BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

JESSE M. CASTRO, Claimant, v. AG EXPRESS, INC., Employer, and NATIONAL INTERSTATE INSURANCE COMPANY, Surety, Defendants.	**IC 2011-028830** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** Filed April 22, 2016

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Michael E. Powers, who conducted a hearing in Twin Falls on August 11, 2015. Claimant was present and represented by Dennis R. Petersen of Idaho Falls. Lora Rainey Breen, of Boise, represented Employer/Surety (Defendants). Oral and documentary evidence was presented and the record remained open for the taking of two post-hearing depositions. This matter came under advisement on March 17, 2016 and is now ready for decision.

ISSUES

Pursuant to a "Stipulation Regarding Issues" filed by the parties on March 9, 2016, the issues to be decided are:

1. Whether, at the time of the hearing, Claimant needed further medical treatment related to his September 29, 2011 industrial accident;

2. Whether Claimant is entitled to future temporary total disability benefits (TTDs); and,

3. Whether the Industrial Commission should retain jurisdiction beyond the statute of limitations to determine Claimant's entitlement to permanent partial impairment (PPI) and permanent partial disability (PPD), if any.

CONTENTIONS OF THE PARTIES

Claimant contends that he injured his left rotator cuff/labrum in an accident wherein he was attempting to free a tarp strap that had become stuck. In an attempt to free the tarp, Claimant put all of his weight on his left arm/shoulder and was dangling "free-fall" from the tarp strap. He claims to need surgery to repair his torn labrum.

Defendants contend that no physician has opined that Claimant needs the requested surgery, and, even if he does, such surgery is not related to his industrial accident. They rely upon the opinions of two IME physicians, as well as Claimant's treating physician, who all opined that left UE MRI performed shortly after the subject accident did not reveal any torn labrum or rotator cuff tear so he must have torn it subsequently.

Claimant counters that the post-accident MRI was "limited" by the position of Claimant's left arm as well as his obesity, so that a torn labrum could easily have been missed on the study.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant taken at the hearing.

2. Claimant's Exhibits (CE) A-U admitted at the hearing.

3. Defendants' Exhibits (DE) 1-4 admitted at the hearing.

4. The post-hearing deposition of Mark Wright, M.D., taken by Claimant on November 10, 2015.

5. Thr post-hearing deposition of C. Scott Humphrey, M.D., taken by Defendants on December 14, 2015.

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

FINDINGS OF FACT

1. Claimant was 45 years of age and residing in Rupert at the time of the hearing. He stood 5'7" tall and weighed about 370 pounds at the time of his accident which he described at hearing as follows:

> I finally got loaded and pulled the truck out of the way, so the next truck could back in and load up the previous driver, who must have driven it during the night shift, when he rolled up the tarp he jumped the rope across one of the hangers. There is usually - - sometimes just three, one in the middle and two on the ends or sometimes it could be four or five hangers that hold the tarp while it's rolled up on the truck in motion down

the road and the rope was crossed underneath the hangers and the tarp was kind of - - not really tight, it was baggy, so I did not see that the - - the rope was caught up on the hanger, so I started pulling the rope. I put my gloves on and they are leather gloves, kind of like, oh, cowboy gloves and I tried to pull the rope after loosening the strap and the tarp wouldn't come over, so in the middle of the trailer there is a ladder. I climbed up the first two steps of the ladder and wrapped the rope around my left hand and using my weight jumped off of the ladder thinking that - -

Q. Jumped off the ladder into the air, so to speak?

A. Yes. I call it commando style where I would just jump - - it's kind of backfired on me before and the rope's broke, but this time I just hung up and my left arm got caught up - -

Q. Okay.

A. - - and right away I could hear like a celery stock [sic] kind of crunchiness.

Q. Okay. You used your right arm when you did that motion and you raised your arm in the air, but it was your left arm that got caught - -

A. Yeah. It was my left arm.

Q. Okay. And the rope was wrapped around your hand, did I understand that?

A. Yes. So, I was kind of pretty much not really hanging myself, but I was kind of dangling with all my weight between me and the rope.

