BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

BRADLEY FURNISS, Claimant, v. BLAINE LARSEN FARMS, INC., Employer, and LIBERTY NORTHWEST INSURANCE CORP., Surety, and STATE OF IDAHO, INDUSTRIAL SPECIAL INDEMNITY FUND, Defendants.	**IC 2011-026179** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** FILED AUG 12 2022 INDUSTRIAL COMMISSION

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Sonnet Robinson, who conducted a hearing on January 28, 2021. Claimant, Brad Furniss, was present in person and represented by Paul Rippel of Idaho Falls. Matt Pappas of Boise represented Defendant/Employer. Paul Augustine of Boise represented Defendant/ISIF. The parties presented oral and documentary evidence. Post-hearing depositions were taken. The matter came under advisement on June 3, 2022 and is ready for decision.

ISSUES

The issues[1] to be decided are:

1. Whether Claimant is entitled to permanent partial disability (PPD) benefits, and the extent thereof;
2. Whether Claimant is entitled to permanent total disability pursuant to the odd-lot doctrine, or otherwise;
3. Whether apportionment for a pre-existing condition pursuant to Idaho Code § 72-406 is appropriate;
4. Whether ISIF is liable under Idaho Code § 72-332;
5. Apportionment under the *Carey* formula.

CONTENTIONS OF THE PARTIES

Claimant contends he is totally and permanently disabled via the 100% method and as an odd lot worker via superhuman effort. If Claimant is not totally and permanently disabled, he suffered significant disability of 82%, none of which can be apportioned to any pre-existing conditions because Claimant's right-hand restrictions subsume any restrictions from his pre-existing left shoulder injury; no part is apportionable under Idaho Code § 72-406.

Defendant/Employer contends Claimant's own expert did not opine Claimant was totally and permanently disabled. Regarding apportionment, Claimant's expert also acknowledged Claimant had already lost 35% of his labor market prior to the subject injury due to his pre-existing left shoulder injury. Defendant/Employer argues their expert's opinion, calculating Claimant's disability at 25.5%, is more accurate and appropriate per *Brown v. Home Depot*, 152 Idaho 605 (2012) and that Claimant's experts' opinions are outdated. Defendant/Employer argues that

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[1] Claimant's further entitlement to medical care and attorney's fees were waived at hearing.

apportioning half of Claimant's disability to his pre-existing left shoulder injury comports with Idaho Code § 72-406. If Claimant is totally and permanently disabled, ISIF is liable.

ISIF contends Claimant is not totally and permanently disabled. No expert has opined he is totally and permanently disabled, and Claimant is not employed by a sympathetic employer, nor is he employed through superhuman effort. Claimant has provided no evidence that his injuries combine to result in total and permanent disability, a required element of ISIF liability.

Claimant responds that his loss of earning capacity and loss of labor market access shows Claimant is significantly disabled, and Claimant's expert's methodology is superior to Employer/Defendant's expert. Apportionment is not appropriate because all of Claimant's disability is due to his industrial injury and his pre-existing left shoulder injury did not increase or prolong his disability.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The Industrial Commission legal file;
2. Joint Exhibits 1-44;
3. Defendant/Employer's Exhibit 45;
4. The testimony of Claimant, Brad Furniss, taken at hearing;
5. The post-hearing depositions of:
    a. Nancy Collins, PhD, taken by Claimant;
    b. Gary Walker, MD, and Kourtney Layton, MRC, taken by Defendant/Employer;

All outstanding objections are overruled.

The parties submitted stipulated facts regarding Claimant's medical history, which appears at ¶ 1 through ¶ 116.

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

STIPULATED FACTS

1. As mentioned above, the injury at question in the present matter occurred in October of 2011. Claimant has a long history of medical treatment for injuries, beginning in 1999, that occurred during his time competing in extreme sports and due to prior work injuries. Claimant was born on June 23, 1983, and was 37 years old at the time of the hearing in this matter.

2. On December 20, 1999, Claimant was admitted to Madison Memorial Hospital and examined by Dr. David V. Hansen. Claimant had been in a snowboarding accident and suffered a non-displaced comminuted fracture in his mid-left clavicle. He was placed in a Figure 8 splint and instructed to follow-up with his primary care provider for future care. (Joint Hearing Exhibit No. 13 pp. 17- 27). Again, on November 12, 2000, Claimant was admitted to the same hospital for another snowboarding accident and examined by Dr. Randall B. Kiser for head trauma. Fortunately for Claimant his CT scans were normal. He was diagnosed with a concussion, but otherwise released to home for further care. (Ex. No. 13 pp. 28-38).

3. On July 25, 2001, Claimant was involved in his first work related accident/injury in Idaho. He was working for Green Valley, Inc. when he suffered a crush injury to one of his toes. Although no medical records are available regarding his subsequent treatment, we do know a Form 1 was filed with the Idaho Industrial Commission documenting this injury (Ex. No. 1).

4. Claimant suffered another work related injury on February 1, 2004, while working for Sure Steel, Inc. The Form 1 indicates Claimant was on a roof when he slipped and fell, injuring his left collar bone. He subsequently underwent surgery to repair this injury and a worker's compensation claim was associated with this incident. The injury records are unavailable, but the

resulting surgery and information would be discussed in later medical records that are part of the record. The surgery was believed to have occurred on June 24, 2004. (Ex. No. 2).

5. On October 12, 2004, Claimant was in a motorcycle accident. It was concluded that Claimant fractured his left foot. Claimant was sent to Dr. K.M. Lee who would later perform surgery on Claimant's left ankle to repair the damage. Upon examination, Dr. Lee discovered that Claimant had a left shoulder injury on March 4, 2004[2], which required surgery on June 24, 2004. When Dr. Lee inquired about his surgery and why Claimant would be riding his motorcycle so soon after his shoulder surgery Claimant responded that his physical therapist stated it would be a good therapy. Dr. Lee would mention that this indicated that Claimant may have been extremely noncompliant with his previous treatments. (Ex. No. 13 pp. 50-113).

6. Claimant complained that although he completed PT his shoulder was still in pain and that it popped out all the time, and in one particular instance he dislocated his shoulder while carrying his brother. Claimant also stated he would pop his shoulder in when it would pop out including the time he dislocated it. Dr. Huntsman's examination of Claimant resulted in the recommendation of an MRI because of Claimant's inability to tolerate Dr. Huntsman's exam due to pain. Id.

7. On October 29, 2004, an MRI exam was conducted by Dr. Michael C. Biddulph at Mountain View Hospital and it revealed an interval rotator cuff tear between the supraspinatus and subscapularis tendons and a Hill-Sachs fracture/contusion of the humeral head. (Ex. No. 14 p. 116). Dr. Huntsman discussed the results of the MRI with Claimant on November 4, 2004. At this time Claimant provided additional information that his pain was constant, it limited his activities

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[2] The date of shoulder injury in Dr. Lee's notes is presumed to be a typographical error and is actually referring to the February 4, 2004, work injury described above.

including overhead lifting, and that it kept him awake at night. Because of the pain Claimant agreed to the recommended surgical intervention. (Ex. No. 14 p. 117). On November 29, 2004, Dr. Huntsman performed surgery on Claimant's left shoulder and repaired the ROTATOR CUFF interval tear and rotator cuff impingement with small supraspinatus frayed type tear with no complications. (Ex. No. 15 pp. 299-300).

8. Twelve days after his shoulder surgery on December 6, 2004, Claimant went for a follow up appointment with Dr. Huntsman. Dr. Huntsman was satisfied with Claimant's recovery and recommend he continue PT and refrain from work for approximately four weeks. (Ex. No. 14 p. 118).

9. On January 4, 2005, Claimant visited Dr. Huntsman for a follow up appointment for his left shoulder. Dr. Huntsman was pleased with Claimant's recovery. Dr. Huntsman recommended that Claimant continue PT and work restrictions of right hand work only. (Ex. No. 14 p. 119).

10. For the following three months Claimant visited Dr. Huntsman for his shoulder. Dr. Huntsman's impressions were Claimant was slowly getting better. In particular, on February 7, 2005, PT was going as planned although he was still feeling pain. (Ex. No. 14 p. 120). On March 7, 2005, Claimant was offered a cortisone shot but refused due his fear of needles. Dr. Huntsman continued his PT and restricted his work activity to lifting no more than ten pounds, no overhead lifting, and use of his left arm close to his body. (Ex. No. 14 p. 121).

11. On April 19, 2005, Dr. Huntsman stated that Claimant was about 50% better and that his range of motion ("ROM") was improving. Claimant still complained of soreness but again refused a cortisone shot. Claimant was positive for Hawkins and impingement but negative for O'Brien's, Speed's, and Yergason's tests. Claimant was given a thirty-pound weight restriction

and instructed he could occasionally reach out and overhead. Dr. Huntsman's believed that that Claimant had likely reached MMI and an impairment rating should be considered. (Ex. No. 14 p. 122).

12. Claimant's next visited Dr. Huntsman on May 26, 2005. It had been six months since Claimant's surgery and Claimant stated that he felt around 75% better. Dr. Huntsman assessed that Claimant would be placed on a fifty-pound permanent lifting limit to shoulder level, no lifting over the shoulder, and rare overhead and reaching type activities. In addition to these restrictions Dr. Huntsman assessed, based on the Fifth Edition of the AMA Guides, that Claimant suffered a 12% impairment of the left upper extremity, which equated to a 7% whole person impairment. (Ex. No. 14 p. 123).

13. Claimant's next visit to Dr. Huntsman would not occur until July 11, 2005. However, between that time Claimant was injured on the job once again. This time he was examined by Dr. Scott M. Packer at Eastern Idaho Regional Medical Center. Claimant lacerated his elbow and was treated with Keflex. In Dr. Pacer's notes he stated that Claimant smelled of alcohol when examined. (Ex. No. 15 p. 301).

14. Claimant, on July 11, 2005, complained that his left shoulder was causing him extreme pain. Dr. Huntsman's examination revealed that Claimant was experiencing increased swelling and stiffness in his left shoulder and that his ROM and strength had decreased. Dr. Huntsman offered Claimant a cortisone shot for the pain but Claimant refused. Dr. Huntsman, concerned about Claimant's increased pain, ordered an MR arthrogram and prescribe[d] Claimant Lodine XL. (Ex. No. 14 p. 124).

15. Dr. John J. Strobel of Mountain View Hospital preformed the MRI of Claimant's left shoulder on September 26, 2005. The MRI revealed that Claimant had a focal defect within

the anterior superior margin of the subscapularis representing either a post-surgical effect or a small tear, contrast in the subacromial and subdeltoid bursa, a possible pinhole defect in the supraspinatus tendon, post-surgical changes in the rotator cuff of the subacromial tendon and supraspinatus tendon anteriorly with marked thickening and irregularity of the subscapularis tendon, and abnormal signal in the humeral head posteriorly subjective of marrow contusion, not excluding enchondroma. (Ex. No. 14 pp. 125-126).

16. Dr. Huntsman reviewed the results of the MRI performed by Dr. Strobel on September 27, 2005. Dr. Huntsman was concerned about the MRI results and ordered an EMG and nerve conduction study of the left upper extremity ("UE") to further evaluate the condition of Claimant's left shoulder and in particular the weakness and pain that had developed. (Ex. No. 14 p. 127). The subsequent results of the EMG, reviewed by Dr. Huntsman on November 1, 2005, revealed that there were no problems with Claimant's nerves but he was still complaining of severe pain in his shoulder. Based upon the results of the MRI conducted by Dr. Strobel, Dr. Huntsman and Claimant concluded that a shoulder arthroscopy and rotator cuff repair would be beneficial to resolve Claimant's pain. (Ex. No. 14 p. 128).

17. Although Dr. Huntsman and Claimant agreed to another surgery the surety wanted Claimant to try an injection in an effort to reduce Claimant's pain. On December 6, 2005, Dr. Huntsman injected the subacromial space with Depo Medrol and Marcaine. (Ex. No. 14 p. 129). However, this did not have the intended results and Claimant returned to Dr. Huntsman's office for a follow up visit on January 3, 2006, and informed the doctor that he was still experiencing extreme pain. Dr. Huntsman's examination determined that Claimant had full ROM but he still exhibited a lot of weakness. Dr. Huntsman also noted that Claimant had a positive Hawkin's and

impingement signs and positive O'Brien's test. Dr. Huntsman recommended shoulder arthroscopy and a rotator cuff repair, which was later performed on January 11, 2006. (Ex. No. 14 p. 130).

