BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

PATRICK L. STUARD, Claimant, v. TURNER CORPORATION, dba ARCHITECTURAL WALL SOLUTIONS, Employer, and LIBERTY MUTUAL FIRE INSURANCE COMPANY, Surety, Defendants.	)	**IC 04-505273** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** Filed December 9, 2005

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Michael E. Powers, who conducted a hearing in Boise on July 28, 2005. Claimant was present and represented by Richard Kim Dredge of Boise. Monte R. Whittier, also of Boise, represented Employer/Surety. Oral and documentary evidence was presented. The parties took one post-hearing deposition and submitted post-hearing briefs. The matter came under advisement on October 7, 2005, and is now ready for decision.

ISSUES

As agreed to by the parties at hearing, the issues to be decided are:

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

   (a) medical;

(b) total and/or partial temporary disability (TTD/TPD);

(c) permanent partial impairment (PPI);

(d) permanent partial disability (PPD); and

(e) retraining.

2. Attorney fees for wrongful denial of benefits.

CONTENTIONS OF THE PARTIES

Claimant contends that Defendants are liable for a thoracic disk fusion that resulted from a lifting injury along with TTD, PPI, and PPD benefits. He also requests attorney fees for Surety's unreasonable denial of the surgery and for discovery abuses.

Defendants contend that Claimant's surgery was unnecessary in the first place and, even if it was necessary, it was due entirely to a pre-existing condition and not as the result of any accident and injury. Because Surety is not responsible for the surgery, they are also not responsible for any of the benefits Claimant seeks. Finally, because they based their decision to deny the surgery on sound medical evidence, they are not liable for attorney fees.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant taken at the hearing;

2. Claimant's Exhibits A-P admitted at the hearing;

3. Defendants' Exhibits A-J; L-R and T admitted at the hearing; and

4. The pre-hearing deposition of Paul J. Montalbano, M.D., taken by Defendants on July 27, 2005, and the post-hearing deposition of Samuel S. Jorgenson, M.D., taken by Claimant on March 14, 2005.

After having considered all the above evidence and the briefs of the parties, the Referee submits the following findings of fact and conclusions of law for review by the Commission.

Preliminary evidentiary matters:

Claimant has objected to the admission into evidence of a narrative report prepared by David J. Giles, M.D., dated February 24, 2005, (Defendants' Exhibit K) and an Independent Medical Evaluation report prepared by Richard A. Silver, M.D., dated May 10, 2005, as well as a letter authored by Dr. Silver to a representative of Surety on the same date. (Defendants' Exhibit S).

Dr. Giles.

Claimant contends Defendants failed to timely disclose Dr. Giles' report and did not do so until Claimant's counsel had completed his direct examination of Claimant's treating physician, Dr. Jorgenson, at his testimonial deposition.

Defendants respond that they were not required to disclose Dr. Giles as an expert unless and until they made the decision to use his report at hearing, and his report is work product as it was prepared to assist Defendants in preparing for Dr. Jorgenson's deposition. Further, the report was not disclosed because it was being submitted to their expert, Dr. Montalbano, to see if he agreed with it and thus, is again work product. Defendants did not receive Dr. Giles' report until March 3, 2005, 11 days before Dr. Jorgenson's deposition.

In reading Dr. Jorgenson's deposition, it is clear he did not think he was "thrown a curve" by being questioned regarding Dr. Giles' report. Dr. Jorgenson agreed with portions of the report and disagreed with other portions and explained his reasoning. The Referee finds that Claimant was not prejudiced by the "late" disclosure of the report and it is admitted into evidence as Defendants' Exhibit K.

Dr. Silver.

Claimant objects to the admission of, or use by any other witness, Dr. Silver's IME report and his letter to a Surety representative, on the ground that said report and letter exceed the scope of Defendants' request to vacate the hearing originally set for April 28, 2005. Claimant argues that the reason for the continuance of the hearing was to allow Defendants time to address Dr. Jorgenson's PPI rating and apportionment issues. Instead, Dr. Silver addressed causation issues. In his report and letter, Dr. Silver did address the issues of PPI and apportionment; he attributed any PPI to Claimant's pre-existing degenerative disk disease with no apportionment. In order to get there, Dr. Silver had to also address causation. Dr. Silver's IME report and letter are admitted as Defendants' Exhibit S.

