BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

JOSEPH LEE POWLUS, Claimant, v. TWIN FALLS SCHOOL DISTRICT #411, Employer, and STATE INSURANCE FUND, Surety, and STATE OF IDAHO, INDUSTRIAL SPECIAL INDEMNITY FUND, Defendants.	**IC 2010-011942** **2013-012375** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **Filed 1/16/18**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Michael E. Powers, who conduced a hearing in Twin Falls on March 22, 2017. Claimant was present as was his attorney, Jeff Stoker of Twin Falls. Scott Hall of Idaho Falls represented Employer, Twin Falls School District #411 (Employer), and its Surety, State Insurance Fund (SIF). Bren Mollerup of Twin Falls represented State of Idaho, Industrial Special Indemnity Fund (ISIF). Oral and documentary evidence was presented and the parties took three post-hearing depositions. The parties then filed post-hearing briefs and this matter is now ready for decision. The Commission disagrees with Referee Powers' treatment of the "combining with" element of ISIF liability and enters its own decision in the matter.

ISSUES

The issues to be decided are:

1. Whether Claimant is totally and permanently disabled; and, if so,

2. Whether ISIF is liable; and, if so

3. Apportionment pursuant to the *Carey* formula;[1] and

4. Whether Claimant is entitled to past and future pain management treatment;

CONTENTIONS OF THE PARTIES

There is no serious dispute in this matter that Claimant is totally and permanently disabled, by either the 100% or odd-lot methods. The real dispute is over whether ISIF is liable for a portion of that disability. Employer asserts that Claimant's total disability is a combination of his pre-existing impairments coupled with the effects of his last two industrial accidents. ISIF contends that Claimant's disability is the result of a combination of Claimant's age, education, and inability to use his dominant right arm, and that ISIF bears no proportional liability in this matter.

Claimant also seeks reimbursement for certain prescriptions and doctor visits as well as continuing payment by Employer for Claimant's pain management program. He also requests the Commission's guidance regarding the applicability *Corgatelli v. Steel West*, 157 Idaho 287, 335 P.3d 1150 (2014) and Employer's right to credit any monies paid for PPI against any total disability benefits awarded.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant taken at the hearing.

2. Joint Exhibits (JE) 1-52 admitted at the hearing.

3. The post-hearing depositions of: Robert H. Friedman, M.D., taken by Employer on May 9, 2017, Nancy J. Collins, Ph.D., taken by Employer on May 19, 2017, and that of Douglas N. Crum, CDMS, taken by ISIF also in May 19, 2017.

[1] *Carey v .Clearwater County Road Dept.*, 107 Idaho 109, 686 P.2d 54 (1984).

All pending objections are overruled. ISIF's motion to strike made during the taking of Dr. Friedman's deposition is denied and the testimony objected to will be assigned whatever weight the Commission deems appropriate.

After having considered all the above evidence and briefs of the parties, the Commission enters the following findings of fact and conclusions of law.

FINDINGS OF FACT

Claimant's Hearing Testimony

1. Claimant was 66 years of age and residing in Twin Falls as of the date of the hearing.

2. Claimant graduated from Twin Falls High School then attended the College of Southern Idaho in general studies; he lacked two credits in obtaining his associate's degree. He is a certified welder.

3. Claimant's entire work life has been in manual labor.

4. Claimant began working for the Employer on September 7, 2009. He described the general nature of his duties as follows:

> Nightly we would clean all the classrooms. Vacuum. Clean off all the white boards. Chalk boards. Dusting. If there was something that got broken during the daytime we would try to repair that, if it was within our ability. We would mop almost every night the large auditorium and we would clean the auditorium itself. And time allowing - - like right now during spring break we will actually be stripping floors with strippers and rewaxing and buffing floors and painting during the summer. A lot of maintenance during the summer, because you have repair work. Changing classrooms for teachers. A lot of lifting.

Tr., p. 19.

5. Claimant described his job as very physically demanding. Despite Claimant's many physical challenges (to be described in greater detail later), Claimant was able to fulfill the requirements of his job:

> I was. I did - - after I sat down and actually went through all the problems I have had in the past I found that I had been accommodating for a lot of things that I had to do. There was different ways I found to accommodate that. I mean with all my prior - - my

> knee problems, my foot problems, even my shoulders where I had steroid shots every so often, there was just a lot of things that were - - that were preexisting that I didn't really think about it at the time in my last deposition, but they did play a large part in the way I had to do my work - - and accommodate for it.

Id., p. 20.

6. On April 22, 2010, Claimant suffered an injury to his right shoulder while pulling a 55-gallon trash container through wet grass. He was evaluated by William May, M.D., on June 8, 2010. Claimant was diagnosed with an acute rotator cuff tear. On July 7, 2010, Dr. May performed an open rotator cuff repair on Claimant's right shoulder. Claimant developed a post-operative wound infection and on July 28, 2010, Dr. May performed irrigation and debridement of the right shoulder.

In a note dated September 14, 2010 Dr. May stated his intention to release Claimant to return to work without restrictions vis-à-vis his right shoulder as of September 20, 2010. Dr. May's contemporaneous office note of September 14, 2010 is somewhat more cautionary:

> I will allow him to return to work but he knows to be careful and not do any real aggressive lifting. He assures me that he is able to do most of his job without doing that. I will therefore release him to return to work. He will continue therapy and gradually increase his theraband exercises. He was cautioned not to do any overhead throwing or jerking with the shoulder and he understands.

D. Exh. 21 at 2409. Claimant's right shoulder complaints persisted even though he returned to work for employer within 6 to 8 weeks following the debridement surgery. (Tr., p. 93). Claimant testified to how he got along at work following his return in the fall of 2010:

> Q. [By Mr. Hall]: Okay. And when you went back to work were you able to do your job?
>
> A. I was able to accomplish my job by accommodating for the pain I was still having. I was a lot more careful when it come to lifting things. I didn't try to lift something that I knew I couldn't without asking for help and, like I said, I was - - yes, I was able to accomplish my job, but I had to accommodate in different ways to accomplish that task.

Id., p. 93-94. He was able to perform his customary work in this fashion until the 2013 left wrist injury.

Id., p. 96.

7. Dr. May eventually referred Claimant to C. Scott Humphrey, M.D., for further evaluation of the shoulder. Dr. Humphrey first saw Claimant on March 24, 2011. Dr. Humphrey noted Claimant's complaints of ongoing discomfort, but noted that he continued to work as of March 2011. Dr. Humphrey suspected that Claimant might be suffering from a partial thickness tear of the supraspinatus and subscapularis tendons, an unstable long head of the biceps tendon and/or a labral tear. Dr. Humphrey recommended repeat surgery and Claimant took this recommendation under advisement. He continued to work for Employer and appears to have next been seen for his right shoulder by Roman Schwartzman, M.D., on or about April 26, 2012. Dr. Schwartzman noted that Claimant continued to work for his time-of-injury employer "within his limitations" and was reluctant to undergo any further right shoulder treatment out of concern for his job. Dr. Schwartzman suspected that Claimant had suffered a recurrent rotator cuff tear with biceps and labral pathology as well.

8. In October 2012, Dr. Schwartzman performed a right knee arthroplasty for Claimant. Subsequent to that procedure, Dr. Schwartzman and Claimant continued to discuss Dr. Schwartzman's recommendation for surgical treatment of the right shoulder. Claimant expressed his reluctance to undergo shoulder surgery, eventually advising Dr. Schwartzman on November 20, 2012, that he had decided against having the revision surgery. At that point, Dr. Schwartzman pronounced Claimant medically stable and gave him a 6% upper extremity rating for the right shoulder. Dr. Schwartzman's note of December 13, 2012 reiterated Claimant's decision to forego further surgical intervention. Dr. Schwartzman noted that Claimant wished to return to his time-of-injury occupation and felt that he could do so. The 6% upper extremity rating was given without apportionment to any pre-existing condition. Dr. Schwartzman also authorized a release to return to work without restriction as of December 13, 2012. See D. Exh. 28 at 3336.

