tablets of 20 mg Oxycodone 6 times per day. This note repeats the December 12 note when it stated Claimant denied needing early refills or taking medication in excess of prescribed amounts. Dr. Marsh stopped the morphine sulfate and increased the strength and frequency of the Oxycodone to 30 mg every 4 hours. The next sentence states "every 5 hrs." This is likely a typographical error. Claimant reported that "he is crying and rolling around on the bed once the medication wears off." Nevertheless, Dr. Marsh stated Claimant "will get one week of meds at a time only." *Id.* at 30-31.

25. On January 19, 2018, Claimant reported the cluneal nerve block was ineffective. *Id.* at 32-33.

26. On February 9, 2018, a pharmacy last filled Dr. Marsh's prescription for Oxycodone, 30 mg, 60 pills. Claimant's Ex. 32, p. 2. Records of this pharmacy are in evidence through March 29, 2018.

27. On February 19, 2018, Claimant reported his hospitalization. Dr. Marsh noted Claimant was short 9 pills. He stopped the Oxycodone and started Clonidine, Ativan, and Promethazine to minimize narcotic withdrawal. Dr. Marsh's records do not show he prescribed any opioids after this date. Claimant's Ex. 27, pp. 34-35.

28. On March 7, 2018, Claimant reported he had begun seeing Dr. Radnovich. *Id.* at 36.

29. On March 14, 2018, Dr. Marsh performed a left SI joint injection. *Id.* at 38.

30. On April 5, 2018, Dr. Marsh characterized the hospitalization as a "mishap with his opioids." *Id.* at 40; 2020 Marsh Dep., 55-56. Claimant reported that he was concerned the fusion

was inadequate. Claimant's Ex. 27, p. 40.

31. On June 4, 2018, Dr. Marsh noted shoulder surgery had been performed on April 19 and that Claimant was prescribed Norco for pain. *Id.* at 42. Claimant reported he had stopped the Norco three weeks ago. *Id.* Claimant reported the Buprenorphine prescribed by Dr. Radnovich was "not working well." *Id.* Claimant reported that "he []has not been working much. For 6 [m]onths he has been able to work." *Id.* Dr. Marsh noted that Claimant reported that "[t]he pain is the exact same pain that he presented with initially." *Id.*

32. On June 27, 2018, Dr. Marsh performed a left S1 transforaminal epidural steroid injection. *Id.* at 44.

33. More or less monthly visits to Dr. Marsh thereafter are mostly unrevealing. They document spinal cord stimulator trials and adjustments. The final note indicates Dr. Marsh was considering a refusion of the SI joint "the old fashion way." *Id.* at 56. However, on August 16, 2018, Claimant admitted to Dr. Marsh that he had taken Oxycodone 30 mg "on occasion" despite the buprenorphine regimen and doctor's orders to the contrary. *Id.* at 50.

34. On August 27, 2018, Claimant reported to Dr. Marsh that Dr. Radnovich's treatment left him feeling much better. *Id.* at 54-55.

35. Having referred Claimant to Dr. Radnovich, Dr. Marsh did not see Claimant after August 27, 2018.

Other Medical Care: After April 14, 2017

36. At a post-surgical follow-up visit on October 3, 2017, Dr. Andrew noted stenosis with lumbar pain and possible left leg radiculopathy was separate from the SI joint problem treated by surgery. He recommended an MRI. Defendants' Ex. 50, pp. 2339-41.

37. On November 21, 2017, Dr. Andrew reviewed the lumbar MRI and opined it

unlikely that Claimant's report of sciatica was related to either the SI joint fusion or to Claimant's lumbar spine. On that date he noted Claimant was taking Oxycodone, 30 mg, 6 per day, and Xtampza ER, 27 mg, 2 per day. *Id.* at 2345-47.

38. On February 8, 2018, a left shoulder MRI showed old 2001 surgical changes and moderate irregularity. Defendants' Ex. 53, p. 2387. This condition is not claimed to be industrially related. Surgery was performed in April. Defendants' Ex. 55, pp. 2406-08. As late as January 10, 2019, he still reported residual pain there. Dr. Thomas Chopp was the primary treater for the left shoulder. Defendants' Ex. 53, pp. 2391-93. A Dr. Shevlin performed the surgery. Defendants' Ex. 55, pp. 2406-08.

39. On February 20, 2018, Claimant completed initial paperwork to begin treating with Richard Radnovich, D.O. Claimant's Ex. 28, pp. 2-6. Claimant identified his private health insurance carrier and not Surety as payor. *Id.* at 2. Where the form asked, "What kind of work do you do?", Claimant reported, "retired, some mechanic work." *Id.* at 5. He reported he played golf once a month. *Id.* Claimant provided a detailed pain diagram on which he marked specific types of pain on specific body parts. *Id.* at 6.

40. Claimant first visited Dr. Radnovich on February 22, 2018. Claimant reported that he intended Dr. Radnovich to provide treatment with Suboxone. *Id.* at 7. He reported that he did not have opioid withdrawal symptoms when he stopped taking narcotics one week after his back surgery in 2017. *Id.* He reported that he had taken 1.5 Oxycodone 15 mg tablets yesterday. *Id.* Claimant reported that his current narcotic medications included Tramadol 50 mg, Opana 10 mg, and Oxycodone 15 mg. *Id.* Dr. Radnovich started Claimant on a Suboxone regimen. *Id.* at 7-8.

41. Contrary to Claimant's report to Dr. Radnovich in February 2018, Dr. Marsh's March 13, 2017 note shows Claimant reduced—but did not discontinue—both Oxycodone and

Opana in the days immediately after surgery. Defendants' Ex. 49, p. 2313.

42. On February 27, 2018, Claimant visited Wesley Flint, M.D., following a nonindustrial accident. Defendants' Ex. 54, pp. 2401-03. He was helping carry a 400-500 pound air conditioning unit which dropped on his right foot. *Id.* X-rays showed only the longstanding plantar fasciitis problem. *Id.* His sensitivity to light touch caused Dr. Flint to consider possible chronic regional pain syndrome. *Id.* at 2402. Dr. Flint noted Claimant "has a history of very high doses of narcotics" and did not offer to prescribe any. *Id.* at 2401.

43. On March 1, 2018, Claimant visited Dr. Radnovich. Suboxone was changed to Zubsolv, likely because of the cost to Claimant. Tramadol was prescribed for breakthrough pain along with non-narcotic analgesics. Claimant's Ex. 28, pp. 9-10.