Q. And where did you feel pain at that point in time?

A. On my left shoulder.

HT., pp. 24-25.

2. Claimant finished tarping his load with the help of a co-worker and reported his accident. He then took three days off and made an appointment to see Mark Wright, M.D., an orthopedic surgeon. Dr. Wright had previously operated on Claimant's right shoulder and left clavicle after an accident occurring on December 1, 2010. Dr. Wright obtained a left shoulder MRI that revealed a full thickness left rotator cuff tear for which Dr. Wright recommended surgery; the surgery was accomplished on February 2, 2012. Claimant then attended physical therapy.

3. On July 30, 2012, Claimant was released from physical therapy to return to work without restrictions regarding his left shoulder. Claimant's discharge summary from physical therapy states:

> The patient reports very little symptoms in the shoulder and rates his pain at a 0-1/10 on a 0-10 scale. He reports that he has been doing all of his activities of daily living without any exacerbation of symptoms. He also reports that he has been continuing with his exercise program. This date we were able to advance his [exercise program] with higher-level activities and weights. The patient has a fair amount of equipment at home so he has been able to do a lot of his program independently with instruction from [his] therapist. He has been released to go back to work and at this time, we find there is nothing related to his shoulder function that would inhibit him from having a safe return back to his driving duties. We appreciate working with this kind gentleman.

DE 1, p. 61.

4. Dr. Wright released Claimant to return to work in May, 2012. However, Claimant remained off work to have bilateral carpal tunnel surgeries (right – June 2012; left – September 2012). The carpal tunnel treatment was related to Claimant's December 1, 2010 accident. Because Claimant continued to have wrist problems, Dr. Wright referred him to hand specialist Tyler Wayment, M.D, who performed another right carpal tunnel release on January 24, 2013. Dr. Wayment released Claimant to return to work on May 22, 2013. Claimant did not work between his February 2, 2012 surgery and his May 22, 2013 release.

5. In May, 2013, Claimant began working for Valley Agronomics hauling 1500 gallon tanks of liquid fertilizer. He began experiencing problems with his left shoulder again:

> Well, when you open the door to climb into the truck there is usually a couple of handles there to pull yourself up onto the step on the gas tank or you grab the steering wheel to pull yourself up, but you definitely need to

> use both arms and your legs to climb into the truck and right away reaching for the steering wheel to climb - - pull myself up I started feeling stinging pain in my [left] shoulder.

HT., p. 36.

6. Claimant returned to Dr. Wright on November 18, 2013 concerning his left shoulder pain. Upon examination, Dr. Wright found Claimant's left upper extremity to have excellent range of motion with excellent strength to resisted abduction and internal and external rotation. Radiographs ". . . clearly show a spur that appears to be a new growth of bone off of the inferior aspect of the acromion." CE F., p. 122. Dr. Wright assessed a left rotator cuff tear with AC arthritis and impingement. He ordered an MRI arthrogram of the left shoulder and noted that he may have to remove the spur.

7. Claimant returned to Dr. Wright on June 16, 2014, to review the result of his left shoulder MRI. Dr. Wright listed the date of injury as December 1, 2010. The MRI revealed ". . . a delamination tear in the supraspinatus tendon. Additionally, there appears to be some damage to the glenoid." *Id.*, p. 128. Dr. Wright sought permission from Surety to proceed with surgical repair.

8. On July 31, 2014, Jeffery Hessing, M.D., an orthopedic surgeon, conducted an IME of Claimant's left shoulder at Surety's request. Dr. Hessing reviewed pertinent medical records, examined Claimant and authored a report dated July 31, 2014. Dr. Hessing also personally reviewed Claimant's May 2014 MRI and commented "No definite full-thickness tear is seen. This intrasubstance tear is an obvious degenerative type tear in poor quality rotator cuff tissue. A posterior inferior labral tear may be present. The acromion is type II."

