BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

RAFAEL TOVAR, Claimant, v. JALAPENOS, INC., Employer, and IDAHO STATE INSURANCE FUND, Surety, Defendants.	**IC 2006-525923** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **Filed July 8, 2019**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Industrial Commission assigned the above-entitled matter to Referee Douglas A. Donohue who conducted a hearing in Coeur d'Alene on April 20, 2018. Starr Kelso represented Claimant. H. James Magnuson represented Defendants. The parties presented oral and documentary evidence. Post-hearing depositions were taken. The parties submitted briefs. The case came under advisement on December 4, 2018 and is now ready for decision. The undersigned Commissioners have chosen not to adopt the Referee's recommendation in order to give different treatment to the issue of causation, and hereby issue their own findings of fact, conclusions of law and order.

ISSUES

According to the Notice of Hearing, the issues are as follows:

1. Causation;

2. Whether Claimant is medically stable, and, if so, on what date;

3. Whether and to what extent Claimant is entitled to benefits for

   a) Temporary disability;
   b) Permanent partial impairment;
   c) Disability in excess of PPI;
   d) Medical care; and
   e) Attorney fees;

4. Whether apportionment of permanent disability for preexisting conditions are appropriate under Idaho Code § 72-406.

Claimant renewed his objection to the noticed issues at hearing and in post-hearing briefing. Claimant's objection is a reiteration of arguments previously made to both the Referee and the Commission. The Referee has twice considered and overruled this objection. The Commission affirmed the Referee's ruling on Claimant's request for reconsideration. The Idaho Supreme Court denied Claimant's request for permissive appeal about the matter. Claimant's objection to the noticed issues at hearing is overruled.[1]

CONTENTIONS OF THE PARTIES

Claimant contends he noticed a gradual onset and progression of upper extremity symptoms while working for Employer as a cook. Eventually, it affected his work to the extent that Employer sent him to a physician on October 31, 2006. A dispute arose between the treating physician and Surety's nurse case manager which affected the nature and extent

[1] Procedurally, Claimant alleged October 31, 2006 as the date of injury for his occupational disease claim, and filed his Complaint on October 11, 2011. On April 17, 2012, Claimant affirmed his readiness for hearing, and requested additional issues, including Impairment, Permanent Partial Disability; Medicals and Attorney Fees to be included. The Referee agreed and issued a Notice of Hearing with all issues raised by the parties. Upon learning that Claimant was receiving additional treatment, the Referee vacated the scheduled hearing. Thereafter, on September 9, 2013, Claimant sought to add additional hearing issues of TTD and Idaho Code § 72-406 apportionment. The Referee conducted multiple telephone conferences to accommodate the parties, and vacated and reset several potential hearing dates. At each telephone conference, the hearing issues were consistently identified, and the parties acknowledged their dispute over Claimant's medical stability. Notwithstanding these communications, Claimant filed a Motion to Clarify Issues shortly before the hearing scheduled for August 31, 2017. The Referee held a telephone conference on July 18, 2017, and allowed Claimant to expand the noticed issues to allow an occupational disease theory claim; the Referee declined to narrowly limit the issues to causation and medical care. Claimant subsequently raised multiple challenges to the noticed issues that necessitated vacating and resetting the hearing. Claimant's objections were denied on reconsideration, and the Idaho Supreme Court denied his permissive appeal. The Referee held the hearing on April 29, 2018.

of treatment. Over the ensuing years, multiple physicians have proposed multiple diagnoses and multiple modes of treatment. Claimant's symptoms have remained and worsened. Claimant is not medically stable and still needs appropriate treatment for thoracic outlet syndrome. Claimant asserts that Defendants should be required to authorize his referral to the University of Washington to evaluate his conditions, including, but not limited to, thoracic outlet syndrome, for treatment. His condition constitutes an occupational disease which was caused by repetitive motion at work. Despite symptoms, Claimant has continued to work through the date of hearing. This was a claim accepted by Surety. At present, only causation and medical care are relevant issues; all others are unripe. Bias and inappropriate methodology of a physician have falsely colored physicians' opinions.

Defendants contend they have paid all appropriate TTD and PPI benefits due Claimant. After right carpal tunnel surgery by John Faggard, M.D., in 2007 and two right shoulder surgeries by treating physician Roger Dunteman, M.D., Dr. Dunteman opined Claimant to be medically stable on December 23, 2013. Surety paid the 10% whole person PPI assigned by Dr. Dunteman. Surety has allowed certain additional medical care since. Over the years, Claimant's symptomatic complaints have varied. Claimant's current condition is not industrially related. He is entitled to no further medical care. Claimant has continued to work and has suffered no permanent disability in excess of impairment. Defendants have acted reasonably throughout the course of this claim.

EVIDENCE CONSIDERED

The record in the instant case included the following:

1. Oral testimony at hearing of Claimant and co-worker Chelsea Page[2];

[2] Claimant objected and filed a Motion in Limine to strike this testimony. Under a strict interpretation of JRP rule 9(c), the Referee sustained Claimant's objection, but then allowed Ms. Page's testimony as "proposed

2. Claimant's exhibits A through Y admitted at hearing;

3. Defendants' exhibits 1 through 30 admitted at hearing;

4. Depositions of physicians Spencer D. Greendyke, M.D.; Roger Dunteman, M.D., and Eric Hofmeister, M.D., and vocational expert Douglas Crum.

Objections in Claimant's Third Supplemental Rule 10 Disclosure to certain Defendants' exhibits are OVERRULED. Objections in post-hearing depositions are OVERRULED.

FINDINGS OF FACT

1. Claimant worked for Employer as a cook beginning in 1993. Claimant testified, "At the beginning … I used to work up to 120 hours per week. … And then later with time I was working 45 hours a week for my salary." HT, 37/15-18; 39/17-18. The record is vague about which weeks he worked longer hours. Claimant's contemporaneous reporting to physicians shows he usually worked 40-45 hours.

2. Claimant's regular schedule was 7:00 a.m. to 4:00 p.m., six days per week. Tr., 47:16-22. The restaurant was open for business 11:00 a.m. to 9:00 or 10:00 p.m. Tr., 48: 12-14.

3. Claimant prepped food—which included a significant amount of cutting meat and vegetables with a knife—and cooked. Tr., 38:4-20. Claimant is right-handed and testified that ordinarily, he cut rapidly with his right upper extremity using his left upper extremity to hold the objects he was cutting. Tr., 38: 23-39:4. As Employer hired additional kitchen staff, Claimant's title became "chef." Tr., 48: 1-2. He maintained that he still did all of the prep work, and supervised the kitchen. Tr., 39:22-25.

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testimony" pending an offer of proof. HT, 53/16-55/13. Upon hearing this testimony, Claimant withdrew his objection and motion.

4. Claimant testified he first noticed pain in 2001, but did not need a doctor until October 31, 2006. Tr., 40:20-25. Since 2006, and despite carpal tunnel surgery and two shoulder surgeries, he has had "more pain. It has never changed. I have never gotten any better. … The pain still continues and [is] getting worse." Tr., 41:19-20. He uses a TENS unit around four or five times a week, depending on his pain. Tr., 43:24-44:5.

5. Claimant has continued to work. Tr., 42:21-25. Except for scheduled vacation, he missed work only for medical appointments and a brief surgical recovery. Tr., 41:21-42:10. He was terminated by Employer's new owners, after about two years working for them, on January 11, 2016, for reasons unrelated to his workers' compensation claim. Tr., 49:18-50:23; Ex. 29. He now works for another restaurant. Tr., 42:17-24.

Medical Care

6. On October 31, 2006, John Faggard, M.D., recorded Claimant's history as right shoulder pain present for four or five years, but progressively worsening. Ex. 6:255. Recent numbness and pain in the right hand into the index finger, less so in the left hand generally; pain over the dorsum and ulnar aspect of the right wrist; pain over the "radial aspect of the [right] thumb and ulnar aspect." Ex. 6:255. Examination revealed swelling over the first dorsal compartment of the right wrist with tenderness and crepitus. Ex. 6:255. X-rays showed no arthritis in wrist or shoulder. Ex. 6:256. Dr. Faggard identified bilateral carpal tunnel syndrome, worse on right, de Quervain's tenosynovitis, possible tendinitis, and right shoulder bursitis. Ex. 6:258.

7. On January 6, 2007, Dr. Faggard noted that EMG and nerve conduction velocity (NCV) studies were positive for right carpal tunnel syndrome but not left. Ex. 6:256. Due to symptoms, "it was felt that he possibly" does have left carpal tunnel syndrome. Ex. 6:256. The

absence of first dorsal compartment symptoms at this examination caused Dr. Faggard to delay performing a tendon release for de Quervain tenosynovitis. Ex. 7: 257.

8. On January 24, 2007, R. Clinton Horan, M.D., performed an EMG and NCV study. Ex. 8:292. Dr. Horan opined that Claimant's results were abnormal, with right carpal tunnel syndrome. There were normal results shown on left, although Dr. Horan conceded that normal nerve conductions results could not absolute rule out early, mild carpal tunnel syndrome. Ex. 7:292.