FINDNGS OF FACT

1. Claimant was 46 years of age and resided in Boise but was working in Reno, Nevada, earning $32.06 an hour at the time of the hearing. He has been an ironworker for the past 15 years and is also a certified welder.

2. On March 1, 2004, Claimant was helping move a large aluminum doorframe in an awkward position when he felt a "twinge" in his back. He thought he had merely pulled a muscle, something ironworkers commonly do, and continued working. However, later that evening, when his wife was unable to massage out the pain, Claimant realized that he had a condition that was not likely to go away on its own. He described the pain as being in the middle of his back just to the left of his spine and radiating around to the left side of his abdomen, ". . . it felt like the pain went straight from my back all the way through to the front of my abdomen." Hearing Transcript, p. 32. Claimant had never experienced that type of pain before.

3. Claimant continued to work with the pain until March 4, 2004, when he presented to St. Luke's Regional Medical Center emergency room. The attending physician diagnosed an avulsion process at the distal tip of the spinous process per x-ray and a back strain/sprain. He placed Claimant on light duty, prescribed medications, and referred Claimant to an orthopedic surgeon.

4. Claimant first saw orthopedic surgeon Samuel S. Jorgenson, M.D., on March 8, 2004. He was complaining of thoracic and lumbar pain. Dr. Jorgenson examined Claimant, took x-rays, and reviewed the emergency room x-rays that all showed no evidence of a focal collapse or trauma. He was suspicious of a soft tissue injury and was concerned that the pain radiating into Claimant's left thorax may represent a disk protrusion so he ordered a thoracic MRI to either confirm or rule out his suspicion.

5. The thoracic spine MRI was accomplished on March 9, 2004, and was read by Dr. Jorgenson to show a central disk herniation at T6-7 that "seems" to indent the spinal cord. He opined that the MRI was consistent with Claimant's symptoms. Dr. Jorgenson recommended epidural steroid injections and physical therapy. He released Claimant to modified work.

6. Claimant experienced minimal relief with the epidural steroid injections and due to increased pain, his physical therapy was discontinued. On March 30, 2004, Joseph M. Verska, M.D., a partner of Dr. Jorgenson, examined Claimant and concluded he would benefit from an anterior thoracic discectomy and fusion at T6-7. However, Dr. Jorgenson opted for a more conservative approach in the hope that Claimant may see some improvement given additional time.

7. On April 19, 2004, Dr. Jorgenson opined that surgery at T6-7 was now appropriate because: there was evidence on MRI of a T6-7 disc protrusion and cord indentation,

Claimant had not responded to treatment over six weeks, his pain was severe enough to limit his work and activities of daily living, and the failure to respond to conservative treatment such as physical therapy, injection therapy, time, and medications. Surety wanted a second opinion.

8. Claimant saw Paul J. Montalbano, M.D., a neurosurgeon, on May 12, 2004, at Surety's request for a second opinion regarding whether Claimant was a surgical candidate on an industrial basis. Dr. Montalbano examined Claimant, reviewed medical records, and reviewed the March 9, 2004, thoracic MRI scan. He concluded that a full body bone scan and post-myelo CT would be in order to further assess Claimant's thoracic radiculopathy and if those tests had positive findings that correlate with Claimant's symptoms, he would agree with the surgical procedure recommended by Drs. Verska and Jorgenson.

9. The whole body bone scan and CT myelogram of the thoracic spine were accomplished on May 14 and 17, 2004, respectively. Dr. Montalbano opined that the bone scan demonstrated no uptake of the thoracic spine[1] and the post-myelo CT demonstrated no evidence of significant canal or foraminal stenosis and no evidence of thoracic nerve root compression. He also concluded that the CT scan revealed a calcified disc herniation at T6-7 that was degenerative and not traumatic in origin. Therefore, Dr. Montalbano disagreed that surgery was the appropriate treatment for Claimant's symptomatology.