18. The procedure included arthroscopy, posterior superior labral debridement, biceps tendon 10% tear debridement, and subacromial decompression with no complications. (Ex. No. 18 pp. 479-480). On January 24, 2006, two weeks after Claimant's surgery, he was still experiencing pain. Dr. Huntsman noted that Claimant had good ROM and that he was pleased with the results. Claimant was allowed to work but only with his right hand. (Ex. No. 14 p. 131).

19. Claimant's follow up visits resulted in little to no change in his pain according to Claimant. On February 21, 2006, Claimant stated that his pain was constant and that it started to radiate to his neck and down into his hand. Dr. Huntsman assessed that Claimant did have a lot of weakness, his ROM was unchanged, but that his shoulder was improving well. Dr. Huntsman recommended that Claimant continue his PT, continue to take anti-inflammatories, and that his work restrictions would remain the same. (Ex. No. 14 p. 132).

20. Claimant's condition remained the same on his next appointment. On April 4, 2006, Claimant still reported that his pain remained constant and at the same intensity. Dr. Huntsman noted a mild Hawkin's and impingement sign. He recommended that Claimant continue with PT and anti-inflammatories with the same restrictions. (Ex. No. 14 p. 133).

21. On May 16, 2006, Dr. Huntsman described a definite improvement in Claimant[']s range of motion; however, Claimant stated his pain remained the same. Dr. Huntsman recommended that Claimant continue PT in an effort to improve his range of motion and to continue his anti-inflammatories. Dr. Huntsman also changed Claimant's restrictions allowing him to lift twenty pounds with his left upper extremity with occasional reaching and overhead use of his left arm. (Ex. No. 14 p. 134).

22. On July 6, 2006, Claimant returned to Dr. Huntsman's office for a scheduled appointment. Six months had passed since Claimant's shoulder arthroscopy. At this visit Claimant stated that his shoulder strength remained that same as his last visit and that his pain had not improved. Claimant also stated that PT had not improved his condition. Dr. Huntsman concluded that Claimant had reached MMI. He recommended that Claimant remain at the twenty pound lifting restriction with occasional reaching and overhead use. Dr. Huntsman also restated that Claimant had a 7% whole person impairment. (Ex. No. 14 p. 135).

23. One year after his shoulder arthroscopy on December 4, 2006, Claimant visited Dr. Huntsman. Claimant complained that his shoulder was not getting better and was only 20% better. Claimant tested positive for Hawkin's and impingement signs, positive for speed's test and mildly positive for O'Brien's test. The doctor said that load testing showed no signs of instability and a negative sulcus sign. Dr. Huntsman was concerned that Claimant may have a bicep problem in the bicipital groove. To ensure this was not the problem, Dr. Huntsman ordered an MR arthrogram to rule out a proximal bicep tendon tear. (Ex. No. 14 p. 136).

24. Claimant, on April 4, 2007, went to Mountain View Hospital for his MR arthrogram performed by Dr. Douglas Greally. Dr. Greally's impressions were that Claimant's rotator cuff showed no signs of a tear, the proximal portion of the long head of the bicep was intact, and distally the biceps was intact and lied within the bicipital groove. He noted that there was a probable Hill-Sachs type deformity involving the humeral head. (Ex. No. 14 p. 137).

25. Dr. Huntsman met with Claimant on April 5, 2007, to discuss the results of the MR arthrogram. At this point Dr. Huntsman noted that he was concerned about Claimant's pain but could not decipher a problem. Thus, Dr. Huntsman recommended that Claimant seek a second opinion. (Ex. No. 14 p. 140).

26. On May 14, 2007, Claimant sought the opinion of Dr. John Andary of the Shoulder and Knee Center. Dr. Andary's examination of Claimant's shoulder centered on his range of motion as Dr. Andary did not have the results of the MRIs performed on Claimant. Dr. Andary did find that during his examination Claimant gave poor effort when performing the required tasks. At the conclusion of his exam Dr. Andary stated that Claimant had significant weakness and pain but that it was out of proportion to what he would expect. Dr. Andary recommended that Claimant should continue PT and keep his weight restrictions. (Ex. No. 20 pp. 534-535).

27. On May 30, 2007, Claimant met with Dr. Andary to discuss the results of the MRIs. Claimant complained of pain and that he was not getting better. Dr. Andary's impression of the April 4, 2007, MRI was that scar tissue remained in the rotator cuff due to the previous surgeries and possible anterior instability with stretching of the anterior capsule. Dr. Andary recommended another shoulder arthroscopy and capsular shift and Claimant agreed. (Ex. No. 20 pp. 535-536). The shoulder arthroscopy was performed on June 26, 2007 at Idaho Falls Surgical Center by Dr. Andary with no complications. (Ex. No. 21 pp. 545-546).

28. On August 29, 2007, Claimant expressed his satisfaction with the operation and stated that he did not have the problems he was having before the surgery although he was still weak. Dr. Andary restricted Claimant's work activities to desk work only, no lifting over ten pounds with his left arm, no overhead work, and to continue his PT three time per week. (Ex. No. 20 p. 537).

29. On September 26, 2007, Claimant returned to Dr. Andary and reported that his therapist felt his range of motion had improved but he felt it was the same. His examination of Claimant's range of motion revealed that he was giving very poor effort and he felt there was nothing that was going to improve Claimant's shoulder. Dr. Andary cleared Claimant for work but

restricted him to a twenty-five pound weight limit and recommended an FCE. (Ex. No. 20 p. 538, 544). An addendum dated October 29, 2007, to the results of the FCE concluded that Dr. Huntsman's assessment of Claimant's impairment was correct. However, Dr. Andary did increase Claimant's whole person impairment from a 7% to 8%. Id.

30. Claimant returned to work on March 5, 2008, and was restricted to no overhead reaching or lifting with the left arm and no repetitive movement or high force griping with the left arm. These restrictions were lifted on March 21, 2008 (Ex. No. 22 pp. 547-558).

31. On May 15, 2008, Claimant injured his right knee while lifting an object. (Ex. No. 7). An x-ray taken at the Community Care facility showed no fracture or dislocation, and that the knee appeared to be normal. Claimant was restricted from squatting or kneeling, and walking on uneven ground. (Ex. No. 22 pp. 559-563). The MRI results, provided on May 20, 2008, showed Claimant's right knee was intact. (Ex. No. 22 p. 564).

32. On June 28, 2008, Claimant was again examined at the Community Care Center, this time for a right hand injury. Claimant was put on work restriction of no repetitive movement or high force with his right arm. Claimant remained on these restrictions until approximately July 7, 2008. (Ex. No. 22 pp. 565-572) (See also Ex. No. 8).

33. Claimant's next work injury occurred on August 20, 2008, when he complained of eye pain due to exposure to a welding spark. Claimant was examined on August 21, 2008 and given eye drops to alleviate the pain and was discharged without any further complications. (Ex. No. 15 p. 304) (See also Ex. 9).

34. On June 18, 2010, Claimant was riding his motorcycle when he collided with a vehicle. Claimant complained of pain in his right leg. X-rays confirmed that Claimant did not

fracture his tibia, fibula, or femur. Claimant was prescribed Vicodin and Naproxen and released. A follow up appointment was scheduled with Benjamin Garner D.O. (Ex. No. 15 pp. 306-315).

35. Claimant's appointment with Benjamin Garner D.O. occurred on July 7, 2010. Claimant complained of severe pain in his right leg. Claimant also stated that his right foot would fall asleep intermittently and that while trying to relieve tightness he "felt a loud pop". Claimant also stated that while he was at work, his leg gave out and he fell down. Dr. Garner ordered an MRI. The results of the MRI on July 15, 2010, were that Claimant had a partial tear of the ACL and no evidence of a meniscal tear. A follow up appointment with Dr. Garner confirmed the ACL tear and Claimant was prescribed an ACL brace and PT for six to eight weeks. (Ex. No. 25 pp. 576-577).

36. Claimant was not satisfied with Dr. Garner's diagnosis and sought a second opinion from Dr. Huntsman on August 5, 2010. Claimant did not have his brace at this time and had not participated in formal PT, only exercises at home. Claimant stated that he had pain, that his knee gave out, and it was getting worse. Dr. Huntsman assessed that Claimant suffered an ACL tear and that he had a meniscus tear and that Claimant should elect to have a knee arthroscopy, Claimant agreed. Claimant testified at hearing that he didn't have personal health insurance and the cost of the proposed surgery was too expensive, so he opted to pay for a custom knee brace. (Ex. No. 14 p. 141) (See also Hearing Transcript, January 28, 2021, pp. 85-88).

37. As described above, Claimant had begun working for Blaine Larson Farms as a welder-fabricator when he was injured working on a semi-truck. Claimant, on October 24, 2011, was using a large wrench to remove a bolt when it broke loose. Claimant tried to prevent himself from falling and in his attempt injured his thumb. The accident was reported and when Claimant's symptoms did not improve, he sought medical treatment.

38. On October 27, 2011, Claimant visited Mountain View Hospital for the injury to his right thumb. In the doctor's notes. Claimant told him that he was tearing apart a trailer when a bolt came loose and he hit his thumb on a hook and his thumb went out and up. He did not seek medical attention because he thought it would get better. An x-ray revealed a healed right fifth metacarpal fracture with retained volar angulation of the metacarpal bone shaft and a deformity of the base of the right fifth metacarpal bone. The x-ray did not identify any new f[r]actures. (Ex. No. 19 pp. 509-513). Additional x-rays were taken on November 3, 2011. Once again they did not display any fractures or acute abnormalities. (Ex. No. 19 p. 517).

39. On November 21, 2011, Claimant had his hand examined by Dr. Huntsman because it was not improving. Dr. Huntsman examined Claimant and diagnosed a right wrist volar radiocarpal joint sprain. Claimant was advised to wear a brace and take Mobic. Claimant was allowed to work full time but was advised to wear his brace and avoid repetitive activities with his right wrist. (Ex. No. 14 pp. 142-143).

40. Claimant returned to Dr. Huntsman's office on December 5, 2011. Claimant complained that his thumb continued to pop out but he was having good results with the pain by taking Mobic. Although he was having some pain, the range of motion in his right wrist was intact. He was diagnosed with a right carpal sprain. He was advised to continue to wear his brace and to continue taking Mobic. He was allowed to continue working with limited repetitive use of his right hand and wrist. (Ex. No. 14 pp. 144-145).

41. On January 3, 2012, Claimant showed no improvement. He reported to Dr. Huntsman that the pain had not improved and that his thumb felt like it was popping out. He was still taking the Mobic daily. Dr. Huntsman's diagnosis stated that Claimant may have a scapholunate ligament tear in his right wrist and right De Quervain's tenosynovitis. Dr. Huntsman

ordered an MRI to rule these conditions out. Claimant's work restrictions remained the same. (Ex. No. 14 pp. 146-148).

42. On January 10, 2012, the MRI, performed by Dr. Peter Vance of Mountain View Hospital, showed a focal perforation of the radial aspect of the TFCC, and a probable full thickness perforation of the membranous portion of the scapholunate ligament. There were early degenerative changes of the triscaphe joint, degenerative changes of the fifth CMC joint, and multiple small ganglion or synovial cysts. (Ex. No. 14 pp. 149-150).

43. Claimant discussed the MRI results with Dr. Huntsman on January 12, 2012. In addition to the above information, Dr. Huntsman noted that Claimant was still in pain. Claimant had a positive Finkelsteins' test, positive ulnar abutment test, and mildly positive Watson's test. Dr. Huntsman diagnosed Claimant with a right wrist TFCC tear with probable scapholunate ligament partial tear. After explaining the risks and benefits of arthroscopy with Claimant, he decided to move forward with the surgery. (Ex. No. 14 pp. 151-154). Dr. Huntsman performed that surgery on January 25, 2012. The procedure included a right wrist arthroscopy, TFCC tear debridement, partial synovectomy, and an open scapholunate ligament repair with no complications. (Ex. No. 18 pp. 481-483).

44. On February 7, 2012, Claimant visited Dr. Huntsman for an examination of his right wrist. Claimant stated his hand was very painful, which Dr. Huntsman explained would be expected after surgery. Dr. Huntsman noted that Claimant's motor and sensory responses were intact. He had Claimant restart Mobic and placed Claimant in a short arm cast. Claimant's work was limited to left handed work only. (Ex. No. 14 pp. 155-157).

45. An unscheduled doctor's visit occurred on February 14, 2012. While at work one of Claimant's co-workers sat on his cast and broke it. Claimant stated that his pain increased after

the incident and a new cast and x-rays were needed. Dr. Huntsman's concern was that the new injury damaged the scapholunate ligament repair. Subsequent x-rays were inconclusive and it was decided that a new cast would be applied and additional x-rays would be taken at the next scheduled appointment. (Ex. No. 14 pp. 158-159).