9. On February 20, 2007, Dr. Faggard submitted a report to Surety. Ex. 7:265-266. Claimant reported that a two-week hiatus from work did not relieve any symptoms. *Id*. Dr. Faggard opined, "I think it is unlikely that the pain in his shoulder or in the carpal tunnel will improve on a permanent basis." Ex. 7:265.

10. On March 27, 2007, James Brinkman, M.D., FACS, performed a forensic record review and examination of Claimant at Surety's request. Ex.1:3-18; 24:626. He is a plastic surgeon and hand surgeon. *Id*. at 3. Claimant reported a history of right shoulder pain since 2001 and right hand and wrist pain and paresthesias for about eight months. *Id*. at 5. Dr. Brinkman reviewed the records and noted that Claimant's pain complaints on the ulnar right wrist lasting for several weeks; swelling over the first dorsal compartment of the right wrist, with tenderness and crepitation with Finkelstein's sign; positive Tinel's over the right cubital tunnel and absent on the left; some pain with crepitation of the right shoulder; and no acromioclavicular joint tenderness. *Id*. at 6. Dr. Brinkman ordered a MR arthrogram of the right wrist and deferred interpretation of the two right shoulder "views" to an orthopedic surgeon. Ex.1:16. After a physical examination, Dr. Brinkman diagnosed right carpal tunnel syndrome and de Quervain's syndrome, as well as right shoulder impingement syndrome, and opined that there was no

clinical evidence for left carpal tunnel syndrome. Ex. 1:17. He opined Claimant's conditions to be work-related. He recommended carpal tunnel surgery on the right hand; surgery to ameliorate the de Quervain's syndrome if conservative measures failed; and continued conservative treatment under his treating physician's care, with "possible steroid injections versus a more compliant physical therapy program." Ex. 1:17.

11. On April 13, 2007, the right wrist MRI showed mild edema at the lunate and an irregular partial tear of the scapholunate ligament, and normal appearance of the remainder of the ligaments and the wrist. Ex. 1: 21.

12. On April 27, 2007, Dr. Faggard checked a box to agree with the IME findings. Ex. 7: 268. Dr. Faggard wrote that Claimant "still may need something done with shoulder." Ex. 7:268.

13. On May 25 2007, based primarily upon "very positive" Tinel's and Phalen's signs, Dr. Faggard performed a right carpal tunnel release. Ex. 7:270. In post-surgical physical therapy visits Claimant complained of pain and discomfort in his right wrist and hand. Ex. 19:457. The physical therapy plan was for Claimant to attend three times a week to work on his right wrist and strength and right grip strengthening. Ex. 19:458.

14. On June 19, 2007, Claimant told Dr. Faggard about pain in his radial right wrist and near the acromion area of the shoulder. Ex. 7:258. Dr. Faggard injected a Xylocaine block, and recommended expanding the scope of Claimant's physical therapy to include shoulder modalities. Ex. 7:258-259.

15. On July 17, 2007, Claimant reported to Dr. Faggard that all of his de Quervain tenosynovitis symptoms had resolved, also, nearly all of the median nerve paresthesias as well. Ex. 7:259. He complained about finger symptoms over the ring and small finger and discomfort

in the ulnar aspect of his wrist. Ex. 7:259. Examination showed no crepitus, negative Tinel's over the carpal tunnel but "slightly positive Tinel test over the ulnar Guyon canal but not at the elbow." Ex. 7:259. Claimant felt that his pain was too severe to try working more than 4-hour intervals. Ex. 7:259. Dr. Faggard performed another injection and recommended no work more than 4 hours per day. Ex. 7:259.

16. On July 31, 2007, Dr. Faggard noted that Claimant reported resolution of all pain except for some ulnar paresthesias and achiness. Ex. 7:260. Claimant showed improvement in grip strength and range of motion. Ex. 7:260. Dr. Faggard noted that this was perhaps "not significant enough to show up on EMG and nerve conduction studies," but "may show up as he has resumed work. Ex. 7:260. Dr. Faggard ordered a repeat EMG and nerve conduction study. Ex. 7:260.

17. On October 3, 2007, Claimant reported his waxing and waning pain symptoms had returned after a return to work following a trip to Mexico. Ex. 7:261. Although Dr. Faggard was "at a bit of a loss of where to go next" he thought Claimant's symptoms resembled ulnar neuropathy and de Quervain tenosynovitis. Ex. 7:261. He recommended a discontinuance of physical therapy, pending an additional evaluation. Ex. 7:261.

18. By September 4, 2007 Claimant was complaining to his physical therapist about constant ache, with tingling and numbness, across all nerve distributions in his hand and wrist. Ex. A:10-11. He also began complaining of occasional left hand numbness. Ex. A:10-11. On September 4, 2007, Dr. Horan performed another EMG/NCV study. Ex. 8:297. It showed normal results throughout with no evidence of an entrapment neuropathy in the right arm; no evidence of an ulnar neuropathy at the elbow or wrist. Ex. 8:297. Dr. Horan conceded that mild nerve entrapment might not be detectable. Ex. 8:297.

19. On November 27, 2007, Patrick Mullen, M.D., examined Claimant upon referral from Dr. Faggard to provide a second opinion about Claimant's right wrist. Ex. 14:369. He found tenderness over the first dorsal compartment and a "strongly positive Finkelstein's test." Ex. 14: 369-370. However, Tinel's and Phalen's signs were negative. Ex. 14:369. Dr. Mullen was "unable to clearly see" the reported irregularity of the scapholunate ligament reported by the radiologist. Ex. 14: 369. Dr. Mullen suspected early Kienböck's disease. Ex. 14:370.

20. On February 20, 2008, another right wrist MRI showed less edema than the prior MRI. Ex. 14:372-374. It did not support the earlier-reported irregularity of the scapholunate ligament. Ex. 14:372-374. Dr. Mullen did not find Kienböck's disease. Ex. 14:372-374.

21. On April 18, 2008, Claimant visited Joan Bloom, M.D., at his attorney's request. Ex. 17:453. Claimant complained of both right hand and right shoulder pain. Ex. 17:453; A:45. On examination he reported paresthesias in his right fourth and fifth fingers. Ex. 17:453; B:45. Dr. Bloom assessed carpal tunnel surgery with residual pain and right shoulder pain. Ex. 17:453; B:45.

22. On May 9, 2008, William Lenzi, M.D., examined Claimant forensically at Surety's request. Ex. 16:445-449. Claimant described palmar pain and pain about the dorsal radial wrist tendons, which was exacerbated by work activity. Ex. 16:447. On examination, Dr. Lenzi found mild swelling at those wrist tendons and at the flexor tendons. Ex. 16:448. Finkelstein's test was negative. Ex. 16:448. Dr. Lenzi noted that Claimant's response to Tinel's test was variable over the median nerve, but positive over the ulnar nerve at Guyon's canal. Ex. 16:448. Dr. Lenzi noted that Claimant's symptomatology changed during the examination,

"sometimes his pain was on the radial side, sometimes in the mid-portion of the wrist. But all and all, he says the very worst area, when asked to point to it with one finger, he pointed to the metacarpal of the long finger entirely distal to the wrist." Ex. 16:448. The x-ray showed no evidence of Kienböck's disease. Ex. 16:448. Dr. Lenzi opined, "Although he could be finaled today as chronic tendinitis," he recommended six months' continuation of anti-inflammatory medication. Ex. 16:449. Either way, he opined there was and would be no permanent impairment. Ex. 16:449.

23. On May 22, 2008, Dr. Faggard checked a box to agree with Dr. Lenzi's findings. Ex. 7:274.

24. On May 26, 2008, Dr. Mullen checked a box to agree with Dr. Lenzi's findings. Ex. 14:376.

25. On July 21, 2008, a right shoulder MRI arthrogram showed some supraspinatus tendinopathy without a tear, a type II acromion with mild hypertrophic changes, and some biceps tendon inflammation suggesting biceps tendionopathy. Ex. 2:178-179; Ex. 7:277-278.

26. On July 30, 2008, Claimant returned to Dr. Faggard "at the request of Workers' Compensation" for evaluation of his right shoulder. Ex. 24:614. Claimant complained more about his wrist than shoulder. *Id*. Dr. Faggard considered a diagnosis of possible bicipital tendinosis of Claimant's right shoulder. Dr. Faggard did not recommend surgery. Ex. 24:614.

27. On November 24, 2008, Dr. Dunteman examined Claimant. Ex. 2:175. He found AC joint crepitus and tenderness, and a positive Hawkins' sign. Ex. 2:176. He noted that X-rays showed mild AC joint degenerative changes, and the recent MRI results showing hypertrophic changes around the AC joint with some tendonitis of the supraspinatus tendon. Ex. 2:176-177.

