BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

CHRIS HOLLAND, Claimant, v. CENTURY CONTRACTORS, INC., Employer, and IDAHO STATE INSURANCE FUND, Surety, Defendants.	**IC 2012-031788** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** Filed March 14, 2017

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Industrial Commission assigned the above-entitled matter to Referee Douglas A. Donohue. He conducted a hearing in Boise on April 4, 2016. The parties presented oral and documentary evidence and later submitted briefs. Dennis Petersen represented Claimant. Russell Webb represented Defendants Employer and Surety. The case came under advisement on September 27, 2016. Referee Donohue submitted proposed findings of fact and conclusions of law to the Commission for review. The undersigned Commissioners have chosen not to adopt the Referee's recommendation and hereby issue their own findings of fact, conclusions of law and order.

ISSUES

The issues to be decided according to the Notice of Hearing and as agreed to by the parties at hearing are:

1. Whether additional biceps surgery is reasonable, and, if so, whether Claimant's noncompliance, if any, in physical therapy removes this surgery as a compensable consequence of the industrial accident;

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

3. Whether Claimant is entitled to temporary total disability benefits;

4. Whether Claimant's entitlement to benefits should be affected by the application of Idaho Code §72-435;

All other issues were reserved.

CONTENTIONS OF THE PARTIES

Claimant contends he is entitled to a third surgery to repair one of the tendon attachments to his biceps. He has reasonably but imperfectly complied with doctor's physical therapy orders, including home exercises. His few no-shows for physical therapy were unavoidable in his circumstances. He faithfully wore his arm sling according to doctor's orders as he understood them. Treating physician Dr. Tashjian considers Claimant a good candidate for this repeat surgery, and disagrees with Dr. Doerr's evaluation, assumptions about noncompliance, and opinions against the reasonableness of repeat surgery. This surgery is reasonable and necessary to maximize Claimant's recovery from the compensable shoulder injury. Getting out of bed—the event which caused the biceps to drop—is not an unsanitary or unreasonable practice within the scope of Idaho Code §72-435. Until this surgery is performed and Claimant recovers from it, he is not medically stable. TTD benefits remain payable for the period November 18, 2013 to the August 27, 2014 surgery and again for the period from September 7, 2015 to date and continuing until medical stability is reached.

Defendants contend the additional surgery is unreasonable because it was caused by Claimant's failure or refusal to follow doctor's orders. Idaho Code §72-435 applies. Claimant's noncompliance constitutes a persistent and unreasonable hindrance of his treatment and there is no reason to believe Claimant's representations that he will change his behavior if another surgery is performed. There is no reason to believe Claimant's unsupported representations that he did his home exercises as ordered. Dr. Doerr opined that this third surgery is neither reasonable nor necessary. Claimant's surgeon, Dr. Tashjian, mostly agrees with

Dr. Doerr. Where he does not, he shows a failure to make himself aware of the extent of Claimant's noncompliance and overrates his duty as treating physician. Further, Claimant is not entitled to additional TTD upon his refusal of suitable light-duty offered by Employer. Despite Employer advising Claimant that light-duty work was available on June 11, 2013, and Claimant's representation on June 13, 2013 to Employer that he would work a specific light-duty job, Claimant did not work except for 2.3 hours on August 12, 2013 after which Claimant left the jobsite without contacting Employer. Suitable light duty remained available. In sum, Claimant has failed to show he is entitled to additional surgery or TTD benefits.

EVIDENCE CONSIDERED

The record in the instant case included the following:

1. Oral testimony at hearing of Claimant and of Justin Kunde, an owner of Employer;

2. Joint exhibits A through U;

3. Post-hearing depositions of orthopedic surgeons Robert Tashjian, M.D., and Timothy Doerr, M.D., which were designated as exhibits T and U at hearing in anticipation of being taken.

All objections in depositions are OVERRULED, except at page 52 of Dr. Doerr's deposition, which is SUSTAINED.

FINDINGS OF FACT

1. In this bifurcated matter, only the proposed treatment for the right biceps is at issue. Limited findings related to the right shoulder are provided for context only and are not intended to bind the Commission or any party should a later dispute arise regarding the nature, extent, or compensability of Claimant's shoulder condition.

2. On September 27, 2012 Claimant began working for Employer as a construction laborer. On or about December 13, 2012 Claimant felt sudden right shoulder pain while using a vacuum hose to clean around forms before a concrete pour.

