BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

JERRY CAMPOS, Claimant, v. RANGEN, INC., Employer, and LIBERTY NORTHWEST INSURANCE CORPORATION, Surety, Defendants.	**IC 2010-019618** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** **Filed August 2, 2013**

Pursuant to Idaho Code § 72-506, the above entitled matter was assigned to Referee Michael Powers, who conducted a hearing on May 3, 2012, in Twin Falls, Idaho. Claimant was present in person and represented by James C. Arnold of Twin Falls. Employer ("Rangen") and Surety (collectively, "Defendants") were represented by E. Scott Harmon of Boise. Oral and documentary evidence was admitted, and two post-hearing depositions were taken. The matter was briefed and came under advisement on March 26, 2013.

ISSUES

Pursuant to the parties' stipulation at the hearing, the issues to be decided as a result of the hearing are:

1. Whether Claimant is medically stable and, if so, the date on which he became so;

2. Whether and to what extent Claimant is entitled to additional medical care; and

3. Whether and to what extent Claimant is entitled to temporary partial and/or temporary total disability (TPD/TTD) benefits.

All other issues are reserved.

CONTENTIONS OF THE PARTIES

There is no dispute that Claimant suffered an industrial injury to his right shoulder on August 2, 2010, when he swung a sledgehammer overhead in the process of dislodging sardines from the inside of a railcar at work. He developed significant pain and an inability to raise his right arm above shoulder height, which has persisted. Claimant contends that he is not medically stable, and he seeks diagnostic arthroscopic shoulder surgery recommended by Dr. Wathne to identify and hopefully treat his injury. Because his shoulder is not medically stable, he also asserts entitlement to temporary total or partial disability (TPD or TTD) benefits since November 5, 2010, when he was laid off by Rangen.

Defendants counter, based upon the opinions of Dr. Johns and Dr. Schwartsman, that Claimant reached medical stability as of November 2, 2010, with no industrial injury-related permanent impairment or medical restrictions, before he was ever evaluated by Dr. Wathne. Further, after reviewing Dr. Wathne's recommendation, Drs. Johns and Schwartsman continue to opine that diagnostic surgery is not warranted. Therefore, Claimant is entitled to neither additional medical treatment nor TTD/TPD benefits.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. Joint Exhibits A through J, admitted at the hearing;
2. The testimony of Claimant, taken at the hearing; and
3. The post-hearing deposition testimony of Richard Wathne, M.D., taken July

26, 2012, and Roman Schwartsman, M.D., taken October 26, 2012.

OBJECTIONS

All pending objections are overruled.

FINDINGS OF FACT

After considering 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.

BACKGROUND

1. Claimant, who is right-hand dominant, was 31 years of age and residing in Twin Falls at the time of the hearing. On August 2, 2010, he was unloading a railcar for Rangen, swinging a sledgehammer overhead to dislodge sardines, when he felt a "pop" in his right shoulder followed by burning pain. He immediately reported the accident to his supervisor, who told him to wait a day to see if he thought he needed to go to a doctor. Claimant's symptoms persisted, so he saw Brian Johns, M.D., an occupational medicine physician, at Rangen's direction.

2. Dr. Johns treated Claimant on five different occasions from August 6, 2010 through November 4, 2010. Three of those visits took place in August. The corresponding chart notes for the August 6 visit confirm the details of the industrial accident and above-described injury. On exam, Dr. Johns noted that Claimant appeared uncomfortable, had moderately limited cervical rotation toward the right, mild limitation toward the left, and at least moderate tenderness to palpation in the right cervical paraspinals. Regarding Claimant's pain and shoulder symptoms, Dr. Johns noted:

> He has exquisite tenderness to palpation in the distal supraspinatus fossa, more mildly in the infraspinatus fossa. No significant anterior shoulder

> tenderness, mild to moderate tenderness lateral to the acromion. Hawkins Kennedy is positive. He has active abduction and forward flexion only to about 30 degrees, passively only a few degrees more. He has breakaway weakness with thumb down Job testing.

JE-50. Dr. Johns prescribed anti-inflammatory medication, as well as a narcotic pain reliever for use only during non-work hours. He also recommended icing and home stretching exercises, and took him off right-handed work.

3. On August 12, Claimant's pain persisted, so Dr. Johns extended his treatment and work modification recommendations, adding three physical therapy sessions. On August 20, Dr. Johns ordered an MRI arthrogram (MRI), which was attempted on September 3. Instead, a CT arthrogram (CT) was performed, for reasons that are not entirely clear from the record. The CT identified a probable tear of the anterior inferior glenohumeral ligament, but no full-thickness rotator cuff tear. On September 7, Claimant's symptoms persisted (including, on exam, tenderness to palpation in the supraspinatus fossa and lateral to the acromion), so Dr. Johns generally referred Claimant to an orthopedist and modified Claimant's right arm restrictions to no overhead reaching, no repetitive gripping or twisting, no lifting in excess of five pounds, and no reaching, pushing, or pulling.

4. Surety sent Claimant to Roman Schwartsman, M.D., an orthopedic surgeon, over Claimant's objections. He did not understand why he and his wife, who needed to drive him, were required to make the day-long journey to Boise. He would have preferred a local orthopedist, but Surety insisted, so Claimant gave in.

5. Claimant's first of three visits to Dr. Schwartsman took place on September 16, 2010. On examination, Claimant had full range of motion, but his right shoulder testing was "limited because of pain in the trapezius at the scapular insertion." JE-39.