CE N., p. 2.

9. Dr. Hessing recorded his "Impressions" as follows:

> I have advised the patient that he demonstrates recurrent degenerative rotator cuff disease with progressive intrasubstance degenerative tearing as the source of his ongoing shoulder symptoms. Any labral tearing would also be degenerative in nature. I described the diagnosis to him. At the time of his previous left shoulder rotator cuff repair on 02/02/12 debridement of a fair amount of his tendon was done before repair since the tendon demonstrated "poor tissue quality." His rotator cuff was obviously undergoing degeneration at that time. His tendon has obviously continued to degenerate and undergo intrasubstance tearing. I therefore believe that his ongoing left shoulder symptoms are degenerative in nature and unrelated to his previous left shoulder rotator cuff tear and repair in 2012. I do not believe his degenerative tearing now present in his rotator cuff is amenable to surgical intervention. I strongly discouraged additional surgery, fearing vascular compromise from swelling associated with the surgery may well cause him to lose additional cuff tissue and leave him with a rotator cuff deficient shoulder. I think surgery could make him a whole lot worse. He tended to agree with this in my office today.

Id., p. 3.

10. Dr. Hessing, in his report, summed up his opinions as follows:

> * Claimant's left shoulder rotator cuff was not injured in his December 1, 2010 accident. Claimant <u>did</u> injure his left clavicle in that accident that healed post-open reduction surgery.
>
> * Claimant's left shoulder rotator cuff was torn completely through in his September 29, 2011 accident. As seen at the February 2, 2012 surgery, Claimant had pre-existing degeneration in his left shoulder. His left shoulder healed after that surgery as is evidenced by his high level of functioning and his lack of treatment for that shoulder for 17 months.
>
> * Claimant's increase in his left shoulder symptoms is due solely to progressive intrasubstance tearing in his left rotator cuff and is unrelated to any previous workers' compensation injuries. Dr. Hessing "strongly" discourages any further surgery on Claimant's left shoulder.
>
> * Claimant can return to his pre-injury work; however, he can expect further degenerative problems and should voluntarily limit the stress he places on his left rotator cuff.
>
> * Claimant can improve the quality of his left rotator cuff by better diabetes control, weight loss and using a CPAP machine to improve his sleep apnea. Claimant will need conservative treatment to address the

worsening of his left rotator cuff degeneration such as injections, exercises, and ultra sound therapy.

11. Claimant returned to Dr. Wright on September 22, 2014 who recorded:

> Left rotator cuff tear with acromioclavicular arthritis and impingement. The MRI scan clearly delineates an ultrasubstance tear. I agree with Dr. Hessing in that the tendon quality is somewhat suspect, especially with the appearance on MRI, from a degeneration perspective. However, I think that if we do not do surgical intervention that he will continue to worsen. I feel that it would be beneficial for him to undergo an open rotator cuff repair and to evaluate the quality of the tendon and try to repair it. Otherwise I just do not think he will do well. He is only 44 years old and works as a truck driver and has to do a lot of overhead activities. I would ask him to be evaluated by Dr. Humphrey in Boise, for a second opinion, to get Dr. Humphrey['s] opinion on this. I would strongly adhere to whatever recommendations he may have, but I would certainly like to get another opinion from someone who is a shoulder surgeon and is an independent examiner from WC.

CE F., p. 131.

12. Claimant saw Scott Humphrey, M.D., on December 3, 2014. Dr. Humphrey reviewed pertinent medical records, examined Claimant and authored a report of that date. He agreed with Dr. Hessing that Claimant's current left shoulder symptoms are unrelated to his September 29, 2011 accident.