3. Claimant visited an urgent care clinic on December 13, 2012. Exh. D1. Documents of record indicate that a lifting event occurred on December 11, 2012 as well as notes indicating that Claimant "[h]as been able to pop [right] shoulder in & out of place for years. Sometimes when it pops out it really hurts. At work 2 days ago, it popped out while lifting over head and this is the worst its [sic] ever been. Worried about new or worse injury." Exh. D1. The x-rays taken the same day showed intact osseous structure without fracture, dislocation, or joint space abnormality with adjacent ribs intact. Exh. E1. The attending physician prescribed Ibuprofen, Norco, a sling and home physical therapy; Claimant was also restricted from all use of his right arm. Exh. D2. During a follow-up on December 20, 2012, PAC Julie Heier ordered an MRI. Exh. D4. Radiologist Dr. Peter Vance read the December 26, 2012 MRI as showing a tear of the posterior labrum, thinning of the articular cartilage of the posterior glenoid with subchondral cystic change suggesting degenerative joint disease, and type 2 acromion. Exh. E2.

4. On December 30, 2012 Claimant received an order to attend physical therapy three times per week for three weeks. This prescription provided a diagnosis of "tear of posterior labrum [right] shoulder." Exh. D6.

5. Claimant was referred to John Andary, M.D., on January 4, 2013 (the referral note inaccurately dates the year as "12"). Exh. D7.

6. On January 9, 2013, Dr. Andary assessed Claimant's condition as a right shoulder posterior subluxation/dislocation with posterior labral tear and some injured cartilage and indicated that he would like to schedule an arthroscopy decompression and labral repair on Claimant's right shoulder. Exh. F2.

7. On February 13, 2013, RehabAuthority provided an initial evaluation of Claimant for physical therapy, documented by Chris Rigby in a Referral Acknowledgement dated February 26, 2013. Exh. F2(A).

8. Dr. Andary performed a right shoulder arthroscopy with posterior labral repair, debridement of articular, central, and anterior glenoid, and subacromial bursitis with decompression on February 28, 2013. Exh. F5. At the postoperative followup on March 6, 2013, Dr. Andary instructed, "Chris will start gentle pendulum and wall-walking exercises. We discussed appropriate restrictions. He will start therapy in three weeks." Exh. F3.

9. In his March 6, 2013 prescription/instructions for physical therapy, Dr. Andary incorrectly identified the diagnosis and surgery as pertaining to Claimant's left shoulder. Exh. F7. A similar May 15, 2013 prescription and a status report preserved this error. Exh. F15-16. However, the majority of Dr. Andary's notes and related correspondence clearly describes the right upper extremity when discussing symptoms, treatment, restrictions, and limitations.

10. Between March 6, 2013 and April 10, 2013 Dr. Andary restricted Claimant from all work, then eased the restriction to allow "desk work only" with limitations against all use of the right upper extremity including driving a stick shift, and requiring a "sling @ all times." Exh. F7-13.

11. Between April 1, 2013 and June 30, 2013, Claimant canceled or failed to appear for twenty-two of his forty scheduled physical therapy appointments. Exh. G.

12. Beginning May 15, 2013, Dr. Andary's notes reference his discussions with Claimant regarding his lack of compliance with and the importance of physical therapy. Exh. F18. Dr. Andary's notes continue to express frustration with Claimant at his June 12, 2013 follow up. Exh. F21.

13. Employer's records show that Claimant had worked June 12, 2013, failed to call in or show up for work on June 13, 2013, and did not return to work under light-duty from June 14, 2013 through June 22, 2013. Exh. R24.

14. A June 14, 2013 physical therapy note indicates Claimant said he had returned to work that day. Exh. G19.

15. Between July 1, 2013 and October 31, 2013, Claimant canceled or failed to appear for fifteen of his forty-one scheduled physical therapy appointments. Exh. G.

16. Claimant had several follow up appointments with Dr. Andary. On July 15, 2013 Claimant reported he "fell out of the shower" and aggravated his right shoulder injury. Exh. F23. On July 31, 2013 Dr. Andary noted that Claimant was improving with therapy. Exh. F27. On August 21, 2013, Claimant told Dr. Andary that "he went back to work only a couple of times and had a lot of pain at work." Because of this, Dr. Andary decided to schedule another MRI. Exh. F28.

17. Dr. Jason Lance conducted the September 4, 2013 MRI, recording the prior surgical work plus a possible reinjury at the base of the labrum, bursitis, mild displacement of the humeral head, and severe cartilage loss previously been described as degenerative in nature. Exh. E3. Dr. Andary reviewed the MRI with Claimant on September 9, 2013 and noted it "does not look any worse than the previous MRI, again it is difficult to interpret as there are a lot of postsurgical changes." Exh. F29. During this same appointment, Claimant reported he "overdid it" at work, that his symptoms were worse, and that therapy has helped. Exh. F29. Dr. Andary opined against another surgical procedure and recommended that Claimant do another month of therapy. Exh. F29. On October 14, 2013, Dr. Andary reported that Claimant presented as being "very frustrated. He is not improving. He feels like he is getting worse. He wants to proceed

with surgery." Exh. F31(A). Dr. Andary opined that "based on his continued symptoms and equivocal MRI that is difficult to interpret, at this point I told him that it is not unreasonable to go in and look." Exh. F31(A).

