BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

LONNIE LABBEE, Claimant, v. RUSH INTERNATIONAL TRUCK CENTER, Employer, and NEW HAMPSHIRE INSURANCE COMPANY, Surety, Defendants.	**IC 2014-026012** **FINDINGS OF FACT, CONCLUSION OF LAW, AND RECOMMENDATION** **FILED** **10 JANUARY 2020**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Alan Taylor. Claimant, Lonnie Labbee, was represented by Andrew A. Adams, of Idaho Falls. Defendant Employer, Rush International Truck Center (Rush), and Defendant Surety, New Hampshire Insurance Company, were represented by Eric S. Bailey, of Boise. The parties agreed to submit the case on a Stipulation of Facts and presented documentary evidence on September 20, 2019. Briefs were submitted and the matter came under advisement on September 24, 2019.

ISSUE

The sole issue presented is whether Claimant's current need for medical treatment, specifically total shoulder replacement, is due to his industrial accident.

CONTENTIONS OF THE PARTIES

All parties acknowledge that Claimant sustained an industrial accident on September 18, 2014. The parties agree that Claimant is in need of a total right shoulder

replacement. Claimant asserts his need for shoulder replacement is due to his industrial accident that permanently aggravated his pre-existing right shoulder condition. Defendants assert his accident only temporarily aggravated his shoulder and his current need for replacement is due to the natural progression of his pre-existing condition.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The Industrial Commission legal file;
2. Joint Exhibits 1-21 submitted by stipulation of the parties.
3. The parties' stipulation of facts dated September 16, 2019;
4. The deposition testimony of Nathan Richardson, M.D., taken by Claimant on April 30, 2019, and constituting Joint Exhibit 19;
5. The deposition testimony of Thomas Faciszewski, M.D., taken by Defendants on May 28, 2019, and constituting Joint Exhibit 20; and
6. The deposition testimony of Richard Wathne, M.D., taken by Defendants on June 11, 2019, and constituting Joint Exhibit 21.

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

FINDINGS OF FACT

1. Claimant described two prior shoulder injuries; the first approximately 22 years ago while mowing lawns in Arizona; and, the second eight years later when working on a truck at Idaho Truck & Trailer. (Ex. 12, p. 254). Industrial Commission records reflect an injury suffered at Idaho Truck & Trailer on August 24, 1995. (Ex. 2, p. 3). Claimant underwent a right

shoulder open Bankart reconstruction by Richard Wathne, M.D., in approximately 1999. [1] (Ex. 6, pp. 48-49, 54, 67). Medical records are not available at this time relating to Claimant's 1999 shoulder surgery.

2. Claimant was age 47 and became employed by Rush International Truck as a full time service technician/diesel mechanic commencing January 21, 2011. (Ex. 1).

3. On May 10, 2011, Claimant suffered a crush injury to his nondominant left thumb while installing a leaf spring in a garbage truck. (Ex. 2, p. 10; Bx. 3, p. 35). He presented for treatment at the emergency room of the Eastern Idaho Regional Center on the date of injury for evaluation of an open fracture of the left thumb distal phalanx. Following consultation with a plastic surgeon, he underwent surgical repair by Dr. Brian Bruggeman on May 11, 2011. (Ex. 3, pp. 36-37). Hardware was removed on June 6, 2011, and thereafter he continued treatment with Dr. Bruggeman. On August 29, 2011, Dr. Bruggeman reported Claimant had recovered and was working and utilizing his thumb without significant complaints, and he recommended evaluation for an impairment rating. (Ex. 4 p. 39). IME physician Dr. David C. Simon evaluated Claimant on September 8, 2011, arriving at a diagnosis of crush injury to the left thumb with open fracture of the distal phalanx, left thumb now shorter than the right, with residual thumb pain and reduced range of motion. Dr. Simon found Claimant MMI with a 15% impairment of the thumb, which corresponded to a 5% upper extremity or 3% whole man PPI rating. (Ex. 4, p. 41).

4. Accident. On September 18, 2014, Claimant was climbing out of a semi-truck at work when he missed a step and reached out with his right hand to brace his fall onto the shop floor.

[1] The parties' stipulation of facts describes the 1999 procedure as a "right shoulder arthroscopy." Stipulation of Facts, p. 16. However, subsequent descriptions of Claimant's right shoulder scarring and other records confirm this was an open surgical procedure.

5. Post-Accident Medical History. Claimant was initially evaluated at Mountain View Hospital Community Care in Idaho Falls on September 18, 2014, for right wrist pain and buttocks contusion. Right wrist x-rays showed no fractures or foreign bodies, no erosions, and no soft tissue calcifications. (Ex. 5, p.44). The provider assessed right wrist sprain and buttocks contusion. (Ex. 5, p. 45). Claimant returned on October 6, 2014 with resolved wrist pain but anterior right shoulder pain that was present for the prior several days. (Ex. 5, p. 46). On exam, Claimant had full range of motion but pain with overhead movement. He reported a history of prior right shoulder surgery. Claimant was referred for orthopedic evaluation.

6. Claimant was evaluated by Justin Pool, PA-C at Pocatello Orthopedics & Sports Medicine on October 15, 2014. PA-C Pool recorded a history as follows:

> He was climbing out of his semi-truck while at work when he slipped. He is not sure how he landed but thinks that all of his weight went to his buttocks and to his right hand. Putting his hand down jammed his shoulder in a superior manner. He had immediate pain and was seen at Community Care in Idaho Falls. He was told that x-rays were ok at that time. Since then, he has not been able to fully flex his arm above his head without moderate to severe pain. He says that this is worse with abduction of the arm. He also has pain when reaching out and back. He has had a history of shoulder dislocations about 10-15 years ago and says he was operated on by Dr. Selznick or Dr. Wathne. He is unclear about the type of procedure but has a longitudinal scar over the anterior aspect of the shoulder.

(Ex. 6, p. 48). Based on the previous history of dislocations and the surgical scarring, PA-C Pool assessed a prior history of Bankart reconstruction. (Ex. 6, p. 49). He opined the examination on this date was consistent with a shoulder subluxation. He referred Claimant to outpatient physical therapy and continued anti-inflammatories (ibuprofen). He released Claimant to work with care in reaching above his head and with external rotation of the shoulder.