10. On July 15, 2004, Dr. Jorgenson performed a thoracic discectomy and fusion at T6-7 with good results.

DISCUSSION AND FURTHER FINDINGS

Idaho Code § 72-432(1) obligates an employer to provide an injured employee reasonable medical care as may be required by his or her physician immediately following an injury and for

[1] Dr. Montalbano testified in his deposition that the bone scan was to determine if there was any degree of instability or inflammation at the affected level; he found none based on the scan.

a reasonable time thereafter. It is for the physician, not the Commission, to decide whether the treatment is required. The only review the Commission is entitled to make is whether the treatment was reasonable. *See, Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989). A claimant must provide medical testimony that supports a claim for compensation to a reasonable degree of medical probability. *Langley v. State, Industrial Special Indemnity Fund*, 126 Idaho 781, 890 P.2d 732 (1995). "Probable" is defined as "having more evidence for than against." *Fisher v. Bunker Hill Company*, 96 Idaho 341, 344, 528 P.2d 903, 906 (1974). No "magic" words are necessary where a physician plainly and unequivocally conveys his or her conviction that events are causally related. *Paulson v. Idaho Forest Industries, Inc*, 99 Idaho 896, 901, 591 P.2d 143, 148 (1979). A physician's oral testimony is not required in every case, but his or her medical records may be utilized to provide "medical testimony." *Jones v. Emmett Manor*, 134 Idaho 160, 997 P.2d 621 (2000).

Defendants argue that they are not liable for Claimant's surgery because the diagnostic testing reveals that Claimant's herniation at T6-7 was calcified, or "old," and was not the result of any trauma Claimant may have suffered by way of his industrial accident. Claimant argues that based upon the records and deposition testimony of Dr. Jorgenson, where he expressed a "very strong" opinion that the surgery he performed was as the result of Claimant's industrial accident, the Commission should find causation.

Drs. Montalbano, Silver, and Giles:

11. Dr. Montalbano testified in his deposition that he was unable to detect any nerve root impingement on either the thoracic MRI or the CT myelogram. He did, however, testify that spinal cord compression was noted on the MRI and the CT scan revealed a mild indentation of the ventral aspect of the spinal cord. He explained: "The spinal cord is protected by spinal

fluid in a sac or the dura mater, which is the sleeve that goes around the spinal cord and the spinal fluid. Mr. Stuard had a central disc protrusion/calcification that was indenting the sac." Dr. Montalbano Deposition, p. 10.

Dr. Montalbano also discussed the potential causes of the calcified disc material at T6-7: "Degenerative arthritis involving the spine, worsened with obesity, worsened with smoking,[2] worsened with significant trauma." Dr. Montalbano Deposition, p. 12. Dr. Montalbano testified that it is important for a surgeon to view MRI and CT scans themselves, rather than rely on the radiologist's interpretation.[3] Regarding what conditions needed to exist before he would operate on a thoracic disc herniation, Dr. Montalbano testified: " If the patient is symptomatic from that disc herniation, that is verified objectively when a patient is examined, then I would recommend surgery on that patient." Dr. Montalbano Deposition, p. 23.

12. At Surety's request, Richard A. Silver, M.D., M.B.A., an orthopedic surgeon, examined Claimant on May 10, 2005. Based on his physical examination of Claimant and his review of the relevant medical records, Dr. Silver opined:

> Patrick L. Stuard sustained a sprain/strain of the thoracodorsal and lumbosacral spine on or about 03/01/04. There was no indication of any focal neurological deficits in the entire musculoskeletal examination by the ER physician, Rourke M. Yeakley, MD, or Samuel S. Jorgenson, MD, or his associate Joseph Verska, MD. In addition, neurological consultation with Paul J. Montalbano, MD, showed no neurological deficit. The X-ray studies, on an objective basis, showed that these were old calcified problems that were unrelated to the injury in question of 03/01/04. Surgical intervention may have very well been appropriate and necessitated by the discussions between Samuel S. Jorgenson, MD, and the claimant. However, two consulting physicians felt that from an industrial standpoint, the surgical intervention had no direct or indirect relationship, [sic] to the industrial injury of 03/01/04. I am in agreement.

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[2] There is nothing in the record indicating Claimant was obese or was a smoker.

[3] The radiologist's reports of the thoracic MRI and bone scan were sent to Dr Jorgenson, however, he testified he does not remember if he reviewed the actual scans. He further testified that after his request for surgery was denied, he was not provided the "courtesy" by Surety to review any further reports or to comment on Dr. Montalbano's opinion.

Defendants' Exhibit S.