18. On November 18, 2013 and November 25, 2013, Stan Griffiths, M.D., reviewed records and evaluated Claimant at Surety's request. Exh. H. On exam, Dr. Griffiths found limited range of motion with complaints of pain. Dr. Griffiths consulted Claimant's prior radiologist, Dr. Vance, to interpret the MRIs as well as new x-rays. They described a "posterior subluxation" of the shoulder joint. Dr. Griffiths opined Claimant needed additional surgery which was causally related to the work accident. Exh. H5. He opined that the "relatively minor incidences"— noncompliance with physical therapy and subsequent aggravating events — did not contribute significantly to Claimant's current condition. Exh. H6. He opined Claimant was not medically stable. Exh. H7. On January 6, 2014 Dr. Griffiths sent a letter to clarify some of his earlier opinions and address Claimant's prior conditions that did not make the November report due to some lost dictation. Exh. H8-10.

19. On February 14, 2014 Dr. Andary disagreed with Dr. Griffiths' opinions regarding surgery in a letter to Surety. Exh. F33-35. He opined against Dr. Griffiths' proposed surgical options based on Claimant's young age, intact cartilage, and current level of shoulder function. Exh. F34. He expressed concern that "there may not be any surgery that will confidently resolve all of Chris' problems." Exh. F35. He did, however, opine that it was reasonable for Claimant to obtain a pain consult or a third medical opinion. He provided the names of several physicians, including Robert Tashjian, M.D., to see if there were any other procedures that could help Claimant. Exh. F34.

20. On April 8, 2014, Dr. Tashjian evaluated Claimant. He noted on examination "TTP over the proximal biceps" with pain under specific load and motion. Exh. I2. This is the earliest mention of Claimant's biceps in the evidence. X-ray findings were posterior glenoid changes consistent with prior surgery of posterior labrum, no subluxation or glenohumeral osteoarthritis. Exh. I3. Dr. Tashjian recommended an injection and additional MRI. Tashjian Deposition, p. 6. An anesthetic and steroid injection was performed on May 7, 2014 to determine if Claimant's pain was in his shoulder or his biceps tendon. Exh. I4-7.

21. On July 10, 2014 a CT scan of the shoulder showed chronic cystic changes and anchor tract resorption in the posterior aspect of the glenoid, resulting in approximately 20% loss of the articular surface, mild glenoid retroversion, and mild osteoarthritis of the right glenohumeral and acromioclavicular joints. Exh. E6.

22. On July 29, 2014 Claimant was released to limited work and directed not to use his right arm. Exh. I12.

23. On August 27, 2014 Dr. Tashjian performed a bone block using a graft from Claimant's pelvis to stabilize the shoulder. He also performed a tenodesis to reconnect the long head of the biceps to its tendon. Post-operative care required "Nonweightbearing in the right arm in ER sling at all times." Exh. I16-21.

24. Dr. Tashjian testified that the October 10, 2014 and October 14, 2014 dates in his notes were likely erroneous—one should be the two-week follow-up visit, the other the six week follow-up visit. Dr. Tashjian agreed that perhaps October 10, 2014 should be September 10, 2014. Regardless, the note for Claimant's follow-up visit marked October 14, 2014 showed the biceps drooping slightly, unknown cause and without symptoms. Dr. Tashjian noted it was "Ok to be out of sling" and ordered physical therapy. Exh. I36. Between November 1, 2014 and

December 31, 2014, Claimant canceled or failed to appear for six of his twelve physical therapy appointments. Exh. G.

25. A December 18, 2014 follow-up visit with x-rays showed no change to Claimant's shoulder, with Dr. Tashjian again noting that the cause of the biceps droop was unknown and that Claimant was not having symptoms. Exh. I58. Dr. Tashjian released Claimant to return to limited work, sedentary only, no lifting, pushing or pulling. Exh. I56. Claimant's physical therapy was increased and an MRI was ordered to determine if Claimant's bicep was still intact. Exh. I58.

26. The January 8, 2015 MRI showed that the procedure appeared to have affixed the biceps as expected. Other chronic shoulder conditions were noted. Exh. E5.

27. On January 28, 2015 Claimant's counsel sent a letter to Dr. Tashjian asking "Is it your opinion that Mr. Holland should have been taken off work completely?" Exh. I68. On February 5, 2015, Dr. Tashjian checked "Yes" with the caveat "if the patient was unable to perform his work duties due to his injury". Exh. I68. Claimant continued with physical therapy, but did not attend all sessions scheduled during January and February 2015. Exh. G50-56.

28. On April 14, 2015 Dr. Tashjian noted, "Patient has concerns over his biceps tendon being too low, loose, and cosmetically different as well. Would like to have better function of the long head of his biceps." Despite the tenodesis remaining intact and without indication of pain in the bicep, Claimant opted for a second revision surgery. Exh. I69-70.