7. Claimant began a course of physical therapy with Randy C. Sidwell, PT, MS, ATC, at Advanced Performance Physical Therapy on October 21, 2014. (Ex. 7). PA-C Pool

noted some improvement with physical therapy on follow-up exams on November 20, 2014, and December 18, 2014, though Claimant still complained of tightness and pain. (Ex. 6, pp. 52-53).

8. Claimant was evaluated by Dr. Richard A. Wathne on January 21, 2015. (Ex.6, p. 57). X-rays revealed post-surgery hardware in the glenoid and humeral head, minimal degenerative changes and no calcifications, and mild degenerative changes in the AC joint and Type II acromion. Based on Claimant's exam and the radiological findings, Dr. Wathne assessed dislocation of the right shoulder, right shoulder pain, and right rotator cuff tendonitis. He referred Claimant for an MRI.

9. The MRI with contrast on February 3, 2015 revealed postsurgical changes versus tear of the subscapularis tendon, SLAP lesion, and degenerative joint disease of the glenohumeral joint and the AC joint. (Ex. 6, pp. 59-60). On follow-up evaluation on February 12, 2015, Dr. Wathne recommended right shoulder arthroscopic evaluation with revision of the Bankart reconstruction with possible subscapularis tendon repair. (Ex. 6, p. 63). He cautioned that the procedure might be converted to a mini-open repair or Latarjet procedure as needed. (Ex. 6, pp. 63-64).

10. In response to an inquiry by the Surety, on February 23, 2015, Dr. Wathne indicated Claimant had likely sustained a subluxation episode to the right shoulder in the fall on September 18, 2014. (Ex. 6, pp. 67 and 112). He further indicated the MRI revealed a disruption of the prior open repair, for which he recommended an arthroscopic evaluation with anticipated revision capsulolabral reconstruction (Bankart) procedure. He related the need for surgery, on a more probable than not basis, to the industrial accident of September 18, 2014. In the pre-op evaluation on April 2, 2015, Dr. Wathne also noted Claimant's continued complaints of ongoing right radial wrist pain since the original industrial accident. (Ex. 6, p. 68). Exam of the wrist

revealed no swelling or effusion, but Claimant had tenderness in the snuffbox as well as over the scaphoid tubercle volarly. (Ex. 6, p. 70). He had minimal tenderness over the radial styloid and a negative Finkelstein's test. There was no ulnar-sided tenderness. Range of motion was from 50 degrees of wrist extension to 50 degrees of wrist flexion. Wrist x-rays revealed mild degenerative changes in the radiocarpal joint and scaphotrapezial joint, with narrowing and radial deviation between the radial styloid and scaphoid, but no fractures or surrounding calcifications. Claimant denied discomfort with radial or ulnar deviation. Dr. Wathne assessed right shoulder pain with subtle instability and SLAP lesion following an on-the-job injury, and right radial-sided wrist pain without fracture. Dr. Wathne recommended proceeding with right shoulder surgery. (Ex. 6, pp. 70-71).

11. On April 8, 2015, Dr. Wathne performed arthroscopy of the right shoulder with arthroscopic revision Bankart capsule labral stabilization, arthroscopic debridement and synovectomy, and mini open biceps tenodesis. (Ex. 6, p. 72; Ex. 8, pp. 143-162). Claimant resumed physical therapy with Randy Sidwell, PT, at Advanced Performance Physical Therapy. (Ex. 7, p. 124). Therapy notes reflect Claimant continued to have painful limited range of motion, weakness, and difficulty sleeping. He also continued to complain of right radial wrist pain. (Ex. 7, p. 131-140). Post-surgery, Dr. Wathne and/or PA-C Pool kept Claimant off work or on light duty, which employer was not able to accommodate. (Ex. 6, pp. 76-85).

12. Dr. Wathne provided a subacromial corticosteroid injection on July 14, 2015. (Ex. 6, pp. 86-88). On follow-up visits on August 6 and September 3, 2015, Claimant demonstrated improved active range of motion in external rotation, and better resistance to deltoid rotator cuff testing, but Claimant still reported pain through the arc or range of motion, especially in abduction. (Ex. 6, pp.89-92). Due to persistent symptoms and physical limitations.

Dr. Wathne ordered a repeat MRI on September 17, 2015 to determine if there was some intra-articular pathology producing ongoing pain and dysfunction. (Ex. 6, p. 92). The MRI showed postoperative changes, advanced osteoarthrosis of the right glenohumeral joint, absence of the superior, anterior, and antero inferior labral segments, nonvisualized intracapsular segment long biceps tendon, and tendinopathy and a partial thickness bursal sided tear of the distal supraspinatus, diffuse irregularity and heterogeneity from the prior surgery and tendinopathy of the subscapularis, and possible partial tear of the subscapularis. (Ex. 6, pp. 93-94).

13. On follow-up evaluation on October 6, 2015, Dr. Wathne noted degenerative changes and intra-articular debris or loose bodies in the inferior axillary recess, and a small partial-thickness bursal side supraspinatus tear shown on MRI. (Ex. 6, pp. 97). Based on Claimant's failure of conservative management and chronic symptoms, Dr. Wathne recommended right shoulder arthroscopic debridement/stabilization/decompression and mini open biceps tenodesis. (Ex. 6, p. 98). In the pre-op history and physical (dated October 6, 2015, but corrected and signed by Dr. Wathne on November 6, 2015), Claimant indicated his desire to proceed with surgical intervention to include a right shoulder arthroscopy debridement and removal of loose bodies. (Ex. 6, p. 99-101).