28. On February 23, 2009 and March 18, 2009, Claimant again visited Dr. Dunteman

and Dr. Dunteman's PA Jeffrey Lien. Ex. 2:170-174. Dr. Dunteman noted that a recent injection—on February 23—in the right biceps tendon had not resolved the pain. Ex. 2:170. PA Lien examined Claimant, found continued tenderness and crepitus, and mentioned possible surgery to Dr. Dunteman. Ex. 2:164.

29. On May 27, 2009, Dr. Brinkman again performed a forensic record review and examination at Surety's request. Ex.1:23-41; 24:635. Claimant complained of daily right acromioclavicular joint pain, frequent shoulder popping, pain radiating from right shoulder to neck, right dorsal distal radioulnar joint pain, swelling and paresthesias in all five right digits. Ex. 1:26. Dr. Brinkman reviewed Claimant's new medical records and performed a physical examination. The examination show positive Neher, Hawkins', and Whipple tests on the right shoulder, and positive thumbs-up/thumbs-down tests with pain detected on palpation of the right acromioclavicular joint. Dr. Brinkman deferred to a specialized orthopedic examination of the right shoulder. Ex. 1: 36. Claimant's wrists had full and symmetrical flexion, extension, and radial and ulnar deviation; palpation of the left wrist is unremarkable with no crepitation, tenderness or instability; right wrist was nontender over the first compartment, and the ulnar triquetral area was tender, as was the palmar surface of the hamate near the incisional scar. Ex.1: 37. Sensory testing showed slight diminishment of soft touch sensation on the right index, middle, ring, and little fingers. Ex. 1:38. Vibratory perception was reported greater on the median distribution of the left as compared to the right. Ex. 1:38. Tinel's sign was negative on the right wrist and the left wrist over the median nerve. Ex. 1:38. Dr. Brinkman suspected recurrent median nerve entrapment at the right wrist, related to his work as a chef, and requested nerve conduction testing. Ex. 1:40. Dr. Brinkman opined that Claimant's ulnar sided wrist pain was work-related, and recommended evaluation for diagnostic wrist arthroscopy. Ex. 1:40. He

also found a "contusion, median nerve, right wrist on clinical subjective/objective findings, but lacking electrodiagnostic confirmation. No specific treatment is planned or recommended for this." Ex. 1:41. He deferred the orthopedic consultation to Dr. Dunteman, and stated that the current examination supported the recommended shoulder arthroscopy with SAD, possible biceps tenodesis, was work-related. Ex. 1:40. He recommended a cortisone injection for the index and middle fingers of the right hand for Claimant's tenosynovitis, and recommended evaluation for diagnostic wrist arthroscopy with suggested re-consultation with Dr. Lenzi. Ex. 1: 41.

30. On June 8, 2009, James Lea, M.D., performed an EMG/NCV study. Ex. 9:301. He found the results entirely normal, ruling out possible cervical radiculopathy. Ex. 9:301.

31. On July 22, 2009, Dr. Dunteman checked a box to agree with Dr. Brinkman's findings. Ex. 2:169.

32. On September 14, 2009, PA Lien, by history, noted, "there has been changes in the nature of the problem." Ex. 2:160. The Referee noted that Dr. Dunteman and PA Lien's medical notes would frequently repeat this ungrammatical statement for the next several years.

33. On February 26, 2010, Dr. Dunteman noted, "Since the patient's last visit, there has been no change in the character and associated symptoms. Since the patient's last visit, there has been changes in the nature of the problem." Ex. 2:157; 10:306. The Referee noted that these statements underscored that Dr. Dunteman's records are internally inconsistent and of limited reliability. After reviewing Dr. Dunteman's records, the Commission would agree that Dr. Dunteman's medical records do contain these inconsistencies and seem to rely heavily on boilerplate based on almost unvarying descriptions of Claimant's condition.

34. On March 11, 2010, Dr. Dunteman performed a right shoulder repair. Ex. 2:154;

10:326. With Claimant under anesthesia, Dr. Dunteman found full range of motion and good stability. Ex. 2:154; 10:326. At surgery, he found that Claimant's biceps tendon, superior labrum, posterior labrum, inferior recess, glenoid cartilage, humeral head, articular surface of the rotator cuff, anterosuperior labrum, middle ligament, and anteroinferior labrum and ligaments were normal. Ex. 2:154; 10:326-327. He observed "slight" fraying of the coracoacromial ligament and inflammation and degenerative changes about the distal clavicle. Ex. 2:154; 10:326. Dr. Dunteman performed a subacromial decompression and distal clavicle excision. Ex.2:154-155; 10:326-327.

35. On April 22, 2010, a physical therapy progress note showed Claimant was still reporting soreness "across the top" of his right shoulder. Ex. 2:144-145; 19:507; Ex. A:14-15.

36. On July 16, 2010, Dr. Dunteman approved the IRCD's Job Site Evaluation for Claimant's current job at four hours per day, with weekly two hours per day increases until Claimant was full-time, without other restrictions. Ex. 2:127; K:129. On July 16, 2010, PA Lien, noted that Claimant had made "good advances with therapy" and was anxious to return to work, and released him to return to work at four hours per day, with weekly two hours per day increases until Claimant was full-time, without other restrictions, consistent with the Job Site Evaluation. Ex. 2:127; K:129.

37. Claimant completed his 36th physical therapy visit on August 18, 2010. Ex. 2:124; 19:532. He had been compliant and was released after substantial, but not total, improvement. Ex. 2:124.

38. On August 25, 2010, in a follow-up visit, Claimant reported mild pain and mild weakness, but much improvement since surgery. Ex. 2:122; K:137. PA Lien examined Claimant and found "very mild" weakness on abduction, but full strength on other shoulder

motions. Ex. 2: 123. He noted Claimant had returned to full-duty, full-time work, and would follow-up as needed, without identifying any additional expected treatment. Ex. 2:123.

39. On September 20, 2010, Dr. Dunteman reported to Surety that Claimant was fixed and stable as of August 26, 2010 and entitled to a 3% upper extremity rating. Ex. 2:93; 121: K:141.

40. The record does not indicate Claimant received relevant treatment for this claim during the period of October 2010 through December 2012.

41. On December 11, 2012, Dr. Brinkman performed a third forensic record review and examination at Surety's request. Ex. 1: 42-62. He opined that Claimant's right carpal tunnel and flexor tendinitis was fixed and stable, without impairment or restrictions, despite subjective numbness in the absence of objective findings. Ex. 1 1:56-58. He suspected that Claimant's lunotriquetral ligament sprain was not fixed and stable, and ordered X-rays for the lunotriquetral area. Ex. 1:56. After reviewing the x-rays, he opined that there was no objective basis for any diagnosis there. Ex. 1:58. He deferred to an orthopedic shoulder surgeon for Claimant's right shoulder. Ex. 1:56.

42. On January 21, 2013, Dr. Dunteman examined Claimant. Ex. 2:117. He found mild AC joint crepitus and tenderness. Ex. 2: 117. Other indicators were consistent with impingement. Ex. 2:117.

43. On February 4, 2013, Dr. Dunteman examined Claimant. Ex. 2:112. He thought the MRI report showed mild AC joint crepitus and rotator cuff tendinosis. Ex. 2:112. Other indicators were consistent with impingement. Ex. 2: 112. An MRI of the right shoulder on that date with Arthur S. Watanabe, M.D., found the AC joint "unremarkable," some thinning at the supraspinatus tendon which suggested post-operative scarring, a possible partial tear of the distal

infraspinatus tendon, and tendinosis. Ex. 2:114-115.

44. On June 17, 2013, Dr. Dunteman examined Claimant. Ex. 2: 109. "At this time, the patient has failed conservative treatment and would like to consider his surgical options which include but are not limited diagnostic arthroscopy and evaluation of the rotator cuff, biceps tendon, labrum, distal clavicle and the subacromial space." Ex. 2:110.

45. On September 15, 2013, Dr. Dunteman examined Claimant. He recommended a diagnostic arthroscopy for Claimant's continuing reports of pain unrelieved by conservative measures.

46. On September 17, 2013, Dr. Dunteman performed right shoulder surgery. Ex. 10:338; D:51-52. He arthroscopically observed mild fraying on the superior border of the subscapularis on the right shoulder. Ex. 10:338; D:51-52. He again observed normalcy at Claimant's biceps tendon, superior labrum, posterior labrum, inferior recess, glenoid cartilage, humeral head, articular surface of the rotator cuff, anterosuperior labrum, middle ligament, and anteroinferior labrum and ligaments. Ex. 10:338; D:51-52. He observed prior surgical changes with mild to moderate inflammation and scar band formation at the AC joint. Ex. 10:338; D:51-52. He shaved the fraying at the subscapularis tendon and AC joint. Ex. 10:339; D:51-52. At a follow-up visit on September 25, Dr. Dunteman recorded that Claimant had good motion with minimal discomfort and improving strength. Ex. D:53.

47. On November 20, 2013, PA Lien examined Claimant and allowed a return to work, starting part time with weekly increasing hours to full time, and a temporary right-handed lifting restriction. Ex. 2:97. He recommended Claimant continue home exercises for his shoulders. Ex. 2: 98.