44. In March 2018 Diana Menchaca, Ph.D., performed a psychological evaluation to evaluate Claimant's candidacy for a spinal cord stimulator. She cleared Claimant as presenting psychologically without restriction. Defendants' Ex. 51, pp. 2364-67; 2020 Marsh Dep., 20.

45. On March 29, 2018, Claimant visited Dr. Radnovich. He reported that he had not been taking Tramadol and that his primary care physician had suggested he avoid NSAID analgesics. The record does not support any physician recommending against NSAIDS. Claimant's Ex. 28, pp. 11-12.

46. On April 12, 2018, Claimant visited Dr. Andrew. Claimant had discontinued the Oxycodone, but he reported his pain had redeveloped. Dr. Andrew checked the surgical site and L5-S1 for signs of facet arthritis. Defendants' Ex. 50, pp. 2348-50.

47. On May 8, 2018, Claimant visited Dr. Andrew. Claimant had added Norco, 4 per day, to the Xtampza. Dr. Andrew reviewed CT and MRI imaging. He found no anatomical basis for Claimant's pain. He suggested possible consideration of nerve ablation. He suggested looking

to Claimant's hip as a potential source of the reported sciatica, piriformis syndrome, or perhaps a spinal cord stimulator. The last of the note indicates referral back to Dr. Marsh to perform medial branch blocks and facet rhizotomy ablation. This is phrased as a recommendation here whereas earlier in the note it is "possible" and "perhaps" a thing to try. *Id.* at 2351-53.

48. On June 21, 2018, Claimant visited Dr. Radnovich. He reported that the buprenorphine (generic for Suboxone or Zubsolv) was not working as well as at first and that his back pain was increasing. Dr. Radnovich prescribed a Butrans patch. The Butrans patch was discontinued at Claimant's August 14, 2018 visit to Dr. Radnovich. Claimant's Ex. 28, pp. 13-14.

49. On July 2, 2018, Linda Lam, D.O., Claimant's primary general care physician, issued a "Final Report" indicating the reason for the examination was osteoporosis. By history, she noted Claimant reported foot pain from plantar fasciitis and left shoulder pain. Claimant rated his pain from each of these conditions significantly higher than he contemporaneously rated his back and leg pain to other physicians. (Mention of a nonrelevant test as having occurred on July 7, 2018 appears to be an obvious typographical error but does not impact relevant analysis.) Defendants' Ex. 42, pp. 2198-2202.

50. On October 18, 2018, Claimant began seeing Shane Maxwell, D.O., to be evaluated for implantation of a spinal cord stimulator. Claimant reported the history of his industrial accident as his primary need for this treatment. Dr. Maxwell reported that a Claimant profile report from the Idaho Board of Pharmacy showed only the expected buprenoprhin and Tramadol narcotics after Dr. Radnovich began treating Claimant in February 2018, except for one May 2, 2018 prescription for hydrocodone-acetaminophen (such as Norco). Upon examination, Dr. Maxwell noted reduced range of motion in Claimant's low back and an antalgic gait without exaggerated pain behaviors. Dr. Maxwell noted, "The patient shows no signs of drug addiction and has no

untreated mental health issues or other contraindications" to spinal cord stimulator implantation. Claimant's Ex. 29, pp. 8-12.

51. An October 23, 2018, note from Dr. Maxwell's office indicated Claimant's private insurance had approved the spinal cord stimulator which implantation was performed on October 29, 2018. Post-implementation testing showed amelioration of low back and left leg pain as intended. *Id.* at 14.

52. On November 6, 2018, Claimant visited Dr. Radnovich. They discussed Claimant's spinal stimulator trial. Claimant's Ex. 28, pp. 17-18.

53. Beginning November 20, 2018, Claimant was hospitalized three days for pneumonia. Defendants' Ex. 41, p. 2122.

54. On December 31, 2018, Tosha Johnson, N.P., noted Claimant reported he was taking Xtampza, extended release, 27 mg, two per day, and Norco, every 6 hours, and unspecified amounts of Tramadol together with his buprenorphine. Defendants' Ex. 48, pp. 2307-10.

55. After an unrevealing December visit, Claimant visited Dr. Radnovich on January 21, 2019. He reported that he did not feel the buprenorphine was helping as much as before. Dr. Radnovich restarted the Butrans patch prescription. At February and March visits Claimant reported that his back and leg pain was increasing. In March 2019 he admitted he had taken "some left over oxycodone" which helped. Claimant's Ex. 28, pp. 21-22.

56. On February 21, 2019, Claimant returned to Dr. Chopp, this time with nonindustrial right shoulder pain. Defendants' Ex. 53, pp. 2394-96.

57. On March 28, 2019, lumbar X-rays showed the presence of the spinal cord stimulator, the SI joint fusion, and multilevel lumbar degenerative changes. Claimant's Ex. 28, p. 27.

58. On April 2, 2019, Claimant visited Dr. Radnovich. He reported that he "took MS that was an old Rx from Dr. Marsh." His wife could not rouse him the next morning, and he was hospitalized via ambulance. *Id.* at 28-29.

59. On April 12, 2019, a cervical CT showed progressive spondylitic change throughout Claimant's neck. *Id.* at 30.

60. On April 16, 2019, Claimant visited Dr. Radnovich. He admitted he took his wife's morphine extended release 60mg tablets before falling down the stairs. *Id.* at 31-32.

61. On May 16, 2019, Claimant visited Dr. Radnovich. He expressed interest in a pain pump. *Id.* at 33-34.

62. On June 13, 2019, Claimant visited Dr. Radnovich. He reported that he would be undergoing shoulder surgery in about one week. At his next visit with Dr. Radnovich on August 8, 2019, Claimant reported a flare-up of back pain with left leg pain. This note is the last date upon which Dr. Radnovich's records indicate Claimant visited. Dr. Radnovich signed all his April - August 2019 notes on August 30, 2019. *Id.* at 35-36.

Medical Opinions

63. On July 23, 2018, physiatrist James Bates, M.D., evaluated Claimant at Claimant's request. He reviewed records and examined Claimant. He noted mild range-of-motion limitations in Claimant's lumbar spine. Dr. Bates opined Claimant was medically stable when examined. He refused to opine about disability. He noted Claimant's current restrictions required sedentary work with frequent, ad lib, changes of position, sitting and standing, every 15-30 minutes. He opined Dr. Radnovich's treatment to be "appropriate" to continue. He opined Claimant suffered a 3% whole person permanent impairment as a result of the accident and SI joint surgery. Claimant's Ex. 34, pp. 1-14.