14. Claimant sought a second opinion evaluation by Nathan D. Richardson, M.D., on November 25, 2015. (Ex. 9, p. 186). Claimant reported no improvement following the April 2015 right shoulder surgery. Dr. Richardson noted the MRI findings of moderate arthritis of the glenohumeral joint, (Ex. 9, p. 187). Dr. Richardson assessed right shoulder osteoarthritis, for which he recommended a total shoulder arthroscopy. However, he advised he needed copies of the April 2015 arthroscopic radiological imaging to help clarify the diagnosis,

15. Dr. Wathne performed a second post-accident surgery at Portneuf Medical Center on December 9, 2015, including arthroscopy of the right shoulder with extensive debridement both in the glenohumeral joint and subacromial space along with removal of nonabsorbable ruptured suture. (Ex. 6, pp. 54-56, and 103-105; Ex. 8, pp. 173-185). On December 17, 2015, PA-C Pool referred Claimant back to outpatient physical therapy for range of motion and strengthening. (Ex. 6, pp. 106-107). Claimant reported some improvement to Dr. Wathne at the post-operative evaluation on February 16, 2016, noting less catching in the shoulder, and objective testing revealed improved active range of motion with elevation, abduction, and external rotation. (Ex. 6, pp. 108-109). Claimant was off work as there was no light duty available for him. (Ex. 6, p. 108). Claimant remained off work and reported steady progress with physical therapy at his evaluation on February 16, 2016. (Ex. 6, pp. 110-111). On March 15, 2016, Claimant reported he was doing better but had only been attending physical therapy once a week due to a family medical illness. (Ex. 6, p. 113). Dr. Wathne released Claimant to modified duty work as of March 21, 2016, with restrictions of 25 pounds lifting in the right upper extremity, no above shoulder lifting, and limited reaching or pulling with the right upper extremity. (Ex. 6, p. 114).

16. On April 12, 2016, Dr. Wathne moved Claimant from formal physical therapy to a home exercise program and released him to full work duties without restrictions. (Ex. 6, pp. 115-117). On follow-up evaluation on May 24, 2016, Claimant reported limited range of motion and pain. (Ex, 17, p. 398). He complained that at work he had episodes of extreme pain and numbness, with tingling down to his hand. He also reported he was working in his job as a diesel mechanic but had difficulty getting into certain positions due to right shoulder pain. Dr. Wathne advised Claimant that it may take a few more months to establish a baseline.

17. On July 5, 2016, Dr. Wathne indicated Claimant had returned to full work duties, though he still had some reported difficulties with certain positions due to lack of motion and discomfort. (Ex. 17, p. 400). On exam, Claimant had limitations in his active range of motion due to discomfort, he lacked 30 degrees of forward elevation and abduction, but he had good external rotation and was able to resist to deltoid and rotator cuff testing with some discomfort. Dr. Wathne indicated Claimant had reached a plateau. Claimant was to continue a strengthening program on his own pending a return visit for a permanent impairment rating.

18. On August 2, 2016, Dr. Wathne found Claimant had successfully returned to full duty work in June of 2016, and at this point he had reached maximum medical improvement. (Ex. 6 pp. 118-119). He assigned a 15% right upper extremity impairment rating pursuant to the AMA Guides, with one-third apportioned to pre-existing conditions, leaving him with a 10% right upper extremity permanent partial impairment (PPI) rating related to the industrial injury of September 18, 2014. (Ex. 6, p. 119). Dr. Wathne released Claimant to full work duties without restrictions. He cautioned, however, that Claimant would try to avoid certain positions that cause him significant discomfort. Claimant was to continue strengthening exercises on a routine maintenance basis, and take ibuprofen and tramadol as needed for discomfort, with weaning off tramadol over the following couple months. Dr. Wathne was to follow Claimant on an as-needed basis.

19. Claimant sought treatment at Health West Chubbuck for multiple medical issues, including shoulder pain on August 11, 2016. (Ex. 10, pp. 211-212). His care on that date was primarily for nonindustrial medical issues. Then on August 17, 2016, Claimant complained that his worker's compensation claim had been closed though he still had persistent shoulder pain impacting his work as a mechanic. (Ex. 10, p. 209). On exam, Brandi Karroum, NP-C, noted

tenderness on palpation of the acromioclavicular joint, tenderness on palpation at the clavicle, limited range of motion, and pain with external rotation and abduction against resistance. (Ex. 10, p. 210). NP Karroum refilled a prior Tramadol prescription with alternating ibuprofen and Tylenol. On October 7, 2016, NP Karroum called in a Tramadol refill. (Ex. 10, pp. 208-209)

20. Claimant returned to Dr. Wathne on November 10, 2016, having recently been terminated from his job at Triple L Towing. (Ex. 6, pp. 120-121; Ex. 14, pp. 367-369; Claimant depo. 11/11/17). Claimant advised Dr. Wathne that he lost his job because he was unable to perform his work duties. (Ex, 6, p. 120). Dr. Wathne recommended vocational rehabilitation based on the representation that Claimant was physically unable to perform job duties as a diesel mechanic. He assigned restrictions of no lifting above the shoulder level and no lifting greater than 20 pounds in the right upper extremity.

21. Triple L Towing's Separation Statement and related correspondence reflects Claimant was terminated on November 4, 2016, due to performance issues, including, failure to answer phone dispatches, being unavailable to perform duties when on an on-call status, failure to keep dispatch informed on status of work and location, excessive time on towing and shop jobs. (Ex. 14, pp. 367-369). Claimant disputed the allegations and successfully obtained unemployment benefits. (Claimant depo. p 13, l. l -p. l4, 1. 24).

22. A Functional Capacity Evaluation by Briggs Horman, PT, at Peak Performance Therapy Services was conducted on December 6, 2016. (Ex. 11). Based on multiple factors, PT Horman found the testing a valid representation of Claimant's physical capacity. (Ex. 11, p. 237). Claimant reported a self-estimated perception of disability at 80% disabled due to his right shoulder injury. (Ex. 11, p. 234). Normal average range-of-motion for shoulder flexion is 0-180 degrees, abduction 0-180 degrees, and external rotation 0-90 degrees. In comparison, Claimant

demonstrated average range of motion as follows: 0-157 flexion on the left and 0-98 on the right; 0-146 abduction on the left and 0-53 on the right; and, 0-75 external rotation on the left and 0-29 on the right. (Ex. 11, p. 235). Peak grip was measured at 94 pounds on the right and 64 pounds on the left. Notably, Claimant is right-hand dominant, and he has a left distal thumb amputation from a prior industrial injury. His fine motor dexterity was comparable as between the left and right. (Ex. 11, p. 236). Claimant scored "poor" for fitness testing. There were differences noted in strength as between the left and right shoulders, and deficits in strength between front to back of the shoulders. In summary, PT Horman concluded Claimant met the Light Medium Physical Demand Classification of lifting or carrying 38.5 pounds. (Ex. 11, p. 237). Claimant scored in the 10th percentile for endurance and work tolerance, he demonstrated he greatly favored his right shoulder and had deficits in grip, range-of-motion, and strength on the right, and he needed the left hand/shoulder to perform many tasks. (Ex. 11, p. 238).