13. Dr. Humphrey reviewed the radiographic studies and concluded:

> I reviewed the MRI from May 2014. To my interpretation, there is an intrasubstance longitudinal tear of his supraspinatus tendon, but most of the insertion of the tendon appears to be intact. The patient has a large tear involving the superior labrum. This involved the anchor site of the long head of [the] biceps tendon. Postoperative changes are noted. The subscapularis, infraspinatus, and teres minor tendons appear to be intact.
>
> I also reviewed the MRI that was performed in November 2011. This was ordered based on the patient's work-related injury. A tear of the rotator cuff is noted on that MRI study. However, the superior labrum appears to be intact.
>
> I believe that most of Jesse's discomfort is coming from the tear of the superior labrum and unstable long head of biceps tendon. I reviewed

> Dr. Hessing's note. Dr. Hessing felt that the current condition is not related to the patient's work-related injury, and I agree with Dr. Hessing's findings. As I reviewed the patient's old MRI from 2011, the labrum appears to be intact. The most recent study shows extensive tearing of the superior labrum and what I believe is unstable long head of biceps tendon. This is a new finding compare[d] to the study in 2011. The patient's rotator cuff shows a longitudinal intrasubstance tear, but by exam today, the patient's rotator cuff actually seems to be in good condition overall. He has minimal discomfort with the Jobe test and has excellent strength. I am not sure that the tearing of the rotator cuff is of any clinical significance.

CE O, p. 14.

14. Dr. Wright expressed his disagreement with Dr. Humphrey in a letter to Defendants' counsel dated May 8, 2015:

> In regard to your letter dated 23 February 2015, I understand that there was some issues where we missed addressing this early on. However, my disagreement with Dr. Humphrey is based on the MRI reading from November of 2011. The reading stated that it was a very limited study because of internal rotation and the size of the patient. The reading from the 13 May 2014 MRI study mentioned that there was evidence of a posterior SLAP tear. Again, understanding that the initial study that we are comparing this to is limited, due to the patient's size and the position of the arm, I do not think that one can definitively state that there was no labral tear on the initial study. The second study that was done in May of 2014 appears to demonstrate [a] more definitive answer, in terms of a labral injury. That is why I disagree with the findings. I do not think that one can definitely state that there was not a labral tear on the first study, because it was a limited study due to the position of the arm and [sic] well as the size of the patient.[1] The secondly [sic] study identified what appeared to be a SLAP tear, which very well may have been present on the first study, but because of the limited nature of the study, was no[t] delineated.

CE F., p. 138.

[1] The radiologist's report regarding Claimant's 2011 MRI indicates: "LABRA: Superior labrum appears to be intact although small. Anterior labrum is irregular without definite tear. Posterior labrum appears to be intact. Inferior labrum is without tear. What is seen of the glenohumeral ligaments is unremarkable, given the limited visibility from patient size and internal rotation." DE 2, p. 1.

Drs. Wright and Humphrey deposition testimony

Dr. Wright

15. Dr. Wright is a board certified orthopedic surgeon. Dr. Wright performed Claimant's left clavicle surgery following his December 4, 2010 accident. Dr. Wright released Claimant to return to work on June 22, 2011 regarding his left clavicle injury. After that time, Claimant returned to Dr. Wright a few times regarding hand numbness issues.

16. Claimant returned to Dr. Wright complaining of left shoulder pain on October 10, 2011 stemming from his September 29, 2011 industrial accident. A November left shoulder MRI revealed a torn rotator cuff but no definitive labral tear. Dr. Wright recommended a left rotator cuff repair which was accomplished on February 2, 2012. Dr. Wright related the need for that surgery to Claimant's September 2011 tarping accident. He released Claimant to return to work June 6, 2012.

17. Claimant again saw Dr. Wright on November 18, 2014 complaining of left shoulder pain. A left shoulder MRI arthrogram done on May 13, 2014 revealed a supraspinatus tendon tear and evidence of a SLAP tear.[2] Dr. Wright related the need for the MRI to Claimant's September 2011 industrial accident. Dr. Wright recommended surgery to repair the rotator cuff, the need for which he also related to Claimant's accident.