64. In his post-hearing deposition in 2020, Dr. Marsh opined that all of Claimant's SI joint and lumbar conditions, including osteoporosis and the need for a spinal stimulator were caused by the accident and delay of obtaining surgery. 2020 Marsh Dep., pp. 15-19. Dr. Marsh opined Claimant's self-described limitations should be considered permanent physician's restrictions. *Id.* at 26-27.

65. In his post-hearing deposition Dr. Friedman explained that opioids are actually a subset of narcotics. Specifically, Tramadol and Methadone are non-opioid narcotics. 2020 Friedman Dep., pp. 7-8.

Additional Findings Regarding Narcotics Use

66. Claimant testified that he received "instant" and complete relief from pain with each of the "60" SI joint injections performed by Dr. Marsh. At first, these provided 24 hours of relief but later only eight to fifteen hours of relief. 2017 Hearing Tr., pp. 64-65.

67. At the first hearing Claimant testified he was taking as many as 12 Opana pills per day before he weaned down to four or five per day. To that date, and despite Dr. Rappaport's recommendation as a prerequisite to surgery, Claimant had never stopped taking Opana. *Id.* at 82. At the second hearing Claimant testified he had not taken any narcotics since 2017. 2019 Hearing Tr., p. 17. Upon leading questions by his attorney, Claimant testified he might have taken some in early 2018. *Id.* at 17-18. Upon cross-examination, he admitted that physicians had prescribed additional opioid medication. He admitted he takes Suboxone, originally in pill form, and recently through a patch. *Id.* at 82. Suboxone is a narcotic which was prescribed to prevent him from taking other narcotics. *Id.*

68. Claimant's wife has a prescription allowing chronic opioid use. In his testimony, he denied that he had access to her medications. *Id.* at 81.

69. At the first hearing Claimant described in detail his post-surgical improvement. His paresthesia had been eliminated, his gait had improved, and he was able to sit comfortably. He claimed he was "100% better" than before the surgery. 2017 Hearing Tr., p. 87. He called his surgical result "a miracle." *Id.* at 94. He did report that he still had "some surgery pain." *Id.* at 86-87.

70. At the first hearing Claimant denied that he had ever taken medication in excess of the amount prescribed. *Id.* at 89. Instead, he reported that he often took less. *Id.* Medical records suggest he did take fewer pills than prescription allowed immediately before and after the SI joint fusion surgery. Defendants' Ex. 49, pp. 2311-13. However, Claimant on more than one occasion admitted to Dr. Marsh that he had taken more than prescribed. When this occurred, Dr. Marsh consistently increased the prescription so that Claimant's allowable quantity would match what Claimant had actually self-administered in excess of the written prescription in the first place. *Id.*

71. Claimant testified that his pill count in early 2018 was actually correct, not nine pills short. 2019 Hearing Tr., pp. 81-82.

72. Claimant testified inconsistently about whether and when he was ever entirely free from taking opioids. His testimony was also inconsistent with medical records. The medical records show a frequent number of prescriptions which would provide a constant supply through March 2018 if taken as prescribed. *See* Claimant's Ex. 32. Dr. Swensen noted, "[w]e did call in some Norco for the patient, but he is on pain contract." Defendants' Ex. 54, p. 2400. Claimant also was on Norco after his shoulder surgery with Dr. Shevlin on April 19, 2018. Claimant's Ex. 27, p. 42

73. In 2018, and again in 2019, Claimant was hospitalized following narcotic overdoses. *See* 2019 Hearing Tr., pp. 49-50, 79-81; Claimant's Ex. 27, pp. 34-35; Claimant's Ex.

28, pp. 29, 31.

74. On April 7, 2015, a drug utilization assessment showed Claimant was receiving 340mg of morphine sulfate equivalent daily. Defendants' Ex. 4, pp. 54-55. This excluded his Oxycodone. *Id.* at 55. The assessment documented risks of harm arising from this excessive intake and recommended "a slow taper be initiated and if possible completely discontinue" all opioids. *Id.* It noted that "Official Disability Guidelines (ODG) recommend that opioids be used only in severe cases and for a maximum of two weeks." *Id.* at 60.

75. This assessment well documents the medical risks and potential adverse consequences of chronic opioid use. It supports the positions of Dr. Friedman who opined that Claimant's chronic opioid use has harmed, not helped, him and who has recommended total reduction and removal of all narcotics from Claimant's palliative regimen. Indeed, all physicians who have commented have at one time or another tried to significantly reduce or discontinue Claimant's narcotic intake. *Id.* at 54-73.

76. Orthopedic spine surgeon Dr. Faciszewski examined Claimant January 10, 2017, and testified later that year in post-hearing deposition. His testimony was given about 90 days after the SI joint surgery had been performed. Based upon a post-surgical conversation with Claimant, Dr. Faciszewski recommended an additional three months of physical therapy. He opined Claimant should return to full function—with a projected 50-pound lifting restriction likely—but should not again lift 300-pound automobile parts. Faciszewski Dep., p. 61. He also opined Claimant was not expected to need narcotics more than six months following surgery. *Id.* at 59. This post-surgical period of narcotics was considered acceptable by Dr. Faciszewski to ameliorate the immediate surgical recovery pain and to allow for weaning from them. *Id.* His opinions about diagnosis and causation supported other evidence found to be the preponderance upon which Claimant's SI joint

surgery was deemed compensable. Dr. Faciszewski also opined that Claimant's diagnoses included opioid dependency. *Id.* at 17.

Other Nonindustrial Accidents or Medical Care

77. Claimant suffers from progressive osteoporosis and osteopenia. He had a DEXA (Dual-energy X-ray absorptiometry) scan in December of 2014, which per Dr. Marsh's report, "shows osteoporosis." Claimant's Ex. 10, p. 95. In that same note, Dr. Marsh opined that "[o]steoporosis can be related to the thyroid." *Id.* Dr. Marsh then referred Claimant to Dr. Haake, with the note, "[Claimant] should see Dr. Haake as I suspect that he [sic] low bone density maybe hormonally related." *Id.* at 97. Claimant saw Dr. Haake on April 29, 2015, and was assessed as having a history of osteoporosis, hypogonadism, hypothyroidism, and profound vitamin D deficiency. Defendants' Ex. 44, p. 2220. However, Dr. Haake did not elaborate on what the cause of these diagnoses was. Claimant began hormone therapy and followed up with Dr. Haake's office on April 6, 2016, where he was assessed as having a history of osteoporosis, hypogonadism/adequately treated, hypothyroidism adequately treated, and previously suboptimal vitamin D/now optimal. *Id.* at 2249. In his chart entry of August 8, 2016, Dr. Marsh noted that Claimant "had a second bone scan that showed a distinct improvement of bone density. He stopped seeing [Dr. Haake] a couplemonths [sic] ago." Claimant's Ex. 10, p. 118. Dr. Marsh assessed Claimant as having "[o]steoporosis with a borderline low lumbar spine Z-score. The [DEXA] study in 2014 shows osteoporosis. The new test after treatment shows improvement moderate osteopenia." *Id.*