48. On December 23, 2013, Claimant returned to Dr. Dunteman. Claimant reported

a little right shoulder pain with activity, much improved since surgery. Examination showed full strength and range of motion. Dr. Dunteman opined Claimant was "fixed and stable and can return to work without restrictions." He rated a 10% upper extremity impairment for the clavicle excision, inclusive of the prior 3% upper extremity impairment from 2010. Ex. 2:94; D:55. Dr. Dunteman wrote that "the previous impairment rating did not include the distal clavicle excision; however (Claimant) has improved range of motion and strength (normal). Therefore, his impairment rating is only 7%." Ex. 2:94.

49. On April 30, 2014, Claimant returned to Dr. Dunteman. Ex. 2:89. He again noted, "there has been changes in the nature of the problem. There is no significant changes in the current symptoms." Ex. 2:89. Claimant reported intermittent trapezius pain with other subjective complaints. On exam, Claimant had mildly positive Spurling's and Hawkins' tests with negative impingement tests. Ex. 2:89. Dr. Dunteman recommended physical therapy with C-spine traction. Ex. 2:89.

50. In May 2014, after a visit to Dr. Dunteman, Claimant again attended physical therapy sessions. Ex. 19:537; Ex. A:20. He was pain free, went on vacation, and upon return to work in June his right shoulder pain came back. Ex. 19:548. He also reported neck, left shoulder and right middle finger pain as well. Ex. A:20-21. He described new qualities of pain and new symptoms–including tingling, numbness, weakness, and locking–in these areas. Physical therapy continued through July. Ex.19:557-552.

51. On June 6, 2014, PA Lien noted "there has been changes in the nature of the problem. There is no significant changes in the current symptoms." Ex. 2:86. His examination was unrevealing. Ex. 2:86-87,

52. On June 25, 2014, Spencer Greendyke, M.D., reviewed records and examined

Claimant at Surety's request. Ex. 3:202-204. Claimant's complaints were all related to his right upper extremity, shoulder and neck and fairly intermittent numbness to the fingers of the right hand. Ex. 3:205. Claimant "displayed no outward signs of pain behavior, symptom magnification, or inappropriate response." Ex. 3:243. Dr. Greendyke opined that Claimant had eleven diagnoses that were industrially related on a more likely than not basis: (1) history of right wrist and right shoulder overuse injuries at work; (2) EMG-documented right wrist carpal tunnel syndrome; (3) Status post right wrist carpal tunnel release, with failure to improve, raising the possibility of double crush syndrome, (4) History of right wrist pain; (5) MRI-documented edema to the lunate of the right wrist, suggestive of early stage of Keinböck's disease, with resolution on subsequent MRI; (6) Right shoulder impingement syndrome, permanently aggravated by overuse activity at work; (7) Status post right shoulder arthroscopy with subacromial decompression, distal clavicle resection; (8) Status post return of right shoulder discomfort, with new symptom of discomfort in the right trapezius; (9) Status post repeat right shoulder arthroscopy with rotator cuff and acromioclavicular joint debridement; (10) Status post return to right shoulder discomfort with continued right trapezius pain and subjective complaints of numbness to the fingers of the right hand; (11) Possible right-sided C5-6 and C6-7 spondylosis/stenosis, producing subjective complaints of numbness to the right hand and discomfort. Ex. 4:215-216. He opined that a causal relationship between Claimant's occupational injury from 2006 and his current cervical complaints was possible, noting that cervical pathology might be causing his failure to significantly improve after his carpal tunnel release. Ex. 4:216. "On rare occasions, individuals can present with a double crush syndrome whereby they have median nerve compression at the wrist which can be documented by EMG, but also a bulging disc in the cervical spine. If more proximal nerve conduction studies are not

performed, this condition can go unnoticed. This can certainly explain the claimant's persistent symptoms of intermittent numbness to the fingers and persistent wrist/hand pain." Ex. 4:216. Dr. Greendyke acknowledged that Claimant did not describe any specific cervical spine injury or any "specific upper extremity injury that would produce his right arm symptoms." He surmises that "this type of cervical spine injury could consist of a simple sprain from lifting something heavy in the kitchen." Ex. 4:216. Ultimately, Claimant would need to undergo MRI evaluation of the cervical spine; if the claimant "displays no significant pathology on the right side at the appropriate level, then this (causation) discussion is essentially moot." Ex. 4:217. Pending the cervical spine MRI evaluation, he approved the prior 10% upper extremity impairment rating, rated a partial thickness rotator cuff tear, and opined a "final upper extremity impairment of 12%." Ex. 4: 217-218.

53. On July 14, 2014, Dr. Dunteman checked a box to show he agreed with the findings of Dr. Greendyke. Ex. W:272.

54. Dr. Greendyke's proposed cervical MRI was performed on July 22, 2014, with Adam K. Olmsted, M.D.. Ex. 4:223. The results showed at C3-4 "rightward uncovertebral joint spur with moderate right foraminal impingement;" at C4-5 the same with mild biforaminal narrowing but without compression, at C5-6-7-T1 no compressive disc abnormality. Ex. 4:223. Per Dr. Greendyke, the July 22, 2014 results did "not explain [Claimant's] persistent complaints of numbness in the right hand." However, it did explain "his right trapezius pain and possibly most of his right shoulder pain." Ex. 4:224. He recommended an evaluation with Michael Ludwig, M.D., for a possible epidural steroid injection at the right C4-5 and C3-4 to see if it alleviates his right shoulder discomfort. Ex. 4:224.

55. On August 28, 2014, Dr. Ludwig examined Claimant in a consultation requested

by Dr. Greendyke. Ex. 6:227-230. He reviewed the recent MRI and recommended steroid injections into the facets at C3-4 and C4-5. Ex. 6:229. He opined as follows:

> His symptoms of muscle pain and chronic aching pain are consistent with possible facet mediated pain, but could also be due to the mild C4/5 disc protrusion. Given the chronicity of symptoms, I cannot state at this time if an injury occurred 10 years ago. The findings could be consistent with normal age appropriate degenerative changes as well. Causation will not be addressed as part of this examination.

Ex. 6:229. Dr. Ludwig recommended regular duty without restrictions. Ex. 6:231.

56. On October 7, 2014, Dr. Ludwig performed the right C-spine injections previously recommended. Ex. 6:232. At his October 22, 2014 follow-up appointment, Claimant reported complete relief of his right-sided neck pain and no longer had right-sided pain to extension of the cervical spine. Ex. 6:233. Dr. Ludwig assessed mild cervical spondylosis with central protrusion at C4/5, moderate foraminal stenosis right C3/4 and chronic right sided neck pain "now resolved." Ex.6:234. He released Claimant to return to regular-duty work on that same date. Ex. 6:235.

57. By February 25, 2015, Claimant reported to Dr. Ludwig that the neck pain was beginning to return. Ex. 6:236. A second set of injections was administered on March 4, 2015. Ex. 6:238. These did not result in long-term improvement and Dr. Ludwig recommended a cervical bone scan. Ex. 6:240.

58. On April 2, 2015, a bone scan suggested "isolated focal activity in the left frontal calvarium (that) may be related to recent trauma." Ex. 6:245. Claimant's SPECT and static nuclear bone scan of the head, neck and upper torso was within normal limits. Ex. 6:245. Dr. Ludwig noted that the bone scan did not show evidence of uptake along the cervical spine to explain the right sided neck pain, and there was no active uptake of the cervical facet joints. On April 8, 2015, Dr. Ludwig opined that he "would not recommend proceeding with RFA or

surgical intervention at this time," but recommended a prescription for a trial of TENS unit and recommended other "non-operative measures." Ex. 6: 248. Dr. Ludwig affirmed Claimant's release to regular full-duty work.

59. Claimant began another round of physical therapy to address neck pain extending into his right shoulder. Ex. 19:535; Exhibit A.

60. On June 3, 2015, Dr. Ludwig reviewed a C-spine MRI and opined that Claimant had reached MMI status with persistent right shoulder pain despite treatment. Ex. 6:252; F:80.

61. On July 20, 2015, Dr. Dunteman, by history, noted "changes in the nature of the problem." Ex. 2:81. Claimant's subjective pain rating increased to 8/10, but the objective examination findings remained largely unchanged from Claimant previous visits. Ex. 2:81-82; 86-87; 88-90.

62. An August 7, 2015, MRI of Claimant's C-spine was taken and compared to the April 2015 MRI. Ex. 2:79. It revealed mild degeneration at C4-5-6 without spinal stenosis or cord compression. Ex. 2:80.

63. On August 31, 2015, PA Lien examined Claimant. Ex. 2:75. His history noted "changes in the nature of the problem," without elaboration. Ex. 2:75, 81. PA Lien diagnosed "osteoarthrosis local primary shoulder region" and "cervicalgia-neck pain." Ex. 2:76. He performed an AC joint injection for pain relief and diagnostic purposes. Ex. 2:76.