9. As developed *infra*, Claimant suffered his second work-related injury, this one involving his left wrist, on April 25, 2013. On or about May 21, 2013, Claimant again presented to Dr.

Schwartzman for evaluation of his right shoulder. Dr. Schwartzman recorded that Claimant was unable to function with the right shoulder the way it was. At hearing, Claimant testified as follows about his reasons for seeking shoulder evaluation following the left wrist injury:

> Q. [By Mr. Stoker] And tell me what happened in May of 2014.
>
> A. I got to the point to where I didn't really want to have any more surgery and I made up my mind I wasn't going to, because they weren't helping, but my fingers on my right hand started going numb and so I had talked to Dr. Schwartzman about it and I was afraid it had something to do with my right shoulder still, so he did - - he did an operation at that time that we lined up.

Tr., p. 25-26. Pending MRI evaluation of the shoulder, Dr. Schwartzman restricted Claimant against lifting, pushing or pulling with the right arm.

10. On June 12, 2013, Dr. Schwartzman performed a right shoulder surgery to repair Claimant's torn rotator cuff. He also performed a biceps tenodesis, subacromial decompression and distal clavicle resection. By September of 2013, Dr. Schwartzman noted that Claimant was progressing in his recovery, and encouraged him to participate in routine house and yard work activities in addition to his physical therapy.

11. By December 10, 2013, Claimant was six months post-op. Dr. Schwartzman noted that Claimant's right shoulder function had regressed. He recommended an MRI arthrogram to assess Claimant's right shoulder for failure of the rotator cuff repair. That study, performed on December 19, 2013, demonstrated, *inter alia*, full thickness tearing of the distal supraspinatus tendon. Discussing a path forward, Dr. Schwartzman stated Claimant's surgical options were limited to a reverse shoulder arthroplasty. He referred Claimant back to Dr. Humphrey for further evaluation of Claimant's candidacy for this procedure. Interestingly, Dr. Schwartzman commented that pending a decision on surgery, Claimant was still at MMI with no change to the 6% upper extremity rating previously rendered by Dr. Schwartzman.

12. Claimant was again seen by Dr. Humphrey on March 20, 2014. Dr. Humphrey proposed that the only procedure that would be expected to alleviate Claimant's pain complaints was a reverse shoulder arthroplasty. He advised Claimant that even with a good outcome, Claimant would be permanently restricted from lifting more than 25 pounds following the procedure. Claimant agreed to proceed, and Dr. Humphrey performed the right shoulder reverse arthroplasty on May 13, 2014. By August 20, 2014, Dr. Humphrey noted that Claimant was doing well. Dr. Humphrey released Claimant to lift up to 10 pounds, but to avoid frequent lifting. He expected that Claimant would be able to return to work within three months following August 20, 2014 without restriction.

13. By October 10, 2014, Claimant's pain complaints had increased. He asked Dr. Humphrey when he might be able to return to work. Dr. Humphrey indicated that he would release Claimant to return to "desk work" with a 1 pound lifting restriction, along with an admonition to avoid lifting the arm above shoulder level and to avoid pushing objects heavier than 1 pound. By November 17, 2014 Dr. Humphrey felt it appropriate to release Claimant with the following limitations/restrictions:

1) No lifting the operative arm past the shoulder level.
2) No pushing or pulling objects heavier than 5 lb. with the operative arm.
3) No lifting any object heavier than 5 lb. with the operative arm.
4) No climbing ladders.

D. Exh. 26 at 3321. Dr. Humphrey's note of December 8, 2014 reflects that Claimant had suffered an increase in symptomatology since Thanksgiving. Dr. Humphrey believed that Claimant had torn the subscapularis tendon repair. He did not think that Claimant would benefit from surgery to repair this defect. Accordingly, he felt it less likely that Claimant would eventually be able to return to his time-of-injury job. However, he nevertheless revised his restrictions for Claimant as follows:

1) No lifting the operative arm past the shoulder level.
2) No pushing or pulling objects heavier than 10 lb. with the operative arm.
3) No lifting any object heavier than 10 lb. with the operative arm.
4) No climbing ladders.

D. Exh. 26 at 3225. By February 2, 2015, Dr. Humphrey felt that Claimant was at a point of maximum medical improvement. He did not believe that Claimant would return to janitorial work, but recommended a functional capacity evaluation to better delineate Claimant's residual functional capacity.

14. In his report of March 15, 2015, Dr. Friedman stated his agreement with Dr. Humphrey's 10 pound lifting restriction.

15. Therefore, while the record does substantiate a 10 pound lifting restriction following Claimant's right shoulder reverse arthroplasty, there is very little evidence describing the functional capacity of Claimant's right shoulder following his return to work in 2010, and until he returned to Dr. Schwartzman for evaluation in May of 2013. For his part, Claimant testified that for this period of nearly three years, he was able to perform the requirements of his job using various self-accommodation strategies. (Tr., p. 93-94). It has been argued that Dr. Schwartzman released Claimant to return in December of 2012 without restrictions, despite his sure knowledge that Claimant actually did have significant right shoulder limitations/restrictions. The record provides no insight either supporting or denigrating this proposition. However, it does seem clear that Claimant continued to have right shoulder limitations during the period 2010 through 2013, although, he was able to perform the requirements of his job notwithstanding these difficulties. While we acknowledge that Claimant was not symptom-free during this timeframe, the record does not give us a more precise description of Claimant's functional abilities relating to his right shoulder during the period 2010 thru 2013. Understanding the extent and degree of Claimant's functional limitations vis-à-vis the right shoulder prior to the April 2013 left wrist injury is important because, as developed *infra*, we conclude that Claimant's right shoulder must be evaluated at this point in time for purposes of evaluating ISIF liability, not as his right shoulder condition evolved subsequent to the April 2013 left wrist injury.

16. On April 25, 2013, Claimant injured his **left wrist** (Claimant's right wrist had been previously fused), when he and others were opening some bleachers and a broken support board allowed the bleacher to "spring back" when it hit the end of the track, forcing Claimant's left wrist backwards. Claimant had surgery on his left wrist in October 2013. Post-surgery, Claimant could not use his left wrist. He eventually underwent another left wrist surgery in December 2013 followed by physical therapy.

17. Claimant described the limitations posed by his left wrist injury this way:

> Just being able to help myself dress. I can't reach behind me with it. I have lost almost all my dexterity with it, like trying to pick something up from the floor. I have a hard time turning knobs with it. I have a hard time dressing myself. My wife helps me a lot of times. I just find - - I mean when you have something fused solid you just lose all - - almost all of your motion of that hand, so it's really hard to do anything as far as like hammering, turning a screwdriver, or anything of that nature and I am in - - I go to the Southern Idaho Pain Clinic once a month. It is constantly throbbing even at this point.

Id., p. 31.

18. As noted, Claimant also has a **right wrist** problem resulting in a right wrist fusion in 2007. Claimant blamed general wear and tear for his right wrist fusion. He was forced to close his fiberglass repair shop after 27 years, due to this injury. Claimant considered his right wrist problem to be a hindrance to his employment with the Employer in that he had to make accommodations regarding gripping and lifting objects. Tr., p. 36-37; 81.

19. Claimant underwent a **right knee** TKA in October 2012. He had experienced right knee problems before his employment with Employer. He constantly limped and at times, when walking, his right knee would "give out' on him. It got to where he would have to drive between two job sites that he could walk to before his right knee got worse. Claimant continued to have problems with his right knee after his TKA and considered it to be a hindrance that he was able to accommodate by using other body parts to accomplish what he had to do.