29. Surety followed up on the surgical recommendation in a May 1, 2015 letter to Dr. Tashjian. Exh. I74-75. Dr. Tashjian responded that Claimant "has pain and spasm in his biceps" and continued to recommend the revision surgery. Exh. I75. As discussed *supra*, spasm is not recorded as a symptom in Dr. Tashjian's contemporaneously-made examination notes, and "cuff

testing and ttp over the aC [sic] joint" as the only indication of pain during the appointment. Exh. I70.

30. Between January 1, 2015 and February 28, 2015, Claimant canceled or failed to appear for three of his seventeen scheduled physical therapy appointments. Exh. G. Progress notes and correspondence to Dr. Tashjian document the physical therapists' frustration with Claimant's noncompliance in March, April, and May 2015. Exh. K. A May 22, 2015 physical therapist's note states:

> Mr. Holland has attended 9 physical therapy sessions in which we have addressed the ROM and strength in his R Shoulder. He has no showed or cancelled the majority of this therapy appts so at this point it is very hard to say that he has made much progress in strength. He showed up today without an appt and anxious to get started. He was able to go through his exercises with minimal pain, but still having major weakness in ER, Flex above 90 degrees, and upper and lower trap musculature. Pt had about full ROM passively except in IR where he was a little tight at end range. Spoke with Pt about the importance of keeping his appts and he continued to make excuses about being in the hospital for different things and that he now has surgery scheduled in 2 weeks. I explained the frustration of missing an appt where another pt could have been scheduled and also him not showing a lot of progress since he first started and that he would not likely improve if he did not put forth the effort. Pt did not have much to say, but he also appeared highly medicated.

Exh. K28.

31. On June 5, 2015 Dr. Tashjian performed the revised tenodesis. Exh. I77(A-B). Dr. Tashjian prescribed a pneumatic compressor to accelerate healing of the tendon after the revised tenodesis. Exh. I77. Nurses' notes following the surgery record "Patient overestimates abilities, is forgetful of limitations or behavior/belief is inconsistent with activity orders" and "Patient is non-compliant with activity restrictions or does not ask for help with needed." Exh. J111.

32. During his July 7, 2015 meeting with Dr. Tashjian, Claimant reported the tenodesis snapped "getting up out of a chair" over the July Fourth weekend and the long head of

Claimant's biceps drooped. Exh. I79. At hearing Claimant testified he was getting out of bed. Hearing Transcript, p. 53-55. Dr. Tashjian noted, "It sounds like he was not wearing his sling which he should still be wearing at this point." Exh. I79.

33. On August 21, 2015 Timothy Doerr, M.D. reviewed records and evaluated Claimant at Surety's request. Exh. N. He opined Claimant had suffered an injury caused by a work accident and that prior treatment had been appropriate, but that Claimant is not a reasonable candidate for a third biceps tenodesis based on several factors:

> First, the patient has demonstrated noncompliance with both physical therapy as well as his use of a sling on several occasions. Second, this would be the patient's third attempt at a biceps tenodesis. It is likely that the biceps tendon tissue will be less than optimal and unlikely to heal in the face of the patient's repeated noncompliance. Third, although the patient does complain of some weakness, he has good functional 5/5 biceps strength to manual testing.

Exh. N10. Dr. Doerr's opinion that Claimant is a poor candidate for the proposed third surgery included Claimant's movement being minimally restricted and a general lack of instability in the right shoulder. Exh. N10-11. He opined Claimant was medically stable with 5% upper extremity impairment, correlating to 3% whole person PPI under the AMA Guides Sixth Edition, with no apportionment to preexisting conditions. Exh. N11. He recommended a permanent 50-pound lifting restriction resulting from the work accident. Exh. N11.

34. Surety mailed Dr. Tashjian a copy of Dr. Doerr's IME report and requested comments on the findings. Exh. I81. On October 12, 2015 Dr. Tashjian indicated that his "only disagreement with the report is regarding the potential reasons for the revision besides cosmesis. Spasm in the biceps muscle is common in young patients in their dominant arm after a tenotomy. With the failure being at a low site, spasm is probably more likely." Exh. I81. As of the date of his deposition, Dr. Tashjian continued to recommend the third biceps revision surgery for Claimant.

Rehabilitation

35. The Industrial Commission Rehabilitation Division ("ICRD") opened a file for Claimant on April 30, 2013. Exh. M7. ICRD consultant Dan Wolford conducted a job site evaluation and interviewed Claimant for the first time on May 8, 2013. Exh. M2.

36. A June 13, 2013 note indicates that Claimant had presented Employer with a light-duty work release on June 12, 2013 and that a suitable job was arranged for Claimant to begin on June 13, 2013. Exh. M9. However, Claimant did not report on that day. Exh. M9. A June 14, 2013 ICRD note records that Claimant excused his no-show to Employer by claiming he was "simply in too much pain to perform work, even if it is light duty." Exh. M9.