64. On November 19, 2015, Bret Dirks, M.D., examined Claimant. Ex. 4:225; G:82. He opined Claimant complaints about his trapezius were related to a shoulder problem and not a neck problem. Ex. 5:226.

65. On December 9, 2015, PA Lien examined Claimant. Ex. 2:69-71. His examination found continued pain over the trapezius musculature, and reviewed an MRI of the

C-spine, which revealed moderate narrowing of the right foramina at the C5-C7 levels without compression. Ex. 2:70. PA Lien recommended NCV/EMG testing to evaluate nerve compression of the brachial plexus and wrist. Ex. 2:70; D:63.

66. On January 19, 2016, Merle Janes, M.D., conducted a well-documented examination. Ex. H: 88-100. He also performed an EMG and nerve conduction velocity study (NCV). *Id*. On examination he found chronic degenerative tendinosis with multiple triggerpoints, and "minor impingement" on right vascular plethysmography testing for TOS. *Id*. The EMG/NCV shows low amplitude with latency at the right brachial plexus. *Id*. On Claimant's right, he found an absence of carpal tunnel syndrome, the presence of median nerve abnormalities, ulnar nerve abnormalities including mild Guyon canal syndrome and mild cubital tunnel syndrome, and the presence of neuropathic TOS crossing the brachial plexus. *Id*. He noted, "This represents a 'focal neuropathy' as opposed to 'generalized, whole-nerve neuropathy.'" *Id*. Claimant's left side examination and EMG/NCV showed abnormalities similar in nature, but much less pronounced. *Id*. at 100. He opined Claimant's "shoulder pain derives from myofascial injury (chronic degenerative tendinosis) in multiple spots"; neuropathic, not vascular, TOS affecting the right ulnar nerve more than the left; double-crush syndrome involving the right cubital tunnel and TOS; possible double-crush syndrome on left involving the carpal tunnel and TOS. Dr. Janes' report neither finds nor denigrates a link between work and these abnormalities. Dr. Janes offered a conditional referral to Dr. Kaj Johansen "if the physiotherapy fails to be sufficiently effective." *Id*. at 100.

67. On February 29, 2016, Dr. Dunteman signified his "agreement" that Claimant should be sent to Dr. Johansen. Ex. M:171.

68. On August 6, 2016, Eric Hofmeister, M.D., reviewed records and examined

Claimant at Surety's request. Ex. 3:180. Dr. Hofmeister concluded that Claimant had the following diagnoses:

> 1. Right carpal tunnel syndrome status post carpal tunnel release, previously administratively accepted as related to his industrial injury of October 31, 2006, without any clinical evidence of recurrence of right carpal tunnel syndrome.
>
> 2. Right shoulder sprain and impingement, status post right shoulder arthroscopy and decompression acromioplasty status post a second right shoulder arthroscopy with subacromial depression, debridement of subscapularis, and acromioclavicular joint resection, administratively accepted as related to the industrial injury of October 31, 2006.
>
> 3. Multilevel cervical spondylosis, not related to the industrial injury of October 31, 2006, on a more-probable-than-not basis.
>
> 4. EMG/nerve conduction evidence of mild compression of the ulnar nerve at Guyon's canal, mild cubital tunnel, and thoracic outlet syndrome right upper extremity, not related to the industrial injury of October 31, 2006, on a more-probable than not basis.
>
> 5. EMG/nerve conduction evidence of left carpal tunnel syndrome, not related to the industrial injury of October 31, 2006, on a more-probable-than-not basis.
>
> 6. Right trapezial myalgias, not related to the industrial injury of October 31, 2006.

Ex.3:195. Per Dr. Hofmeister, Claimant was medically stable. Dr. Hofmeister found no objective evidence to support an impairment rating higher than the 10% upper extremity which others had rated. Ex. 3:196.

69. On November 21, 2016, Dr. Dunteman checked a box to indicate he agreed with the August 6, 2016 findings of Dr. Hofmeister. Ex. 29:1132; Ex. 2:67.

70. On June 26, 2017, Dr. Dunteman examined Claimant again. Ex. 2:64; M:177. He reported X-ray findings: "AP, outlet and axillary views of the right shoulder demonstrate no degenerative changes about the glenohumeral joint." Ex. 2:64. Dr. Dunteman recommended an MRI and felt that Claimant should be referred to either to the University of Washington or

Spokane for thoracic outlet syndrome. Ex. 2:65; M:178; Ex. Y:296-302. Surety relied on Dr. Hofmeister's opinion to deny this referral.

71. On July 18, 2017, Claimant's attorney reported that he intended to return Dr. Dunteman's report to him to allow the doctor to correct "several misspellings and incorrect factual assertions." Ex. M:176.

72. On August 28, 2017, another right shoulder MRI showed moderate cuff tendinopathy and peritendinobursitis without a cuff tear. Ex. J:106; O: 210.

73. On September 25, 2017, Dr. Dunteman's history again recited, "there has been changes in the nature of the problem" without elaboration. Ex. 28: 2; M:188. He acknowledged the recent MRI findings. *Id.*; Ex. D: 70. Dr. Dunteman's impressions were "impingement syndrome of right shoulder" and "cervicalgia". Ex. 28:1002.

Other Medical Care

74. Claimant's prior medical records are noncontributory for any analysis of finger, hand, wrist, shoulder, or neck conditions relevant to this claim. A 2004 surgery to graft a severed fingertip does not indicate any other symptoms in the fingers, hand, or wrist. For this claim, Claimant asserts that relevant symptoms began as early as 2001. However, given the emergency nature of the 2004 procedure, the absence of corroboration of that assertion in the 2004 record is not deemed significant.

75. Claimant sought certain intervening medical care, including a fingertip laceration and skin graft, which is similarly noncontributory.

Vocational Factors

76. Born March 17, 1971, Claimant was 47 years old at the time of hearing. Ex. 21:564. Claimant has a 6th grade education from Mexico and work experience in landscaping,

construction, and clothing manufacturing. Ex. 21. Claimant has no further history of academic or vocational training on a formal basis. Ex. 27:707. Since 1993, Claimant's work history has consisted of cooking in Mexican restaurants. Ex. 27:707. Claimant has limited fluency in English; he could communicate with his supervisor in English but has difficulty reading English and used an interpreter at hearing. Ex. 27:707.

77. Claimant's 2006 wage was $17.00 per hour. Ex. 21:564. His 2010 wage increased from $20.51 to $23.95 per hour. Ex. 21:582.

78. On May 29, 2007, Employer reported that Claimant earned $17.00 per hour and worked 40 hours per week. On December 1, 2011, Employer reported Claimant received an annual salary of $48,000 and worked 45 hours per week. Ex. 23:591.

79. ICRD consultant Teresa Reed began assisting Claimant on July 2, 2007. Ex. 22:569. In April 2008 she closed the claim because Claimant had not responded to multiple IRCD contacts, and had been deemed medically stable and returned to work at his time-of-injury position without restrictions. Ex. 21:572. IRCD revisited the claim in 2010 after Claimant's shoulder surgery with Dr. Dunteman, and closed the file when Claimant returned to work without restriction. Ex. 21:574-581.

80. Defendants' vocational expert, Doug Crum, interviewed Claimant on October 11, 2012. Mr. Crum has spent over 15 years in vocational rehabilitation and his credentials are well known to the Commission. His written report is dated March 29, 2018. Ex. 27:700. Mr. Crum opined that, because impairment is an assessment of the impact of medical conditions on functionality, it is beyond Mr. Crum's analysis to consider impairment without physician-imposed permanent restrictions. Ex. 27:707-708. He opined that without any physician-imposed permanent restrictions, and given that Claimant had continued to work for Employer for a

significant time and was employed by the next employer, and that Claimant's current wage was greater now than at the time of his claim, Claimant suffered no permanent disability. Ex. 27: 707; Crum Deposition: 707-708.

Medical Opinions

81. Dr. Greendyke, orthopedic surgeon, reviewed records and examined Claimant at Surety's request. He opined Claimant's right upper extremity overuse syndrome and carpal tunnel conditions were work-related. Greendyke Depo.: 11-12. While Claimant did have some symptoms that could represent nerve compression at the Guyon's canal, EMG testing did not confirm this diagnosis. *Id*. at 12. Dr. Greendyke testified that he originally entertained the possibility that Claimant's persistent right wrist problems following his carpal tunnel release might be related to double crush syndrome involving nerve impingement not just in the wrist but in the cervical spine as well. However, the MRI he recommended did not bear out this hypothesis. (Greendyke Depo.: 29/21-31/6). Instead, the MRI demonstrated impingement of exiting nerve roots at C4-5, which enervate the trapezius, supraspinatus, periscapular and infraspinatusm pereiscapular and infraspinatous areas of the shoulder. These findings led Dr. Greendyke to conclude that Claimant's persistent shoulder and trapezius pain was related to the C4-5 impingement. However, he did not propose that Claimant's shoulder pain was mediated by a double crush syndrome. Greendyke Depo.: 30-15-31/6. As to the cause of Claimant's multi-level cervical spine findings demonstrated on the MRI, Dr. Greendyke proposed that these changes were related to something he "supposed to have happened at work."