18. Dr. Wright was aware of Dr. Hessing's contrary opinion regarding the need for surgery and the relation of the proposed surgery to Claimant's September 29, 2011

[2] In his deposition, Dr. Wright testified that a SLAP tear is the same as a labral tear.

accident. Dr. Wright then referred Claimant to Dr. Humphrey, who did not think Claimant would benefit from any surgery to his rotator cuff, but did have concerns about his labrum tear and recommended surgery for that condition; Dr. Wright agreed. Dr. Wright testified that he no longer believes further treatment of Claimant's right rotator cuff would be of any benefit to him.

19. Dr. Wright testified as follows regarding his opinion that the surgery recommended by Dr. Humphrey is related to Claimant's September 2011 industrial accident:

> First of all, I think it's important to understand how the mechanism of injury occurred with Mr. Castro.
>
> Q. (By Mr. Petersen): Ok.
>
> A. The mechanism could be consistent with the way a biceps/labral injury could [have] occurred. It's described historically with military recruits, actually, navy men.
>
> When they had an anchor, they'd drop it over the side of the boat. As the anchor hit the end of the rope and the rope pulled out of their hands, they could sometimes get a biceps tear, much like jumping off a truck and allowing all of that weight to come down on his arm. It would not be so different, number one.
>
> Number two, we have an MRI study that was done earlier and then one done later - -
>
> Q. The 2011?
>
> A. - - but they were different - - you and I spoke about this earlier - - they were different studies. One was very limited in terms of the patient's size and the position of the arm. They were very clear that there were some limitations to the study, but the second study seemed to be better.
>
> Q. So when you say there was [sic] some limitations on the first study, that's the 2011 study?
>
> A. That's correct.
>
> Q. And what were those limitations?

A. Limitations because of the patient's size and the actual position of the arm when they did the MRI study. When it's internally rotated, they make comment on that in the study.

Q. So are you saying that the tear in the labrum could have been there in 2011?

A. Yes.

Q. And that the study in 2011 would not show the tear?

A. Did not.

Q. Does the study in 2014 show the tear?

A. Yes. And like I pointed out earlier, unfortunately, when I did his open rotator cuff repair I did not put a scope in the shoulder, which would have answered the question at that time.[3]

Q. And we talked about this before we went on the record. When you did the rotator cuff repair there, in 2012, you did not look at the labrum at that time?

A. I did not do an arthroscopic evaluation; that is correct.

Dr. Wright Dep., pp. 24-26.

20. Under cross-examination, Dr. Wright bolstered his opinion regarding the presence of Claimant's labral tear in 2011:

The evidence is that, one, he never got better after the surgery that we did, which addressed his rotator cuff tear; two, that we never looked at the labrum at the time; three, we had a limited study prior to the surgery; and, four, we have a more recent study that shows it.

If there was another injury that had been involved on that shoulder, I would then start to listen to that. However, I don't have any evidence of a new injury.

The last thing I would say is that he never got better after the surgery on the rotator cuff.

Id., pp. 29-30.

[3] Dr. Wright testified that he did not examine Claimant's labrum at the time of Claimant's rotator cuff surgery because he had no "surgical reason" to do so.

21. Dr. Wright discharged Claimant to return to his regular work on July 30, 2012. In an attempt to counter Dr. Wright's assertion that Claimant never got better after his rotator cuff surgery, defense counsel referred him to the physical therapist's discharge summary:

> The patient reports very little symptoms in the shoulder and rates his pain at 0 to 1 out of 10 on a 0 to 10 scale. He reports he's been doing all of his activities of daily living without any exacerbations of symptoms. He also reports that he's been continuing with his exercise program.

Id., p. 31.

Dr. Wright testified that he would rely on his own notes regarding Claimant's improvement, or lack thereof, post-surgery, and not the physical therapy notes.