46. On March 5, 2012, Claimant complained of extreme pain and that swelling was occurring on a daily basis. Dr. Huntsman examined Claimant and noted tenderness over his ulnar styloids, dorsal aspect of the wrist. No tenderness was evident over the volar aspect of the radiocarpal joint, distal radioulnar joint, palm, fingers, or thumb. Claimant had full flexion of all five fingers and his range of motion was twenty-degrees flexion and twenty-degrees extension and full supination and pronation. Dr. Huntsman noted that the x-rays showed no changes and that although Claimant had a partial tear of the scapholunate ligament, the ligament was still intact. Dr. Huntsman recommended that Claimant continue with normal rehabilitation, discontinue the cast, and continue to take Mobic. Claimant's work restrictions remained left handed work only. (Ex. No. 14 pp. 160-163).

47. Claimant's April 2, 2012, appointment with Dr. Huntsman showed little to no improvement of his condition. Claimant had been participating in PT and his ROM was improving; however, his pain remained the same and his strength had not returned. Claimant's ROM improved to a forty-five-degree flexion and a sixty-degree extension and eighty-degree supination and pronation. Dr. Huntsman voiced his concerns about the scapholunate ligament and the pain that Claimant was experiencing. However, Claimant wanted to continue with his PT to see if his pain would improve. Dr. Huntsman had Claimant continue with PT to work on his range of motion and strengthening, and continue to take Mobic. Claimant's work restrictions remained left hand work only. (Ex. No. 14 pp. 164-168).

48. Claimant saw Dr. Huntsman on April 30, 2012. Claimant expressed that his ROM increased but that his pain remained the same. His range of motion was equal to his previous visit. An x-ray showed that Claimant's DISI position of the wrist had a three millimeter scapholunate widening. Dr. Huntsman noted that Claimant was not progressing as quickly as he would like. An MRI was ordered because the doctor was concerned that he Claimant had a scapholunate ligament full tear. Claimant's work restrictions remained that same. (Ex. No. 14 pp. 167-170).

49. Dr. Peter Vance preformed the MRI at Mountain View Hospital on May 7, 2012. As suspected by Dr. Huntsman the MRI showed that Claimant had a full thickness tear of the scapholunate ligament of the membranous portion and a focal full thickness perforation of the radial aspect of the triangle fibrocartilage. (Ex. No. 14 pp. 171-172).

50. That same day Claimant saw Dr. James Edlin of Mountain View Hospital for a right wrist arthrogram for installation of gadolinium into the joint space. Dr. Edlin's findings were that Claimant's wrist displayed a widening of the scapholunate interval, which the doctor suggested may be related to a tear. (Ex. No. 14 p. 173). Dr. Huntsman performed surgery on May 30, 2012, to repair the scapholunate ligament for a partial tear, a right wrist perilunate pinning procedure, and right wrist dorsal capsulodesis with no complications. (Ex. No. 18 pp. 484-485).

51. Claimant saw Dr. Huntsman on July 9, 2012, for a routine follow up from his surgery. Claimant reported that he had numbness over the dorsal aspect of his hand. Dr. Huntsman's conclusion were that Claimant was healing well, that the gross position of the wrist was good, normal sensation in the finger and thumb, slight decreased sensation in the radial nerve distribution, the pins in the carpal bones were in a good position, and that the position of the carpal bones were good in relation to each other. A new thumb spica cast was put on Claimant and a date

was set to remove the pins from his wrist. Claimant was required to not use his right hand. (Ex. No. 14 pp. 172-183).

52. On July 25, Claimant had the pins removed from his wrist by Dr. Huntsman. When performing the procedure Dr. Huntsman discovered two pins that were broken and could not be removed. After consultation with Dr. Gregory Biddulph, Dr. Huntsman's colleague, the decision was made to leave the pins because both doctors believed removal would cause more harm than it would help. (Ex. No. 18 pp. 486-489).

53. A follow up visit after the pin removal on August 6, 2012, had Claimant complaining of severe pain that was not relieved with Hydrocodone and Mobic. The pain was located in the fourth and fifth digits. Claimant had a twenty-degree range of motion in both flexion and extension and full supination and pronation. Claimant displayed good finger abduction, flexion, extension, and pinch. The two broken pins had not moved from their previous position. Claimant was prescribed Percocet rather than Hydrocodone for pain and remained on the Mobic and required to attend PT to improve strength and mobility. He was allowed to discontinue the use of a brace but remained on his work restriction. (Ex. No. 14 pp. 185-188).

54. Dr. Biddulph performed Claimant's next post-op evaluation on September 4, 2012. Claimant still reported pain in the fourth and fifth fingers with no relief from the prescribed medication. He displayed no tenderness in the radial and ulnar styloids, dorsal and volar aspect of the radiocarpal joint, over the distal radioulnar joint, the anatomic snuffbox, or palm. Claimant had full active and passive flexion of his fingers and the ROM in his wrist was fifty-degrees flexion, forty-degrees extension, and eighty-degrees pronation and supination. X-rays showed that the broken pins remained in their previous positions and that the position of the scapholunate joint was good. Claimant was required to continue his PT for ROM and strengthening and continue his

medication as prescribed. Claimant expressed that he felt that he was developing a tolerance to his pain medication; thus, an appointment with a pain specialist, Dr. Jason Poston, was made to help Claimant discontinue the use of his pain medication. Claimant's work restrictions remained the same. (Ex. No. 14 pp. 193-197).

55. An October 2, 2012 visit with Dr. Huntsman saw no change in Claimant's pain. Claimant complained that his wrist was painful all the time. His motion in his right wrist remained relatively unchanged. The position of the scapholunate joint remained the same and the position of the broken pins had not changed. Claimant's current medication regimen would continue as prescribed. (Ex. No. 14 pp. 198-199). Dr. Huntsman also requested that Claimant seek a second opinion concerning the broken pins by Dr. Douglas Hutchinson of the University of Utah for the best course of action. (Ex. No. 14 p. 200).

56. As ordered by Dr. Huntsman, Claimant visited Dr. Gary C. Walker of Walker Spine and Sports Specialists for pain management on October 8, 2012. Claimant stated that his PT helped with the pain but only temporarily. Claimant reported that his pain increased with movement or activity. After a series of tests, Dr. Walker concluded that there were no indications that the pain was related to RSD or CRPS and recommended that the best course of action was to cease the use of narcotics. Dr. Walker prescribed Voltaren gel for pain and continued his current medication. Claimant's visit to Dr. Walker on October 23, 2012, saw no change in Claimant's pain with the Voltaren gel. (Ex. No. 26 pp. 583-585).

57. Claimant received a second opinion for his wrist pain and possible solutions from Dr. Hutchinson on October 29, 2012. Dr. Hutchinson's notes state that he had a hard time deciphering what Claimant's goals for treatment were. Nevertheless, after a thorough examination the doctor concluded that the best course of action to alleviate the pain would be to remove the

broken pins. Dr. Hutchinson noted that complications could arise from the procedure. For instance, in the doctor's notes he states that getting the pins out could affect the scapholunate reconstruction. In addition, the mid carpal joint was already ruined by one of the pins. Dr. Hutchinson also stated that a fusion of the mid carpal joint could improve Claimant's pain but would decrease his range of motion. He also stated that he was in favor of taking out the scaphoid and throwing it away in the case there were any scaphoid residual problems and this would provide a better chance of removing one of the pins. Dr. Hutchinson also informed Claimant that a four corner fusion, scaphoidectomy and pin removal were all reasonable. (Ex. No. 27 pp. 615-618).

58. Claimant visited Dr. Huntsman on October 30, 2012, for a routine follow up. Claimant stated that his wrist was painful. His ROM remained constant from the last visit. Dr. Huntsman was aware of Claimant's visit with Dr. Hutchinson but had not spoken with the doctor about his findings. (Ex. No. 14 pp. 201-202).

59. During this time Claimant continued to see a pain therapist. It was at a November 7, 2012, visit with Dr. Walker that Claimant complained that his pain increased when the weather got colder. Claimant was off his pain medication only taking Meloxicam. (Ex. No. 26 pp. 587-588).

60. Claimant spoke with Dr. Huntsman on December 13, 2012 this time for an examination of his knee. Claimant stated that he still had pain in his knee every day and that the intensity varied but that it was improving. Dr. Huntsman also examined Claimant's right shoulder after shoulder arthroscopy with a non-repairable rotator cuff tear debridement preformed four weeks prior. Claimant stated that he was satisfied with the progress of both his knee and shoulder. (Ex. No. 14 pp. 203-204).

61. Claimant elected to have the pins removed from his wrist in an effort to relieve his pain. On December 18, 2012, Dr. Hutchinson performed the surgery. A wrist arthrotomy with removal of two pins, extensor carpi radialis longus tenodesis to scaphoid for scapholunate instability, and posterior interosseous nerve neurectomy were performed without complications (Ex. No. 27 pp. 619).

62. On December 20, 2012, Claimant went to the emergency room at Eastern Idaho Regional Medical Center complaining of severe pain in his wrist. Claimant was two days removed from a wrist arthrotomy to remove two broken pins. An examination of Claimant by Dr. Lee concluded that Claimant's symptoms were consistent with acute carpel tunnel syndrome and a possible flexor tenosynovitis involving the flexor tendons of the right finger. Claimant was taken to the operating room and a carpal tunnel release procedure was performed to relieve the pain. (Ex. No. 15 pp. 316-338).

63. On December 27, 2012, Claimant visited Dr. Huntsman. Claimant was nine days removed from surgery to remove broken pins in his right wrist. Two days after the procedure Claimant developed carpel tunnel syndrome and had a carpal tunnel release procedure on December 20, 2012. Dr. Huntsman's examination of Claimant determined that Claimant displayed signs of moderate edema in his wrist and fingers. Claimant was experiencing numbness in his fingers but the doctor was confident this would dissipate over time. Claimant did not have thenar atrophy and his intrinsic muscles appeared to be in working order. Dr. Huntsman required Claimant to continue to wear his thumb spica brace continually. (Ex. No. 14 pp. 205-206).

64. On January 3, 2013, Claimant reported that his wrist continued to be painful and had not improved since his last visit. Claimant had moderate edema about the wrist and mild edema in the fingers. His ROM was twenty-degrees extension and ten-degrees flexion. Claimant had

decreased sensation in the median nerve distribution with sensory intact in the ulnar and radial nerve distributions. Dr. Huntsman stated he was pleased with this diagnosis and that he would continue to have Claimant wear his thumb spica brace and had him take Mobic. (Ex. No. 14 pp. 207-209).

65. Claimant returned to Dr. Huntsman's office on February 5, 2013, for his scheduled monthly appointment. Claimant still complained of wrist pain and stated he did not notice an improvement. The numbness he was experiencing before his emergency carpal tunnel release improved but he still experienced numbness in his index finger and thumb. His range of motion improved with twenty-degrees in both flexion and extension and he had full pronation and supination. Dr. Huntsman continued to express that he was pleased with Claimant's progress and discontinued the brace. He also ordered Claimant start PT for his range of motion and strength and continue to take Mobic. Claimant was allowed to work but restricted to left handed work only. (Ex. No. 14 pp. 213-217).

66. Claimant's next appointment for his wrist occurred on March 5, 2013. Claimant continued to experience pain in his wrist and numbness in his fingers. He had been in PT and attended three times per week. He had full active and passive flexion in all fingers and his range of motion continued to increase, twenty-degrees flexion, forty-five-degrees extension, and eighty-degrees supination and pronation. His grip and pinch strength remained a three out of five. X-rays showed that the carpal bones were in a good position. Dr. Huntsman expressed that he was concerned that the median nerve was not coming back as quickly has he would like and ordered an EMG to assess any potential problems. (Ex. No. 14 pp. 218-220).

67. Dr. Walker performed the EMG on March 19, 2013. Dr. Walker concluded that there were electro-physiologic findings of a severe median neuropathy at the right wrist with active

denervation changes present and mild findings suggestive of subtle ulnar neuropathy distally. (Ex. No. 26 pp. 289-290).

68. On March 21, 2013, Claimant visited Dr. Huntsman for the results of his EMG. Dr. Huntsman expressed his concerns that the function of the median nerve had not returned on its own. He suggested that Claimant visit Dr. Hutchinson for an opinion of the nerve, its current state, and solutions. Dr. Huntsman prescribed Lyrica and Hydrocodone to use sparingly. (Ex. No. 14 pp. 221-222).