23. Two years after his last evaluation by Dr. Richardson, Claimant returned for a second opinion evaluation and for help with ongoing care on July 7, 2017. (Ex. 9, pp. 188-190). He noted the subscapularis repair approximately 20 years prior, and his November 2015 exam findings of advanced osteoarthritis of the glenohumeral joint with some question as to whether the subscapularis was functional based on Claimant's physical exam and the MRI. (Ex. 9, p. 188). X-rays at this visit revealed moderate to severe glenohumeral arthritis with an inferior humeral head bone spur, normal AC joint, and retained hardware from the two prior surgeries. (Ex. 9, p, 190). Dr. Richardson assessed osteoarthritis of the right shoulder and right subscapularis tear. He recommended a diagnostic ultrasound of the subscapularis and an ultrasound-guided injection by Dr. Jared M. Kam to assess pain relief.

24. Dr. Kam conducted a diagnostic ultrasound of the right shoulder on July 14, 2017. (Ex. 9, p. 193). Based thereon, he assessed degenerative thinned or significantly torn subscapularis tendon on the right. Then per Dr. Richardson's recommendation, Dr. Kam provided an ultrasound-guided injection. On follow-up on August 4, 2017, Dr. Kam noted Claimant responded well to the injection. (Ex. 9, p. 194). However, the doctor expressed concerns about possible partial subscapularis tearing and degenerative arthrosis identified on the ultrasound, and he recommended follow-up evaluation by Dr. Richardson to discuss surgical options. (Ex. 9, p. 195).

25. On August 23, 2017, Dr. Richardson noted Dr. Kam's concerns about the subscapularis tendon. (Ex. 9, p. 196). Claimant reported that his left bicep pain was gone, but he still had limited range-of-motion. He also reported that his left arm was painful due to compensating for his right arm. Dr. Richardson recommended a new MRI of the subscapularis tendon, expressing concerns that a tear would compromise the outcome of a shoulder replacement surgery. He instructed Claimant on a home exercise regimen to work on strength and motion in the left shoulder pending the MRI and further definitive assessment.

26. Claimant was in the news in September of 2017 as the subject of a large-scale search with another person apparently lost while hunting near the city of Inkom in eastern Idaho. (Ex. 15, p. 370 2). The search was considered urgent due to concerns about Claimant's heart condition. Emergency responders found the two hunters in good condition the following day after spending the night in the backcountry. (Ex. 15, p. 371 D 5).

27. A right shoulder MRI on February 3, 2018 at Portneuf Medical Center was interpreted by Brett Talbot, MD, as compared to the MRI on September 17, 2015, showing progressive glenohumeral degenerative changes, with similar-appearing rotator cuff

tendinopathy with suspected low-grade partial-thickness tearing in the subscapularis. (Ex. 17, p. 401). The intra-articular long head biceps tendon was not seen. There were postsurgical changes of the labrum. Claimant returned for follow-up evaluation by Dr. Richardson on February 9, 2018 to review the MRI results. (Ex. 17, p. 403). Dr. Richardson felt the MRI findings demonstrated that the subscapularis was still intact and "good enough" to support a shoulder replacement. He added, a shoulder replacement was the only surgery he would recommend at that time, and Claimant could elect to have the surgery when he felt ready.

28. Claimant was scheduled for an Independent Medical Evaluation by Tom G. Faciszewski, M.D., on February 22, 2018. Claimant was unable to attend the IME due to illness. Accordingly, Dr. Faciszewski prepared a records review on February 23, 2018. (Ex. 12, pp. 240-251). Dr. Faciszewski diagnosed subluxation event, right shoulder, related to the claimed injury of September 18, 2014. (Ex. 12, p. 248). He found Claimant medically stable as of August 2, 2016 in connection with this industrial injury, and assigned 10% upper extremity 6% whole man PPI rating. He agreed with Dr. Wathne's apportionment of 2/3 related to the industrial injury. (Ex. 12, pp. 249-250). This equates to a 4% whole man PPI rating relating to the industrial injuries. (Ex. 12, p. 250).

29. As to non-industrial conditions, Dr. Faciszewski assessed status post right shoulder dislocations and instability with open Bankart reconstruction 17-20 years prior, subscapularis tear right shoulder, advanced osteoarthritis of the right shoulder, and acromioclavicular joint degenerative changes of the right shoulder. (Ex. 12, p. 248), He also noted Dr. Wathne documented ongoing symptoms were related to Claimant’s glenohumeral arthritis, and thus not industrially related. (Ex. 12, p. 249). He felt the right total shoulder arthroplasty recommended by Dr. Richardson was appropriate given Claimant's symptoms and

diagnosis, but the surgery was related to the pre-existing osteoarthritis and thus pre-existing and unrelated to the claimed industrial injuries. (Ex. 12, p. 251). He also related the permanent physical restrictions imposed by Dr. Wathne to the pre-existing, non-industrial condition. (Ex. 12. P.249). Specifically, he noted Dr. Wathne released Claimant to full activities on May 2, 2016, but recounted his restriction in November 2016, assigning permanent restrictions of less than 20 pounds above shoulder height lifting. Dr. Faciszewski felt that Dr. Wathne's notation within the medical records made it clear that the ongoing symptoms were related to Claimant's pre-existing glenohumeral arthritis, and thus the restrictions were not related to the industrial injury of September 18, 2014.

30. Claimant returned for evaluation by Dr. Nathan D. Richardson on May 9, 2018. (Ex. 17, p. 405-408). He summarized his understanding of the issues in the claim:

> This 50-year old male presents with a chief complaint of right shoulder pain. [T]his patient has been well-known to us for a couple of years now is embroiled in a discussion with Worker's Compensation about whether or not the osteoarthritis of his right shoulder was pre-existing and or caused by his work-related injury in September 2014. He has had two surgeries done by Dr. [Wathne], the first of which was to repair labral tear that he had had from a subluxation event that occurred at work. Of note at that time Dr. [Wathne] said that there is [sic] central and inferior grade 4 arthritic changes. This makes sense given a 17-20 year history of previous dislocation subluxations. However, following his initial surgery, he developed normal [sic] range of motion, and then all of a sudden without any provocation, he started developing stiffness pain and increased weakness. Dr. [Wathne] repeated his surgery in December 2015[, and] noted that he still had grade 4 changes but that it was now the entire anterior half of the glenoid. He also termed this has [sic] unchanged progression of arthritis. The patient has continued to have pain stiffness very similar to most everyone else with the glenohumeral osteoarthritis his x-rays that I [sic] have been taken sequentially here have shown a degradation of the joint with increasing bone spur size and increasing joint space narrowing. His symptoms have constantly and steadily gotten worse since we first met. We have discussed performing a total shoulder arthroplasty. This has been put on hold due to the Worker's Compensation Claim.