78. Later, Dr. Marsh opined that Claimant's opiate use was a cause for his osteoporosis. In his deposition from January 2020, Dr. Marsh states, "And, you know, being on opioids affects the osteoporosis and being inactive affects the osteoporosis." 2020 Marsh Dep., p. 16. However,

without further elaboration, the Commission does not find this testimony adequate to establish that Claimant's osteoporosis is causally related to his opioid use. If Claimant's osteoporosis/osteopenia is related to hormonal deficiencies, are we to conclude from Dr. Marsh's comments that Claimant's hormonal problems, in turn, derive from his opioid use? There is no testimony to this effect, and without it the Commission is left to accept the unsupported assertion that opioid use is the cause of Claimant's osteoporosis. This, we decline to do.

79. In early 2018 Claimant injured his foot. He disputes the medical records as inaccurate—he was "kind of steadying," not lifting, a machine which tests and fills freon in an air conditioner, and it weighed about 200 pounds, not 400-500 pounds. 2019 Hearing Tr., pp. 47-48.

80. A 2018 left shoulder surgery was not preceded by accident. It became necessary because of progressive degenerative arthritis. *Id.* at 48-49.

81. Late in 2018 Claimant was hospitalized twice, once to remove "14 pounds of fluid" from his chest and once for bacterial pneumonia. *Id.* at 49-50. The medical record reported removal of "860 ml" of fluid, less than a quart or just under two pounds. Defendants' Ex. 41, p. 2122.

Prior Medical Care

82. Claimant had bilateral shoulder surgeries around 2000 or 2001. Claimant's Ex. 28, p. 3.

83. Claimant underwent a double hernia repair. *Id.*

84. In April 2007 Claimant underwent a psychiatric evaluation. He was diagnosed with major depressive disorder, single episode. Defendants' Ex. 38, p. 2051. Treatment included follow-up visits and medication. After a few months, Claimant reported significant improvement. *Id.* at 2053-57. His then recent lay-off from Micron was cited as a stressor which factored in the diagnosis. *Id.* at 2057. Claimant progressed and was eventually hired by Employer. Nevertheless,

follow-up visits and medication continued through November 2011.

85. In November 2008 Claimant was hospitalized for symptoms of a suspected stroke. Medical staff later determined the symptoms were likely the result of overdose of non-narcotic psychiatric medications. Defendants' Ex. 37, pp. 2000-01.

86. At both hearings Claimant denied that he had experienced any symptoms relatable to his low back before the accident. Dr. Chenore's note dated May 14, 2012—one week before the subject accident—reported that Claimant described rare episodes of left-sided sciatica which predated the 2012 accident. Defendants' Ex. 37, p. 2022.

Vocational Factors

87. Born March 2, 1955, Claimant was 64 at the second hearing. 2019 Hearing Tr., p. 56.

88. Claimant graduated from high school. He attended classes at Boise State University in electrical-mechanical repair and diagnostics. Defendants' Ex. 62, p. 2610. He graduated from a small-engine mechanics' program sponsored by College of Western Idaho in 2010.

89. The majority of his adult work life included employment as a DSL technician for Mountain Bell. After 29 years of service, he retired in 2007. The job involved significant heavy lifting, climbing ladders and poles, and working in physically awkward positions. 2017 Hearing Tr., p. 22.

90. After Mountain Bell, Claimant worked for a few months each at PODS and Micron. *Id.* at 24.

91. He worked for Employer for five years, including about one year after this 2012 industrial accident. *Id.* at 24-25.

92. While employed by Employer, Claimant began his own small engine repair shop.

At the first hearing he testified he began it in 2010. *Id.* at 26. Claimant described it as a way to keep busy since he had retired. He managed the business and, as it grew, hired employees. He described his relationship with Mike White as a "loose partnership." 2019 Hearing Tr., p. 20:4. Mr. White clarified that he and Claimant split labor fees charged to customers 50/50. *Id.* at 113. In 2018, Mr. White declared $10,400 in income from that arrangement. 2019 Hearing Tr., p. 117:12-14.

93. According to Claimant's bookkeeper, the business partnership, an LLC, ceased operation in 2015. *Id.* at 122. Any business thereafter was evaluated for taxes as a sole proprietorship, but Claimant did not have sufficient income to require filing an individual income tax return in 2016, 2017, or 2018. *Id.* at 123-124.

94. However, the LLC was advertised online as having begun "25 July 2013 (almost 3 years ago)." Defendants' Ex. 5, p. 84. No earlier than 2016, the online Better Business Bureau (BBB) report Claimant opened "Steve's Small Engine Repair" in 2011, had garnered an "A+" rating (on a scale of A+ to F), and had been an "Accredited Business" since July 29, 2014. *Id.* at 81-83.

95. Claimant's own online advertising identified the business as "Steve's Small Engine Repair and Automotive Repair" on some pages and as "Steve's small engine Repair Mowers & Trimmers" on other pages. It boasted "over 6 years of successful business." *Id.* at 74-75.

96. At the second hearing Claimant testified he started the business in 2014. 2019 Hearing Tr., p. 25. Photographic evidence from 2013 shows Claimant had built the repair shop by that date. Claimant amended his testimony to state he "was kind of doing small engines on the side" as early as 2010 but that after the industrial accident, he "didn't do anything out there but some paperwork once in a while." *Id.*

97. Claimant testified inconsistently about whether cars depicted in photographic evidence were or were not intended to be repaired and sold. He denied that any of these cars were owned by any customer outside his family or Mr. White. He admitted that over time some of these cars had been sold. *Id.* at 24.

98. At some point, Claimant moved his business to a commercially zoned location and hired "a few mechanics." 2019 Hearing Tr., p. 25:25. He renamed the business McConnell Auto Solutions. *Id.* at 28. Both automobile repair and small engine repair were performed there. He closed the business at the new location in November 2017 and moved it back to his residential location. At the second hearing Claimant's business was still operating. He testified it was "nonfunctional," with Mr. White repairing things only for his and Claimant's friends and family. *Id.* at 39. It is not generally open to the public.