69. Claimant went to Salt Lake City, Utah, on April 1, 2013, to see Dr. Hutchinson. After review of the EMG, Dr. Hutchinson surmised that Claimant suffered from complex regional pain syndrome ("CRP") which he verified with the physical therapist in his office. Dr. Hutchinson recommended that Claimant begin mirror therapy, stress therapy, and desensitization, and communicated this to Claimant's therapist in Idaho. Dr. Hutchinson also recommended that Claimant receive stellate ganglion blocks and recommended a return visit in three months to evaluate Claimant's nerve to see if it improved. (Ex. No. 27 pp. 621-627).

70. On April 15, 2013, Claimant saw Dr. Huntsman to discuss his visit with Dr. Hutchinson. Claimant reported that he still had wrist pain at the same intensity as his last visit. Claimant stated that Lyrica helped but that he needed to take Hydrocodone at night. Examination of Claimant revealed that he still had numbness in his fingers and that his range of motion remained relatively the same. Dr. Huntsman recommended that Claimant continue PT and taking Lyrica and a possible ganglion block injection, which was discussed with Dr. Hutchinson. Claimant was restricted from work completely. (Ex. No. 14 pp. 223-224).

71. On May 10, 2013, Claimant had his first of many appointments with Dr. Jake Poulter of Pain & Spine Specialists of Idaho. Claimant, at this point, had undergone four surgeries

on his right wrist and complained that the pain remained the same. Claimant reported his pain was ten out of ten at its worst and when taking Lyrica regularly and Hydrocodone at night the pain would decrease to an eight out of ten. Dr. Poulter examined Claimant and concluded that he showed signs of reflex sympathetic dystrophy. Dr. Poulter recommended a stellate ganglion nerve block, which was administered on May 15, 2013, continue to take Lyrica and Hydrocodone as prescribed, and to continue with PT. A spinal cord stimulator was also discussed as a last resort. (Ex. No. 32 pp. 663-665).

72. On June 10, 2013, Claimant saw Dr. Huntsman for a routine visit. It had been six months from the carpal tunnel release procedure and roughly a month since his stellate ganglion nerve block injection. Claimant stated that the injection did not provide any relief and made his pain worse. He also reported that the injection temporarily paralyzed his vocal cords, that the right side of his face drooped, and that he had diaphragm problems; these all rectified themselves. Claimant experienced no tenderness throughout his hand. His range of motion was increasing, full active and passive flexion of all five fingers, forty-five-degree flexion and extension in his wrist, and full supination and pronation. Dr. Huntsman prescribed Claimant Voltaren XR and ordered an EMG to re-evaluate the median nerve. Claimant was restricted to left hand work only. (Ex. No. 14 pp. 228-231).

73. Claimant was on a monthly schedule with his pain specialist, Dr. Poulter. On his June 10, 2013, visit Claimant stated that his pain increased since his last visit. Claimant described his pain as numb, aching, pins and needles, stabbing, and constant. He also reported that the injection increased the pain. Dr. Poulter suggested that Claimant continue on Lyrica three times a day and continue using Hydrocodone. They also discussed a therapeutic axillary nerve block and having a transcutaneous electrical nerve stimulator. (Ex. No. 32 pp. 669-673).

74. Dr. Walker performed the second EMG on June 24, 2013. He concluded that Claimant, compared to his March 19, 2013 EMG, had marked improvements with normal motor amplitude now present and resolved presence of the previous fibrillation potentials. (Ex. No. 26 pp. 591-592).

75. Claimant saw Dr. Hutchinson on July 1, 2013, for their scheduled appointment. Claimant reported that his pain was better with the Lyrica and Hydrocodone. In the doctor's notes he states that he did not believe Claimant was wearing his brace and Claimant stated he was told he did not have to wear it. Dr. Hutchinson's notes state that he believed that Claimant's range of motion was improved, that his pain seemed to be throughout the wrist rather than a designated area, and that he did not believe that Claimant's subjective data of the pain was helpful and more objective data by a therapist was needed. Dr. Hutchinson also stated that it appeared that the EMG showed improvement of Claimant's nerve conduction velocity over his wrist. Dr. Hutchinson's opinion was that Claimant would never not complain of pain and that a wrist fusion previously discussed in the last appointment was not necessary. He also believed that Claimant could not continue in his current employment. The doctor explained that Claimant's ability to lift more than a couple pounds, push and pull, reaching above his shoulder, and climbing were all affected by his shoulder and wrist surgeries. He believed that Claimant should not be allowed to return to his current employment unless it was very light work. (Ex. No. 27 pp. 628-633).

76. Claimant's July 9, 2013, appointment with Dr. Poulter did not see any improvement with his pain or symptoms. Claimant stated that the medication was helping with pain and his life activities. He also reported that the use of the transcutaneous electrical nerve stimulation ("TENS") unit provided pain relief. Dr. Poulter recommended that Claimant continue his current medication regimen and PT. (Ex. No. 32 pp. 674-677).

77. At his July 15, 2013, appointment with Dr. Huntsman Claimant reported that he did not notice much improvement with his condition. Dr. Huntsman's examination did not show a noticeable difference. His recommendation were to continue with his current medications, Hydrocodone, Lyrica, and Voltaren, and to try and wean Claimant off of the Lyrica. Claimant was to continue to increase his activities as tolerated and follow-up with Dr. Poulter for pain management. Claimant was restricted from lifting more than two pounds with his right upper extremity at work. (Ex. No. 14 pp. 232-235).

78. A follow up appointment with Dr. Huntsman was scheduled for August 13, 2013. Claimant was present with his attorney and two representatives from the Idaho Industrial Commission. Claimant stated there was no improvement with his pain, that his ROM was not improving, but that his numbness was mostly gone. He did have tenderness over the ulnar styloid and dorsal aspect of the radiocarpal joint, but none over the other aspects of his wrist. His ROM was forty-five-degrees flexion and extension, and seventy-degrees pronation and supination. Grip strength was reported as a three out of five and pinch a four out of five. Dr. Huntsman expressed his pleasure with the continued improvement of sensation in the wrist and that he expected the Claimant's strength would improve with the nerve improvements. Claimant was to continue his medication and TENS unit per Dr. Poulter's recommendations and refrain from lifting over two pounds with his right upper extremity. (Ex. No. 14 pp. 236-237).

79. Claimant reported forearm pain at his next appointment at Pain & Spine Specialists of Idaho on September 3, 2013; Travis Allen PA[-]C examined Claimant. PA-C Allen's assessment of Claimant was that the pain radiated from his elbow into his fingertips. Claimant described the pain as constant with numbness, tingling, and weakness, with tenderness at his right wrist. PA-C Allen performed a Tine's, diadochokinesis, and finger to nose test that were all

negative. PA-C Allen discussed the use of a scrambler machine and a trial was scheduled. Claimant was to continue his current medication regimen. (Ex. No. 32 pp. 678-681).

80. Claimant's appointment with Dr. Huntsman on October 8, 2013, saw no change in Claimant's condition. Claimant did state that his pain was tolerable on the medication and with the use of the TENS unit. Tenderness and ROM remained relatively the same. Claimant was becoming impatient with his condition and expressed his frustration with not improving. He and Dr. Huntsman discussed a partial fusion. A four corner fusion had been recommended in the past by Dr. Hutchinson and Claimant was informed that he would lose all motion in his wrist. Claimant inquired about a partial fusion and keeping the scaphoid but was told this was not favorable. The doctor's notes explained that a partial fusion was needed. (Ex. No. 14 pp. 240-242).

81. The November 6, 2013, appointment with pain specialist PA-C Allen found Claimant's pain had improved slightly and while taking medication it improved dramatically. Claimant reported that while on the medication his pain was a two out of ten and when off eight out of ten. Claimant reported that his range of motion and strength had decreased but when examined by PA-C Allen he stated it had only slightly decreased. Claimant was to continue his medication regimen as prescribed. (Ex. No. 32 pp. 682-685).

82. A November 11, 2013, appointment with Dr. Huntsman saw no improvement with Claimant's condition. Claimant continued PT three times a week and was seeing a pain specialist. Because of the lack of improvement after several appropriate conservative measures Claimant and Dr. Huntsman discussed surgical treatments. Dr. Huntsman, Dr. Hutchinson, and Dr. Biddulph consulted on the best treatment for Claimant. Their concerns were that Claimant had a bad scapholunate joint that needed to be fused and a scapholunate dissociation that appeared to be worsening. For this type of problem, a four corner fusion with excision of the scaphoid was the

best solution. Claimant was concerned because he did not want to lose too much of his joint surface when the radial scaphoid joint was in good condition. A scapholunate capitate fusion was decided because it would leave both the scaphoid and the lunate as bearing surfaces. This would cause more stiffness to the radial and ulnar deviation but would give him more bearing surface. (Ex. No. 14 pp. 243-244).

83. Claimant's scheduled pain specialist appointment occurred on December 2, 2013. The medication regimen stabilized Claimant's pain enough to make it tolerable. An appointment was scheduled after Claimant's fusion to discuss treatment for pain. (Ex. No. 32 pp. 694-697).

84. On December 4, 2013, a right scapholunate capitate fusion and right iliac crest bone graft were performed on Claimant with no complications. (Ex. No. 18 pp. 490-491).

85. Claimant visited the Pain & Spine Specialists of Idaho on January 2, 2014. It had been approximately a month since Claimant's fusion surgery. Claimant stated that his pain had increased after surgery and because he ran out of medication it was getting worse. PA-C Allen refilled Claimant's medication, MS Contin, Norco, Lyrica and required that he agree to drug monitoring. (Ex. No. 32 pp. 698-701).

86. On January 14, 2014, a post-surgical appointment occurred with Dr. Huntsman. Claimant stated that he was in a lot of pain and that it hurt to move his fingers. Dr. Huntsman's examination concluded that there were early stages of fusing of the scapholunate capitate fusion and he was happy with Claimant's progress. Dr. Huntsman also decided to remove Claimant's cast and transition him into a soft wrist splint. Claimant was advised to avoid lifting with his right arm. (Ex. No. 14 pp. 248-249).

87. Claimant reported to PA-C Allen on January 30, 2014, that his pain was worse than the prior visit and it worsened when his cast was removed. PA-C Allen continued that Claimant on his current pain medication and prescribed Lidoderm patches. (Ex. No. 32 pp. 702-705).

88. X-rays taken on February 18, 2016 [sic – 2014], showed that the fusion was progressing well between the lunate and capitate and the scaphoid and capitate. Dr. Huntsman expressed his pleasure with the progress. He required that Claimant wear his brace for two more weeks and allowed him to remove it to work on his motion. PT would start in two weeks to work on Claimant's ROM and strength. (Ex. No. 14 pp. 250-252).

89. Claimant's next appointment with PA-C Allen occurred on March 3, 2014, and Claimant reported that his pain was improving; however, he was still at a four out of ten and the pain was constant. PA-C Allen did not notice any signs of complications with the surgery but did want to monitor Claimant for signs of CRPS symptoms. PA-C Allen continued Claimant on his current medications for pain. (Ex. No. 32 pp. 706-708).

90. Claimant's monthly appointment with Dr. Huntsman occurred on March 18, 2014. Claimant was three and one half months removed from his surgery and attending PT for approximately two weeks. Claimant stated that he felt he had not made progress in his range of motion. Dr. Huntsman's examination concluded that Claimant had an eighty-degree flexion and extension and full supination and pronation. The doctor was pleased with the progress and ordered him to continue PT and in addition use a bone stimulator to heal the fusion. (Ex. No. 14 pp. 253-255).

91. Claimant saw PA-C Allen on April 3, 2014. PA-C Allen['s] assessment of Claimant was that the medication regimen was very therapeutic and increased his function and quality of life. PA-C Allen refilled his medications as prescribed. (Ex. No. 32 pp. 713-716).

92. Dr. Huntsman saw Claimant on April 14, 2014, for his monthly appointment. Claimant stated that his pain was equivalent to that of his last visit. Claimant's range of motion remained consistent. Dr. Huntsman expressed his pleasure with Claimant's progress and stated that there was an appearance of continual filling at the fusion site. Dr. Huntsman continued Claimant's PT and bone stimulator, and suggested he continue to increase his activities to the extent it was comfortable. (Ex. No. 14 pp. 256-258).

93. Claimant's visit to his pain specialist on May 1, 2014, was reminiscent of his last visit with Claimant stating there was little change in his pain. Dr. Allen continued Claimant on the same medication regimen. (Ex. No. 32 pp. 717-720).