20. Claimant was diagnosed with **rheumatoid arthritis** (RA) in 2007 after his left wrist fusion. His RA resulted in pain in both of his knees and ankles as well as knuckle and finger joint pain. Claimant was unable to have his RA treated until 2011 at which time his bilateral knee pain improved. Claimant still has some problems with his right ankle and he wears a right ankle brace "most of the time." Claimant was able to continue working by making accommodations for his RA.

21. Claimant was also diagnosed with **cervical spine degenerative arthritis** before his 2010 accident. This condition affected Claimant's lifting capabilities as well as vacuuming and floor sanding.

22. Claimant has suffered from **asthma** or chronic bronchitis for the past 15 or 20 years. He uses two inhalers almost daily and sometimes three times a day for shortness of breath. It would take 15-20 minutes for him to clear up enough to resume his duties. Claimant considered this condition to be a hindrance to his employment.

23. Claimant also suffers from **depression** that he attributes to the time when he had to sell his business due to his right wrist fusion. He uses Alprazolam to help him calm down.

24. Claimant also experienced bilateral hand **tremors** that affect his ability to lift and manipulate fine objects before his 2010 right shoulder injury.

25. Claimant also has a **TMC left thumb** injury that he relates to his 2013 left wrist injury.

26. Claimant also had a **bunionectomy**. He pulled a lawn mower over his left foot when he was 13 or 14 years of age, causing his big toe to start growing outward, creating pain and interfering with his ability to walk. Claimant eventually had corrective surgery; the bunionectomy and a redo. His left big toe is essentially fused, leaving Claimant with no flexibility in that toe. Claimant was left with a limp that caused him to feel like he was going off balance and would have to catch himself.

27. Claimant experienced **left shoulder** pain from time to time for which he received steroid injections. His left shoulder condition (caused by overuse according to Claimant) limited his ability to reach overhead with his left arm.

28. Claimant also experienced numerous **hernias** (five or six surgeries) as of 2010 that limited the way he lifted.

29. Claimant sees Dr. Dille at the Southern Idaho Pain Institute primarily for right shoulder and left wrist pain. Surety ceased paying for Dr. Dille's treatment on April 9, 2015 and Claimant's private insurance has paid since. Claimant continues to see Dr. Dille monthly for pain management.

30. Claimant testified that had he not injured his left wrist in 2013 (even when considering his right shoulder surgeries), he planned on continuing to work until age 66 or 67 because, during his 27 years of self-employment, he had not built up much Social Security Retirement earnings.

31. Claimant underwent **carpal tunnel** surgery in 2016 that was unrelated to his employment.

32. Claimant had a **pacemaker** installed in 2017 to help with fatigue issues.

33. Since his last two accidents at Employer's, Claimant has been unable to fish, hunt, play with his grandkids, or have a sexual relationship with his wife. Due to right shoulder pain, Claimant does most of his driving with his left hand.

Cross examination by Employer's counsel

34. Claimant has suffered from **GERD** for at least 20 years and has had two surgeries associated therewith. Other than having to stop work to take an anti-acid on occasion, Claimant's GERD did not affect his ability to do his work.

35. Claimant's depression/anxiety affected his work in 2013 and he considers it to be a hindrance to his employment.

36. Besides his bunion condition, Claimant also suffered from **plantar fascitis** since the 1980s. He has had releases on both feet which have left his bilateral heels numb and have an affect on his walking and balance. His plantar fascitis and his knee condition made it so that he would have to "single step" when ascending stairs or ladders. He would ask for assistance when using tall ladders.

37. Claimant has suffered from **COPD** since 2008. He would get fatigued easily upon exertion and had to use his inhalers "quite constantly."

38. Claimant's employment ended in April 2013 after efforts by Employer to accommodate him proved to be futile. Claimant applied for and receives SS Retirement and is on Medicare.

39. Claimant is a certified TIG and MIG welder, has run an overhead hoist and can operate a Hyster. He repaired and manufactured anything made from fiberglass and made canvas boat covers at his own business for 27 years. He has knowledge regarding the installation of sprinkler systems, painting, and stitching conveyor belts together, and also repairing jet skis and hot tubs.

40. Claimant's right wrist fusion in 2007 resulted in a complete loss of flexion making it impossible for him to use a screwdriver or hammer with his right (dominant) hand. He would accommodate by using his left hand. He also had difficulty opening jars and screwing on bolts.

41. By the time of Claimant's 2010 seventh hernia operation, Claimant was restricted to lifting no more than 50 pounds. He would generally ask for help lifting heavier items but there were times when he exceeded the 50-pound limitation.

42. Claimant was diagnosed with a torn rotator cuff in his left shoulder in 2003. In lieu of surgical repair, Claimant has been getting epidural steroid shots a couple of times a year. His left shoulder has made it difficult for him to reach up with his left arm.

43. Claimant had his right knee replaced in 2012. Before that, Claimant wore knee pads or knee braces and drove to places where he had previously walked.

44. Claimant has had difficulty with his left wrist since his 2013 fusion and takes pain medication to be able to function. He attributes his inability work to a combination of his pre-existing impairments and his left wrist injury. Claimant testified that but for his left wrist injury, he would still be working.

Cross examination by ISIF counsel

45. Claimant acknowledged that he was still undergoing treatment for his right shoulder injury in November 2012 and informed his treating physician in December that, in spite of the offer, he did not want any more right shoulder surgeries (after having two that "failed"). At hearing, Claimant testified that his right shoulder caused some limitations on performing his work prior to his right shoulder injury of 2010; however, he admitted that in his deposition he testified that his right shoulder caused no such limitation. After his 2013 left wrist injury, Claimant decided to have an additional shoulder surgery to address numbness in the fingers of his right hand.

46. Claimant testified in his 2016 deposition that his left shoulder[2] and low back gave him no problems at work prior to 2013. He also testified that his right knee replacement in 2012 caused him no problems at work post-surgery.

Medical Evidence

Robert Friedman, M.D.

47. Dr. Friedman is a physiatrist whose credentials are well-known to the Commission and will not be repeated here. His CV may be found at JE 42, beginning at p. 4242. The parties stipulated that Dr. Friedman is qualified to testify as an expert medical witness in this matter and the Commission so finds.

[2] Claimant clarified at hearing that after he had a chance to review his deposition transcript, he does not know why he so testified, other than trying to be a "he-man," that his left shoulder did not bother him before he was diagnosed with a rotator cuff tear in 2013. His left shoulder did, in fact, bother him and he made accommodations as a result.

48. Employer asked Dr. Friedman to conduct an IME and assign certain PPI ratings which was accomplished on March 12, 2015 (See JE 42). Dr. Friedman testified as follows in his deposition regarding when it is appropriate to give PPI ratings:

> Well, the AMA Guide is pretty clearly outlined. It says, "Impairment should not be considered permanent until a reasonable time has passed for healing or recovery to occur." And that, of course, depends on the specific injury. "That the medical condition is static and well stabilized for the person [sic] who have reached MMI." It also says that "if the patient either declines or fails to comply with treatment can be considered at MMI. It says, "MMI determination may still be required even when logistic barriers or compliance issues preclude optimal disease control and/or organ functioning." And it says, "If the patient declines therapy for permanent impairment that decision does not decrease or increase the estimated percentage of impairment, nor does it preclude any impairment valuation per se." And it says when you do your documentation you should write down that the patient is at MMI with or without treatment and estimate the impairment rating if patient had cooperated with the treatment recommendations.
>
> So that is what the AMA Guide says. I have to recognize that it is usually patients who chose not to go through certain procedures either because any procedure has a risk of benefits, as well as risks to complications. And some people chose not to go through treatments because they might have a bad outcome or a complication. It doesn't change that they can reach MMI and be rated.