99. Mr. White testified that the business at the new location failed, not because there was little work, but because he and Claimant could not keep enough good mechanics to do the work. *Id.* at 116-117. As a result, Mr. White could not keep up with the volume. At the second hearing, Mr. White concurred that work was performed mostly for family and close friends, with occasional repeat customers bringing work to the business. *Id.* at 118:8-23

100. Bookkeeper's records show "service income" for 2016 was $75,578.63 for the business. This merely reflects bank deposits and does not account for cost of parts, depreciation, or other expenses of the business that year. *Id.* at 126.

101. After leaving Employer, Claimant worked for Carquest for about two years. 2017 Hearing Tr., p. 26.

102. Claimant's primary source of income since 2015 has been Social Security Disability benefits. 2019 Hearing Tr., p. 63.

Vocational Experts

103. On February 14, 2019, Doug Crum issued a report. He interviewed Claimant on December 14, 2018, and reviewed records. He noted Claimant had been approved for Social Security Disability "based only on his back injury" in 2017. Claimant's Ex. 33, p. 5. He noted Claimant was "basically retired" from 2007 to 2010. *Id.* at 7. He noted Claimant began self-employment after he left Carquest. He opined that Claimant was 100% permanently disabled with a 100% loss of labor market access and 100% loss of wage-earning capacity. *Id.* at 10. He relied upon opinions of Drs. Marsh and Bates.

104. On October 4, 2019, Nancy Collins issued her report. Dr. Collins reviewed records, but Claimant's attorney denied her an opportunity to interview Claimant. Defendants' Ex. 62, p. 2608. Dr. Collins recited the salient physicians' opinions about restrictions. She opined that using opinions of Drs. Doerr, Montalbano, and Friedman, Claimant suffered no loss of labor market access or loss of wage-earning capacity; Dr. Bates' restrictions would result in a 79% loss of access with an overall permanent disability, inclusive of permanent impairment, of 39.5%; Dr. Marsh's restrictions would result in total loss of access, except possibly for continuing his self-employment with employee mechanics to perform most physical labor. *Id.* at 2615-17. She identified specific jobs available to Claimant in the labor market.

DISCUSSION AND FURTHER FINDINGS OF FACT

105. The provisions of the Idaho Workers' Compensation Law are to be liberally construed in favor of the employee. *Haldiman v. American Fine Foods*, 117 Idaho 955, 956, 793 P.2d 187, 188 (1990). The humane purposes which it serves leave no room for narrow, technical construction. *Ogden v. Thompson*, 128 Idaho 87, 88, 910 P.2d 759, 760 (1996). Facts, however, need not be construed liberally in favor of the worker when evidence is conflicting.

Aldrich v. Lamb-Weston, Inc., 122 Idaho 361, 363, 834 P.2d 878, 880 (1992). Uncontradicted testimony of a credible witness must be accepted as true, unless that testimony is inherently improbable, or rendered so by facts and circumstances, or is impeached. *Pierstorff v. Gray's Auto Shop*, 58 Idaho 438, 447–48, 74 P.2d 171, 175 (1937). *See also Dinneen v. Finch*, 100 Idaho 620, 626–27, 603 P.2d 575, 581–82 (1979); *Wood v. Hoglund*, 131 Idaho 700, 703, 963 P.2d 383, 386 (1998).

106. The record is replete with instances in which Claimant's testimony and statements to physicians have been factually inconsistent with his other testimony and statements to physicians. Not all are catalogued within these Findings. Some can be dismissed as failure of memory or inconsequential hyperbole. Many cannot.

107. Moreover, Claimant's responses to leading questions at the hearings and his statements to physicians show a willingness to give the expected, or benign, answer rather than admitting an unpleasant fact. Also, this willingness is well established in Claimant's responses involving his subjective perceptions and opinions. For example, when reporting to a physician who was treating him for shoulder pain his pain-scale numbers for shoulder pain were higher and his pain-scale numbers for back pain were lower, but when an essentially contemporaneous report was given to a physician who was treating him for back pain, the pain-scale numbers were reversed. This does not unambiguously suggest Claimant was being intentionally untruthful. It does undercut the weight which can be assigned to his testimony. Thus, findings about things Claimant said merely show he is reported to have said these things and does not, by itself without confirming objective evidence, show such things are found to be true.

108. Here, Claimant's testimony about his opinions of the bedside manner of various physicians is reasonable and, as to some physicians, consistent with the opinions of other claimants

who have testified before the Commission. However, the record shows Claimant has no medical training. For example, at the time of early treatment following the accident, he did not think "sacroiliac" was "a real word." The record shows Claimant's attorney repeatedly asked leading questions about subjects which Claimant could have no genuine understanding. Claimant was asked to testify about whether physicians' examinations were thorough or sufficient, what the physicians found or even thought, and whether they were competent. Clearly, such testimony was beyond the knowledge of Claimant. Thus, Claimant's testimony about his medical care and his opinions about physicians is entitled to little weight, particularly where it is inconsistent—as it often is—with the medical records of the physicians themselves. Only his opinions about physicians' bedside manner carry significant weight on their own.

109. This credibility analysis does not affect the earlier assessment of demeanor or credibility of Claimant. Indeed, the Referee found the record indicative of a sincere Claimant caught in the effects of iatrogenic narcotic dependence. The Commission finds no reason to disturb the Referee's findings and observations on Claimant's presentation or credibility.

Causation

110. Pursuant to Idaho Code § 72-102(17), Claimant must demonstrate that the subject accident caused an "injury", defined as follows: "'Injury' and 'personal injury' shall be construed to include only an injury caused by an accident, which results in violence to the physical structure of the body. …." Idaho Code § 72-102(17)(c). It is Claimant who bears the burden of proving the existence of an injury related to an industrial accident. *Callantine v. Blue Ribbon Supply*, 103 Idaho 734, 653 P.2d 455 (1982). Claimant must adduce medical proof in support of his claim and he must prove his claim to a reasonable degree of medical probability. *Dean v. Dravo Corporation*, 95 Idaho 558, 511 P.2d 1334 (1973).