94. Claimant's visit with Dr. Huntsman on May 13, 2014, had Claimant reporting no tenderness in his wrist or hand, and his ROM remained the same. Claimant's medication included Hydrocodone-Acetaminophen, Lyrica, MS Contin, and Voltaren-XR, and he stated that he had been using his bone stimulator at night. Dr. Huntsman was pleased with Claimant's progress and restricted his work to lifting one pound with this right arm. Claimant reported that his pain was unchanged at his May 29, 2014, appointment with PA-C Allen and they continued Claimant on his current medication regimen. (Ex. No. 14 pp. 259-260).

95. Claimant's visit with Dr. Huntsman on June 10, 2014, saw relatively no change in his condition. Claimant's pain, range of motion, and tenderness in his wrist and hand remained the same. X-rays of Claimant's wrist displayed that the hardware in his hand remained in its position and the fusion appeared to be healing well. Dr. Huntsman expressed his pleasure with Claimant's progress. Claimant was to continue his current medication, PT three times per week, and restricted to a five pound lifting limit with his right arm. (Ex. No. 14 pp. 261-262).

96. At Claimant's visit to PA-C Allen on June 26, 2014, he reported his frustration with his wrist pain and his displeasure that it was not improving after six months post[-]surgery. Claimant stated that his pain was most significant when he would lift objects off the ground and he could push without issue but to pull was excruciating and painful. He also stated that lifting objects of only a few pounds was excruciating. Claimant's pain was most evident on the ulnar side of the wrist and worsened with pronation and supination movement. PA-C Allen believed Claimant's pain was associated with nociceptive and neuropathic pain and that he would likely have chronic pain issues for many years. PA-C Allen refilled Claimant's medication, increased his Lyrica dose slightly, and had Claimant try Gabapentin with the Lyrica. PT would continue as ordered. (Ex. No. 32 pp. 725-728).

97. On July 8, 2014, Claimant reported that his pain was intermittent. Claimant had moderate tenderness over the ulnar styloid, dorsal aspect of the radiocarpal joint but no tenderness over the other aspect of his wrist and hand. His motion increased with an eighty-degree flexion and extension and full pronation and supination. X-rays displayed a good position scaphocapitolunate fusion and hardware; however, two screws in the lunate appeared to have lucency around them. Dr. Huntsman ordered a CT scan to evaluate for possible nonunion of the scaphocapitolunate fusion. The results of the CT scan were minimal dorsal bridging along the dorsal aspect of the scapholunate capitate fusion. (Ex. No. 14 pp. 263-264).

98. On July 17, 2014, Claimant was presented with the result of the CT scan and the information of the nonunion of the fusion. Claimant was advised to quit smoking to increase the chances of fusion. Claimant and Dr. Huntsman also decided that a full fusion would be the appropriate course of action. (Ex. No. 14 pp. 265-268). On August 15, 2014 Dr. Huntsman

performed the surgery. The procedure included the removal of the previous plate and screws, right wrist fusion, and left iliac crest bone graft with no complications. (Ex. No. 18 pp. 494-496).

99. On August 25, 2014, Claimant saw PA-C Allen for post treatment management. It had been decided at the July 25, 2014, appointment with PA-C Allen he would assume Claimant's pain management exclusively. On this particular visit Claimant reported that he had constant pain. Claimant's medication included Percocet, MS Contin, and Norco. (Ex. No. 32 pp. 733-736).

100. A post operation appointment with Dr. Huntsman on August 26, 2014, occurred 11 days after Claimant's full wrist fusion. Dr. Huntsman was pleased with the progress of the fusion. Claimant was placed in a short arm cast and allowed to participate in light activities and ROM with his right hand but was to refrain from lifting. (Ex. No. 14 pp. 273-274).

101. On September 23, 2014, Claimant saw Dr. Huntsman for cast removal. Claimant's cast was removed and he was placed in a splint to keep the wrist immobilized. Dr. Huntsman was still pleased with Claimant's progress. Claimant was to avoid lifting more than one to two pounds, restricted from work, and told to only remove his splint to bathe. (Ex. No. 14 pp. 279-280).

102. The same day Claimant also saw pain specialist PA-C Allen. Claimant reported pain in his wrist and hip, as expected from his surgery and PA-C Allen noted that Claimant had an antalgic gain [sic-gait] from his hip pain. PA-C Allen refilled his medication but planned on de-escalating the Percocet to five tablets a day and to slowly de-escalate his medication over time as long as his pain improved. (Ex. No. 32 pp. 737-741). On October 21, 2014. PA-C Allen noted that Claimant had been taking less of his Oxycodone, only three pills a day, and the plan was to cease its use and substitute with Hydrocodone and Norco. (Ex. No. 32 pp. 742-746).

103. Ten weeks after his surgery on October 28, 2014, Claimant reported to Dr. Huntsman's office for his monthly examination. Dr. Huntsman noted that Claimant reported that

he did have pain but that it was improving. There were no signs of infection in the incision areas and that tenderness in Claimant's wrist and hand was mild. Claimant had full active and passive flexion in all fingers. Claimant was to begin PT to work on his ROM. He was limited to lifting ten pounds with his right hand but not perform work with his right. (Ex. No. 14 pp. 281-283).

104. Fifteen weeks after his surgery Claimant, on December 2, 2014, visited Dr. Huntsman. At this visit Claimant reported that his wrist was still in pain but that the pain was slowly improving and that he had been following weight restriction. Dr. Huntsman's examination found mild tenderness in areas of the hand but nothing major. X-rays showed that there was a solid fusion and that the radiocarpal joint was in a good position. Dr. Huntsman noted how pleased he was with Claimant's progress. PT was to continue with work on the extensor tendonitis and grip strength. Work restrictions were upgraded to five pounds with the right upper extremities. (Ex. No. 14 pp. 284-286).

105. Claimant reported that his pain was slowly improving as his fusion continued to heal on December 18, 2014. PA-C Allen explained that Claimant had significant tendonitis in his wrist; however, he was prevented from taking anti-inflammatories because Dr. Huntsman did not want to slow the healing process of the fusion. PA-C Allen was confident that the tendonitis would improve with anti-inflammatories once Dr. Huntsman gave his approval for their use. PA-C Allen also noted this would allow for the de-escalation of opioid use. PA-C Allen continued Claimant's current medication regime. (Ex. No. 32 pp. 747-751).

106. On January 6, 2015, Claimant reported to Dr. Huntsman that his wrist felt the same as his last visit and added that the weather affected his pain levels. Claimant also reported that he had been attending PT three times a week and that it helped decrease the pain and helped improve

his strength. Tenderness remained the same, as did active and passive flexion. PA-C Allen continued PT and the current work restrictions. (Ex. No. 14 pp. 287-288).

107. PA-C Allen reported on January 15, 2015, that Claimant's pain was gradually improving. He noted that Claimant had tendonitis in his right wrist and Claimant complained of neuropathy in his fingers, hand, and forearm. He also noted that the medications, Hydrocodone-Acetaminophen, MS Contin, Norco, and Lyrica had been beneficial with Claimant's function. PA-C Allen continued Claimant on his current medication and in approximately a month, with Dr. Huntsman's approval, begin anti-inflammatories to combat Claimant's tendonitis. (Ex. No. 32 pp. 752-756).

108. On February 12, 2015, Claimant had his monthly visit with Dr. Huntsman. Dr. Huntsman was very pleased with Claimant's progress. There had been no major complications. Claimant had mild to no tenderness in his wrist or hand. His ROM was very limited but [that was] to be expected with the fusion; x-rays showed that the fusion was solid with no signs of loosening of the hardware. Claimant was allowed to begin the anti-inflammatory Mobic. Dr. Huntsman noted that Claimant was having a functional capacity evaluation done to determine he work capabilities and if he had reached MMI. Claimant's work restriction remained that same. (Ex. No. 14 pp. 289-290).

109. PA-C Allen examined Claimant on February 16, 2015. Claimant reported that his pain was gradually improving. He also reported that he was approved to begin anti-inflammatories and he wanted PA-C Allen to monitor the prescription. PA-C Allen continued Claimant's pain medication regime and continued Meloxicam. (Ex. No. 32 pp. 757-761).

110. The March 10, 2015, appointment with Dr. Huntsman did not see a change in Claimant's condition. Claimant's tenderness throughout the hand and wrist remained the same, as

well has [sic-as] his pain. The range of motion remained that [sic-the] same and was expected due to his fusion in the right wrist. He did experience some decreased sensation in the tips of his fingers. The FCE determined that he had decreased grip strength on his right and this prevented the examiner from determining what weight he could tolerate lifting with his right upper extremities. Dr. Huntsman believed that Claimant had reached MMI and that an impairment rating would be performed. Claimant was put on a permanent five-pound weight restriction with his right upper extremity. (Ex. No. 14 pp. 292-295).

111. Claimant reported to PA-C Allen on March 12, 2015, that his pain remained relatively unchanged and that he was also experiencing intense muscle spasm in his right forearm. PA-C Allen noted that the FCE limited his right arm pain at under 10% of normal strength as compared to his left arm and that Claimant would never have strength or dexterity similar to before surgery. To relieve the muscle spasm PA-C Allen prescribed a muscle relaxer to be used on a trial basis for a month and he refilled Claimant's medications. (Ex. No. 32 pp. 762-765).

112. Claimant met with pain specialist PA-C Allen over the course of several months, beginning on April 9, 2015, through October 15, 2015. Claimant reported in these meeting that his pain remained relatively the same as it did before his surgery. Claimant reported that his pain slightly improved after his fusion but in large part remained the same and cold weather would increase his pain. Claimant was prescribed Clonidine patches to increase the blood flow to his hand to prevent it getting cold. PA-C Allen recommended a stellate ganglion block but Claimant refused due to a bad experience in the past. PA-C Allen also recommended a spinal cord stimulator in the future if his pain persisted, Claimant refused this treatment. Claimant remained on his current medication regimen from April 9, 2015, through October 15, 2015. (Ex. No. 32 pp. 776-806).

113. On October 26 and 27, 2015, Claimant underwent a functional capacity evaluation performed by Dr. Huntsman. Dr. Huntsman reported that Claimant used maximum effort during the test, an indication of validity. Dr. Huntsman opined that Claimant would not return to work similar to that of a welder-fabricator. Dr. Huntsman's opinion was based on the belief that Claimant's work capabilities were severely limited because of his right wrist injury and the injury to his left shoulder. Dr. Huntsman went on to conclude that the jobs best suited for Claimant are ones that he is not required to use his right hand or the physical use of his left upper extremity above shoulder level. (Ex. No. 16 pp. 466-474).

114. Claimant's November 12, 2015, appointment with PA-C Allen did not see an improvement with his pain. PA-C Allen reported that Claimant had chronic and severe pain in his right UE and no improvement in his right wrist. Claimant stated that cold weather exacerbated his pain. PA-C Allen reported that Claimant had sympathetic mediated changes and a likely full diagnosis of CRPS of the right upper extremity. Claimant's medication improved his condition and quality of life but a spinal cord stimulator was discussed as a possible long term solution. (Ex. No. 32 pp. 807-818).

115. On April 16, 2018, Claimant met with Dr. Walker for an independent medical evaluation at the Employer/Surety's request. Dr. Walker, after reviewing of Claimant's medical records and performing an examination, determined that Claimant's injuries, which included his left shoulder and right wrist, equated to an 18% whole person permanent impairment. Dr. Walker utilized the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition for his rating. Dr. Walker went on to conclude that Claimant should be put on a permanent lifting restriction of five pounds with his right extremity and twenty pounds with his left shoulder injury. Each

extremity's restrictions were apportioned to the respective injuries to each side. (Ex. No. 26 pp. 593-610).

116. Claimant continued to see PA-C Allen for his pain management from December 10, 2015, through May 16, 2019. Throughout his treatment, Claimant continued to experience pain in his right UE and his right wrist and managed his pain with the medication prescribed to him. Cold weather or extreme weather changes continued to exacerbate his pain, and he and PA-C Allen discussed the use of a spinal cord stimulator, which Claimant has rejected on several occasions. Claimant continues to treat with Dr. Poulter's office for pain management. No further surgeries or procedures are recommended. (Ex. No. 32 pp. 819-1058).

FURTHER FINDINGS OF FACT

117. Claimant has injuries which are unrated, such as Claimant's ACL and meniscus tear, or for which medical records were not provided, such as Claimant's claimed compression fracture at L4-L5. See ¶ 35-36; 2019 Depo. 59:12-65:25. In 2019, Claimant testified his low back fracture made it difficult for him to bend and lift and his ankle fracture made it difficult to walk, stand, and climb. *Id.* at 37:24-38:17. At hearing, Claimant discussed the residuals from his knee injury, and testified that his knee was stable and not an issue as long as he used fatigue pads; regarding his ankle, he testified he had "never had any issues with it," but did occasionally use a stool to "correct" for it. Tr. 87:1-14; 71:10-72:3. None of these conditions are rated, nor have restrictions associated with them.