(Ex. 17, p. 405). Dr. Richardson opined the glenohumeral osteoarthritis was pre-existing, however it had been exacerbated by the work-related injury in September of 2014. He commented he was unable to obtain and review the arthroscopic images taken in the two surgical procedures in order to substantiate the industrial nature of the claim, specifically to see any progression in the arthritis between the two surgeries. (Ex. 17, p. 407). Based on the significant clinical changes in the shoulder between the first and second surgery, and the absence of new injuries that occurred between the two surgeries, he concluded the subluxation event in September 2014 caused an exacerbation of the arthritic changes in his glenohumeral joint. (Ex. 17, pp. 407-408). Dr. Richardson again recommended a total shoulder arthroplasty, but indicated steroid injections and continued conservative management for symptom control would also be appropriate management at that point. (Ex. 17, p. 408). He suggested a third orthopedic surgeon who does not practice in the same community as Dr. Wathne and him review and evaluate the arthroscopic images.

31. In response to an inquiry by Claimant's counsel dated June 18, 2018, Dr. Richardson indicated that Claimant's need for surgery was more likely than not related to his workers' compensation injury of September 18, 2014. (Ex. 9, p. 200). He added, "progressive [osteoarthritis] of shoulder since injury."

32. Claimant submitted to an Independent Medical Evaluation by Dr. Tom G. Faciszewski, Orthopedic Surgeon, on August 9, 2018. (Ex. 12, pp, 252-261). Dr. Faciszewski summarized additional records received subsequent to his records review on February 23, 2018, including Dr. Richardson's records and the FCE. (Ex. 12, pp. 253-254). Dr. Faciszewski recorded Claimant's history of a prior right shoulder injury approximately 21 years prior in Arizona. (Ex. 12, p. 254). His symptoms resolved within a month with

conservative treatment. Then approximately eight years later (IC records reflect August 24, 1995), Claimant suffered an industrial injury when he became stuck in the space between the bottom of a truck and the engine and transmission with his arms above him. Claimant was pulled up by his arms resulting in a right shoulder injury. Claimant tried physical therapy and then underwent shoulder surgery by Dr. Wathne. Claimant stated he had no residual symptoms or limitations related to his right shoulder. Finally, Claimant reported that his shoulder came out again at work in 2015, but he did not turn this injury in to worker's compensation, and he was let go from his job (at Triple L Towing) about a month later. (Ex. 12, pp. 254-255).

33. At the time of the exam, Claimant complained of restricted range of motion and pain in the right shoulder, with markedly reduced strength in the right as compared to the left. (Ex. 12, p. 255). He also described some numbness down the right arm into the fingers, which he developed after one of the surgeries by Dr. Wathne. He also complained of his right elbow clicking. He noted Claimant now hunts with a crossbow pursuant to a permit by Dr. Richardson due to his right shoulder issues. On exam, there was no swelling and equal temperature in the upper extremities. (Ex. 12 p. 257). There was no edema noted, and radial pulses were 2+ symmetrical. Claimant had a positive Tinel's test over the right elbow for pain at the right elbow, positive Hawkins on the right, negative on the left, bilateral positive Neer. He had a positive empty can test on the left with pain over the trapezius area, and positive Speed test on the left, negative on the right. Claimant had global pain with any extreme of motion about the right shoulder. Muscle strength and tone were normal and even in the bilateral upper extremities, but full muscle testing was not performed on the right due to restricted range of motion. Claimant's hands were noted to be dirty consistent with the appearance of a mechanic. Light touch to

sensation was intact with the exception of the entire fifth digit of the right upper extremity and the ulnar distribution of the ring finger of the right hand.

34. Based on the review of the medical and radiological studies and Claimant's examination, Dr. Faciszewski assessed the following:

> 1. History of prior right shoulder dislocations/instability with open Bankart reconstruction 17 to 20 years prior, pre-existing, unrelated to injury of September 18, 2014;
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> 2. Subscapularis tear right shoulder, pre-existing, unrelated to injury of September 18, 2014;
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> 3. Advanced osteoarthritis right shoulder, pre-existing, unrelated to injury of September 18, 2014;
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> 4. Acromioclavicular joint degenerative changes, right shoulder, pre-existing, unrelated to injury of September 18, 2014;
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> 5. Subluxation event, right shoulder, related to injury of September 18, 2014;
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> 6. Left shoulder pain, unrelated to injury of September 18, 2014; and
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> 7. Right cubital tunnel syndrome, unrelated to injury of September 18, 2014.

(Ex. 12, p. 258).

35. Since the original records review, Dr. Faciszewski noted Claimant had progression of his restricted range of motion and shoulder pain as would be expected given the glenohumeral arthritis of the right shoulder. (Ex. 12, p. 259). Also in the interim, he also developed left shoulder symptoms consistent with impingement syndrome and/or degenerative changes of the left shoulder. Dr. Faciszewski agreed with Dr. Wathne's determination of Maximum Medical Stability as of August 2, 2016. As to Claimant's hunting incident, Claimant stated he was physically able to hunt with a crossbow with a permit from Dr. Richardson. (Ex. 12, p. 260).

36. As to permanent restrictions, Dr. Faciszewski reiterated his prior opinion that Dr. Wathne's notations within the medical records made it clear that Claimant's ongoing symptoms were related to Claimant's pre-existing glenohumeral arthritis, and thus the permanent restrictions were not related to the industrial injury of September 18, 2014. He recommended right total shoulder arthroplasty as recommended by Dr. Richardson, but opined the procedure was necessary due to Claimant's right glenohumeral arthritis, which is pre-existing and unrelated to the industrial injury of September 18, 2014. Dr. Faciszewski concluded, on a more probable than not basis, the industrial injury of September 18, 2014 did not accelerate Claimant's underlying osteoarthritis of the right shoulder. (Ex. 12, p. 261). He further opined that Claimant's glenohumeral arthritis symptoms and objective findings had progressed since his records review in February of 2018, and the need for surgery was related to the underlying right shoulder glenohumeral arthritis. He agreed with Dr. Richardson's statement of May 9, 2018, "certainly posttraumatic arthritis from the prolonged dislocations that he was having previous to his work-related injury would cause arthritis." He also noted Dr. Wathne's surgery report of December 9, 2015 showed advanced grade 4 chondromalacia in the anterior one-half of the glenoid, unchanged from the previous arthroscopy.