22. Dr. Wright testified that he ". . . never got that clean of a history, ever" and that every note that he has states that Claimant was having some trouble with his left shoulder. Dr. Wright did not see Claimant from July of 2012 until November of 2013 and has no idea of the types of activities Claimant was engaged in the interim. Dr. Wright did not know that Claimant had returned to work in May of 2013. Claimant told Dr. Wright in November 2013 that his left shoulder pain had been ongoing for six weeks, although Claimant did not tell Dr. Wright of any specific incident or activity that may have been the source of that pain.

23. Dr. Wright requested that Claimant be evaluated by Dr. Humphrey in Boise as he is a shoulder specialist and Dr. Wright is a general orthopedic surgeon. The only real disagreement he has with Dr. Humphrey's opinion is that he (Dr. Wright) believes that Claimant's labral tear was present in 2011 at the time of Claimant's rotator cuff surgery.

Dr. Humphrey

24. Dr. Humphrey is an orthopedic surgeon whose Boise practice is limited to treating people with shoulder problems. As stated above, Dr. Wright recommended Dr. Humphrey see and evaluate Claimant; that was accomplished on December 3, 2014. Dr. Humphrey reviewed Dr. Wright's medical records and deposition testimony, Dr. Hessing's IME report, physical therapy records, and the actual scans of Claimant's 2011 and 2014 left shoulder MRI arthrograms.

25. Upon exam, Dr. Humphrey believed Claimant's symptoms were most likely coming from a tear of the superior labrum and an unstable long head of biceps tendon. Dr. Humphrey testified that the rotator cuff and labrum are two separate, distinct structures, each having their own functions. The rotator cuff helps people move, rotate, and raise the arm. The labrum is responsible for shoulder stability and is the anchor site for the biceps tendon. Once the biceps tendon becomes unstable, it will continue to cause pain unless the biceps tendon is stabilized either by releasing it or anchoring it to the bone.

26. Dr. Humphrey disagrees with Dr. Wright's opinion regarding whether Claimant's labral tear identified in the 2014 MRI was present at the time of the 2011 MRI:

> I disagree with it. I've spent quite a bit of time looking at the original (2011) MRI. And, if anything, I tend toward giving the patient the benefit of the doubt.
>
> If you look at the motivation of me as a surgeon who gets paid by doing surgery, if I find that, I would have no problem calling, if there were [sic] a tear back in 2011. It would mean I get a surgery. I would have made a lot more money. And so, no, I looked at it and called it what it was. I felt that it would be hard for me to justify calling this a labral tear. The

> place where the biceps tendon connects to the labrum and the labrum connects to the bone, it seemed like a solid connection.

Dr. Humphrey Dep., p. 16.

27. Dr. Humphrey also disagrees with Dr. Wright regarding the quality of the 2011 MRI:

> I don't concur with it (Dr. Wright's opinion). I thought it was a good quality MRI.
>
> To me, the biceps anchor site seemed solidly connected to the bone. There was no contrast dye leaking between the two, which is how we identify a superior labral tear. So I really could not indentify it as a superior labral tear, based on my interpretation.

Id., pp. 17-18.

28. Dr. Humphrey testified that another way to identify a labral tear is to send the patient to physical therapy. Dr. Humphrey reviewed Claimant's physical therapy notes wherein Claimant was discharged after five months with a zero to one out of ten pain level and concluded:

> Well, he had rotator cuff repair. It's hard to make people as good as new again, and so I'm not surprised that he had some discomfort. But a zero to one over ten, to me, seems like a good result.
>
> When somebody has a superior labral tear and we're trying to diagnose this, I'll often send people to physical therapy, knowing that if they have a superior labral tear, their shoulder is going to hurt more when they try to do physical therapy exercises.
>
> And I tell them, "if this is a superior labral tear like I think it is, what I expect to happen is you go to physical therapy, and if it's really a labral tear, it may make your shoulder hurt more. And if that happens, call me, and we'll go back to [the] clinic and we'll go from there.
>
> So when I look at what was reported by the physical therapist, the zero to one pain and him being able to participate in exercises doesn't fit in with an active superior labral tear, in my opinion.

Id., p. 21.