37. Employer made a written offer of light-duty work on June 24, 2013. Exh. R26. Defendants offered copies of Employer's Supplemental Reports of Light Duty Hours for June 9, 2013 through August 28, 2013 during Mr. Kunde's deposition. Exh. R24, 28, 30, 36, 38, 40. Claimant used a doctor's order to wear his sling as an excuse for no-showing on July 1, 2 and 3 2013. Exh. R30. Claimant reported for scheduled work on August 12, 2013, worked for 2.3 hours of his scheduled 8-hour shift before he left without authorization from a supervisor. Exh. R38.

38. On August 20, 2013 Claimant told Mr. Wolford he had attempted the light-duty for about one and a half days. Exh. M11. Mr. Wolford noted, "Regardless of Dr. Andary's opinion, the claimant does not feel able to perform light-duty work." Exh. M11.

39. Mr. Wolford continued to try to help Claimant return to work with Employer through August 20, 2013. Exh. M11. Claimant spoke with Mr. Wolford on October 16, 2013 about his surgery with Dr. Andary; Mr. Wolford told Claimant that they could work together after it was completed to identify a new vocational direction. Exh. M12. Wolford's notes thereafter show Claimant repeatedly deferred or declined offers to help him return to work.

Mr. Wolford closed Claimant's file on February 12, 2014, stating "there if very little that can be done from a vocational standpoint." Exh. M15.

40. Mr. Wolford reopened Claimant's file on January 28, 2016 on referral from Claimant's Counsel. Exh. M17. During the re-open interview, Claimant proffered several reasons why "there is no way he could return to work". Exh. M18. Mr. Wolford closed the file, noting that "it is quite clear from my conversations with the claimant that he has no interest in returning to work currently." Exh. M18.

Testimonial Credibility of Witnesses at Hearing

41. The Commission notes several instances in the record that call Claimant's substantive credibility into question. Claimant gave long explanations to simple questions when testifying, particularly when discussing his failures to follow prior treatment recommendations. The record indicates that Claimant demonstrates a willingness to omit or include details inconsistently, as evidenced by his omissions of material facts to physicians despite being forthcoming with them during the hearing. For example, the record shows he denied prior substance abuse and as a result had significant complications with his prescribed pain medication. However, at hearing Claimant testified to prior alcohol and drug abuse, including three overdoses, and the time he spent in rehab as a result. These inconsistencies lead the Commission to conclude that Claimant is a questionable historian. When Claimant's testimony is in conflict with contemporaneous evidence in the record, the latter is afforded more weight.

42. By contrast, Mr. Kunde's hearing testimony appeared direct and responsive to the questions asked without apparent deception or evasion.

DISCUSSION AND FURTHER FINDINGS

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

793 P.2d 187, 188 (1990). The humane purposes which it serves leave no room for narrow, technical construction. *Ogden v. Thompson*, 128 Idaho 87, 88, 910 P.2d 759, 760 (1996). Facts, however, need not be construed liberally in favor of the worker when evidence is conflicting. *Aldrich v. Lamb-Weston, Inc.*, 122 Idaho 361, 363, 834 P.2d 878, 880 (1992). Uncontradicted testimony of a credible witness must be accepted as true, unless that testimony is inherently improbable, or rendered so by facts and circumstances, or is impeached. *Pierstorff v. Gray's Auto Shop*, 58 Idaho 438, 447−48, 74 P.2d 171, 175 (1937). *See also Dinneen v. Finch*, 100 Idaho 620, 603 P.2d 575 (1979); *Wood v. Hoglund*, 131 Idaho 700, 703, 963 P.2d 383, 386 (1998).

44. An employer is required to provide reasonable medical care for a reasonable time. Idaho Code § 72-432(1). A reasonable time includes the period of recovery, but may or may not extend to merely palliative care thereafter, depending upon the totality of facts and circumstances. *Harris v. Independent School District No. 1*, 154 Idaho 917, 303 P.3d 604 (2013). What constitutes reasonable medical care is to be determined by a totality of the circumstances approach. *Chavez v. Stokes*, 158 Idaho 793, 353 P.3d 414 (2015).

45. It is for the physician, not the Commission, to decide whether the treatment is required; the only review the Commission is entitled to make is whether the treatment was reasonable. *Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989). Where there is both a positive and negative diagnosis between two qualified doctors, the fact finder may examine the methodologies of both physicians to determine which physician is more credible. *Mazzone v. Texas Roadhouse, Inc.*, 154 Idaho 750, 759, 302 P.3d 718, 727 (2013). It is the role of the Commission to determine the weight and credibility of testimony and resolve conflicting interpretations of testimony. *Henderson v. McCain Foods, Inc.*, 142 Idaho 559, 565,

130 P.3d 1097, 1103 (2006). The Commission is not bound to accept the opinion of the treating physician over that of a physician who merely examined the claimant for the pending litigation. *Gooby v. Lake Shore Management, Co.*, 136 Idaho 79, 86, 29 P.3d 390, 397 (2001).