> Q. And you indicate "industrially related." What would be the basis for that opinion?
>
> A. Again, I felt that probably straining to lift product, you know, into the walk-in, that you bend over, maybe you're looking up as you lift, you strain, and you're 40 or 50 years old, it pretty easy to bulge a disc, it doesn't take much.

Q. Gradual process over the 21 years.

A. Yes.

Greendyke Depo.: 27/16-24. While Dr. Greendyke imagined a particular event, he was also agreeable to Counsel's suggestion that the cause was cumulative.

82. He testified that thoracic outlet syndrome is not a differential diagnosis for double-crush syndrome, and represents a different physical injury altogether. Dr. Greendyke has "never seen a case of thoracic outlet syndrome where they just got symptoms in the middle, index, and thumb. I suppose it could happen, but I've never seen it." *Id*. at 15. He also differentiated a brachial plexus injury from thoracic outlet syndrome and described Kienböck's disease as essentially avascular necrosis for the lunate bone. *Id*. at 20. While Dr. Greendyke did entertain a diagnosis of Keinböck's disease for Claimant, he eventually concluded that Claimant's lunate findings represented a temporary condition. Greendyke's Deposition: 19-22.

83. Dr. Dunteman, orthopedic surgeon, has treated Claimant since November 2008. He rated Claimant at 3% upper extremity impairment on September 2, 2010. He next examined Claimant in January 2013. In December 2013, after a second shoulder surgery he increased the rating to 10% upper extremity. At deposition, Dr. Dunteman reviewed Claimant's treatment history, and explained why he recommended considering thoracic outlet syndrome as a diagnosis for Claimant.

> Q. Now, on that date for the first time the term thoracic outlet syndrome is inserted into the discussion on page 3 of that. And what led to the discussion of the thoracic outlet syndrome as being a consideration that should be looked into?
>
> A. Well, the—the—he has—besides pain in the extremity, shoulder extremity, he has numbness and tingling in the extremity, and so we had at that point felt like we had done a fairly significant workup for the neck. You know, we had MRI, I think a bone scan, CT, Ludwig, a pain specialist, Dirks, so we were kind of at a loss of what other things could be causing his symptoms. So that was one of the diagnosis that was entertained, because of the symptoms like

the numbness and the pain, the radicular component of it.

Depo.: 18:3-18. However, because thoracic outlet syndrome is a rare condition, Dr. Dunteman acknowledged it requires a specialist's evaluation and referred Claimant to the University of Washington. *Id*. at 27, 30.

84. At different times Dr. Dunteman has recorded his agreement with the opposing opinions of Drs. Greendyke and Hofmeister.

85. Dr. Hofmeister, an orthopedic surgeon with additional qualifications in hand surgery, reviewed records and examined Claimant at Surety's request. Dr. Hofmeister is based in San Diego and performed the examination in Spokane. He qualifies as an expert physician witness in this matter. In his nineteen page report he summarized the prior medical records he reviewed, and results of his physical examination of Claimant. He eventually arrived at a number of diagnoses for Claimant, along with his opinion on which of Claimant's conditions are causally related to his employment. Per Dr. Hofmeister, Claimant's first diagnosis is right carpal tunnel syndrome status post carpal tunnel release, without clinical evidence of recurrence. Next, Dr. Hofmeister diagnosed Claimant as suffering from a right shoulder sprain and impingement status post right shoulder arthroscopy and decompression times two. Because both Claimant's right carpal tunnel syndrome and right shoulder problems had previously been "administratively accepted" by Surety, Dr. Hofmeister did not offer an opinion on the medical cause of these conditions. Hofmeister Depo.: 15-16.

86. Dr. Hofmeister's third diagnosis was multi-level cervical spondylosis, which he opined was not related to Claimant's industrial injury, because "there's no mechanism of injury that causes this. There's no symptom—there's no activity or etiology other than natural aging to the cervical spine." *Id*. at 17. Dr. Hofmeister's fourth diagnosis was mild compression of the

ulnar nerve at Guillian's [Guyon's] canal, mild compression at the cubital tunnel, and a thoracic outlet syndrome on the right upper extremity, which he opined were not related to Claimant's industrial accident. *Id*. at 17.

> Q. As to the mild compression of the ulnar nerve at Guillain's [Guyon's] canal, can you explain your medical reasoning why you concluded that was not related to the industrial injury that we're here for today?
>
> A. Yeah. Well, first, all three of those, I did not find evidence –the only evidence I found for that to be—for that condition to be noted was from a nerve—a single nerve conduction study. Also, the Guillain's [Guyon's] canal is a canal within the hand where the ulnar nerve runs, and the most common reason people have swelling at the Guillain's [Guyon's] canal is secondary to a mass or some type of anatomic variation. Furthermore, releasing the carpal tunnel will often decompress that condition. And lastly, I found nothing in his history to support that his work would contribute to that condition.

Hofmeister Depo.: 18/1-17. Dr. Hofmeister also explained that the "vast majority of the exam did not support any objective evidence of ulnar nerve compression at the Guyon's canal. Claimant did "have a Tinel's sign over his Guillain's [Guyon's] canal, which is a –it's what I call a pseudo objective sign. In other words, it's when you tap on a nerve, if there is irritation of the nerve, then the individual will have symptomology in the distribution of that nerve. I call it pseudo objective because it relies on the patient to give you input, as opposed to a true objective exam which would not require any subjective input." *Id*. at 19-20. The questionable significance of Claimant's positive Tinel's sign at the Guyon's canal is demonstrated by the fact that Claimant also had positive Tinel's signs at points under which no nerve ran. Hofmeister Depo.: 19.

87. While acknowledging that there was some objective evidence of thoracic outlet syndrome, in the form of Dr. Janes' EMG testing, Dr. Hofmeister found "no other objective evidence that this condition was present," and opined that this condition, "even if it was present, would not be industrially related." *Id*. at 21:11-17. He cogently explained that injuries to nerves

running through the brachial plexus are rare. They are most frequently seen in connection with severe trauma to the brachial plexus. Less common are infections to the brachial plexus. Even less common is compression of the brachial plexus caused by vascular problems, tumors or a congenital cervical rib. Dr. Hofmeister found nothing to suggest that if Claimant has a brachial plexus injury, it is in any way connected to his occupation. Hofmeister Depo.: 25/22-24/16. He also pointed out limitations in the EMG testing's reliability. The nerve conduction study was performed nine years after the industrial injury and the condition has "not been noted by any other electromyographer," and such bilateral orthopedic conditions are "vastly almost always not due to any type of isolated injury or condition but, rather, some type of systemic type condition." *Id*. at 22:6-21. He also explained that Claimant lacks corroborating evidence of thoracic outlet syndrome, such as "muscle atrophy, muscle wasting, decreased strength, reliable reproducible discrimination along with findings on physical exam when you do provocative maneuvers to the thoracic area that would recreate his symptoms." *Id*. at 25/9-21. These were all negative on examination.

88. Dr. Hofmeister's fifth diagnosis is left carpal tunnel syndrome that he opined was not related to his industrial injury for three reasons. First, it's not part of Claimant's claim as he has been seen for his right upper extremity. Second, he had minimal symptomology related to his left hand and third, there's no mechanism of injury performing his work duties that would lead to this condition. *Id*. at 23/1-9. Finally, he cited the lack of corroborating evidence as he acknowledged that Dr. Janes' EMG study is the only possible evidence supporting that diagnosis.

89. Dr. Hofmeister's sixth diagnosis is right trapezius myalgia which he opined was not related to the industrial accident, but could be related to his ongoing multi-level neck

arthritis. *Id*. at 23/20-24/2. Finally, Dr. Hofmeister opined that Claimant had reached maximum medical improvement, and did not recommend further treatment, although physical therapy would be the preferred treatment for his non-industrial related possible bilateral thoracic outlet syndrome.

90. Claimant's Counsel made no effort to hide his contempt for Dr. Hofmeister during cross examination. Counsel spoke combatively and frequently interrupted the witness. For example, Counsel took exception to Dr. Hofmeister's disagreement with Drs. Brinkman and Dunteman and his reliance on "evidence-based medicine."

> Q: So the end-all, know-all doctor on all of this is you, a doctor from Southern California who is brought up here to north Idaho because our poor doctors and orthopedic surgeons up here in north Idaho aren't able to properly diagnose people. Is that what you're testifying to, Doctor?
>
> A. No, and I feel like you're trying to belittle me as we're talking here and I just think this is inappropriate. I have—I'm here and I set aside several hours from my clinical practical to try to give input to this case, and I don't quite understand. I'm not saying mean or belittling things to you, I'm sitting here trying to give you sound medical opinions based on my examination and review of the records.