111. Here, there is no dispute concerning the occurrence of the industrial accident. There is, however, a dispute concerning the nature and extent of the injury caused by the accident. As we stated in *Davis v. U.S. Silver-Idaho, Inc.*, IC 2008-031273 (Idaho Ind. Comm. Dec. 20, 2012):

> An injury is defined as a personal injury caused by an accident arising out of and in the course of employment. An injury is construed to include only an injury caused by an accident which results in violence to the physical structure of the body. [Citation omitted]. The occurrence of pain alone, without evidence of damage to the physical structure of a claimant's body, is not sufficient to constitute an injury. *See, Perez v. J.R. Simplot Company*, 120 Idaho 435, 816 P.2d 992 (1991). Therefore, the question which we must answer in the affirmative in order to award benefits in this case is not whether claimant experienced a sudden and severe worsening of his pain contemporaneous with his work activities of September 4, 2008. Rather, in order to conclude that claimant is entitled to workers' compensation benefits, we must be satisfied that the accident described by claimant is responsible for causing physical injury to the structure of his body.

Davis, IC 2008-031273 at ¶ 33. Here, the Commission has previously determined that the accident of May 20, 2012 caused an injury to Claimant's sacroiliac joint. The Commission further ruled that Claimant was entitled to recover medical expenses incurred in connection with the sacroiliac fusion surgery performed by Dr. Andrew on or about March 3, 2017. Our previous decision, however, does not satisfy Claimant's burden of proving that his current complaints and alleged disability are causally related to the subject accident. Claimant's sacroiliac joint was successfully fused by Dr. Andrew. The relief initially provided by this procedure was only temporary. Not long following the hearing at which compensability of the SI joint fusion surgery was considered, Claimant experienced the return of symptomology. Per Dr. Marsh, Claimant's current pain is exactly the same as the pain with which he presented prior to the fusion surgery. 2020 Marsh Dep., p. 58. Dr. Marsh proposes that the SI joint fusion has failed and that Claimant's complaints continue to emanate from the SI joint. Indeed, he proposes that Claimant requires a redo of the SI joint fusion, this one to be done via a more invasive approach. 2020 Marsh Dep., pp. 40-44. The

Commission does not find Dr. Marsh's opinion concerning the failure of the SI joint fusion, or the SI joint as the source of Claimant's pain complaints, to be persuasive. Radiographic studies performed subsequent to the October 2017 fusion have consistently shown a good fusion. Dr. Andrew, the physician who performed the fusion surgery believes that it is intact. He has no good explanation for the source of Claimant's persistent pain complaints.

112. Dr. Bates, the IME physician retained by Claimant, offered the following comments following his July 23, 2018, evaluation of Claimant:

> In the recent evaluation, there has been no specific pain generator identified. No specific treatment course recommended that can be attributed on a more likely than not basis to the May 20, 2012, injury. Therefore, the plan will be to continue with the current maintenance of medication for the pain management as a result of that injury.

Claimant's Ex. 34, p. 12. Dr. Marsh has also entertained the possibility that Claimant's persistent pain complaints might be mediated by an injury to the piriformis muscle, or that Claimant might be suffering from an S1 radiculopathy. According to Dr. Marsh, the latter possibility finds some support in the transforaminal epidural steroid injections he performed following the return of post SI joint fusion symptoms. However, these additional explanations are not persuasive. Again, radiological studies performed subsequent to the SI joint fusion failed to demonstrate any lumbosacral spine condition that might explain radicular complaints. Moreover, the spinal cord stimulator that would be expected to address a true radicular complaint eventually proved ineffective, just as the SI joint fusion proved ineffective. 2020 Marsh Dep., pp. 18-19. More persuasive to the Commission are the opinions expressed by Drs. Friedman, Andrew, Bates, Doerr, Reedy, and Montalbano. These physicians have struggled to find any explanation for Claimant's pain and have been unable to identify an injury, i.e., damage to the physical structure of Claimant's body, that might explain Claimant's persistent symptoms. Although the Commission previously

found that Claimant suffered a compensable SI joint injury, that injury has been successfully treated. The Commission rejects Dr. Marsh's testimony that the fusion has failed. We are not persuaded that Claimant's SI joint is the explanation for Claimant's persistent symptoms. Nor are we persuaded that Claimant has met his burden of proving the existence of some other injury caused by the subject accident which does explain his persistent low back and left lower extremity symptoms. It is Claimant who bears the burden of proof in this regard, and based on the evidence before us, we are unable to conclude that Claimant has adduced persuasive evidence of an injury which explains his intractable pain. Indeed, it seems more likely that Claimant's pain complaints have an iatrogenic ideology. Notwithstanding Dr. Marsh's efforts to downplay the issue, the evidence before the Commission makes it clear that Claimant suffers from a long-standing dependence to habit-forming analgesic medications. However, the Commission also concludes that Claimant's unfortunate dependence on such medications is causally related to the subject accident and that this condition is a compensable consequence of the accident.

Medical Care

113. A claimant is entitled to reasonable medical care for a reasonable period of time for an industrial injury. Idaho Code §72-432. Future medical benefits for merely palliative care may be awarded. *Rish v Home Depot, Inc.*, 161 Idaho 702, 390 P.3d 428 (2017). A reasonable time includes the period of recovery, but may or may not extend to merely palliative care thereafter, depending upon the totality of facts and circumstances. *Harris v. Independent School District No. 1*, 154 Idaho 917, 303 P.3d 605 (2013); *Rish*, 161 Idaho 702, 390 P.3d 428 (2017). One factor among many in determining whether post-recovery palliative care is reasonable is based upon whether it is helpful, that is, whether a claimant's function improves with the palliative treatment. *Id.*; *see also*, *Sprague v. Caldwell Transp., Inc.*, 116 Idaho 720, 591 P.2d 143 (1979) (limited and

overruled on other grounds by *Chavez v. Stokes*, 158 Idaho 793, 353 P.3d 414 (2015)).

114. Defendants have previously been ordered to compensate Claimant for the expenses associated with the October 2017 SI joint fusion. Claimant requests that Defendants be ordered to pay for other non-surgical treatment/palliative care required by Claimant's physicians both before and after the March 3, 2017, SI fusion surgery. Claimant requests that the Commission approve past and prospective treatment for his persistent pain complaints, including care provided by Drs. Marsh and Radnovich, along with the spinal column stimulator (SCS) recommended by Dr. Marsh and provided by Dr. Maxwell.