46. *Dr. Andary*. The physician who performed the first surgery on Claimant's shoulder and provided treatment thereafter, Dr. Andary strongly opined against Dr. Griffith's suggestions for an additional shoulder surgery and recommended instead that Claimant seek a third opinion. He did not offer opinion on the biceps procedures performed by Dr. Tashjian and was not deposed by the parties. His opinions are afforded weight only to the degree that they were relied on by Defendants in the chain of referrals for Claimant's medical treatment.

47. *Dr. Griffiths*. Dr. Griffiths conducted his IME with Claimant prior to the two surgeries performed by Dr. Tashjian and has not examined Claimant since November 2013. For the purposes of this litigation, his medical opinions are afforded weight only with regards to the shoulder condition.

48. *Dr. Tashjian*. As the treating physician recommending the proposed third surgery, Dr. Tashjian's treatment notes and deposition have been entered into the record. His reasoning for supporting the revision surgeries are inconsistent, and despite his testimony that his opinions are held to a reasonable degree of medical probability, the bulk of his testimony does not so demonstrate. Dr. Tashjian seems willing to perform surgeries that Claimant wants, but did not indicate in his notes nor could not recall at deposition why he supported the second and third revision surgeries. He also testified that such revisions were quite rare in his practice. For example, when asked about the second revision biceps tenodesis during his deposition, Dr. Tashjian testified:

> [N]ormally, I wouldn't do that. I'll be honest that for me, it's an unusual complaint or problem. So typically, like I get – like I was telling you, why do

> people complain about bicipital problems? They complain of two things. They complain of cramping or they complain of pain. And typically, with a tenodesis, the major complaint that they have is pain. And the reason why most patients complain of pain is because it's too tight. And so if you overtension or overtighten the biceps tenodesis, often times patients will hurt themselves exactly where you tenodesed them. And so if I do anything at the time of when I do a tenodesis, I like to make them just a little bit looser than tighter because I don't like patients coming back to me and having a painful arm.

Tashjian Deposition, p. 28, ll. 5-22. Dr. Tashjian testified prior to the second revision, he thought Claimant's bicep was looser than he would generally see for a revision. Tashjian Deposition, p. 29. He testified that in his practice, he had performed over 250 tenodeses and that Claimant's request for the second revision was unusual. Tashjian Deposition, pp. 29-30. Here, he recalled his major basis for the second revision was "for whatever reason, [Claimant] was really bothered by this from the looseness [of the muscle]. And I said we could move it up. And it's not like it can't be done." Tashjian Deposition, p. 29, ll. 21-24. He admitted he had never before performed a revision for purely cosmetic reasons. Tashjian Deposition, pp. 29-30. His medical notes made at the time do not mention any functional complaint as a basis for the recommendation for the second revision, but he testified that "[Claimant] and I think his wife, maybe, were concerned with regards to the biceps. And they were pretty focused on the cosmetic issued from one side to the other" during the discussion about the second revision. Tashjian Deposition, p. 21, ll. 13-16. Finally, Dr. Tashjian testified that the uncommon part of the second revision was Claimant "coming back and saying, 'Doc, I'm just unhappy with it.' And – because usually the reason why people come back and say they're unhappy is because they hurt." Tashjian Deposition, p. 30, ll. 13-16. His notes indicate that Claimant had no symptoms prior to the second revision surgery. Despite his hesitations and the MRI demonstrating that the biceps was still intact, Dr. Tashjian performed the second revision on June

5, 2015. By the previously scheduled follow-up appointment on July 7, 2015, Claimant was requesting the now-proposed third revision. Tashjian Deposition, pp. 50-51.

49. Dr. Tashjian testified that he would usually revise a tenodesis only for complaints of pain or muscle cramps. Tashjian Deposition, p. 80. At his deposition, he could not recall Claimant listing pain or functional limitations stemming from the dropped bicep; however, based on his practice, Dr. Tashjian doubted that his decision was based solely upon Claimant's dissatisfaction with the appearance of his arm. Tashjian Deposition, pp. 30-31. "[I]n general, if someone just came in with a cosmetic deficit without any significant symptoms, I would probably say to leave it. […] So what's the chance that he probably is having some pain in his arm? I've got to imagine that it was probably not zero." Tashjian Deposition, p. 45, ll. 7-14. He testified that patients react to having a dropped bicep muscle differently, with some complaining of weakness, spasm, and pain while others do not complain at all. Tashjian Deposition, p. 47. "Everyone's different. But this is something that's real and I think that for him to have a deposition that says he has complaints, I believe him." Tashjian Deposition, p. 47, ll. 19-22. He testified that "having a dropped biceps tendon, it's not necessarily the worst situation in the world. Patients -- typically, if you have a dropped biceps, they don't have pain usually. The one thing that sometimes patients complain about is cramping in the biceps muscle belly." Tashjian Deposition, p. 13, ll. 17-22. Dr. Tashjian agreed that Claimant's history of noncompliance reduced the likelihood of a near optimal outcome for the third tenodesis. Tashjian Deposition, p. 81.