37. Dr. Wathne apportioned one-third of Claimant's 15% right upper extremity impairment rating to pre-existing conditions, which equates to 5% right upper extremity permanent partial impairment (PPI) rating related to Claimant's pre-existing right shoulder condition. (Ex. 6, p. 119).

DISCUSSION AND FURTHER FINDINGS

38. The provisions of the Idaho Workers' Compensation Law are to be liberally construed in favor of the employee. Haldiman v. American Fine Foods, 117 Idaho 955, 956, 793

P.2d 187, 188 (1990). The humane purposes which it serves leave no room for narrow, technical construction. Ogden v. Thompson, 128 Idaho 87, 88, 910 P.2d 759, 760 (1996). Facts, however, need not be construed liberally in favor of the worker when evidence is conflicting. Aldrich v. Lamb-Weston, Inc., 122 Idaho 361, 363, 834 P.2d 878, 880 (1992).

39. **Causation.** The sole issue is whether the need for the total right shoulder arthroplasty Claimant seeks was caused by the industrial accident.

40. Idaho Code § 72–432(1) requires an employer to provide an injured employee such reasonable medical, surgical or other attendance or treatment, nurse and hospital service, medicines, crutches and apparatus, as may be reasonably required by the employee's physician or needed immediately after an injury or manifestation of an occupational disease, and for a reasonable time thereafter. If the employer fails to provide the same, the injured employee may do so at the expense of the employer. Of course an "employer cannot be held liable for medical expenses unrelated to any on-the-job accident or occupational disease." Henderson v. McCain Foods, Inc., 142 Idaho 559, 563, 130 P.3d 1097, 1102 (2006). Thus claims for medical treatment must be supported by medical evidence establishing causation. 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). "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). Magic words are not necessary to show a doctor's opinion was 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 (2001). A pre-existing disease or infirmity of the employee does not preclude 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. Wynn v. J.R. Simplot Co., 105 Idaho 102, 666 P.2d 629 (1983).

41. In the present case several physicians have addressed the causation of Claimant's need for total shoulder replacement. Their opinions are examined below.

42. Dr. Richardson. Dr. Richardson is a neurosurgeon specializing in shoulder and elbow surgery. He examined Claimant for a second opinion in November 2015, and again in May 2018. Questioned about his May 9, 2018 note regarding causation, Dr. Richardson testified:

> Q. (by Mr. Adams) …. your reasoning with regard to causation in this claim and it says: Certainly, post-traumatic arthritis from the prolonged dislocations that he was having previous to his work-related injury would cause arthritis; however, there is significant clinical change in the shoulders between the first surgery and second surgery. No new injuries were occurred [sic] during the time of those two surgeries, thus my only conclusion logically is that the subluxation ….
>
> --subluxation event he had in September of 2014 became an extreme exacerbation of the arthritic changes in his—
>
> A. Glenohumeral joint. The shoulder, the bone socket.
>
> Q. Okay. Can you explain to—can you explain to us a little bit more of about that thought process and your reasoning behind that logic?
>
> A. Sure. So anybody who has had multiple dislocations, which I believe was the thing that he had had operated on twenty years ago that you had mentioned earlier, anybody who's had subsequent dislocations is at risk for developing arthritis.
>
> The cartilage in our shoulder loves to have compressive forces on it; so, the two balls—the ball and socket pushing into each other. When you dislocate that we have something called a shearing force where the two are basically rubbing against each other back and forward like a rocking horse. That breaks down cartilage, and at some point if you let your shoulder be unstable or dislocate multiple times, it will end up being arthritic.
>
> Q. Okay. And so you're—you're saying that—

> A. I'm saying that there's a process happening here that when you're young there's more resilience in the cartilage, but at some point there'll be something that breaks the camel's back, that last straw. And whatever that may be, another dislocation or wear-and-tear or a trip and slip-and-fall, once the cartilage begins to break down, it can break down rapidly.
>
> Q. Okay. So then you're saying that this—this accident in 2014 was the straw that broke the camel's back and is why he needs the total shoulder replacement?
>
> A. Yeah. So, what I was saying is he seemed to be dealing with it well enough up until this point and then there was an exacerbation of what process was going on. Not necessarily cause and affect [sic], but certainly there was something that made it dramatically worse.

(Ex. 19, Richardson Deposition, p. 11, l. 23 through p. 14, l. 3.)

43. Dr. Richardson affirmed that the shoulder replacement Dr. Wathne recommended is appropriate and summarized his opinion:

> Q. (by Mr. Adams) Okay. So based upon–and based upon your review, has anything changed, in your opinion, that you think that the need for this surgery is more likely than not related to his claim—or to his accident in September of—excuse me, in September 18th of 2014?
>
> A. I would—I would say more likely than not the current state of his shoulder is an exacerbation of an underlying condition made worse by the accident.

(Ex. 19, Richardson Deposition, p. 17, l. 17 through p. 18, l. 1.)

44. Dr. Richardson apportioned 30% of Claimant's present need for shoulder surgery to his pre-existing arthritis and 70% to his September 2014 industrial accident. (Ex. 19, Richardson Deposition, p. 33.)

45. Dr. Faciszewski. Dr. Faciszewski is a board certified orthopedic surgeon who reviewed Claimant's medical records and issued a report on February 23, 2018. Dr. Faciszewski later examined Claimant and issued another report. In his deposition he opined that Claimant's severely degenerated pre-existing right shoulder condition was largely responsible for his current need for total shoulder replacement and testified:

> Here's what the facts in this case show. The facts of the MRI scan, February 23rd, 2015, the operative report of Dr. Wathne, April 2015, none of those indicate any kind of acute injury. What both of those indicate, as well as Dr. Wathne's statements within the medical record documented, is that this is an endstage degenerated joint.
>
> So in my opinion, his need for total shoulder arthroplasty is 100 percent related to his destroyed joint which was present prior.