115. Turning first to the SCS, Dr. Marsh has testified that he recommended it for treatment of Claimant's persistent pain complaints. There are several objections to the compensability of this treatment. First, Claimant has failed to prove that his current pain complaints are causally related to the subject accident. It follows that the implantation of the SCS, though "required" by Claimant's physicians to treat this pain is likewise not compensable. Next, Dr. Marsh noted that screening for the implantation of an SCS involves a trial to test for efficacy, and a neurophysiological evaluation to rule out drug seeking behavior and to assess the reasonableness of the patient's expectations from the procedure. 2020 Marsh Dep., pp. 18-20. Dr. Marsh testified that Claimant had good relief of symptomatology during the trial. He was also evaluated by Dr. Maxwell, who eventually implanted the device, and Dr. Menchaca, who performed the neuropsychological evaluation. However, in making her recommendation in support of the implantation of the SCS, Dr. Menchaca did not take an accurate history of Claimant's medication usage. At the time of her March 6, 2018, evaluation she reported that Claimant had no history of abuse of prescription medications, an assertion that is demonstrably incorrect. *See* Claimant's Ex. 51. By March 6, 2018, Claimant had suffered one of the two overdose episodes of

which led to hospitalization. Dr. Marsh's note of February 19, 2018 references this hospitalization along with Dr. Marsh's suspicion that it resulted from an overdose. Dr. Marsh acknowledged that following his referral to Dr. Radnovich, Claimant was only supposed to be taking buprenorphine, but had somehow managed to obtain the oxycodone which led to his hospitalization. 2020 Marsh Dep., p. 62; Claimant's Ex. 27, p. 50. The Commission concludes that Dr. Menchaca's opinion in support of Claimant's candidacy for an SCS is without adequate foundation.

116. Similarly, preparatory to the implantation of the SCS, Dr. Maxwell stated that Claimant showed no signs of drug addiction and was an "excellent" candidate for the SCS. Claimant's Ex. 29, p. 12. This opinion, too, is contrary to the great weight of the medical record, and the Commission concludes that it is without adequate foundation. Likewise, Dr. Friedman noted that in the past, "[Claimant] had problems being compliant with his antidepressants like Lexapro, he had problems being compliant with his antipsychotics including Zyprexa and Seroquel… It implies that he has addiction behaviors. These are noncompliant behaviors with structured drugs, and he is at high risk for having a problem." 2020 Friedman Dep., pp. 23-24. Although Dr. Marsh required the implantation of the SCS, the Commission concludes that the procedure was not reasonable based on the inadequacy of the medical opinions supporting the same. The Commission's decision in this regard is also buttressed by the opinion of Dr. Friedman that Claimant was not a candidate for the SCS. The fact that Claimant did not enjoy anything but temporary relief from his pain following the implantation further supports the Commission's conclusion that the SCS is not reasonable.

117. The matter of Claimant's entitlement to past and future palliative care in the form of treatment and medications provided by Drs. Marsh and Radnovich is more difficult to unwind. In his report of December 30, 2015, Dr. Friedman found that further use of narcotic pain

medications was not indicated, and that Claimant should be weaned from these medications. Defendants' Ex. 47, p. 2302. Claimant did not undergo the tapering recommended by Dr. Friedman, and as a result he has continued to be dependent upon habit-forming narcotic analgesics with the eventual result of at least two episodes of drug overdose requiring hospitalization. Dr. Friedman found that Claimant "[was] continuing to have difficulties with high-dose opiate use, noting he was narcotic-dependent by November of 2012." 2020 Friedman Dep., p. 23. The Commission concludes that while Claimant is entitled to the treatment he received through December 30, 2015, as well as the benefits referenced in the Commission's previous decision, the Commission concludes that medical treatment provided subsequent to Dr. Friedman's December 30, 2015, findings was not reasonable. However, it is important to recognize that by the time of Dr. Friedman's 2015 evaluation, Claimant had already become dependent on narcotic analgesics by way of medical care that had, until that time, been approved by Surety. Even though the Commission finds that continued use of narcotic analgesics post-December 30, 2015, is not reasonable, the Commission nevertheless concludes that Claimant's dependance on narcotic analgesics is a natural and probable consequence of the treatment he received with Defendants' approval. In so ruling, the Commission is aware of the Court's treatment of the issue of pain and addiction in *Rish v. Home Depot, Inc.*, 161 Idaho 702, 390 P.3d 428 (2017). One difference between the facts of *Rish* and the facts of this case is that in *Rish*, the claimant had a recognized injury which caused the pain requiring palliative care. Here, the Commission has concluded that Claimant has not met his burden of demonstrating that his current symptoms are related to damage to the physical structure of his body resulting from the compensable accident. Nevertheless, per *Rish*, it is clear that Claimant's dependence can be a compensable consequence of the accident, even though there is not a physical injury that is responsible for causing the pain that led to the

prescription of habit-forming analgesics. However, nothing in *Rish* compels the conclusion that a compensable dependence requires the continuation of habit-forming medications, and the facts of this case do not warrant continued use of narcotics. Dr. Radnovich has assessed Claimant as suffering from opioid dependence as recently as August 30, 2019. Claimant's Ex. 28, p. 38.

118. Claimant has already had two episodes of narcotic overdoses which required hospitalization. Although continued narcotic pain medication is not reasonable, Defendants are responsible for the fact of Claimant's dependency. Dr. Friedman has recommended that Claimant's dependency be treated by weaning him from the habit-forming medications over a period of ten weeks. This recommendation is now over five-and-a-half years old. Dr. Marsh appears to have elected to treat Claimant's dependency by referral to another pain management specialist, Dr. Radnovich, who has placed Claimant on an opioid antagonist, buprenorphine. This medication is intended to address Claimant's pain complaints yet prevent use of other opioid derivatives; when using buprenorphine, other opioids are not effective. Nevertheless, Claimant continued to use opioids following his referral to Dr. Radnovich.

119. Had Claimant demonstrated that his pain results from a compensable injury, we would be required to consider lifetime treatment for his pain, preferably by some measure that addressed his dependency as well. However, as we have concluded, the Claimant's pain is not compensable, and Defendants' obligation is limited to treating his narcotic dependence. The medical record in this case leaves us unable to reach a conclusion about how best to accomplish this. We retain jurisdiction over this matter and direct the parties to adduce such additional medical evidence as they would have us consider on the question of how best to treat Claimant's dependence on narcotic analgesics. For example, is it appropriate to wean Claimant from medications as proposed by Dr. Friedman, or is it better to maintain him on an opioid antagonist?

Is there other treatment that should be considered for what we have determined to be the principal compensable consequence of the original injury, i.e., Claimant's narcotic dependence?

Temporary Disability

120. A Claimant is entitled to temporary disability benefits during his recovery until he becomes medically stable. *Jarvis v Rexburg Nursing Center*, 136 Idaho 579, 38 P.3d 617 (2001). Benefits are payable under Idaho code § 72-408.

121. Here Claimant returned to work for Employer after the accident and continued to do so for more than one year. Also, Claimant pursued his self-employment before and after the accident. He later worked for another employer as well.