50. Dr. Tashjian testified that he was more likely to recommend the revision for an existing patient than if he was consulted as a second opinion. Tashjian Deposition p. 83. Despite Claimant's history, Dr. Tashjian would "give him the benefit of the doubt" about future

compliance following a third revision surgery. Tashjian Deposition, p. 81, ll. 16. Dr. Tashjian explained his basis for revising the second tenodesis was largely Claimant's subjective dissatisfaction and reports of spasms, as opposed to objective findings on diagnostic imaging or examination. Dr. Tashjian explained that there are many people with dropped biceps that do not have problems, including two of his colleagues. Tashjian Deposition, p. 46. "[F]rom a functional standpoint, often times a biceps is not necessarily a hundred percent needed in order to actually be at a very high level." Tashjian Deposition, p. 46, ll. 22-24. Finally, when asked if he was still of the opinion that Claimant needs the proposed surgery, Dr. Tashjian responded, "I think if it's for cosmetic reason, then I would say no. But if he has deficits with regards to his *perceived* function of limited strength and use of the arm, then I think it's a reasonable operation to restore that." Tashjian Deposition, p. 52, ll. 8-12 (emphasis added). Dr. Tashjian's process notes do not mention spasm, and at deposition he said he "would probably presume that he was hurting or having problems with deficit." Tashjian Deposision, p. 45, ll. 5-6. Dr. Tashjian appears to be relying on Claimant's subjective reports of spasm, self-reported limitations, and concern with the appearance of his right arm. Dr. Tashjian acknowledges that he has the ability to give Claimant the desired procedure and generally seems to want to help Claimant. In Claimant's case, Dr. Tashjian appears to give a lot of deference to Claimant's subjective complaints of spasm and general desire for surgery:

> [I]n general Chris had been a good patient and he comes from a long way and he had participated in his care. He had a bad problem. He had been really complaining about this, complaining about it, and I thought trying to make him better would be okay.

Tashjian Deposition, p. 32, ll. 15-20. While admirable, Dr. Tashjian's genuine desire to give Claimant what he wants is not the best foundation upon which to support his recommendation for the proposed third revision procedure. Dr. Tashjian appears to have taken the position of

advocacy for Claimant, insofar as Claimant desires the third revision and Dr. Tashjian has the skills necessary to perform it. Without specific, objective findings regarding Claimant's symptoms or lack of function informing his recommendation for the third revision surgery, Dr. Tashjian's opinion is afforded less weight.

51. *Dr. Doerr*. Dr. Doerr conducted an IME on August 21, 2015. He opined that Claimant was not a reasonable candidate for the proposed revision surgery for several reasons. Exh. N10-11. First, Claimant's history of noncompliance following earlier surgeries increases the likelihood that Claimant will not improve after the proposed surgery. Second, prior multiple attempts at the procedure likely make the results of the third revision "less than optimal" and Claimant's "repeated noncompliance" make tissue unlikely to heal. Dr. Doerr explained that the chances of a near optimal result decline with additional trimming of the tendon as the process impairs the quality of the remaining tissue. Doerr Deposition, p. 45. He characterized the chances of successfully performing a third tenodesis as being "extremely remote." Doerr Deposition, p. 46, l. 13. Third, subjective reports of pain on biceps testing were not supported by any lack of function, voluntary or otherwise. Dr. Doerr testified that although Claimant had some subjective complaints of weakness, he had good strength on physical exam testing. Doerr Deposition, p. 10. He did not notice spasm in the biceps muscle during his exam. Doerr Deposition, p. 27. Dr. Doerr noted on exam that Claimant indicated he was having mild discomfort in the biceps during the strength testing, but that he did not observe any negative effects corresponding to the reported discomfort. Doerr Deposition, p. 27. Fourth, the only basis for performing the surgery is a complaint of subjective weakness not confirmed by strength testing during Claimant's physical examination. Fifth, such a repair is not critical to shoulder function. Dr. Doerr noted "mild discomfort with overhead elevation of the right shoulder"

during the IME. Exh. N10. He expanded by saying that overhead elevation is not really "the function of biceps." Doerr Deposition, p. 24, ll. 1-5. Sixth, despite Dr. Tashjian's comments in correspondence to Surety, Dr. Doerr did not observe muscle spasm in the examination and believes Dr. Tashjian's comments suggest he did not actually observe it either. Doerr Deposition, p. 51. Also, with proper physical therapy, Dr. Doerr opines that spasms would diminish over time. Seventh, best practices indicate the tenodesis attachment should be anchored at a spot on the bone lower than the original anatomical attachment, because raising the attachment tends to create additional postsurgical problems. In summary, Dr. Doerr testified:

> I think you have to look at the whole clinical picture, you know, the function of the shoulder -- the patient's symptoms, the function of the shoulder, any residual deficits, and the risk versus the benefit of surgery. And I believe it's -- in my opinion, it's very clearly medically more probable than not that the surgery is unlikely to provide the patient with any benefit over his current level of functioning.