(Ex. 20, Faciszewski Deposition, p. 39, ll. 10-19.)

46. Dr. Faciszewski opined Claimant's right shoulder demonstrated endstage severe cartilage loss, multiple tendon injuries and history of multiple subluxations thus "he was going to have trouble with his shoulder irrespective of whether or not he had a fall at that point in time." (Ex. 20, Faciszewski Deposition, p. 22, ll. 3-5.) In cross-examination, Dr. Faciszewski elaborated:

> Q. (by Mr. Adams) Okay. What is your response to Dr. Richardson's straw that broke the camel's back argument?
>
> A. Um-hmm. So the—there's just many ways to think about this. And you can use a lot of different examples, but let's say you have a car tire that has 100,000 miles on it. I mean, you look at it and everyone knows it has 100,000 miles on it, you can see—you can see steel belts that are protruding, there's bulges in it, it's bald, and someone runs over a nail with it and now the tire is flat, it's like, nope, see, it's the nail. And the reality is that that tire was destined to be done, just as his shoulder was.

(Ex. 20, Faciszewski Deposition, p. 42, l. 21 through p. 43, l. 8.)

47. When further asked about the effect of Claimant's September 18, 2014 industrial accident, Dr. Faciszewski testified:

> Q. (by Mr. Bailey) Dr. Wathne in his report—and I realize you don't necessarily agree with his opinion as to stability, but he indicates that—he actually gave him a 15 percent right upper extremity impairment rating with one-third attributable to the pre-existing underlying condition given his prior right shoulder surgery, and those are his words. Assuming there was medical stability back the, would you agree with the apportionment of one-third to pre-existing, two-thirds to the industrial accident of September 18, 2014?

> A. So I was asked that specific question in my medical record review. And what I—I was asked the question of specifically the impairment rating that Dr. Wathne gave. And Dr. Wathne—I—I performed my own calculation based on what Dr. Wathne gave for apportionment. And as I've stated here previously, I would attribute the subsequent pain that Mr. Labbee—and disability that Mr. Labbee had to 100 percent of his pre-existing shoulder problem, and that this fall, if you will, did not aggravate it or cause the natural history to change in any shape or form.

(Ex. 20, Faciszewski Deposition, p. 31, ll. 3-24.)

48. Dr. Faciszewski opined that Claimant's failure to voice right shoulder pain complaints until several weeks after his industrial accident was not consistent with an acute shoulder injury but rather with endstage shoulder joint degeneration. (Ex. 20, Faciszewski Deposition, pp. 48-49.)

49. Dr. Wathne. Dr. Wathne is a board certified orthopedic surgeon and Claimant's treating surgeon. Dr. Wathne testified that Claimant's 2014 work accident caused acute injuries including right biceps tendon tear, right labral tear, and right shoulder subluxation. (Ex. 21, Wathne Deposition, p. 10.)

50. Dr. Wathne testified that without Claimant's pre-existing right shoulder condition, it would be very unusual for the type of shoulder injuries Claimant sustained from his industrial accident to progress to degenerative arthritis requiring shoulder replacement surgery. (Ex. 21, Wathne Deposition, p. 21.) Dr. Wathne concluded that Claimant's need for shoulder replacement surgery is related 75% to his pre-existing condition and 25% to his industrial accident. (Ex. 21, Wathne Deposition, p. 22.) He opined that the industrial accident accelerated the progression of Claimant's shoulder degeneration and need for total shoulder arthroplasty: "I think that would be a reasonable amount to suggest that with two surgeries—an on-the-job injury and two subsequent surgeries, did it accelerate it a percentage? Yes, I would stick to it." (Ex. 21, Wathne Deposition, p. 34, ll. 6-10.)

51. Weighing the expert medical opinions. Dr. Richardson and Dr. Wathne opined that Claimant's industrial accident aggravated his right shoulder condition and accelerated his need for shoulder replacement surgery. Dr. Faciszewski concluded Claimant's 2014 industrial accident did not accelerate his need for total shoulder arthroplasty.

52. Claimant had right shoulder open Bankart surgery in approximately 1999 and functioned well after recovering from this surgery. Commencing in 2011, he worked as a diesel mechanic for Defendant for three years without limitation or complaint. After Claimant's fall at work and jamming his right shoulder in September 2014, Dr. Wathne performed arthroscopic right shoulder Bankart repair and reconstruction in April 2015, and when Claimant continued to have limiting right shoulder pain and catching, Dr. Wathne performed arthroscopic right shoulder clean-up removing loose cartilage bodies from the joint in December 2015. Claimant's right shoulder improved and he was anxious to return to work as a diesel mechanic. By August 2, 2016, Dr. Wathne found Claimant had reached maximum medical improvement, rated Claimant's permanent right shoulder impairment at 15% of the right upper extremity with 1/3 attributable to his pre-existing condition and 2/3 attributable to his industrial accident. That same day Dr. Wathne released Claimant back to full-duty work without restrictions but cautioned him to avoid positions that caused discomfort. Claimant returned to work but experienced increasing shoulder symptoms. Scarcely a week later, on August 11, 2016, Claimant sought medical treatment for right shoulder pain and other medical issues, reporting continuing shoulder pain that hindered his work. By November 10, 2016, Claimant had lost his job and returned to Dr. Wathne reporting he could not perform the work of a diesel mechanic. Dr. Wathne restricted Claimant from all above shoulder lifting and to lifting no more than 20 pounds with his right arm.

53. "An employer takes an employee as it finds him or her; a pre-existing infirmity does not eliminate the opportunity for a worker's compensation claim provided the employment aggravated or accelerated the injury for which compensation is sought." Spivey v. Novartis Seed Inc., 137 Idaho 29, 34, 43 P.3d 788, 793 (2002), citing Wynn v. J. R. Simplot Co., 105 Idaho 102, 104, 666 P.2d 629, 631 (1983).

54. It is undisputed that Claimant had degenerative changes in his right shoulder well prior to his industrial accident. However, he had returned to full-time work and functioned at a high level for more than a decade before his 2014 accident. As the pain from his right wrist and buttocks resolved, he noted the onset of right shoulder symptoms shortly after his September 18, 2014 work accident. Medical records between the time of Claimant's recovery from his first shoulder surgery in 1999 and his work accident in September 2014 contain no mention of ongoing right shoulder symptoms or limitations and thus corroborate his reports that his right shoulder was fully functional. It quickly became symptomatic and functionally limiting after his 2014 work accident.