Friedman Depo., p. 7-8.

49. Dr. Friedman recalled that Claimant's right shoulder was rated by his treating physician (Dr. Schwartsman) at the time when Dr. Schwartsman was recommending further surgery to repair a re-torn rotator cuff. Claimant refused the surgery and wanted to be rated so that he could return to work. Dr. Schwartsman assigned a 6% upper extremity PPI rating without apportionment.[3] Dr. Friedman testified that assigning a PPI rating under these circumstances is consistent with the Guides and presumes that if Claimant had undergone the recommended surgery, and the surgery had been successful, he would be entitled to the 6% rating.

50. Between the time when Dr. Friedman expressed his agreement with the 6% upper extremity PPI rating and the time he saw Claimant in his IME, Claimant had decided to submit to

[3] Dr. Friedman would have apportioned 50% of the 6% to Claimant's preexisting rheumatoid arthritis.

another right shoulder surgery. However, that does not mean that Claimant was not at MMI at the time his treating surgeon initially rated him.

51. Dr. Friedman was asked to prepare a total body PPI rating. He calculated Claimant's **right shoulder** whole person PPI to be 18% whole person with 50% apportioned to pre-existing conditions. Dr. Friedman assigned a higher rating than the original 6% because, since then, Claimant had undergone a right shoulder replacement.

52. Dr. Friedman also assigned an 18% whole person PPI rating with 50% apportioned to pre-existing conditions for Claimant's **left wrist**.

53. Dr. Friedman assigned an 18% whole person PPI rating with 50% apportioned to pre-existing conditions for Claimant's **right wrist** fusion. He considers this condition to be a hindrance to Claimant's employment.

54. Dr. Friedman assigned a 10% whole person PPI rating without apportionment for Claimant's **right knee** arthroplasty. He considers this condition to be a hindrance to Claimant's employment.

55. Dr. Friedman assigned a 10% whole person PPI rating without apportionment for Claimant's **rheumatoid arthritis**. Although well-controlled, Dr. Friedman considers this condition to be a hindrance to Claimant's employment.

56. Dr. Friedman assigned a 6% whole person PPI without apportionment for Claimant's **cervical condition**. He considers this condition to be a hindrance to Claimant's employment.

57. Dr. Friedman assigned a 6% whole person PPI rating without apportionment for Claimant's **chronic asthma**. He considered this condition to be a hindrance to Claimant's employment.

58. Dr. Friedman assigned a 5% whole person PPI rating without apportionment for Claimant's gastroesophageal reflux disease (**GERD**). He did not consider that condition to be a hindrance to Claimant's employment.

59. Dr. Friedman assigned a 5% whole person PPI rating without apportionment for Claimant's **depression**. He considered that condition to be a hindrance to Claimant's employment.

60. Dr. Friedman assigned a 5% whole person PPI rating without apportionment for Claimant's **bilateral hand tremors**. He considered this condition to be a hindrance to Claimant's employment.

61. Dr. Friedman assigned a 2% whole person PPI rating for Claimant's **CMC left thumb** injury. Dr. Friedman considered this injury to be related to Claimant's left wrist injury in 2013 and not pre-existing.

62. Dr. Friedman assigned a 1% whole person PPI rating for Claimant's **bunionectomies**. Dr. Friedman considered this condition to be a hindrance to his employment.

63. Claimant has testified that prior to the April 2013 left wrist injury, he used his left upper extremity to perform most tasks, and used his right, mainly as an assist.

64. Regarding Claimant's testimony that but for his left wrist injury he would still be working, even with his right shoulder injury, Dr. Friedman offered the following comments on the impact of Claimant's loss of left wrist function on his ability to perform work:

> Well, not only did he have a right shoulder problem, but prior to that he had his right wrist fused. I don't think I asked him that question. But from a medical standpoint your hands are the functional unit for your arms. And that your shoulders [sic] job is to put your hand in space so you can do things. And the fact that he had a right wrist fusion, and even a right shoulder problem, he was still able to work left-handed. Because his left hand and wrist was still able to be placed in space functionally and do activities. And it wasn't until he had his left wrist injured and fused that he now has both wrists that have very limited motion. And to be employable with both of your wrists having limited motion would be - - I would anticipate that would be extremely difficult given the limitations of motions of your hands. So I would expect him with his wrists being fused to have difficulties in doing even some basic things from activities of daily living like buttoning buttons, zipping zippers, tying shoes, because he doesn't have the wrist motion

> to do it. So I think the tip over for him was he has no wrist motion in 2013 after he injures his left wrist. He was doing fine up until then because he had a normal left wrist. And until he injured his - - I'm trying to think how to say it. Yeah, there is no reason why he wouldn't keep working. I am assuming, because I have no knowledge of this, that he was getting reasonable reviews at work and they weren't saying you're not able to perform your job. He had been successfully performing his job for three years. And assuming nothing changes he would be able to continue to work until he either retired or elected not to work.

Friedman Depo., p. 23-24.

65. It was following the April 2013 left wrist injury that Claimant returned to Dr. Schwartzman to review options for surgical repair of the right shoulder. As for Claimant's renewed interest in right shoulder surgery, Dr. Friedman has speculated that because Claimant's left wrist injury left him unable to perform many tasks with his left upper extremity, it became important to restore some function to the right. *Id*., p. 25-26. However, Dr. Friedman testified that he did not discuss this matter with Claimant, and that the supposition is Dr. Friedman's alone. *Id*., p. 52. As noted, *infra*, Claimant's explanation is different.

66. Dr. Friedman explained that restrictions are given after an injury to prevent further injury; limitations are what a person cannot do physically after an injury such as being able to rotate a fused wrist.

67. While Dr. Friedman agreed with Dr. Schwartsman's 6% upper extremity rating for Claimant's right shoulder, he would have apportioned 50% to Claimant's pre-existing RA. Dr. Friedman does not know why Dr. Schwartsman did not acknowledge Claimant's RA, as it was well-managed but pervasive. Even so, for unknown reasons, RA is not in all joints at the same time. Claimant's RA did not contribute to his post-arthroplasty right shoulder restrictions and should not be apportioned.

68. Regarding Claimant's continued pain following his right shoulder arthroplasty, Dr. Friedman opined that there could be three causes therefor. First, did the nerves get damaged in the implanting process? Second, were the muscles and ligaments stretched during the implanting process?

And three, did a bone get cracked during the implanting process or was the prosthesis put in too tightly so that it is putting pressure on the bone? Dr. Friedman was unable to state the exact cause of Claimant's continuing right shoulder pain as he does not have a "pain-o-meter." *Id.*, p. 45.

69. In spite of the above three potential causes for Claimant's ongoing right shoulder pain, Dr. Friedman remains of the opinion that it is Claimant's RA, and not his right shoulder itself, that is causing his pain:

> Well, at least from my recollection of meeting Mr. Powlus, he has pain in places where he can't move. Where he is fused he complains of pain there. And if he is complaining of pain where he has got fusions he has pain in his wrist. My exam doesn't show any nerve injuries. And he can't move the joint. So it can't be hurting. So my interpretation would be he has rheumatoid arthritis, and the erosions, and the inflammatory processes causing pain.

Id., p. 47-48.

70. Dr. Friedman acknowledged that his 50% RA and 50% industrial injury apportionment for Claimant's left wrist and right shoulder is an estimate based on his clinical experience. He explained how he arrived at the 50% apportionment for Claimant's right shoulder:

> I came to 50 percent for the right shoulder because that is my estimate. It is just an estimate. There is no way to calculate because I don't have all the pieces and parts. I know he had got rheumatoid arthritis. I know it is in multiple joints. I think it was in his shoulder before. He told me he had a previous left shoulder injury that he never reported.

Id., p. 52.