118. Claimant is a high school graduate. Tr. 30:10-11. Claimant was certified in welding and is currently certified in numerous small engine repairs. *Id.* at 38:12-17;42:22-43:5. Claimant regularly gains new small engine repair certificates for his current job by watching videos and taking quizzes on his own time. *Id.* at 42:22-43:5;139:5-23.

119. Claimant's job history is predominantly welding and repair, but Claimant also has experience in supervising, customer service, glass installation, construction, landscaping, and stereo installation. 2017 Depo. 19:12-30:15; Tr. 67:16-68:21.

120. Claimant secured his current employment by referral from a friend but was hired by the service manager. 2019 Depo. 31:9-32:16. The job started as temporary recall repair position and grew into a full-time small engine repair position. At the time of hearing, Claimant had been employed there for almost five years. Tr. 105:3-5. Claimant is the most senior technician at his place of employment and is a supervisor. Tr. 67:16-68:21;128:18-20. Claimant is paid by the job, not hourly, and his pay averages about $27 an hour. Tr. 103:9-105:2;112:7-15. Claimant's employer has three other flat-rate technicians and three hourly employees; the hourly employees help with lifting and cleaning. *Id.* at 98:23-24; 102:23-6. Claimant purchases specialty tools to accommodate his restrictions, but purchasing tools is a standard in mechanic work and not unique to Claimant. *Id.* at 64:17-25.

121. Claimant testified that his current employer has "been more than cooperative to work around my limitations." 2017 Depo 9:6-8. Claimant's current employer has hourly employees that help Claimant lift. 2019 Depo. 30:2-31:1; Tr. 49:1-8. Claimant is slower than his colleagues because he requires help with lifting and because of his injuries. 2019 Depo. 51:24-52:7, 57:1-24. Claimant testified he was unaware of any lifting policy at his employer, but that other flat rate technicians did sometimes have help with lifting heavy engines. Tr. 105:20-106:25.

122. At hearing, Claimant testified he had started looking for jobs that week and asked a friend about working at his window business but noted there was "not a whole lot." Tr. 56:19-22; 65:10-24. Regarding small engine repair jobs, Claimant testified there were three dealers in the Idaho Falls area which were large enough to "actually employ" people. Tr. 69:1-16.

123. Nancy Collins, PhD, issued her first report on December 9, 2015 and an addendum on January 27, 2020 on behalf of Claimant. JE 35. Dr. Collins interviewed Claimant, reviewed records, and utilized the Dictionary of Occupation Titles (DOT), SkillTran, Occupational Employment Quarterly, and the Occupational Requirements Survey.

124. Dr. Collins identified Claimant's restrictions as follows: (1) 25-pound lifting restriction above left shoulder, related to the 2007 injury; (2) sedentary to light work, with no overhead reaching on the left shoulder, no crawling or climbing, occasional overhead reaching with right shoulder, occasional squatting or kneeling, from the FCE; (3) limited to frequently lifting 5 pounds on the right upper extremity with no hour limitation, related to the industrial injury. Dr. Collins noted the FCE was valid but that the evaluation revealed indications of "high pain disability exaggeration." *Id.* at 1200.

125. Dr. Collins noted Claimant attended high school through 12th grade. Claimant self-reported ADHD and that he was a "very poor" reader but learned well through demonstration and on-the-job training. *Id.* at 1203. At the time of the evaluation, he only had basic computer skills and no other vocational education. Dr. Collins wrote Claimant's vocational history was one of welding, fabricating, and construction work, and that he could no longer perform any of those duties. Dr. Collins opined formal retraining was not an option due to Claimant's learning difficulties.

126. Dr. Collins wrote Claimant's prior work was in the very heavy, heavy, and medium strength categories and Claimant's capacity was now less than sedentary with his dominant hand. Claimant "has very few transferable skills," no sedentary work skills, and poor academic aptitude. *Id.* at 1206. In analyzing Claimant's transferable skills, Dr. Collins assumed a light lifting restriction and occasional reaching because Claimant could still lift with his left hand and reach

overhead with his right hand. *Id.* at 1207. Utilizing these restrictions, Dr. Collins wrote "realistically, he has lost access to all directly transferable work," but noted Claimant still had access to light driving or retail jobs, which paid approximately $9.00 in 2015. *Id.* at 1208-1209.

127. In conclusion, Dr. Collins opined Claimant had lost 98% of his labor market access and 50% of his loss of earning capacity. Dr. Collins weighted Claimant's loss of access heavier than his loss of earning capacity and rated Claimant's disability at 82%. Dr. Collins wrote she was reluctant to find Claimant totally and permanently disabled because of his young age, but that he may need too many accommodations to be competitively employable. *Id.* at 1209.

128. For her updated report on January 27, 2020, Dr. Collins reviewed Ms. Layton's report, the surveillance report, Claimant's 2017 and 2019 depositions, Claimant's pay stubs from Action Motor Sports, and updated medical records and also spoke to Claimant and his boss at Action Motor Sports, Ivan. *Id.* at 1211.

129. Dr. Collins wrote Claimant had assistance at work with lifting and was slower than he would be without his injuries, but that his boss Ivan thought Claimant "was one of his best line technicians, with good knowledge, and good people skills." *Id.* at 1213. Ivan agreed Claimant would be more productive if he could use his right hand. *Id.* Ivan explained the shop had a general policy of not lifting over 50 pounds without help and that they have lifts the technicians use. *Id.*

130. Dr. Collins calculated that Claimant lost 35% of his labor market access when considering his left shoulder restrictions <u>only</u>. Dr. Collins then observed:

> Assuming he can lift a light level with his LUE, but only 5# with his right hand, he has lost access to 60% of the jobs he could have performed with the pre-existing restriction for his left shoulder. When I then consider the percentage of jobs that require handling, and gross manipulation with both hands, his loss of access increases to 98% to 100%.

Id. at 1215. Dr. Collins maintained that Claimant lost 98% of his labor market access due to both injuries and that "realistically, [Claimant] is working in an occupation where the restriction for his right hand would preclude this work without significant accommodation." *Id.* Dr. Collins felt Claimant had lost earning capacity, despite making more than he did at the time of injury, because Claimant was not able to work as fast due to his hand injury; she estimated 25% and 50% loss of earning capacity. *Id.* Drilling down, she found Claimant suffered 37% loss of earning capacity when considering the sales jobs in Claimant's residual labor market. Dr. Collins maintained that Claimant's disability was 82% based on his significant loss of labor market access and loss of earning capacity.

131. Kourtney Layton issued her report on November 12, 2019 on behalf of Defendant/Employer. Ms. Layton observed Claimant at his 2019 deposition, reviewed records, and utilized the DOT database and OASYS software. Ms. Layton recorded Claimant was a high school graduate with a welding certificate and mechanical certificates. JE 36:1315.

132. Ms. Layton conducted a transferable skills analysis based on Claimant's past job experience and limitations. Ms. Layton found Claimant had access to 48 jobs with medium duty limitations based on his past work experience; Ms. Layton did not provide an estimate for how many jobs Claimant had access to without the medium duty restriction with his transferable skills. In estimating loss from his left shoulder injury, Ms. Layton added a restriction for "occasional" use of the upper extremity to the medium duty limitations and found just one job within those restrictions. Ms. Layton therefore estimated Claimant lost 97.91% of labor market access due to his pre-existing left shoulder injury. When analyzing the subject injury, she considered Claimant limited to light and sedentary duty with an "occasional" restriction on upper extremity use which yielded zero jobs within Claimant's skill set. Therefore, she concluded he had lost 100% of his

labor market access when considering the subject injury and pre-existing injury. *Id.* at 1316. However, Ms. Layton concluded that Claimant still had access to sales jobs with minimal accommodation which were not captured in the DOT transferable skills analysis. *Id.* at 1317.

133. In her summary, Ms. Layton reiterated that under her first analysis, Claimant had lost all ability to return to past work and had 100% loss of access. Utilizing OASYS software, Ms. Layton found that Claimant's loss of labor market due to the subject injury was only 51.04% because Claimant had access to one job prior to the subject injury due to his pre-existing left shoulder injury and zero jobs after the subject injury. Ms. Layton opined Claimant had no loss of earning capacity because he was making more at his current job then his time of injury job. Ms. Layton elaborated on her prior point, writing:

> Dr. Collins agrees that, regardless of his history of learning difficulties, [Claimant] "can learn a new skill on the job if an occupation can be found where he does not have to use his right dominant hand on a more than occasional basis." Since [Claimant] is already working above his prescribed residual functional capacity and has been doing so successfully for quite some time, it is arguable that he could successfully transition to lighter work utilizing industry-specific skills gained through his past work that are not specifically identified through a DOT Transferable Skills Analysis.

Id. at 1320. Ms. Layton considered Claimant capable and qualified for positions as a recreational vehicle salesperson, parts salesperson, or auto accessories salesperson. Ms. Layton reiterated that Claimant had no loss of earning capacity comparing those occupations to Claimant's time of injury occupation because he made approximately $28,000 at his time of injury job in 2011 and would make approximately $28,000 in 2019 as a parts salesperson. *Id.* at 1322. Ms. Layton concluded that Claimant's disability was approximately 25.25% considering a loss of access of 51% and no earning capacity loss.

134. On November 26, 2019, Barbara Nelson issued a report on behalf of ISIF. Ms. Nelson focused solely on whether Claimant was totally and permanently disabled in her analysis. Ms. Nelson opined in relevant part as follows:

> [Claimant] has been evaluated for disability by two other forensic vocational consultants other than myself. Neither of them have opined that he is totally disabled. I certainly agree that he is not totally and permanently disabled. Further, I see no indication whatsoever that his employer would be classified as a "sympathetic" employer. It would be highly unusual to see an unrelated employer who was getting little benefit from an employee, but sympathized with his situation, pay that employee approximately $56,000 per year. Everything points to the fact that [Claimant's] skills, diligence, and efforts are valued by his current employer and that his work is real work.

JE 37:1342. (emphasis in original).

135. Dr. Walker was deposed on August 19, 2021. Dr. Walker explained Claimant was more functional with opioids and that they had allowed him to return to work. Walker Depo. 18:1-14. Regarding Claimant's left shoulder, he understood Dr. Andray's restriction against lifting more than 25 pounds above the shoulder be a left sided only restriction, not bilateral, meaning he could lift 50 pounds overall. *Id.* at 19:18-20:2. Regarding Claimant's job at Action Motor Sports, Dr. Walker testified that Claimant could perform that job within his restrictions; Claimant was "obviously very restricted" but "at least in the here and now, he seems to be actually functioning at quite a high level." *Id.* at 20:21-22:3.

136. Dr. Collins was deposed on July 20, 2021. Dr. Collins thought that Claimant's employer was "not necessarily a sympathetic employer, but he has provided accommodations that other employers might - - probably would not provide, and that's the only reason [Claimant] can do the work." Collins Depo. 12:2-5. Dr. Collins reaffirmed her opinion that Claimant was not totally and permanently disabled because of his age, desire to keep working, and the limited number of jobs that remained available to him, namely light delivery driving and RV or parts sales.

Id. at 14:12-21. Dr. Collins thought Claimant's narcotic use was vocationally relevant as it would keep some employers from hiring him. *Id.* at 15:20-16:9.

137. Dr. Collins felt that Ms. Layton's opinion that Claimant lost 98% of his pre-injury labor market because of his 2004 left shoulder injury was "overstated." Dr. Collins explained that the Dictionary of Occupational Titles (DOT) does not discriminate between types of upper extremity use (overhead vs. in front vs. behind), which is why Claimant had 98% loss of access under a "occasional upper extremity use" restriction under Ms. Layton's analysis; there is no way to limit to just overhead reaching on the left side when utilizing that tool to estimate loss. Dr. Collins pointed out that Claimant did perform jobs that required "reaching" after his 2004 left shoulder injury such as welding, driving truck, installing audio equipment, and work as a glazier. *Id.* at 26:12-27:20. Dr. Collins felt her estimate of 35% also "probably overestimate[d]" his loss of access from his 2004 left shoulder injury because she calculated his loss of labor market excluding all heavy jobs, when realistically he could do heavy jobs which did not require heavy overhead lifting. *Id.* at 38:8-39:1. Later Dr. Collins explained Claimant could still lift 100 pounds ground to waist, which also factored into why she felt 35% was an overestimation of Claimant's loss of labor market due to the left shoulder injury. *Id.* at 47:12-18.