122. Claimant failed to show he is entitled to temporary disability benefits in excess of amounts previously paid.

Permanent Impairment and Disability

123. Permanent impairment is defined and evaluated by statute. Idaho Code §§ 72-422 and 72-424. When determining impairment, the opinions of physicians are advisory only. The Commission is the ultimate evaluator of impairment. *Urry v. Walker & Fox Masonry*, 115 Idaho 750, 769 P.2d 1122 (1989); *Thom v. Callahan*, 97 Idaho 151, 540 P.2d 1330 (1975). Impairment is an inclusive factor of permanent disability. Idaho Code § 72-422.

124. The preponderance of evidence in the record supports a finding of permanent impairment to a very small degree. Dr. Bates' opinion is most nearly in line with the totality of the evidence. Claimant should be entitled to a PPI rating of 3% of the whole person.

125. "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 as provided by Idaho Code § 72-430.

126. 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, 766 P.2d 763 (1988). In sum, the focus of a determination of permanent disability is on a claimant's ability to engage in gainful activity. *Sund v. Gambrel*, 127 Idaho 3, 896 P.2d 329 (1995).

127. Permanent disability is defined and evaluated by statute. Idaho Code §§ 72-423 and 72-425 *et. seq.* Permanent disability is a question of fact, in which the Commission considers all relevant medical and non-medical factors and evaluates the purely advisory opinions of vocational experts. *See*, *Eacret v. Clearwater Forest Indus.*, 136 Idaho 733, 40 P.3d 91 (2002); *Boley v. ISIF*, 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). Where preexisting impairments produce disability, all impairments and disability should be accounted for with a subtraction back for the compensable portions. *Page v. McCain Foods, Inc.*, 145 Idaho 302, 179 P.3d 265 (2008).

128. In the instant matter both Dr. Collins and Mr. Crum have rendered opinions on Claimant's disability. Both have considered the question of the impact of the subject accident on Claimant's ability to engage in gainful activity in light of various assumptions concerning the physical restrictions stemming from Claimant's injury. However, as explained above, the Commission is unable to conclude that Claimant's current complaints are referable to damage to

the physical structure of his body arising as the result of the subject accident. We are unable to say, for example, that the restrictions imposed by Dr. Marsh as the result of Claimant's persistent pain are related to a compensable physical injury. Therefore, we find neither the opinion of Dr. Collins nor Mr. Crum particularly helpful. More important, because of our ruling on the compensability of Claimant's narcotic dependency, we are unable to conclude that Claimant's disability is ripe for consideration. We accept for the purposes of discussion that Claimant's narcotic-dependence may well restrict him in terms of gainful activity. However, we deem it premature to consider the impact of Claimant's narcotic dependence on his present and future ability to engage in gainful activity when we have invited the parties to adduce further evidence on how, or whether, Claimant's dependence is amendable to further treatment. In short, our ruling is the equivalent of an acknowledgement that Claimant is not yet at a point of medical stability such as to allow consideration of his "permanent" disability. We retain jurisdiction over this issue of Claimant's disability.

Attorney Fees

129. Attorney fees are awardable where Defendants have unreasonably delayed or denied a claim. Idaho Code § 72-804. Here, Claimant asserts Defendants unreasonably relied upon Dr. Friedman's opinion. In hindsight, Dr. Friedman's opinion about the effectiveness of the SI joint surgery appears prophetic. Dr. Marsh's opinions wane in comparison and his continued narcotics prescriptions have been found unreasonable.

130. Dr. Marsh recommended surgery. Surgeons were consulted in California and Arizona. After weeks of complications, due in part to Dr. Marsh's office miscommunicating with these surgeons, surgery was scheduled by a Dr. Rappaport in Phoenix. On September 30, 2014, Claimant failed to arrive at the airport in time to board a flight which would have taken him out of

state for surgery. After rescheduling, Claimant met with Dr. Rappaport and was informed surgery would not be performed until Claimant was "completely weaned off" narcotics. Weeks later, Dr. Rappaport amended his prerequisite – Claimant could have the surgery if he tapered his narcotics to only four hydrocodone per day. Ultimately, Shane Andrew, D.O., an Idaho physician, performed the surgery.

131. The record does not show a preponderance of evidence to support a finding of unreasonable denial or delay. Claimant failed to show that a basis likely exists for an award of attorney fees.

CONCLUSIONS

1. As set forth in the Commission's original decision, Claimant has proven that as a result of the subject accident he suffered an injury to his SI joint for which he is entitled to and has received medical care. Claimant has not met his burden of proving that his current pain complaints are related to his SI joint injury or to any other injury referable to the subject accident;

2. Claimant's dependence on habit-forming analgesic medications is a natural and probable consequence of the treatment he received following the subject accident and this condition is a compensable consequence of the accident;

3. Claimant is not entitled to medical costs of the Spinal Cord Stimulator (SCS); the procedure was not reasonable due to the inadequacy of the medical opinions supporting the procedure;

4. If not already paid by Defendants, Defendants shall pay for medical treatment required by Claimant to December 30, 2015. Defendants are not responsible for medical treatment received by Claimant subsequent to that date, except as provided in the Commission's previous decision. Claimant is entitled to prospective treatment for his dependence on narcotic analgesics.

However, the record is insufficient to inform the Commission as to how Claimant's narcotic-dependency is best treated. The Commission retains jurisdiction on this matter and directs the parties to adduce such additional medical evidence they would have the Commission consider on how best to treat Claimant's dependence on narcotic analgesics;

5. Claimant has not proven entitlement to TTD benefits;

6. Claimant is entitled to impairment of 3% of the whole person. He may be entitled to further PPI for any permanent residuals of his dependence;

7. The Commission retains jurisdiction on the matter of Claimant's permanent disability until such time as Claimant reaches a point of medical stability from his dependency; and

8. Claimant has not shown he is entitled to attorney fees under Idaho Code § 72-804.

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

DATED this 7th day of October, 2021.

INDUSTRIAL COMMISSION

INDUSTRIAL COMMISSION SEAL STATE OF IDAHO

Aaron White, Chairman

Thomas E. Limbaugh, Commissioner

Thomas P. Baskin, Commissioner

ATTEST:

Kamerron Slay
Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 8th day of October, 2021, a true and correct copy of the **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** was served by regular United States Mail and email upon each of the following:

MATTHEW STEEN
4850 N. ROSEPOINT WAY, STE. 104
BOISE, ID 83713
Storerlit@gmail.com

SCOTT WIGLE
PO BOX 1007
BOISE, ID 83701
swigle@bowen-bailey.com

el