71. Dr. Friedman testified that there was no specific process followed to reach his conclusion that Claimant's RA warranted a 10% whole person PPI rating, again relying on his clinical experience and judgment.

Vocational Evidence

Nancy J. Collins, Ph.D.

72. Employer and its Surety, SIF, retained Dr. Collins to assess Claimant's employability. Dr. Collins is well known to the Industrial Commission and her credentials need not be repeated here.

Her CV may be found at JE 48, pp. 4306-4314. She is qualified to provide expert vocational testimony in this matter.

73. Dr. Collins reviewed medical and vocational records regarding Claimant, interviewed him to gain information about his education and employment history, subjective complaints, and his understanding of his restrictions. Dr. Collins then conducted a Transferrable Skills Analysis and checked local wage data and job openings in the Twin Falls area. She then prepared a report dated October 4, 2016. JE 48.

74. Dr. Collins noted that Claimant injured his right shoulder in 2010 and his left wrist in 2013. Previous to 2010, Claimant injured his right wrist in 2007, resulting in a right wrist fusion which forced him to close his business of 27 years, and which was also a hindrance to his employment at Employer's; he was required to use his left hand and upper extremity to accommodate.

75. Dr. Collins was aware of Claimant's RA, right knee, cervical spine, chronic asthma, GERD (not . . . "terribly vocationally limiting"), depression, hand tremors, left hand CMC joint problems, bunionectomies, multiple hernias, hearing loss, difficulty swallowing, chronic bronchitis, peptic ulcer disease, bowel incontinence, urinary infrequency, osteoporosis, and osteoarthritis.

76. Dr. Collins identified the following restrictions assigned by his physicians:

> Well, in 2014 Dr. Wayment released him with a 25-pound permanent restriction on the left hand.
>
> In November of '14 he changed that to 20-pound permanent lifting restriction for the left arm/wrist.
>
> In 2015 Dr. Humphrey gave a 10-pound lifting restriction on the right shoulder.
>
> In 2015 Dr. Friedman gave a variety of restrictions.
>
> He felt he was unable to return to work as a janitor.
>
> He should be lifting ten pounds with the right shoulder, ten pounds for the left wrist.
>
> No repetitive upper extremity movement of activity on his right.
>
> He had limited lifting supination and pronation on the left consistent with his preexisting - - I guess - -right wrist.

And that he had preexisting cervical degenerative disease also placing him at a sedentary level work restriction.

So his restrictions varied from the 2010 and 2013 accidents from a sedentary restriction - - not a true sedentary restriction because he's not restricted to sitting, but a sedentary lifting to light/medium level lifting of 25 pounds.

Then he also had limited use of his right upper extremity on a repetitive basis.

Collins Depo., p. 14-15.

77. Regarding postural/positional limitations, Dr. Collins testified:

So he could sit. He didn't really have a limitation for sitting, other than his knees would stiffen when he would rise.

* * *

Okay. He could stand, but he needed to kind of move around and shift weight, but he was exhausted after too long if he was standing.

With walking, he said everything hurt, but he was trying it because he had this pacemaker and cardiac issue.

So he was most comfortable alternating sitting, standing, and walking, but he could do it for fairly long periods of time - - each position. So that wasn't terribly limiting.

He understood that he was not to lift over 25 pounds with the right wrist, but he felt that he could only lift 10 to 15 pounds.

He had limited range of motion in the back.

Twisting, he could feel it in the low back.

Stooping, limited range of motion.

He could lose his breath if he bent over for too long. I think that's probably related to both his cardiac condition and his asthma.

Kneeling was limited because of the knees.

Crouching, the same.

Climbing stairs, painful for the knees and difficulty breathing.

Climbing a ladder, he was told not to climb a ladder or carry a ladder.

The manipulative limitations - - reaching all directions - - he was limited in reaching with both upper extremities, to both left right and left [sic]. He did demonstrate for me that he really could only get both hands shoulder height, and then he would have to assist lifting them over shoulder height.

Hand being limited by poor grip strength and range of motion, and he had a hard time turning off faucets with both hands.

He had a painful left knee, and that affected both pushing and pulling. So it was left knee, wrists, and shoulders.

He couldn't twist the wrists at all because they were both fused, and he was significantly limited working with hand tools because both wrists were affected.

Id., p. 16-17.

78. In formulating her opinions on the impact of Claimant's right shoulder condition, it is important to understand that Dr. Collins assumed the 10-pound lifting restriction discussed by both Dr. Humphrey and Dr. Friedman. These medical opinions were generated in 2015, following Claimant's failed right shoulder reverse arthroplasty. The opinions on which Dr. Collins relied do not support the proposition that Claimant had identical right shoulder restrictions immediately prior to the April 2013 accident. Regardless, Dr. Collins was aware that Claimant continued to have some difficulties with his right shoulder following his return to work in 2010. She was also aware of the limitations/restrictions arising from Claimant's other pre-existing conditions, including the 2007 injury to Claimant's right wrist. Though well aware of the impairment and restrictions attributable to Claimant's various ailments, Dr. Collins focused on three conditions which she felt are implicated in causing Claimant's total and permanent disability. Specifically, Dr. Collins believed that Claimant is totally and permanently disabled as a consequence of his bilateral wrist injuries, and possibly his right shoulder injury:

Q. [By Mr. Hall]: -- when you took all of those and then combined -- added in from that the left wrist, you then did an analysis with regard to that; is that correct?

A. Well, actually, the second analysis was really just the right shoulder, the left wrist, and the right wrist because what I did in that analysis was I assumed light work and occasional handling, and I did that because he had difficulty handling with both wrists. So that's literally what took him out of the labor market. If you don't have the ability to use either hand in a functional manner, particularly with somebody with this work history -- that realistically takes you out of the labor market.

Q. Okay. Had he never had this left wrist injury, would he have been able to continue to work?

A. I think so because he would have been able to do some -- well, with the left wrist -- okay. Ask your question again. These cases get so complicated.

Q. That's okay. In the fall of 2010 --

A. Right.

Q. -- he'd already had his right shoulder injury, had had a couple of surgeries, refused to have further surgery on it, and had that right shoulder -- the wrist on the right shoulder -- the wrist on the right arm had been fused?

A. Yes.

Q. At that point, he goes back to work for almost three years; is that correct?

A. Yes.

Q. And, essentially, functioning with his left hand with his right arm being a "helper hand," I guess, is really what's happening; is that right?

A. That's what's happening, yes.

Q. Okay. Absent the left wrist injury, would you have expected him to have been able to continue his work?

A. Oh sure. He still had full function of the left arm -- and that's, basically, what he had been doing for a long time for the right wrist.

Q. So, ultimately, you make a determination that after his left wrist, he's totally and permanently disabled; is that correct?

A. That's correct.

Q. What is it that makes him totally and permanently disabled?

A. It's his inability to use either upper extremity for completion of work tasks, basically. An example that I've used -- just to demonstrate how impactful that is -- is if you spend a day and you stick one hand in your pocket, you can get almost everything done; you just use the other hand. If you put both hands in your pockets and try and get anything done, it's really virtually impossible. So if you have one arm that you can use as an assist, you can really still complete a lot of work duties or work tasks, but if you lost function of both, you're extremely limited.

Q. So is it your opinion that the pre-existing right shoulder and right wrist -- when you added on or when you combined the left wrist -- it was the left wrist that made him totally and permanently disabled?

A. It is a combination of both, yes.

Id., p. 21-23. Per Dr. Collins, Claimant's bilateral upper extremity restrictions took him out of the labor market, but it is not entirely clear whether it is Dr. Collins' opinion that only the addition of Claimant's right shoulder injury to the bilateral wrist injuries causes total and permanent disability:

> Q. [By Mr. Stoker]: So even if we took the left wrist and the right shoulder, it still takes a combination with that right wrist before he really reaches the level of total disability. Is that, basically, your opinion?
>
> A. That's my opinion yes.
>
> …
>
> A. It's the left wrist/right wrist combination that, in my opinion, takes him out of the labor force.