13. Defendants provided David J. Giles, M.D., a radiologist, with the following diagnostic studies: thoracic spine x-ray from St. Luke's of March 4, 2004; MRI of the thoracic spine without contrast of March 9, 2004; whole body bone scan of May 14, 2004; and the thoracic CT myelogram of May 17, 2004. Without discussing in detail Dr. Gile's comments on each of the studies, his overall opinion may be summarized as follows:

> The decision to proceed to surgery is a complex one and involves not only imaging data but also clinical laboratory and other data. I can speak to the imaging data in this case, however.
>
> . . .
>
> Based on purely imaging grounds, therefore, the focal T6-T7 disk protrusion appears to be old, very unlikely to have occurred at the time of the patient's stated trauma on 03/01/04, and is associated with deformity of the spinal cord signifying mild focal atrophy at that location, but no active spinal cord compression. A surgical procedure to decompress the spinal cord, therefore, may not be necessary in the absence of frank spinal cord compression.

Defendants' Exhibit K, p. 80.

<u>Dr. Jorgenson</u>:

14. Dr. Jorgenson is a board-certified orthopedic surgeon whose orthopedic practice consists solely of treatment of the spine. He performed the surgery on Claimant's thoracic spine and testified that it was Claimant's industrial accident that caused the disk protrusion at T6-7. His response to Dr. Montalbano's opinions was elicited in his deposition as follows:

> Sure. Let me first say that Dr. Montalbano is a respected physician in the community and I have no – this is not meant to be a criticism of him, I just happen to disagree with him in this particular case.
>
> There are several points that I disagree with. First of all, he seems to contradict himself in the initial consultation of May 14th of 2004. He stated that he recommended a bone scan and if the bone scan had positive findings, he would recommend an operation. And then in subsequent findings he stated the bone scan showed no significant increased uptake, and therefore, did not recommend surgery.

In my opinion, the indications of the patient's surgery were based on his MRI findings as well as his symptoms and lack of response to conservative care.

The second disagreement is the reliance on the bone scan. Although a bone scan does indicate if there is an acute fracture in the area of inflammation, a bone scan is usually not positive in a pure disk situation. So in my opinion, the bone scan findings are inconsequential.

And finally, he indicates in his report that the CAT scan is – the CT, quote: The post mile [sic-myelo] CT demonstrates no evidence of significant canal or foraminal stenosis. It is my opinion that the CT scan showed significant central stenosis and indentations on the spinal cord. And the radiology report confirms this, stating that there is indentation in the ventral aspect of the thoracic cord.

So in summary, I suppose I disagree with Dr. Montalbano's rational for deciding that the herniation was not related to his injury and I also disagree with his recommendation that no surgery is indicated.

. . .

Regarding his observations at surgery, Dr. Jorgenson testified:

Q. (By Mr. Dredge): Doctor, at the time of surgery what did you actually observe with respect to herniation?

A. At the time of surgery he was found to have both calcification as expected on the studies, as well as the focal herniated disk that herniated into the canal.

Q. From the observation you made of the focal disk herniation, would that correlate with an injury that occurred March 1, 2004, that time frame?

A. Yes.

. . .

Regarding whether a calcified disk can herniate, Dr. Jorgenson testified:

Q. (By Mr. Whittier): You might explain that a little bit more. The outer part of it becomes calcified and hard or bony, then how does it become herniated?

A. First of all, the entire outer part of the disk doesn't become hard and bony and calcified, it's just a small part of the periphery of the disk that becomes calcified or has calcifications overlying it. The central part of the disk still remains cartilaginous and soft. So what happen is the portion of the disk that's not calcified is still capable of having a herniation project through it.

Regarding the degree to which he holds his opinions, Dr. Jorgenson testified:

Q. (By Mr. Dredge): And what I would like to do is give you an opportunity to comment on how strongly you feel about your opinion, and I will do that now.

> A. Sure. Without giving percentages, I feel very strongly in my opinion, and I felt so preoperatively and my opinions, I felt, were borne out of [sic-by] my surgical findings.

Dr. Jorgenson Deposition, pp. 15-17, 19-20, and 26.