Hofmeister Depo.: 51/21-52/10. Dr. Hofmeister maintained his composure and explained that he was offering his medical opinion based on his examination and review of the record, independent of what the other experts testified. He also explained that he "didn't disagree with every opinion in all of them. In fact, many of the opinions I agree with many of these providers," and that time and extensive treatment could explain some of the differences in the expert opinions. *Id*. 53:15-54:8. He also explained that "evidence-based medicine" is part of a medical trend to rely on "well documented studies to prove disease causation or treatment recommendations that they truly are effective, and so we rely on that now to make sound medical decisions. In other words, it's been peer-reviewed type material that's been published for clinicians to refer to. *Id*. 54: 14-

21. Evidence based medicine is the cumulative result of "well done studies" and "knowledge gained from attending national meetings, talking to your peers, review results with people, teaching: It relies on all that." *Id*. 55: 2-8; 56:8-13.

DISCUSSION

Credibility

91. The Referee observed that Claimant appeared at hearing to be fairly stoic. The Referee believed that Claimant understands English better than he speaks it. While the Referee found the interpreter to be helpful, the Referee noted that the language barrier obscured his ability to gauge how realistic Claimant's expectations are about future medical treatment ameliorating his pain. Otherwise, the Referee found that Claimant appears entirely credible.

92. The Referee found Claimant's credibility is important because the medical history of his symptoms shows intermittent presence and absence, as well as waxing and waning, of multiple specific complaints about his right upper extremity. Physicians have generally found Claimant's reports of symptoms to be anatomically consistent with expected nerve distribution patterns. The record does not indicate Claimant is exaggerating the location or intensity of his symptoms. Because Claimant is credible, these reported symptoms are accepted as genuine. They are neither consciously manufactured nor histrionic. The Commission finds no reason to disturb the Referee's findings and observations on Claimant's presentation or credibility.

Causation

93. A claimant must prove that he was injured as the result of an accident arising out of and in the course of employment. *Seamans v. Maaco Auto Painting*, 128 Idaho 747, 751, 918 P.2d 1192, 1196 (1996). Proof of a possible causal link is not sufficient to satisfy this burden. *Beardsley v. Idaho Forest Industries*, 127 Idaho 404, 406, 901 P.2d 511, 513 (1995). 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, 785, 890 P.2d 732, 736 (1995). Magic words are not necessary to show a doctor's opinion is held to a reasonable degree of medical probability; only their plain and unequivocal testimony conveying a conviction that events are causally related. *Jensen v. City of Pocatello*, 135 Idaho 406, 412-13, 18 P.3d 211, 217-18 (2001). Aggravation, exacerbation, or acceleration of a pre-existing condition caused by a compensable accident is compensable in Idaho Worker's Compensation Law. *Nelson v. Ponsness-Warren Idgas Enterprises*, 126 Idaho 129, 879 P.2d 592 (1994). 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). However, facts 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).

94. Here, the parties dispute which conditions were caused by the occupational exposure, and whether those have resolved. Certain conditions, such as Claimant's right carpal tunnel syndrome and his right shoulder sprain and impingement (twice surgically treated), have been acknowledged by parties to be caused by the Claimant's work as a chef. However, Claimant contends that he has ongoing symptomatology that is referable to thoracic outlet syndrome, and perhaps other conditions as well. Claimant contends that this is a component of his occupational disease and that he should be allowed a referral to the University of Washington for treatment.

95. Claimant relies on Drs. Dunteman and Janes to provide the needed medical opinion to establish the causal relationship between his pre-2006 occupational disease exposures and his current condition.

96. Primarily, Dr. Dunteman's testimony expressed his concurrence with the premise of leading questions posed by Claimant's Counsel, with little elaboration or discussion of why Claimant's current condition, and specifically the thoracic outlet syndrome, was related to his occupational exposure. His repeated one word answer of "Correct" failed to assist in illuminating his opinions or convincingly explain why his "check-the-box" agreements with multiple physicians left him espousing opinions which directly contradict each other.

97. Dr. Dunteman's medical records, including those from his PA, are similarly opaque on the matter. The Referee found that the medical records had some inconsistent boilerplate which severely undercut the weight assigned to these physicians' notes made after September 2010. Although he feels a referral for thoracic outlet syndrome is reasonable, Dr. Dunteman's deferral to a specialist's evaluation, which has not occurred, does not shine light on the much-disputed causation issue surrounding thoracic outlet syndrome.

98. Dr. Janes was not deposed to elaborate on his findings, and his report does not offer a convincing opinion on causation. Dr. Janes acknowledged Claimant's work and medical history, without expressly correlating Claimant's present condition to his occupational disease. Ex. H. Whether or not certain medical care is reasonable is a different issue from whether or not the need for such care was caused by the industrial accident. Even though medical care is reasonable, it is still not compensable unless the care was due to the industrial accident. *Henderson v. McCain Foods, Inc.*, 142 Idaho 559, 564, 130 P.3d 1097, 1104 (2006) While Dr. Janes opined that it would be reasonable to have additional studies at the University of

Washington in Seattle, that does not mean that this treatment would necessarily be causally related to his industrial disease.

99. Claimant submitted a substantial amount of general medical literature taken from the internet in Claimant's Exhibits R through U and X. While helpful in providing general background for the various diagnoses that physicians have entertained, the internet research is not a substitute for persuasive medical testimony about Claimant's individual condition or causation. Actual medical records and physicians' opinions of record receive weight as evidence.

100. Dr. Hofmeister's deposition testimony explained why Claimant was not in need of any further medical treatment regarding his occupational disease, and why the proposed diagnosis of thoracic outlet syndrome was not related to Claimant's work. He opined that Claimant's right carpal tunnel syndrome, and right shoulder sprain and impingement, were accepted and related to the occupational disease claim. He opined that Claimant's multi-level cervical spondylosis was the result of the aging process, and could not be attributed to Claimant's occupational disease. Dr. Hofmeister also explained that the mild compression of the ulnar nerve at Guyon's canal with mild compression at the cubital tunnel were not related to Claimant's occupational disease, as the evidence was thin. While Dr. Hofmeister acknowledged Dr. Greendyke's numerous diagnoses, he did not agree with all of them. He explained that some of these disagreements could be attributed to the passage of time and treatment. Dr. Hofmeister acknowledged that it has been about four years since Dr. Brinkman's last evaluation, and almost one or two more years with further treatment since Dr. Greendyke's evaluation. Hofmeister Depo.: 53:15-54:8.

101. Claimant's assertion is not well taken that Dr. Hofmeister's approach to his opinions disqualifies these opinions from consideration.[3] One would hope that every medical expert would examine the evidence of record and apply his scientific knowledge to any particular claimant before opining about causation. The Commission is persuaded by Dr. Hofmeister's explanation that evidence-based medicine is premised on well-documented and peer-reviewed studies; the Commission cannot find fault with physicians using thorough medical research to improve the practice of medicine. To be clear, Dr. Hofmeister's opinion was not a generic ivory-tower proclamation; he evaluated Claimant's personal medical records and conducted a physical evaluation. Claimant's experts did not disclose whether their own opinions were based on evidence-based medicine, or explain why Dr. Hofmeister's use of it was faulty in Claimant's unique circumstances.

102. Although Claimant has not advocated specifically for additional treatment of double crush syndrome or Kienböck's disease, multiple physicians have entertained these diagnoses. Dr. Greendyke first considered the possibility that Claimant had industrially related double crush syndrome, and ordered an MRI for verification. However, after reviewing the MRI results, the MRI did not validate double crush syndrome as an explanation for Claimant's persistent right hand complaints, but suggested right trapezius pain related to a cervical spine impingement at C3-4 and narrowing at C4-5. As noted, Dr. Greendyke eventually concluded that Claimant's lunate condition did not represent Kienböck's disease. Dr. Greendyke referred

[3] Claimant was critical of Dr. Hofmeister's use of "Evidence-Based Medicine," as inappropriate to diagnose a very rare diagnosis, such as thoracic outlet syndrome. Claimant argued that Dr. Hofmeister's opinions should not be afforded weight because he lacked knowledge of this particular claimant's fundamentally necessary information to make a valid diagnosis and causation opinion and he was inherently biased. Claimant's Brief, 20. The Commission rejects these arguments. Dr. Hofmeister performed a thorough examination of Claimant and reviewed numerous medical records, and explained his conclusions. While Evidence-Based Medicine provided awareness of patterns in the patient population, it did not substitute for an evaluation of Claimant's particular condition. Claimant argues vehemently against Evidence-Based Medicine, yet submits unverified internet research as evidence he expects the Commission to consider.

Claimant to Dr. Ludwig for additional evaluation of his cervical spine. Dr. Ludwig recommended a course of cervical spine injections. Thereafter, Dr. Ludwig found Claimant medically stable and stated that he would not address causation. Even so, he expressly acknowledged that Claimant's conditions could be the result of "age appropriate degenerative changes." Ex. 6:229.