DISCUSSION AND FURTHER FINDINGS

Idaho Code § 72-432(1) obligates an employer to provide an injured employee reasonable medical care as may be required by his or her physician immediately following an injury and for a reasonable time thereafter. It is for the physician, not the Commission, to decide whether the treatment is required. The only review the Commission is entitled to make is whether, under the totality of the circumstances, the treatment was reasonable. *See Chavez v. Stokes,* 158 Idaho 793, 353 P.3d 413 (2015) overruling in part *Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989). A claimant must provide medical testimony that supports a claim for compensation to a reasonable degree of medical probability. *Langley v. State, Industrial Special Indemnity Fund*, 126 Idaho 781, 890 P.2d 732 (1995). "Probable" is defined as "having more evidence for than against." *Fisher v. Bunker Hill Company*, 96 Idaho 341, 344, 528 P.2d 903, 906 (1974). No "magic" words are necessary where a physician plainly and unequivocally conveys his or her conviction that events are causally related. *Paulson v. Idaho Forest Industries, Inc*, 99 Idaho 896, 901, 591 P.2d 143, 148 (1979). A physician's oral testimony is not required in every case, but his or her medical records may be utilized to provide "medical testimony." *Jones v. Emmett Manor*, 134 Idaho 160, 997 P.2d 621 (2000).

29. While not discounting the opinion of Claimant's treating physician, Dr. Wright, the Referee is more persuaded by opinions expressed by Dr. Humphrey to whom Claimant was referred by Dr. Wright for a third opinion. Dr. Wright made that referral in light of Dr. Humphrey's expertise as a shoulder specialist and ". . . would

certainly adhere to whatever recommendations he may have . . ." Dr. Humphrey employed that expertise in reaching his opinion that Claimant's left shoulder labral tear was not caused by his September 29, 2011 industrial accident.

30. Dr. Humphrey reported and testified that Claimant's labrum was visible in the 2011 MRI and was not observed to be torn.[4] Dr. Humphrey viewed the actual scan and opined that the 2011 MRI was of good quality and he could actually see where the biceps tendon attached to the labrum and the labrum attaches to the bone and observed a solid connection. Dr. Humphrey saw no evidence of a contrast dye leakage, which one would expect if a torn labrum was present.

31. Dr. Humphrey also credibly opined that if Claimant had suffered a torn labrum in 2011, it is doubtful that he could have participated in physical therapy and worked for a number of months wherein he used his left arm/shoulder in labor-intensive activities without experiencing shoulder pain. The fact that Claimant did not seek treatment for his left shoulder until about a year after he was released to return to work without restrictions by Dr. Wright post-surgery contradicts Dr. Wright's opinion that Claimant did not improve after the surgery.

32. Claimant testified that after he returned to work, he was handling 1500-gallon tanks and doing other strenuous activities that both Drs. Wright and Humphrey believed could have caused Claimant's labral tear. When Claimant returned to Dr. Wright in November 2013, he informed Dr. Wright that his left shoulder pain had

[4] Dr. Hessing's opinion that, even if there was a labral tear in 2011, it was the result of degeneration and not Claimant's industrial accident. Unlike Drs. Wright and Humphrey, Dr. Hessing did not spend a lot of time in his report parsing out whether the tear existed in 2011.

begun six weeks prior (at the time Claimant had been working with the tanks, climbing ladders, etc.). Claimant could not relate his recurring shoulder pain to any specific event.

33. The Referee finds that Claimant has failed to prove that his labral tear is related to his September 19, 2011 industrial accident.

CONCLUSIONS OF LAW

1. Claimant has failed to prove that his labral tear is related to his September 29, 2011 industrial accident.

2. All remaining issues are moot.

RECOMMENDATION

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

DATED this 15th day of April, 2016.

INDUSTRIAL COMMISSION

___/s/_____
Michael E. Powers, Referee

CERTIFICATE OF SERVICE

I hereby certify that on the 22nd day of April, 2016, 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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