15. As is not unusual in contested workers' compensation matters, there is a legitimate difference of medical opinion regarding causation and the need for surgery. There was much "medical minutia" in this case and both parties did an admirable job in questioning the medical experts regarding their opinions and the foundations therefor. The Defense experts opine that Claimant's injury was an old one that was not caused by his industrial accident and, in any event, surgery was not indicated. However, the Referee is more persuaded by the opinions of Dr. Jorgenson. While the Defense experts were very precise in their reading of the diagnostic studies and their findings on examination, Dr. Jorgenson was also very precise in his opinions and had the added advantage of actual observation at surgery. Further, the timing of events and common sense would indicate that Claimant, who suffered an uncontested industrial accident, had immediate symptomatology that did not improve with a number of modalities of conservative treatment, and had surgery that alleviated the worst of his symptoms, has indeed suffered a work-related injury that caused the need for his surgery. He no doubt had a pre-existing degenerative back condition, however, he was able to perform the hard work of an ironworker before his accident and could not immediately thereafter. A pre-existing disease or infirmity of the employee does not disqualify a workers' compensation claim if the employment aggravated, accelerated, or combined with the disease or infirmity to produce the disability for which compensation is sought. An employer takes the employee as found. *Wynn v. J.R. Simplot Company*, 105 Idaho 102, 666 P.2d 629 (1983).

16. Under the *Sprague*, *Id.* guidelines, the Referee finds that Dr. Jorgenson required the treatment he provided and the treatment was reasonable. Claimant has met his burden of proof that he suffered a compensable accident and injury on March 1, 2004, and Defendants are liable for all the costs associated with his medical care and treatment for that injury.

TTD benefits:

Idaho Code § 72-408 provides for income benefits for total and partial disability during an injured worker's period of recovery. "In workmen's [sic] compensation cases, the burden is on the claimant to present expert medical opinion evidence of the extent and duration of the disability in order to recover income benefits for such disability." *Sykes v. C.P. Clare and Company*, 100 Idaho 761, 763, 605 P.2d 939, 941 (1980); *Malueg v. Pierson Enterprises*, 111 Idaho 789, 791, 727 P.2d 1217, 1220 (1986). Once a claimant is medically stable, he or she is no longer in the period of recovery, and total temporary disability benefits cease. *Jarvis v. Rexburg Nursing Center*, 136 Idaho 579, 586, 38 P.3d 614, 621 (2001) (citations omitted).

Once a claimant establishes by medical evidence that he or she is still within the period of recovery from the original industrial accident, he or she is entitled to total temporary disability benefits unless and until evidence is presented that he or she has been medically released for light work and that (1) his or her former employer has made a reasonable and legitimate offer of employment to him or her which he or she is capable of performing under the terms of his or her light duty work release and which employment is likely to continue throughout his or her period of recovery, or that (2) there is employment available in the general labor market which the claimant has a reasonable opportunity of securing and which employment is consistent with the terms of his or her light duty work release. *Malueg*, *Id*.

17. Claimant asserts he is entitled to TTD benefits from when Surety terminated them on May 26, 2004, based on Dr. Montalbano's letter, or from July 15, 2004, the date of his surgery to November 10, 2004, the date Dr. Jorgenson released him to return to work. The Referee finds it reasonable to award TTD benefits from the date they were terminated through November 10, 2004, with a credit for any wages Claimant may have earned in the event he worked for Employer between May 26, 2004, and July 15, 2004.

PPI benefits:

"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 the 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 worker's personal efficiency in the activities of daily living, such as self-care, communication, normal living postures, ambulation, elevation, 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. *Urry v. Walker and Fox Masonry Contractors*, 115 Idaho 750, 755, 769 P.2d 1122, 1127 (1989).

18. The only PPI rating assigned in this case is that given by Dr. Jorgenson:

> The patient best falls under the category IV of the DRE thoracic spine of the AME [sic] Guidelines, Fifth Edition. He has alteration in motion segment, being a fusion at the T6-7 level. His radiculopathy is resolved but the loss of motion segment is permanent. Based on this categorization and the fact that the patient does still have restrictions, he carries a 22% whole-person impairment.

Claimant's Exhibit G., p. 56.

Defendants sent Claimant to Dr. Silver for a PPI/apportionment evaluation after having received Dr. Jorgenson's rating. In fact, the hearing had to be vacated once for this purpose. Question number 5 contained within a letter dated April 28, 2005, from Surety to Dr. Silver states:

> If medically stable, based on the AMA Guide [sic], 5th Edition, does Mr. Stuard have a permanent partial impairment? If so, please identify the impairment and apportion any impairment that may relate to a pre-existing or subsequent condition.

Claimant's Exhibit P., p. 5.

Dr. Silver responded: "Not for the injury of 03-01-04. Yes for the fusion at T6-7. 100% of the impairment and apportionment of any impairment is related to the preexisting discogenic disc disease and calcified HNP (herniated nucleus pulposis) at T6-7." Defendants' Exhibit S. Dr. Silver never indicated what that rating would be, or whether he agreed with Dr. Jorgenson's rating, but it may be reasonably inferred that he assigned a 0% PPI rating for Claimant's March 1, 2004, injury.