Id., p. 32; 33. Dr. Collins was asked to speculate about the impact of Claimant's right shoulder and left wrist injuries alone. Subtracting out the limitations referable to the right wrist, Dr. Collins testified that Claimant's left wrist and right shoulder limitations, standing alone, would still leave him with employment opportunities. *Id*., p. 36. This testimony suggests that Claimant's shoulder condition is less of a limiting factor than the right wrist fusion. Whether the Claimant's upper extremity restrictions are the result of the right shoulder plus the bilateral wrists, or the bilateral wrists standing alone, it is clearly Dr. Collins' view that it is Claimant's inability to lift and manipulate things with his hands which cause him to be totally and permanently disabled, notwithstanding that he had many other pre-existing impairments which historically interfered with his ability to perform certain tasks. In all those cases, however, Claimant was evidently able to find a work-around. *Id*., p. 32-33. There was no work-around, however, for the loss of left upper extremity function. Previous to the accident of April 2013, Claimant relied on his left hand to do all, or almost all, of the things he could no longer do with his dominant right hand, which was useful only as an assist. Losing significant use of the left upper extremity left Claimant with a practical inability to use his arms in gainful employment.

79. Dr. Collins authored a Supplement Report dated February 7, 2017 based on receiving additional records including the installation of a pacemaker that improved Claimant's stamina, a

change in Claimant's RA medications that reduced his pain, the use of a CPAP machine that helped him to sleep, and a report from Dr. Friedman discussing medication management and the relationship to Claimant's industrial accidents. The additional information did not change Dr. Collins' previously stated opinions.

80. Dr. Collins expressed disagreement with Mr. Crum's opinion (discussion to follow) regarding Claimant's permanent disability:

> Well, he injured his right shoulder in 2010, and he went back to work for three years and did a good job for employer. The employer liked him.
>
> He was able to make accommodations for a multitude of conditions, but he was still able to work because he still had the use of his left upper extremity and his right arm as an assist.
>
> His right shoulder really - - he had a lifting restriction on it, but the primary limitation for shoulders is reaching overhead, reaching behind. So you still have the ability to work with your hands in front of your body, basically in kind of a box.
>
> So my disagreement is that he did return to work, he was able to do his job, so I don't really know how Mr. Crum came to the opinion that it was his right shoulder that took him out of the work [force].

Id., p. 26-27.

81. Dr. Collins summed up her take on Claimant's vocational situation this way:

> Well, this gentleman is a classic kind of physical worker that continued to return to work year after year, injury after injury. He just "cowboyed-up" for many years.
>
> He did have to leave occupations because of injuries, but he continued to work in occupations that required a lot of physical activity - - particularly, extremity work.
>
> So, you know, he - - I mean we all see clients or Evaluees who, you know, they injure their index finger and they can't do something, but these older gentlemen who kind of grew up in that era, you know, I think he really did want to work.
>
> Until that left wrist injury, combined with his right arm injuries, he was able to "make due," [sic] you know?
>
> He made accommodations. Even though he had a lot of subjective hindrances that he talks about, he was able to do the job. He just figured out a way to do it.

Id., p. 28.

Douglas N. Crum, CDMS

82. Mr. Crum was retained by ISIF to assess Claimant's employability. Mr. Crum's credentials are well known to the Industrial Commission and need not be repeated here. He is qualified to testify as a vocational expert in this matter. Mr. Crum's CV may be found at Exhibit 1 to his deposition.

83. Mr. Crum reviewed copious medical records,[4] interviewed Claimant (a "nice guy") on November 24, 2016, and took Claimant's education (just shy of an AA degree), employment (manual labor), and skills histories. At the time of the interview, Claimant was 66 years of age.

84. Mr. Crum testified that Claimant's right shoulder was not vocationally stable at the time of his April 2013 left wrist injury. Per Mr. Crum, while Dr. Schwartsman was recommending a further right shoulder surgery, Claimant needed to return to work, so Dr. Schwartsman released him without restrictions.

85. Even though Claimant returned to work for about three years, albeit with self-accommodations, after his right shoulder injury, Mr. Crum concluded that Claimant is totally and permanently disabled as the result of his right shoulder injury alone:

> Okay. Well, first of all, as I said, the right shoulder required surgery after he was released back to work, and he continued to have problems with his shoulder up through the time of the total shoulder replacement by Dr. Humphrey.
>
> He was never released, as far as I know, by any physician after Dr. Schwartsman's release when he tried to go back to work.
>
> Then there was an intervening wrist injury, so he was obviously trying to perform his job when he went back to work before the wrist injury in an accommodated fashion. I think that was in the record somewhere.
>
> It just seems to me that the right shoulder - - for an individual again with his educational background, skill set, employment history, where he lives - - with the restrictions given for basically very light-duty work and limited repetitive use of the right upper extremity for a right-handed guy that's now 66 years of age - - that is not a profile that is going to be successful in returning to work.

Crum Depo., p. 12-13.

86. Mr. Crum agreed that Dr. Friedman testified that the pain Claimant was experiencing in his right shoulder was caused by his RA and that the RA was a pre-existing condition. Mr. Crum testified that if what Dr. Friedman stated is true, then it could be a combination of his right shoulder injury in 2010 and his RA that is the cause of Claimant's total disability.

DISCUSSION AND FURTHER FINDINGS

"Permanent disability" or "under a permanent disability" results when the actual or presumed ability to engage in gainful activity is reduced or absent because of permanent impairment and no fundamental or marked change in the future can be reasonably expected. Idaho Code § 72-423. "Evaluation (rating) of permanent disability" is an appraisal of the injured employee's present and probable future ability to engage in gainful activity as it is affected by the medical factor of impairment and by pertinent non-medical factors provided in Idaho Code §72-430. Idaho Code § 72-425. Idaho Code § 72-430(1) provides that in determining percentages of permanent disabilities, account should be taken of the nature of the physical disablement, the disfigurement if of a kind likely to handicap the employee in procuring or holding employment, the cumulative effect of multiple injuries, the occupation of the employee, and his or her age at the time of the accident causing the injury, or manifestation of the occupational disease, consideration being given to the diminished ability of the affected employee to compete in an open labor market within a reasonable geographical area considering all the personal and economic circumstances of the employee, and other factors as the Commission may deem relevant, provided that when a scheduled or unscheduled income benefit is paid or payable for the permanent partial or total loss or loss of use of a member or organ of the body no additional benefit shall be payable for disfigurement.

The test for determining whether a claimant has suffered a permanent disability greater than permanent impairment is "whether the physical impairment, taken in conjunction with non-medical

[4] Mr. Crum did not have the benefit of reviewing Dr. Friedman's IME.

factors, has reduced the claimant's capacity for gainful employment." *Graybill v. Swift & Company*, 115 Idaho 293, 294, 766 P.2d 763, 764 (1988). In sum, the focus of a determination of permanent disability is on the claimant's ability to engage in gainful activity. *Sund v. Gambrel*, 127 Idaho 3, 7, 896 P.2d 329, 333 (1995).

A two-step analysis is appropriate in impairment and disability evaluations and requires, "(1) evaluating the claimant's permanent disability in light of all his physical requirements, resulting from the industrial accident and any pre-existing conditions, existing at the time of the evaluation; and (2) apportioning the amount of permanent disability attributable to the industrial accident." *Horton v. Garrett Freightlines, Inc.*, 115 Idaho 912, 915, 772 P.2d 119, 122 (1989).