103. Dr. Janes assessed double-crush syndrome on the right and left involving the cubital tunnel as the distal component, and thoracic outlet syndrome as the primary component. However, Dr. Janes' report lacks a clear causation opinion, and it is of little help in determining Claimant's industrially related conditions. Dr. Janes also did not offer testimony via deposition, which leaves us without clarity on his opinions and the reasoning behind them.

104. For similar reasons, Dr. Dunteman's opinions are not persuasive. Dr. Dunteman is certainly committed to referring Claimant for additional workup for thoracic outlet syndrome, but his deposition testimony lacked an explanation for whether these conditions exist and why these conditions are industrially related.

105. Dr. Hofmeister did not diagnose Kienböck's disease or double crush syndrome, and disagreed that Claimant's remaining cervical spine issues are industrially related. While noting there was evidence of "mild compression of the ulnar nerve of Guyon's canal and thoracic outlet syndrome," he did not describe this compression to be double crush syndrome. Most importantly, Dr. Hofmeister did not believe these conditions were industrially related. Hofmeister Depo.: 195. Double crush syndrome was been raised by multiple physicians, but the evidence is conflicting and inconclusive on the matter of causation.

106. In summary, the Commission finds Dr. Hofmeister's opinion more persuasive. Claimant has shown that his right shoulder sprain and impingement, and right carpal tunnel

syndrome arise as a result of his work activity. Claimant has failed to prove that multi-level cervical spondylosis, mild compression of the ulnar nerve at Guyon's canal, cubital tunnel syndrome, double crush syndrome, Kienböck's disease, thoracic outlet syndrome on the right upper extremity and the left extremity, left carpal tunnel syndrome, right trapezius myalgia are causally related to his employment.[4]

Maximum Medical Improvement

107. A claimant's "period of recovery" ends upon achieving maximum medical improvement. *Hernandez v. Phillips*, 141 Idaho 779, 118 P.3d 111 (2005). Continued pain is not evidence supporting a lack of medical stability. *Shubert v. Macy's West, Inc.*, 158 Idaho 92, 343 P.3d 1099 (2015).

108. Claimant was declared fixed and stable by Dr. Dunteman as of August 26, 2010 after the first shoulder surgery. Indeed, Claimant sought no relevant treatment for more than two years after September 2010 when Dr. Dunteman made the above declaration.

109. Claimant was declared fixed and stable by Dr. Dunteman as of December 23, 2013 after the second shoulder surgery, and given a 10% PPI of the upper extremity for the distal clavicle excision. Ex. 2:92.

110. Treatment since that date has been diagnostic or palliative. The preponderance of medical opinion does not suggest that surgery or other treatment will likely be curative. Despite the waxing and waning of intermittent symptoms, the preponderance of evidence supports a date no later than December 23, 2013 as the date of medical stability.

[4] In his proposed decision, the Referee concluded that Claimant had "not shown it likely that a C-spine condition was caused by work" and denied the referral for thoracic outlet syndrome. Recommendation, 24.

Temporary Disability

111. Eligibility for and computation of temporary disability benefits are provided by statute. Idaho Code §72-408, *et. seq*. Upon medical stability, eligibility for temporary disability benefits does not continue. *Jarvis v. Rexburg Nursing*, 136 Idaho 579, 38 P.3d 617 (2001). An injured worker who is unable to work while in a period of recovery is entitled to temporary disability benefits under the statutes until he has been medically released for work and Employer offers reasonable work within the terms of the medical release. *Malueg v. Pierson Enterprises*, 111 Idaho 789, 727 P.2d 1217, (1986).

112. TTD benefits were identified as an issue, but the parties did not advance the matter. Claimant has been stalwart in continuing to work, and has not shown that any additional temporary disability benefits are owed.

Medical Care

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

medical helicopter transport of claimant following his finger injury was reasonable medical care). Reasonable medical treatment may include palliative measures even though they are not curative. *Poss v. Meeker Machine Shop*, 109 Idaho 920, 925, 712 P.2d 621, 624 (1985) (denial of pain medication and additional physical therapy was supported by the evidence). Reasonable medical treatment benefits may continue for life; there is no statute of limitation on the duration of medical benefits under Idaho Workers' Compensation Law. *See*, Idaho Code § 72-706(5) (right to medical benefits not affected by statute of limitations).

114. Here, Claimant suffers an occupational disease associated with the work activity of chopping meat and vegetables in his employment prior to 2006. The Referee found his presentation credible, and that Claimant's symptoms related to the accepted conditions may recur intermittently and that the physicians do not believe Claimant likely can be surgically cured.

115. At this juncture, the parties' arguments on medical care have centered on the reasonableness of Claimant's referral to the University of Washington for thoracic outlet syndrome evaluation and treatment. Because Claimant has not proven that thoracic outlet syndrome is causally related to the demands of his employment, the Commission cannot award that referral for treatment. Claimant is entitled to future medical treatment for the conditions found compensable in this decision. Defendants are obligated to provide such future care as may be required pursuant to the provisions of Idaho Code § 72-432.

Permanent Impairment

116. 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).

117. Physicians generally agree upon a 10% upper extremity permanent impairment caused by work. Claimant has proven his entitlement to a 10% upper extremity impairment

Permanent Disability

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

119. 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).

120. 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).

121. The Commission finds Mr. Crum's vocational testimony persuasive. He opined that without any physician-imposed permanent restrictions, and given that Claimant had continued to work for Employer for a significant time and was employed by the next employer, and given that Claimant's current wage was greater than at the time of his claim, Claimant suffered no permanent disability. Ex. 27: 707; Crum Deposition: 707-708.

122. The record supports that Claimant has continued to work for over a decade after the onset of his occupational disease, and Claimant does not have physician imposed permanent restrictions, and was found stable in 2013.

123. Claimant has failed to establish entitlement to permanent disability in excess of 10% right upper extremity impairment.

124. Apportionment pursuant to Idaho Code § 72-406. Idaho Code § 72-406 (1) provides that in cases of permanent disability less than total, if the degree or duration of disability resulting from an industrial injury or occupational disease is increased or prolonged because of a pre-existing physical impairment, the employer shall be liable only for the additional disability from the industrial injury or occupational disease. The evidence presented does not lend itself to the quintessential two-step process apportionment analysis outlined by the Court in *Page*. Claimant has shown his entitlement to permanent disability of 10% right upper extremity, without apportionment.

Attorney Fees

125. The final issue is Claimant's entitlement to attorney fees pursuant to Idaho Code § 72-804. Attorney fees are not granted as a matter of right under the Idaho Workers' Compensation Law, but may be recovered only under the circumstances set forth in Idaho Code § 72-804 which provides:

> If the commission or any court before whom any proceedings are brought under this law determines that the employer or his surety contested a claim for compensation made by an injured employee or dependent of a deceased employee without reasonable ground, or that an employer or his surety neglected or refused within a reasonable time after receipt of a written claim for compensation to pay to the injured employee or his dependents the compensation provided by law, or without reasonable grounds discontinued payment of compensation as provided by law justly due and owing to the employee or his dependents, the employer shall pay reasonable attorney fees in addition to the compensation provided by this law. In all such cases the fees of attorneys employed by injured employees or their dependents shall be fixed by the commission.

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

126. Applying Idaho Code § 72-804, Defendants have acted reasonably at all times. In hindsight, they have been patient and willing to consider newly-raised, possible, diagnoses as Claimant has seen numerous doctors in his attempt to identify and resolve his symptoms. Claimant failed to establish that he is entitled to an award of attorney fees.

CONCLUSIONS OF LAW AND ORDER

1. Claimant has shown that his right shoulder sprain and impingement, and right carpal tunnel syndrome arise as a result of his work activity;

2. Claimant has failed to prove that multi-level cervical spondylosis, cervical spine disease mild compression of the ulnar nerve at Guyon’s canal with mild compression at the cubital tunnel, double crush syndrome, Kienböck's disease, thoracic outlet syndrome on the right upper extremity and the left extremity, left carpal tunnel syndrome, right trapezius myalgia are causally related to his employment;

3. Claimant was medically stable as of December 23, 2013;

4. Claimant is entitled to future medical treatment for the conditions found compensable in this decision. Defendants are obligated to provide such future care as may be required pursuant to the provisions of Idaho Code § 72-432;

5. Claimant failed to show he is entitled to temporary disability benefits beyond those previously paid;

6. Claimant is entitled to permanent disability rated at 10% of the upper extremity, inclusive of the same rating for permanent impairment, without apportionment; and

7. Claimant failed to show he is entitled to an attorney fee award;

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

DATED this ___8th___ day of ____July_____, 2019.

INDUSTRIAL COMMISSION

_____/s/_____
Thomas P. Baskin, Chairman

_____/s/_____
Aaron White, Commissioner

_____/s/_____
Thomas E. Limbaugh, Commissioner

ATTEST:

_____/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the _____8th_____ day of _____July_____, 2019, a true and correct copy of the **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** was served by regular United States Mail upon each of the following:

STARR KELSO
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_____/s_____