Defendants argue that Dr. Jorgenson's PPI rating should be ignored because he did not apportion any of the rating to a pre-existing degenerative condition that he admitted Claimant had. However, Dr. Jorgenson's rating is the only one in evidence and the Referee is not inclined to average the 0% and the 22% in this case or arrive at his own apportionment percentage. Defendants had the opportunity to ask Dr. Jorgenson about apportionment once they received his rating and gave him the chance to explain why he did not apportion; however, they chose not to do so.

19. The Referee finds that Claimant has incurred a 22% whole person PPI rating for his March 1, 2004, injury without apportionment for pre-existing conditions.

PPD benefits:

"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 impairment and by pertinent non-medical factors provided in Idaho Code § 72-430. Idaho Code § 72-425. Idaho Code § 72-430(1) provides that in determining percentages of permanent disabilities, account should be taken of the nature of the physical disablement, the disfigurement if of a kind likely to handicap the employee in procuring or holding employment, the cumulative effect of multiple injuries, the occupation of the employee, and his or her age at the time of the accident causing the injury, or manifestation of the occupational disease, consideration being given to the diminished ability of the affected employee to compete in an open labor market within a reasonable geographical area considering all the personal and economic circumstances of the employee, and other factors as the Commission may deem relevant, provided that when a scheduled or unscheduled income benefit is paid or payable for the permanent partial or total loss or loss of use of a member or organ of the body no additional benefit shall be payable for disfigurement.

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 non-medical 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).

20. Claimant asserts he is entitled to PPD benefits of 40% of the whole person in excess of his 22% PPI. He bases this assertion on his 40-pound lifting restriction and his testimony that the only reason he returned to ironworking was due to the financial hardship created by Surety's actions. However, Dr. Jorgenson noted when he assigned the 40-pound restriction that it was essentially self-imposed. *See,* Claimant's Exhibit G., p. 55.

Claimant has presented no vocational evidence regarding any loss of access to his pre-injury labor market and he has certainly suffered no loss of earning capacity as he was earning significantly more at the time of hearing than he was at the time of his injury.

21. The Referee finds that Claimant has failed to prove he is entitled to any PPD above his PPI.

Retraining benefits:

Idaho Code § 72-450 allows for retraining benefits under certain circumstances. Here, Claimant has presented no retraining plan nor has he argued for such in his opening post-hearing brief, therefore, the Referee finds that Claimant has failed to prove his entitlement to retraining benefits.

Attorney fees:

Idaho Code § 72-804 provides for an award of attorney fees in the event an Employer or Surety wrongfully denies or delays the payment of benefits. Claimant seeks attorney fees for Surety's wrongful denial of Claimant's surgery as well as for various discovery violations discussed above. The Referee notes that Idaho Code § 72-804 does not provide for an award of attorney fees as a sanction for discovery violations even if such existed here. Surety had

reasonable grounds for denying Claimant's surgery based on the reports of Drs. Montalbano and Giles. Claimant has not proven his entitlement to attorney fees.

CONCLUSIONS OF LAW

1. Claimant is entitled to medical benefits relating to his thoracic surgery.

2. Claimant is entitled to TTD benefits from May 24, 2004, through November 10, 2004, and Defendants are entitled to a credit or reduction in the event Claimant worked for Employer from May 24, 2004, until his surgery on July 15, 2004.

3. Claimant is entitled to a 22% whole person PPI rating for his March 1, 2004 injury without apportionment for pre-existing conditions.

4. Claimant is not entitled to PPD benefits above PPI.

5. Claimant is not entitled to retraining benefits.

6. Claimant is not entitled to attorney fees.

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Referee recommends that the Commission adopt such findings and conclusions as its own and issue an appropriate final order.

DATED this __1st ___ day of December, 2005.

INDUSTRIAL COMMISSION

__/s/_____
Michael E. Powers, Referee

ATTEST:

__/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __9th ___ day of December, 2005, a true and correct copy of the **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

RICHARD KIM DREDGE
PO BOX 9499
BOISE ID 83707-3499

MONTE R WHITTIER
PO BOX 6358
BOISE ID 83707-6358

___/s/_____

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