87. Both vocational experts retained in this matter opined that Claimant was totally and permanently disabled as of the time of the hearing and the Commission so finds.[5] The remaining question is to what extent, if any, ISIF must share some responsibility with SIF for that total disability.

Idaho Code § 72-332 provides:

> **Payment for second injuries from industrial special indemnity account, --** (1) If an employee who has a permanent physical impairment from any cause or origin, incurs a subsequent disability by an injury or occupational disease arising out of and in the course of his [or her] employment, and by reason of the combined effects of both the pre-existing impairment and the subsequent injury or occupational disease or by reason of the aggravation and acceleration of the pre-existing impairment suffers total and permanent disability, the employer and surety shall be liable for payment of compensation benefits only for the disability caused by the injury or occupational Idaho Code § 72-332 disease, including scheduled and unscheduled permanent disabilities, and the injured employee shall be compensated for the remainder of his income benefits out of the industrial special indemnity account.
>
> (2) "Permanent physical impairment" is as defined in section 72-422, Idaho Code, provided, however, as used in this section such impairment must be a permanent condition, whether congenital or due to injury or occupational disease, of such seriousness as to constitute a hindrance or obstacle to obtaining employment or to obtaining re-employment if the claimant should become unemployed. This shall be interpreted subjectively as to the particular employee involved, however, the mere fact that a claimant is employed at the time of the subsequent injury shall not create a

[5] The Commission finds that Claimant is totally and permanently disabled by either the 100% or odd-lot methods.

> presumption that the pre-existing permanent physical impairment was not of such seriousness as to constitute such hindrance or obstacle to obtaining employment.

Under this section, a party attempting to prove ISIF liability must show that there was a pre-existing impairment, which was manifest, which constituted a subjective hindrance to Claimant's employability and which combined with the work-related injury to cause total and permanent disability. *Bybee v. State Industrial Special Indemnity Fund*, 129 Idaho 76, 921 P.2d 1200 (1996). To satisfy the final requirement of Idaho Code § 72-332, the Court has made it clear that the "but for" standard is the appropriate test to determine whether a claimant's total and permanent disability is the result of the combined effects of the pre-existing condition and the work-related injury. *See, Garcia v. J.R. Simplot Co., 115 Idaho 966*, 772 P.2d 173 (1989). Essentially, the party asserting ISIF liability must demonstrate that Claimant would not have been totally and permanently disabled following the industrial accident but for (if not for) the pre-existing impairment or impairments. *Corgatelli v. Steel West, Inc*., 157 Idaho 287, 335 P.3d 1150 (2014). This test anticipates that not all pre-existing impairments which are manifest and which constitute a subjective hindrance need necessarily combine with a work-related injury to cause total and permanent disability. It must be shown that if not for a particular pre-existing impairment, the industrial injury would not have left Claimant totally and permanently disabled.

Pre-existing Permanent Physical Impairment

88. In his report of February 7, 2017, Dr. Friedman articulated the impairment ratings assigned to each of Claimant's pre-existing and accident-produced impairments:

> Based on this, I would rate his total body impairment as follows:
> 1. Right shoulder 18% whole person.
> 2. Left wrist 18% whole person.
> 3. Right wrist 18% whole person.
> 4. Total knee arthroplasty 10% whole person.
> 5. Rheumatoid arthritis 10% whole person.
> 6. Cervical spine degeneration arthritis 6% whole person.
> 7. Asthma 5% whole person.
> 8. GERD 5% whole person.
> 9. Depression 5% whole person.

10. Tremor 5% whole person.
11. CMC 2% whole person.
12. Bunionectomy 1% whole person.

D. Exh 44 at 4267-B. Of the listed impairments, a couple are worthy of further discussion. First, Dr. Friedman gave Claimant an 18% whole person rating for his right shoulder. However, this rating was given for Claimant's shoulder as it existed following a failed right shoulder reverse arthroplasty. The evidence establishes that Claimant's right shoulder condition was not as bad immediately prior to the April 2013 left wrist injury. Clearly, Claimant's right shoulder condition had worsened by the time Dr. Friedman performed his rating. Dr. Schwartzman, however, did rate Claimant's right shoulder in December 2012, not long before the April 2013 left wrist injury. Dr. Schwartzman gave Claimant a 6% upper extremity rating, which Dr. Friedman did not quarrel with. Dr. Friedman, however, would have assigned half of the 6% rating to rheumatoid arthritis, and half to the 2010 industrial accident. We must also be mindful of the fact that Claimant's right shoulder condition is not simply a pre-existing physical impairment; it is a condition attributable to the earlier of the two claims involved in this proceeding, and we must make some judgment as to whether the impairment stemming from the 2010 right shoulder claim can be deemed to be a pre-existing permanent physical impairment for purposes of evaluating ISIF liability vis-à-vis the April 2013 left wrist claim.

89. There are two lines of cases which inform our treatment of the right shoulder condition. In the case of a pre-existing impairment which is progressive, as is arguably the case here, some rule must be applied to determine the point in time in which the impairment is rated, and to determine whether it is manifest, constitutes a subjective hindrance to employment and combines with the work accident to cause total and permanent disability. *Colpaert v. Larson's, Inc.*, 115 Idaho 852, 771 P.2d 46 (1989) establishes that in determining whether the elements of ISIF liability are satisfied, a pre-existing condition must be assessed as of the date immediately preceding the work injury. A snapshot of Claimant's pre-existing condition must be taken as of that date and from that snapshot Claimant's

impairment must be determined, as well as whether Claimant's condition was manifest, constituted a subjective hindrance to Claimant and combined with the accident-produced condition to cause total and permanent disability. *See Richie v. State of Idaho, Industrial Special Indemnity Fund*, 2016 IIC 0038 (August 15, 2016). Considered as a non-work related pre-existing condition, *Colpaert* makes it clear that Claimant's right shoulder condition would have to be evaluated as of the date immediately preceding the 2013 left wrist injury. Of course Claimant's right shoulder injury is itself work related, though the product of an earlier injury. In the context of a claim for total and permanent disability involving the ISIF, *Quincy v. Quincy*, 136 Idaho 1, 27 P.3d 410 (2001) provides guidance on the treatment to be afforded the 2010 claim. Generally speaking, an earlier industrial claim cannot be considered to have produced a pre-existing physical impairment unless Claimant was pronounced stable and ratable prior to the occurrence of the last claim in line. See also *Smith v. J.B. Parson Co*., 127 Idaho 937, 908 P.2d 1244 (1996).

90. While it is true that Claimant's right shoulder condition has progressed, this progression does nothing to denigrate the proposition persuasively established by Dr. Friedman that Claimant was stable and ratable at the time Dr. Schwartzman deemed it appropriate to award Claimant a 6% upper extremity rating for his right shoulder condition in December of 2012. The reasoning of the cases referenced above leads us to conclude that Claimant's right shoulder condition, as it existed in December 2012, does constitute a pre-existing physical impairment of 6% of the upper extremity for purposes of the evaluation of ISIF liability.

91. Next, for Claimant's left wrist injury, Dr. Friedman gave Claimant an 18% whole person rating, with half attributable to the 2013 accident and half attributable to Claimant's pre-existing diagnosis of rheumatoid arthritis. We conclude that vis-à-vis the 2013 left wrist injury, the 9% rating for rheumatoid arthritis constitutes a pre-existing physical impairment.

Manifest

92. A pre-existing physical impairment is "manifest" when either the employer or the employee was aware of a pre-existing condition such that the condition can be established as having prior to the work injury. *Royce v. Southwest Pipe of Idaho*, 103 Idaho 290, 647 P.2d 746 (1982). There is no dispute that each of the aforementioned impairments meets this definition.