Doerr Deposition, p. 48, ll. 5-12. Finally, Dr. Doerr testified that "even in a compliant patient with this clinical picture, I would not recommend a third attempt at a biceps tenodesis." Doerr Deposition, p. 58, ll. 12-14. The concern about Claimant's compliance with post-operative directions is only one component of Dr. Doerr's opinion against the third surgery. When weighed against the conflicting opinion of Dr. Tashjian, Dr. Doerr's conclusions regarding Claimant's condition, functional ability, decreased likelihood of a successful outcome with repeated surgical procedure, and other related circumstances more adequately support the finding that the proposed surgery is unreasonable per *Chavez*. Dr. Doerr's opinion that Claimant is not a good candidate for proposed biceps tenodesis is persuasive.

52. The Idaho Workers' Compensation Law supports an injured worker getting medical care to restore his ability to return to the workforce. The Commission's desire to effectuate fully this principle includes cases in which purely palliative care has been approved

and required. Here, a treating physician opines the procedure is reasonable and is willing to perform it. That was enough of a basis in a recent case. *See, Hernandez v. Taco Shop, Inc.*, IC 2013-021538 (December 9, 2016). However, the recommendation in Hernandez for an additional surgery was grounded in objective conditions observable by the physician, including knee swelling and a posterior tear on the medial meniscus confirmed by MRI. Claimant in the instant case has one physician who noted a lack of objective symptoms and another who failed to note objective symptoms in his records and could not recall observing spasm in Claimant's bicep prior to recommending the surgery at deposition. Based on a totality of the circumstances surrounding Claimant's case, including Claimant's current level of function, the number of prior surgeries to the same part of Claimant's body, a general lack of supporting medical documentation establishing that the third revision surgery is required, and Claimant's past lack of compliance with post-surgical doctor's directives, the Commission is not persuaded that the third revision procedure is reasonable. Claimant has failed to establish that the proposed tenodesis constitutes reasonably required medical treatment pursuant to Idaho Code § 72-432.

Idaho Code § 72-435

53. Idaho Code § 72-435 allows for the suspension or reduction of compensation if an injured employee "persists in unsanitary or unreasonable practices which tend to imperil or retard his recovery." As Claimant has failed to establish that the proposed surgery constitutes reasonably required medical treatment, the issue of whether his failure to comply with post-operative doctors' instructions regarding physical therapy and the use of the sling as causing the need for the third revision is moot.

Medical Stability

54. Having found that Claimant is not entitled to the proposed third revision surgery, Dr. Doerr's date of medical stability, August 21, 2015, is appropriate.

Temporary Disability

55. Once a claimant establishes by medical evidence that he is within a period of recovery from the original industrial accident, he is entitled to total temporary disability benefits unless and until evidence is presented that he has been medically released for light work and that his former employer has made a reasonable and legitimate offer of employment to continue throughout his period of recovery that the claimant is capable of performing under the terms of his light work release. *Malueg v. Pierson Enterprises*, 111 Idaho 789, 727 P.2d 1217 (1986).

56. Claimant avers he is entitled to TTD benefits from November 18, 2013, the date of his appointment with Dr. Griffiths, through the date of the first surgery by Dr. Tashjian on August 27, 2014. Dr. Griffiths opined that Claimant was not medically stable as of November 18, 2013 and required additional surgery related to the industrial injury. Surety accepted responsibility for the August 27, 2014 surgery and commenced TTD benefits effective the date of the surgery. Claimant is entitled to TTD benefits for the period of November 18, 2013 through August 27, 2014.

57. Claimant further avers he is entitled to TTDs after September 7, 2015, when Surety ceased the payment of benefits based on Dr. Doerr's opinion that Claimant was at MMI. As Claimant has failed to demonstrate that the third revision surgery is reasonable, Claimant is not entitled to additional TTDs beyond August 21, 2015, the date of medical stability. Defendants are entitled to a credit for TTD overpayment as available per Idaho Code § 72-316.

CONCLUSIONS OF LAW AND ORDER

1. Claimant failed to show a third biceps tenodesis constitutes reasonable medical care.

2. Claimant reached medical stability no later than August 21, 2015.

3. Claimant is entitled to temporary total disability benefits from November 18, 2013 through August 27, 2014.

4. The issue of temporary total disability benefits related to the reasonableness of additional surgery is moot.

5. The issue of the impact of Idaho Code § 72-435 on Claimant's entitlement to benefits is moot.

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

DATED this 14th day of March, 2017.

INDUSTRIAL COMMISSION

___/s/_____
Thomas E. Limbaugh, Chairman

___/s/_____
Thomas P. Baskin, Commissioner

___/s/_____
R.D. Maynard, Commissioner

ATTEST:

___/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 14th day of March, 2017, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** was served by regular United States Mail upon each of the following:

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