138. On cross-examination, Dr. Collins explained she felt loss of earning capacity was more appropriate in calculating disability because of Claimant's young age; he had not yet reached the pinnacle of his earning capacity when he suffered the injury and therefore a straight wage loss comparison was not a good illustration of Claimant's overall loss of earning capacity due to the injury. *Id.* at 41:20-43:6.

139. Dr. Collins did not think Claimant ceasing narcotic use would necessarily improve his access to jobs because "he still has the hand injury that limits strength, motor coordination,

finger dexterity, speed," but noted it would impact his access to certain professional driving positions because Claimant would require a waiver to drive on narcotics. *Id.* at 43:25-44:22; 49:3-7. Regarding sales type jobs, Dr. Collins noted he had no transferable skills in sales because he had not done that type of job before; she did not consider it a good fit for Claimant overall because Claimant was not computer literate and because Claimant had said "he's really not a salesperson." Dr. Collins clarified that Claimant could do a sales job with training, but that those jobs were likely to pay less and be limited in availability. *Id.* at 45:3-46:6. Dr. Collins reiterated that Claimant was a poor academic learner, but that he was bright and a good hands-on learner. *Id.* at 52:7-24.

140. Lastly, Dr. Collins felt superhuman efforts were relevant to Claimant's case because of Claimant's chronic pain and narcotic use and her opinion that Claimant's current job was "way outside of his restrictions." *Id.* at 59:13-60:1.

141. Kourtney Layton was deposed on November 15, 2021. Ms. Layton explained that she considered Claimant's pre-existing left upper extremity limitation to be lifting 25 pounds at the shoulder level, which was not the same limitation Dr. Collins used in her analysis. Layton Depo. 27:15-25. Ms. Layton thought Claimant would be well suited for sales jobs in RV or auto parts because of his extensive knowledge regarding those products, not any previous sales experience. *Id.* at 42:19-43:21. Ms. Layton confirmed that the DOT data she utilized did not breakdown an upper extremity limitation by side, i.e., reaching with one arm. *Id.* at 46:8-16.

142. **Credibility.** Claimant testified credibly, however, Claimant testified "[m]y memory is fried," and Claimant did struggle with recall at hearing. Clt 2019 Depo. 79:22.

DISCUSSION AND FURTHER FINDINGS

143. The provisions of the 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). A worker's compensation claimant has the burden of proving, by a preponderance of the evidence, all the facts essential to recovery. *Evans v. Hara's, Inc.*, 123 Idaho 473, 479, 849 P.2d 934 (1993). 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).

144. **Total Permanent Disability.** There are two methods by which a claimant can demonstrate that he or she is totally and permanently disabled. The first method is by proving that his or her medical impairment together with the relevant nonmedical factors totals 100%. If a claimant has met this burden, then total and permanent disability has been established. The second method is by proving that, in the event he or she is something less than 100% disabled, he or she fits within the definition of an odd-lot worker. *Boley v. State of Idaho, Industrial Special Indemnity Fund*, 130 Idaho 278, 281, 939P.2d 854, 857 (1997). An odd-lot worker is one "so injured that he can perform no services other than those which are so limited in quality, dependability or quantity that a reasonably stable market for them does not exist." *Bybee v. State of Idaho, Industrial Special Indemnity Fund*, 129 Idaho 76, 81, 921 P.2d 1200, 1205 (1996). Such workers are not regularly employable "in any well-known branch of the labor market — absent a business boom, the sympathy of a particular employer or friends, temporary good luck, or a superhuman effort on their part." *Carey v. Clearwater County Road Department*, 107 Idaho 109, 112, 686 P.2d 54, 57 (1984).

145. Claimant's total impairment from the subject injury is 18% per Dr. Walker[3] and this impairment is undisputed by the parties. Claimant's pre-existing impairment from his left shoulder injury is 8% per Dr. Andary.

146. Claimant is not totally and permanently disabled. No vocational expert has opined that Claimant is totally and permanently disabled via the 100% method or via odd lot through futility, a sympathetic employer, or superhuman effort.

147. Claimant's own expert believes Claimant remains competitive for positions in light driving and RV and parts sales, demonstrating it would not be futile for Claimant to look for work. Defendant/Employer's expert agrees that Claimant is competitive for retail positions that align with his expertise in RVs and small engines. Claimant identified three other small engine repair shops in his immediate area that would hire small engine mechanics, the same type of position Claimant holds now. It would not be futile for Claimant to look for work in the Idaho Falls area.

148. Claimant's employer is not a sympathetic employer. Claimant was referred to the position by a friend but hired by the service manager, an unrelated third party. Claimant is valued at work per Dr. Collins' conversation with Ivan, Claimant's manager, and Claimant's own testimony that he is valued for his electrical knowledge and that he is the most senior service technician. Claimant is treated the same as similar situated co-workers with regard to time off, per diem pay, and tool purchasing. According to Claimant's own testimony, he is not the only technician that receives help with lifting heavy engines. Claimant is slower than his co-workers and requires more help with lifting, but Claimant bears the brunt of this accommodation because he is paid per diem; Claimant's employer pays Claimant less because he is slower. The only

[3] The stipulated findings of fact state that Dr. Walker "determined that Claimant's injuries, which included his left shoulder and right wrist, equated to an 18% whole person permanent impairment." This is a misstatement because Dr. Walker only rated Claimant's wrist at 18% WP and does not mention the left shoulder in his rating. JE 26:608-609.

imposition on Claimant's employer is the increased use of hourly-paid employees to help Claimant lift certain items. Ms. Nelson's opinion that "[e]verything points to the fact that [Claimant's] skills, diligence, and efforts are valued by his current employer and that his work is real work" is accepted: Claimant is not employed by a sympathetic employer.

149. Dr. Collins opined that superhuman effort was "relevant" to this case because Claimant works at his current employer's while on a heavy narcotic regime and that the position was "way outside" of his restrictions. However, superhuman effort only becomes relevant if Claimant is only employable through superhuman effort. Dr. Collins did not opine that the retail and light delivery jobs she identified would require superhuman efforts, only that it was a relevant consideration for Claimant's current job. Further, Dr. Walker disagrees that Claimant's current job is way outside of his restrictions; Dr. Walker acknowledged Claimant was very obviously restricted, but that narcotics had helped Claimant return to work and that his current job was within his abilities. Claimant does not have to put forth superhuman effort[4] to remain employed at his current job or employable in the general Idaho Falls labor market.

150. **Permanent Disability.** 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 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 nonmedical 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

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[4] See *Glenn v. Idaho State Police*, IC 2006-530833 (August 30, 2013) for a thorough discussion and example of superhuman effort.

should be taken of the nature of the physical disablement, the cumulative effect of multiple injuries, the age and occupation of the employee at the time of the accident causing the injury, consideration being given to the diminished ability of the 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. 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). Generally, the proper date for disability analysis is the date of the hearing. *Brown v. Home Depot*, 152 Idaho 605, 272 P.3d 577 (2012).

151. "When deciding the weight to be given an expert opinion, the Commission can certainly consider whether the expert's reasoning and methodology has been sufficiently disclosed and whether or not the opinion takes into consideration all relevant facts." *Eacret v. Clearwater Forest Industries*, 136 Idaho 733, 737, 40 P.3d 91, 95 (2002). Permanent disability is a question of fact, in which the Commission considers all relevant medical and non-medical factors and evaluates the purely advisory opinions of vocational experts. See, *Id.* at 136 Idaho 733, 40 P.3d 91; *Boley v. ISIF*, 130 Idaho 278, 939 P.2d 854 (1997).

152. Dr. Walker agreed with the FCE findings regarding Claimant's restrictions. Those restrictions are light to sedentary capacity, 20-pound lifting limitation on the left side, never crawling, climbing, or reaching overhead on the left side, occasional squatting and kneeling, and "low speed assembly" on his right hand. JE 16:474. More specifically, Dr. Huntsman wrote: "he was rated into a negligible category for frequent or constant work that required the use of his bilateral upper extremities." *Id.* at 472.

153. *Loss of Labor Market Access*. The vocational experts did not agree on how to classify Claimant's restrictions, either pre-existing or accident produced. Regarding Claimant's

pre-existing left shoulder restriction, Dr. Walker explained that a 25-pound left shoulder lifting restriction translated to being able to lift 50 pounds with both extremities, a medium duty restriction. In their reports, both Ms. Layton and Dr. Collins analyzed Claimant's disability under a medium[5] duty work restriction as a result of his left shoulder injury, but disagreed regarding the degree to which he could utilize that extremity and its impact on his pre-existing disability. Dr. Collins opined that Ms. Layton overestimated Claimant's loss of labor market access by utilizing an "occasional" upper extremity restriction:

> The primarily [sic] problem with adjustments for reaching and overhead work is that it does not consider what kind of reaching, or whether it requires one arm or both arms. Mr. Furniss's restrictions [are] for his nondominant LUE alone, not bilateral use. He had full use of his dominant RUE, so restricting him to occasional upper extremity significantly overestimates his loss of access.

JE 35:1214. At deposition, Dr. Collins pointed out that Claimant did perform jobs that required "reaching" after his 2004 left shoulder injury such as welding, driving truck, installing audio equipment, and work as a glazier. Collins Depo. 26:12-27:20.

154. Ms. Layton testified that she thought Dr. Collins underestimated Claimant's labor market loss as a result of his left shoulder injury. Ms. Layton did not expand on her reasoning other than a vague criticism of ORS data being survey data provided by busy employers. Layton Depo. 32. Ms. Layton confirmed that the DOT data she utilized did not breakdown an upper extremity limitation by side, i.e., reaching with one arm. *Id.* at 46:8-16. Ms. Layton was not asked to address the fact that Claimant performed jobs that required more than occasional upper extremity use after his left shoulder injury but before the subject injury.

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[5] Ms. Layton emphasized in her deposition that she conducted her calculations "at" the shoulder level with a 25-pound lifting restriction. Layton Depo. 27:14-25. Ms. Layton's written report does not reflect she made any kind of 'at the shoulder' vs. 'overhead' lifting distinction, only occasional upper extremity use. Ms. Layton analyzed Claimant's left shoulder injury under a medium duty restriction, which she cites as 50 pounds occasionally or 25 pounds frequently, and "occasional" upper extremity use. JE 36:1226, 1316.

155. In addition to their significantly different treatment of Claimant's left shoulder injury, they also treated the subject injury's limitations differently in conducting their analysis. Ms. Layton utilized an "occasional" upper extremity use limitation to account for both Claimant's left shoulder injury and right-hand injury. The only difference between her pre-subject injury and post-subject injury analysis is changing the exertion level from medium exertion to light and sedentary exertion. On the other hand, Dr. Collins utilized a 5-pound right upper extremity limitation and a limitation on gross manipulation with both hands, in addition to a light/sedentary limitation for exertion. Ms. Layton's "occasional restriction on upper extremity use" limitation is an overestimation of Claimant's left shoulder limitations, as explained by Dr. Collins, and an underestimation of Claimant's right-hand limitations, based on the restrictions identified by the FCE.

156. Another difficulty with Ms. Layton's analysis stems with the assumption she makes at the beginning of her report. Ms. Layton conducted a transferable skills analysis utilizing Claimant's past work. Then when analyzing what jobs Claimant would have access to based on those skills, Ms. Layton adds a medium duty level restriction. In other words, Ms. Layton's analysis starts with a presumption that Claimant was limited to medium duty work prior to his left shoulder injury. See JE 36:1316. Ms. Layton wrote: "Utilizing the transferable skills model, available jobs subsequent [sic] to Mr. Furniss's past work identified as follows: Pre subject injury. **Limited to Medium work but no restriction upper extremity use** 48 out of 12,761 occupations identified." *Id* (emphasis added). Ms. Layton then added a limitation for occasional upper extremity use, which resulted in only one job in Claimant's labor market as a result of pre-existing shoulder injury. Claimant had no medium duty limitation prior to his left shoulder injury. Claimant had access to very heavy and heavy jobs within his skillset prior to his left shoulder injury. Those

jobs are unaccounted for in Ms. Layton's analysis.

157. Despite this, Dr. Collins and Ms. Layton came up with strikingly similar loss of market access numbers even though they utilized different datasets (DOT vs ORS) and different restrictions for the right-hand injury (occasional upper extremity use vs. gross manipulation with both extremities). Both Ms. Layton and Dr. Collins estimate Claimant has suffered a significant loss of labor market access as a result of his accident-related right-hand injury and his pre-existing left shoulder injury. Ms. Layton estimated Claimant had lost 100% of his labor market access because of both injuries, but opined Claimant still had a small number of sales jobs he could perform by virtue of his expertise in recreational vehicles and auto parts. Dr. Collins estimated Claimant lost 98% to 100% of his labor market access, but similar to Ms. Layton, opined Claimant still had access to a small number of light delivery jobs and sales jobs. Due to both injuries, Claimant has lost access to 99% of his labor market.