55. Dr. Faciszewski has been inconsistent in his opinion of the effects of Claimant's industrial accident. Dr. Faciszewski conducted a record review on February 23, 2018, and concluded that Claimant's 2014 accident caused him injury, including right shoulder subluxation. He reported that Claimant sustained 4% whole person right shoulder impairment due to the industrial accident. In contrast, Dr. Faciszewski indicated in his deposition that he was unconvinced Claimant sustained an injury from his 2014 industrial accident:

> Q. (by Mr. Bailey) I presume that you do not dispute that Mr. Labbee had some sort of an industrial accident and injury; is that accurate?
>
> A. I would debate that.

(Ex. 20, Faciszewski Deposition, p. 21, ll. 1-4.) Regarding Claimant's September 18, 2014 industrial accident, Dr. Faciszewski then testified that "based on my previous testimony, as well as the imaging findings of February 23, 2015, and Dr. Wathne's operative report, there was not an acute injury on that date." (Ex. 20, Faciszewski Deposition, p. 30, l. 24 through p. 31, l. 2.)

56. The apparent rationale for Dr. Faciszewski's changed opinion is that Claimant's diagnostic studies show long time right shoulder degenerative changes and Dr. Faciszewski's interpretation of Dr. Wathne's notes as showing that Claimant's right shoulder pain was solely related to his pre-existing shoulder condition and not to his 2014 industrial accident. Regardless of how Dr. Faciszewski may interpret the notes, Dr. Wathne, the author thereof, actually reached a different conclusion; namely, that Claimant's 2014 industrial accident caused right shoulder subluxation and acute injury to the right biceps tendon and right labrum, aggravating his pre-existing condition and accelerating his need for shoulder replacement surgery.

57. Dr. Faciszewski also noted that Claimant reported no right shoulder pain at the time of his accident, when he presented that same day at the emergency room, or for at least a week or more thereafter. Dr. Faciszewski testified:

> During my exam of August 9, 2018, I specifically had him describe for me the development of the onset of symptoms And, in fact, he states—and this is—I'll read this directly out of my note, "It was not until approximately one week later that he developed pain in the right shoulder."

(Ex. 20, Faciszewski Deposition, p 48, ll. 1-6.) While this may initially appear concerning, Claimant's failure to immediately voice right shoulder complaints is not dispositive given his highly symptomatic right wrist injury—sufficiently painful that wrist fracture was suspected and was only ruled out by x-ray. At the time of Claimant's September 18, 2014 fall he noted immediate right wrist and buttock pain and hurt his back such that he "couldn't even stand up for four hours." (Ex. 18, p. 58, ll. 6-7.) He told his supervisor that he was concerned about his

shoulder. He wore a right wrist for a time, necessarily limiting the use of his right shoulder. When he started back to work again he promptly told his supervisor that he felt "something going on" with his right shoulder and thereafter sought further medical attention for his shoulder.

58. In cross-examination, Dr. Faciszewski acknowledged a critical assumption underlying his opinion and conclusions:

> Q. (by Mr. Adams) [Claimant] had been working, functioning, at his other jobs as he testified to, what is your response to—to his perceived functional loss after the accident of what he can and can't do?
>
> A. It would be the progression of the natural history of a destroyed shoulder joint.
>
> A. So the progression of that joint and his limitations just happened to coincide at the same time?
>
> A. That's correct.

(Ex. 20, Faciszewski Deposition, p. 42, ll. 12-20.)

59. Dr. Faciszewski's opinion virtually ignores the impact of the work accident on Claimant's functionality and the reality that Claimant worked without limitation or restriction from the time of his 1999 surgery until his September 2014 work accident and thereafter was not able to maintain his usual work due to his right shoulder symptoms. The notion that the progression of the degenerative condition of Claimant's right shoulder joint with its resulting limitations, and his September 18, 2014 industrial accident "just happened to coincide" per Dr. Faciszewski's explanation is unconvincing. In contrast, Dr. Wathne's and Dr. Richardson's opinions are well explained, consistent with the evidence as a whole, and thus persuasive.

60. Claimant has proven his 2014 industrial accident aggravated his pre-existing right shoulder condition and accelerated his need for reasonable medical care therefore, including right shoulder replacement surgery as recommended by Dr. Wathne.

CONCLUSION OF LAW

Claimant has proven his 2014 industrial accident aggravated his pre-existing right shoulder condition and accelerated his need for reasonable medical care therefore, including right shoulder replacement surgery as recommended by Dr. Wathne.

RECOMMENDATION

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

DATED this __20_ day of December, 2019.

INDUSTRIAL COMMISSION

_/s/_____
Alan Reed Taylor, Referee

ATTEST:

_/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __10__ day of _January_____, _2020_, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSION OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

ANDREW A ADAMS
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ERIC S BAILEY
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_/s/_____

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

LONNIE LABBEE, Claimant, v. RUSH INTERNATIONAL TRUCK CENTER, Employer, and NEW HAMPSHIRE INSURANCE COMPANY, Surety, Defendants.	**IC 2014-026012** **ORDER** **FILED** **10 JANUARY 2020**

Pursuant to Idaho Code § 72-717, Referee Alan Taylor submitted the record in the above-entitled matter, together with his recommended findings of fact and conclusions of law, to the members of the Idaho Industrial Commission for their review. Each of the undersigned Commissioners has reviewed the record and the recommendations of the Referee. The Commission concurs with these recommendations. Therefore, the Commission approves, confirms, and adopts the Referee's proposed findings of fact and conclusions of law as its own.

Based upon the foregoing reasons, IT IS HEREBY ORDERED that:

1. Claimant has proven his 2014 industrial accident aggravated his pre-existing right shoulder condition and accelerated his need for reasonable medical care therefore, including right shoulder replacement surgery as recommended by Dr. Wathne.
2. Pursuant to Idaho Code § 72-718, this decision is final and conclusive as to all matters adjudicated.

DATED this __10__ day of _January_____, 2020__.

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 __10_ day of _January__, 2020__, a true and correct copy of the foregoing **ORDER** was served by regular United States mail upon each of the following:

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