Subjective Hindrance

93. The third prong of the *Dumaw*[6] test considers "whether or not the pre-existing condition constituted a hindrance or obstacle to employment for the particular claimant." See *Archer v. Bonners Ferry Datsun*, 117 Idaho 166, 786 P.2d 557 (1990). The record supports a finding, based on Claimant's hearing testimony, and the records and testimony of Dr. Collins and Dr. Friedman that Claimant's pre-existing bilateral shoulder injuries, right wrist injury, right knee condition, hernia, asthma, rheumatoid arthritis, depression, bilateral hand tremors and bunionictimies constituted subjective hindrances to Claimant's employment prior to the April 2013 left wrist injury. Claimant's GERD and cervical spine are not found to have constituted subjective hindrances to employment prior to the left wrist injury. Claimant's CMC thumb injury was incurred at the same time as was his left wrist injury in 2013, and is not considered to be pre-existing.

Combining With

94. As frequently seems to be the case, the determination of whether the ISIF is liable turns on the question of whether Claimant's pre-existing impairments can be said to have combined with the subject accident to cause total and permanent disability. As noted, combining with is tested pursuant to the "but for" test, which requires a showing by the party invoking ISIF liability that Claimant would not have been totally and permanently disabled following the industrial accident, but for the pre-existing impairments. Said differently, where, as here, there are multiple pre-existing impairments,

[6] *Dumaw v. J.L. Norton Logging*, 118 Idaho 150, 795 P.2d 312 (1990).

which of them, along with the left wrist injury, are essential for the determination that Claimant is totally and permanently disabled? On this point, we find the testimony of Dr. Friedman and Dr. Collins to be the most persuasive. We are less persuaded by the testimony of Mr. Crum, mainly because of his conclusion that the right shoulder, alone, is responsible for Claimant's total and permanent disability. Both Dr. Friedman and Dr. Collins persuasively explained that so long as Claimant had a meaningful use of one of his upper extremities, he was employable. Only after the left wrist injury denied him meaningful use of his left upper extremity, did he become totally and permanently disabled. While the record establishes that Claimant's other pre-existing impairments were manifest and constituted a subjective hindrance, the evidence does not establish that Claimant would not have been totally and permanently disabled following his last accident "but for" these conditions. Acknowledging the existence of the other pre-existing impairments does not constitute evidence of "combining with." The only evidence relating to the impact of Claimant's various impairments that we find persuasive come from Dr. Friedman and Dr. Collins. Neither of the experts suggest that Claimant's other impairments were important to causing his total and permanent disability.

95. While it is relatively straightforward to come to the conclusion that the pre-existing right wrist injury combined with the left wrist injury to contribute to Claimant's total and permanent disability, it is less clear to us that Claimant's right shoulder injury, as it existed immediately prior to April of 2013, must be added before Claimant can be deemed to be totally and permanently disabled. In other words, what does the right shoulder condition, as it existed prior to April 2013, add to the mix in terms of the limitations/restrictions which cause Claimant's total and permanent disability? Depending upon which portion of Dr. Collins' testimony one reads, the right shoulder is or is not important to causing Claimant's total and permanent disability. Moreover, Dr. Collins offered these comments using the limitations/restrictions as they existed after the failed right shoulder reverse

arthroplasty had been performed. It is unclear what significance Dr. Collins would attach to the right shoulder, had she conducted her evaluation with the limitations/restrictions that existed for the right shoulder as of a date immediately preceding the April 2013 left wrist injury.

96. We think it important to recognize that Claimant has similar functional deficits for each wrist following the bilateral wrist fusions. If the left wrist, alone, prevents him from meaningful use of the left upper extremity, why is there any reason to think that the right wrist, standing alone, would not also prevent Claimant from making meaningful use of the right upper extremity? If, as Dr. Friedman has discussed, the purpose of the right shoulder is to get the right hand into the work space, why does right shoulder dysfunction matter, if the right hand is dysfunctional? Is it important to get the right hand anywhere if it has severe restrictions on lifting and fine manipulation?

97. While we are in general agreement with the views expressed by Dr. Friedman and Dr. Collins concerning the significance of Claimant's upper extremity injuries in causing his total and permanent disability, we are unable to conclude that the evidence is sufficient to prove that Claimant's right shoulder condition, as it existed in April of 2013, combines with the right wrist and the left wrist to cause total and permanent disability. Said differently, we are not persuaded that Claimant would not now be totally and permanently disabled if not for the pre-existing right shoulder condition.

98. From the foregoing, we conclude that Claimant's accident-produced left wrist injury combines with the pre-existing right wrist condition to cause total and permanent disability. Claimant's right wrist condition equates to an 18% PPI rating. Claimant's left wrist condition also equates to 18% impairment, but Dr. Friedman has persuasively explained that this impairment rating should be apportioned equally between Claimant's pre-existing rheumatoid arthritis and the subject accident. Because Claimant's pre-existing rheumatoid arthritis is, in part, responsible for Claimant's loss of left wrist function, we conclude that this impairment, too, combines with the right wrist and the accident-caused impairment to the left wrist to cause total and permanent disability.

Carey Apportionment

99. Claimant's total impairment equals 36%, with 27% referable to pre-existing conditions (18 + 9) and 9% referable to the subject accident. This leaves 64% disability (100-36) to be apportioned between the ISIF and Employer. Employer's liability is calculated as follows 9/36 x 64 = 16% over and above impairment + 9% work related left wrist impairment = 25% disability, inclusive of impairment. Therefore, Employer is responsible for the payment of permanent disability benefits at the appropriate rate for 125 weeks (500 x 25%) commencing on November 24, 2014, Claimant's date of medical stability following the left wrist injury. For this 125 week period, ISIF shall be responsible for paying the difference between the disability award and Claimant's entitlement to statutory total and permanent disability benefits. Thereafter, ISIF shall bear responsibility for statutory benefits for the remainder of Claimant's life.

Continued Treatment by Dr. Dille

100. Claimant requests that Employer continue paying for pain management for his right shoulder injury. In a letter dated February 2, 2017, Dr. Dille's PA, John Urrutia, states that he sees Claimant about once a month for right shoulder and left wrist pain as well as Claimant's RA, but advises that " . . . these symptoms are controlled by treatments from his rheumatologist for the most part." See attachment to Claimant's Opening Brief.

101. Employer stopped paying for Claimant's pain management with Dr. Dille after Dr. Friedman's IME wherein Dr. Friedman opined that such treatment was not necessary because Dr. Dille was treating Claimant's pre-existing RA and not his right shoulder which had been replaced and would not be the source of pain.

102. The Commission finds that continuing pain management by Dr. Dille is reasonable and the responsibility of Employer until such time that he is either released by Dr. Dille or referring

physician Dr. May. Mr. Urrutia's letter indicates that the pain clinic is also treating Claimant's left wrist pain.

CONCLUSIONS OF LAW AND ORDER

1. Claimant has proven that he is totally and permanently disabled.

2. Employer is responsible for the payment of permanent disability at the appropriate rate for 125 weeks following Claimant's date of medical stability for the 2013 accident. During this timeframe, ISIF shall pay the difference between the PPD rate and the statutory rate for permanent and total disability. Thereafter, ISIF shall pay total and permanent disability for the remainder of Claimant's life. Per *Dickinson v. Adams County* 2017 IIC 0007, Defendants are entitled to a credit for disability previously paid as impairment, such credit to be applied commencing November 24, 2014.

3. Claimant is entitled to continuing payment by Employer for pain management at Southern Idaho Pain Center.

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

DATED this __12th__ day of ___January___, 2018.

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 __16th__ day of ___January____, 2018, 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:

JEFF STOKER
PO BOX 1597
TWIN FALLS ID 83303-1597

SCOTT R HALL
PO BOX 51630
IDAHO FALLS ID 83405-1630

BREN E MOLLERUP
PO BOX 366
TWIN FALLS ID 83303-0366

_____/s/_____