158. *Loss of earning capacity*. While the experts are very close in their loss of labor market access estimates, where they diverge sharply is how to calculate Claimant's loss of earning capacity. Ms. Layton found no loss of earning capacity because Claimant was making more at his current employer than he made at his time of his injury Employer. Dr. Collins estimated a 50% loss of earning capacity based on both of Claimant's injuries in 2015, utilizing restrictions of light lifting and occasional reaching. Dr. Collins estimated a 37% loss of earning capacity in 2020 based on Claimant's slower work at his current employment and sales jobs Claimant could perform within his restrictions.

159. Earning capacity per Dr. Collins "refers to the capability of a worker to sell to his/her labor in any market reasonably accessible to them." Ex 35:1208. Dr. Collins explained that she thought an earnings comparison was fairer for an older worker, i.e., comparing their time of

injury wage with their time of hearing wage, because they've typically already reached their highest wage versus someone who is injured in their 20s, such as Claimant, where loss of earning capacity was fairer. Dr. Collins testified that obviously there was no wage loss when comparing Claimant's time of injury wage with his time of hearing wage. Collins Depo. 42:4-43:6.

160. Dr. Collins was critical of Ms. Layton's estimate because she only compared time of injury wages with Claimant's current wage and did not consider Claimant's overall loss of earning capacity due to his young age at the time of injury and that he was slower in his current job due to his injuries, and therefore paid less.

161. Dr. Collins' criticism is well taken. Claimant is slower than his co-workers because of his injuries and earns less, which Ms. Layton did not consider in her analysis. Further, it seems quite obvious that Claimant lost earning capacity due to both injuries. Claimant's left shoulder injury removed very heavy and heavy occupations from his labor market (lifting more than 50 pounds occasionally) and his right-hand injury removed medium occupations (lifting more than 20 pounds occasionally) and occupations requiring gross manipulation with both hands. Claimant's residual job market includes modified light duty jobs that do not require a college education, mostly sales and driving jobs, which are lower paying.

162. Dr. Collins' methodology better accounts for Claimant's loss of earning capacity than Ms. Layton's. Dr. Collins convincingly argued that Claimant has significant loss of earning capacity due to his slower rate of work and the low wages of the jobs Claimant has access to post-injury. Dr. Collins' 37% estimated loss of earning capacity as a result of both injuries is accepted.

163. *PPD.* Disability determinations are usually an average of the claimant's loss of earning capacity and loss of labor market access. The Commission has criticized this methodology when the loss of labor market access is extremely high and the wage loss negligible:

> the averaging method itself is not without conceptual and actual limitations. As the loss of labor market access becomes substantial, and the expected wage loss negligible, the results of the averaging method become less reliable in predicting actual disability. For illustration, as judged by the averaging method, a hypothetical minimum wage earner injured sufficiently to lose access to 99% of the labor market may theoretically suffer no expected wage loss if she can still perform any minimum wage job. Calculation of such a worker's disability according to the averaging method would produce a permanent disability rating of only 49.5% ([99% + 0%] ÷ 2) even though her actual probability of obtaining employment in the remaining 1% of an intensely competitive labor market may be as remote as winning the lottery. The averaging method fails to fully account for the reality that the two factors are not fully independent.

Deon v. H&J, Inc., IIC 2007-005950, IIC 2008-032836 (May 3, 2013). Dr. Collins weighed Claimant's loss of labor market access heavier in her calculation of Claimant's disability, rating him at 82% at the highest. Dr. Collins justified this because Claimant's loss of access was so high, it made sense to her to weight it heavier than his loss of earning capacity:

> Q: [by Mr. Rippel]   Loss of wage. Now, your statement is - - it's there, it's kind of cryptic, you talk about you're giving the loss of access twice the weight as the loss is so significant. So can you explain for me how your opinion forms on that as a vocational expert?
>
> ...
>
> A: So say for instance, you have a 98% loss of access, but there's a job out there that you can do that pays the same wage, that doesn't mean that the disability should be minuscule. You know if you only have access to three jobs but they pay what you made before that's not really a true picture of what a person's disability should be.

Collins Depo. 24:3-17.

164. Dr. Collins' reasoning would be accepted if Claimant's loss of earning capacity was zero or if he resembled Dr. Collins' example. However, Claimant suffered a significant loss of earning capacity, per the above discussion, and the jobs he has access to now do not "pay what [he] made before." Claimant was not a minimum wage earner who remained at minimum wage after the accident; Claimant was a skilled welder and is a skilled mechanic. Claimant is not the worker whose chances of getting a job in his residual job market are as "remote as winning the

lottery." Both Dr. Collins and Ms. Layton believe Claimant has access to sales jobs; Dr. Collins also includes light delivery jobs that do not require a CDL. Claimant's loss of earning capacity is not negligible and will be used to calculate his overall disability. Claimant's overall disability, as a result of both his left shoulder injury and his right-hand injury, is 68% (99 + 37 = 136/2 = 68%).

165. **Apportionment.** Idaho Code § 72-406(1) provides as follows: "In cases of permanent disability less than total, if the degree or duration of disability resulting from an industrial injury or occupational disease is increased or prolonged because of a preexisting physical impairment, the employer shall be liable only for the additional disability from the industrial injury or occupational disease." In *Horton v. Garrett Freightlines, Inc.*, 115 Idaho 912, 772 P.2d 119 (1989), the Idaho Supreme Court held that Idaho Code § 72-406 requires a two-step process to determine whether a claimant's permanent partial disability should be apportioned, as follows: first, determine the claimant's disability based upon all impairments, including preexisting impairments and impairment from industrial injury; and second, apportion the liability of employer based upon the degree to which the industrial injury contributed to claimant's disability. *Id.*, 115 Idaho at 917, 772 P.2d at 124. There is a presumption that the Commission, by its experience, is capable of judging how such apportionment should be made. However, the Commission must explain its apportionment determination in such detail as to allow review on appeal. *Reiher v. American Fine Foods*, 126 Idaho 58, 878 P.2d 757 (1994).

166. The first step required by *Horton* is to calculate Claimant's disability from all causes. In this case, Claimant's disability from all causes is 68%.

167. The second step is to apportion the disability that is due to the subject injury. Claimant was already unable to compete for very heavy and heavy jobs and jobs that required overhead lifting on the left side due to his pre-existing injury at the time of the accident; Dr. Collins

estimated this loss of labor market access at 35%, leaving 65% of Claimant's total labor market available after the left shoulder injury. The accident that is the subject of this claim removed all medium jobs and any light/sedentary jobs that required gross manipulation with both hands. Dr. Collins testified:

> The primary problem for him is that he injured his right dominant hand. We use that in almost every job. What happens is that you lose - - if you have to use your non-dominant hand, you lose speed, you lose accuracy, you lose strength. So you're really a different - - you're functioning differently.
>
> Had it even been a non-dominant hand it wouldn't have been so significant, but it was his dominant hand… That's the reason I felt like this high loss of access was accurate because if you look at how - - even in the DOT how many jobs require frequent reaching, handling, fingering, it's like 95% so it's a very significant injury.

Collins Depo. 20:15-21:4. Dr. Collins wrote in her report "Assuming he can lift a light level with his LUE, but only 5# with his right hand, he has lost access to 60% of the jobs he could have performed with the pre-existing restriction for his left shoulder. When I then consider the percentage of jobs that require handling, and gross manipulation with both hands, his loss of access increases to 98% to 100%." Overall, Claimant's loss of access due to both injuries is 99% and as a result of the subject injury. This is because, as Dr. Collins explained, almost all jobs require manipulation with both hands and therefore Claimant lost 99% of his residual labor market. Despite appropriately limiting her analysis to only those jobs Claimant could perform after his pre-existing left shoulder injury, Claimant's restrictions still result in a 99% loss of residual labor market access because the restrictions are for his dominant right hand. In other words, Claimant lost 99% of the 65% of his residual labor market left to him after the subject injury and only lost 65% of his total labor market as a result of the subject injury.

168. Claimant's loss of earning capacity due to the subject injury is much trickier to calculate. Neither expert opined on this point of fact. Dr. Collins clearly provides her 37% loss of

earning capacity as a result of the jobs available to Claimant after both injuries, but does not provide an estimate of what Claimant's loss of earning capacity would be from just his right-hand injury alone.

169. Claimant clearly suffered a loss of earning capacity from both injuries, as outlined in the PPD section. To reiterate, Claimant's left shoulder injury ruled out very heavy and heavy jobs Claimant was qualified for, and the subject injury ruled out medium duty jobs and certain light and sedentary jobs which required use of both hands that Claimant was qualified for. Per Dr. Collins' 2015 report there were welding and construction jobs that were light/sedentary, but all required both hands. Claimant did perform light welding at his time of injury job, which he is no longer able to perform due to the subject injury. Taken together, this evidence shows that Claimant had some loss of earning capacity as a result of the subject accident due to the loss of certain semi-skilled medium, light, and sedentary jobs, such as his time-of-injury position, and that Claimant is slower in his current position than he would be but for the subject injury.

170. In light of all the evidence of record, Claimant's disability apportioned to the subject injury is 55% inclusive of impairment. Claimant's overall disability inclusive of impairment is 68%. Claimant's significant loss of labor market access as a result of his subject injury weighs heavily in favor of this apportionment. Claimant lost 99% of his pre-injury labor market because he injured his dominant right hand. Per Dr. Collins, this type of injury is one of the most limiting an employee can have. Claimant's loss of earning capacity as a result of the subject injury is much less because Claimant was already limited in the type of work he could accept because of his left shoulder restriction, and although slower than his co-workers, Claimant still makes $27 and hour. In other words, Claimant lost access to some medium/light/sedentary duty work which was higher paying, then retail (light/sedentary welding and construction) due to

the subject injury. Claimant had already lost access to higher paying very heavy/heavy welding and construction jobs due to his left shoulder injury.

171. Claimant is entitled to 55% PPD inclusive of impairment as a result of this injury.

172. **ISIF Liability.** Idaho Code § 72-332 provides that if an employee who has a permanent physical impairment from any cause or origin, incurs a subsequent disability by injury arising out of and in the course of his employment, and by reason of the combined effects of both the pre-existing impairment and the subsequent injury suffers total and permanent disability, the employer and its surety will be liable for payment of compensation benefits only for the disability caused by the injury, and the injured employee shall be compensated for the remainder of his income benefits out of the ISIF account.

173. Claimant is not totally and permanently disabled, therefore ISIF liability is moot.

CONCLUSIONS OF LAW

1. Claimant's disability from all causes is 68% inclusive of impairment;

2. Claimant's disability apportioned to the subject accident is 55% inclusive of impairment;

3. Claimant is not totally and permanently disabled;

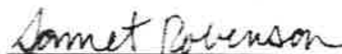
4. All other issues are moot.

RECOMMENDATION

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

DATED this 19th day of July, 2022.

INDUSTRIAL COMMISSION



Sonnet Robinson, Referee

CERTIFICATE OF SERVICE

I hereby certify that on the 12th day of August, 2022, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

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Gina Espinosa

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

BRAD FURNISS, Claimant, v. BLAINE LARSEN FARMS, INC., Employer, and LIBERTY NORTHWEST INSURANCE CORPORATION, Surety, and STATE OF IDAHO, INDUSTRIAL SPECIAL INDEMNITY FUND, Surety, Defendants.	**IC 2011-026179** **ORDER** FILED AUG 12 2022 INDUSTRIAL COMMISSION

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

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

1. Claimant's disability from all causes is 68% inclusive of impairment.

2. Claimant's disability apportioned to the subject accident is 55% inclusive of impairment.

3. Claimant is not totally and permanently disabled.

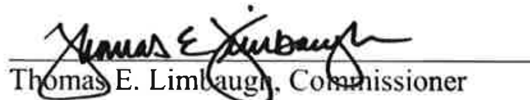
4. All other issues are moot.

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

DATED this 12th day of August, 2022.

INDUSTRIAL COMMISSION

Aaron White, Chairman



Thomas E. Limbaugh, Commissioner

Thomas P. Baskin, Commissioner

ATTEST:

Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 12th day of August 2022, a true and correct copy of the foregoing **ORDER** was served by *E-mail transmission* and by regular United States Mail upon each of the following:

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