> The patient has significant discomfort with attempts at scapular stabilization.

> Supraspinatus test is negative for pain in the supraspinatus muscle, but is positive for pain along the medial scapular border. Provocative labral maneuvers are negative. Apprehension test is negative, no instability. Pain consistently localizes to the medial scapular border and the trapezius as well as to the lateral deltoid."

Id.

6. Dr. Schwartsman diagnosed derangement of the right shoulder with trapezius strain and inferior glenohumeral ligament injury. He referred Claimant to physical therapy and restricted him from lifting more than five pounds on the right. He allowed Claimant to return to his job as a delivery truck driver, so long as he did not do any lifting.

7. Claimant attended a few physical therapy sessions at the direction of Drs. Johns and Schwartsman. He was discharged on September 20, 2010 because he was not improving. On discharge, the therapist noted:

> The patient continued to have significant pain with all motions and limited active range of motion; however, passive range of motion was within functional limits. The patient reported little subjective improvement. … The patient's primary area of pain was along the infraspinatus muscle belly and insertion with decreased tenderness to palpation with manual therapies and stretching of that area. The patient continued to have poor scapulothoracic rhythm and tested positive for both pain and weakness of the subscapularis and with the internal lag sign and the bear hug.

JE-69.

8. On October 14, 2010, Claimant's symptoms were unresolved, his exam results were unchanged, and Dr. Schwartsman had "no clear-cut explanation for his pain." JE-43. Dr. Schwartsman affirmed his prior diagnosis, maintained Claimant's restrictions, and ordered an MRI in Boise, since there was a prior problem at the Twin Falls facility.

9. Claimant underwent the MRI on November 2, 2010, the report from which is not in evidence. On that same day, Dr. Schwartsman released Claimant from care, opining he had reached medical stability with no resulting permanent impairment. "At this point,

the patient has a negative MRI. I have nothing further to offer him. He is released from my care. No restrictions are imposed in the absence of any objective findings. Follow up is on p.r.n. basis. The patient can return to full duty effective of 11/3/10. MMI with no PPI." JE-44.

10. Claimant, frustrated, returned to Dr. Johns on November 4, 2010, reporting the same persistent right shoulder pain. Dr. Johns noted, among other things, a mildly positive Hawkins Kennedy test. He opined, "After several months of abnormal shoulder mechanics, this in and of itself may explain his ongoing symptoms at this point. I tried to offer reassurance based on the fact the MRI arthrogram was negative." JE-59. Dr. Johns administered a corticosteroid injection, resumed his prior treatment regimen and issued right arm restrictions for one week, including no overhead reaching, no repetitive gripping or twisting, and no lifting in excess of 10 pounds. In addition, for the next three days he restricted Claimant from reaching out, lifting, pushing and pulling with the right arm. The injection provided little or no relief.

11. Upon review of Dr. Johns' November 4, 2010 chart note, Dr. Schwartsman confirmed his opinion of November 2, 2010. Thereupon, Surety denied further benefits.

12. On November 5, 2010, Rangen placed Claimant on a two-week leave of absence "to sort out [his] medical issues." JE-19. Claimant understood that he was laid off because he could not return to full-duty work. At some point prior to mid-December, Claimant returned, advising that he was ready to go back to work. Rangen informed him that no positions were available, due to the seasonal slow-down.

13. Claimant sought, and was found eligible for, employment assistance through the Industrial Commission Rehabilitation Division (ICRD). On or about December 3,

Dr. Johns wrote to ICRD regarding Claimant: "No significant shoulder pathology on MRI. Have not seen him in one month but anticipate MMI soon." JE-9. Claimant's file was closed on December 16, 2010 based upon conclusions drawn from the opinions of Dr. Schwartsman and Dr. Johns that Claimant was medically stable and could return to his former employment without restrictions or limitations. Apparently, ICRD was unaware of Dr. Wathne's opinions at the time (see below).

RECOMMENDATION FOR FURTHER TREATMENT

14. Richard A. Wathne, M.D., an orthopedic surgeon, examined Claimant on December 2, 2010. Prior to detailing his findings in his report, Dr. Wathne reviewed Claimant's relevant medical records and confirmed that his imaging demonstrated no rotator cuff or labral pathology. On review of the MRI films, however, Dr. Wathne noted "tendinosis within the supraspinatus portion of the rotator cuff tendon, although the radiologist has not remarked about that." JE-35; *see also* Wathne Deposition, pp. 12-13.

15. Dr. Wathne's exam findings were consistent with Dr. John's and Dr. Schwartsman's in that they all recognized that Claimant had pain and tenderness in the supraspinatus muscle belly area.

16. Dr. Wathne performed a repeat subacromial corticosteroid injection because he suspected that the prior injection was not correctly placed.

> Following the injection he had significant relief of his symptoms and his motor strength and supraspinatus returned back to 5/5. He will ice this down over the next few days and we will get him started working on some rotator cuff strengthening exercises. I provided him with a Thera-band and instruction sheets on this today. I would like to see how he progresses over the next six weeks then reevaluate him.

JE-35.

17. Dr. Wathne opined Claimant had significant pain on impingement

maneuvers, among other things, that decreased following the pain injection:

> His symptoms by physical exam - - on physical exam correlated to a rotator cuff inflammation. He had tenderness. Directly over the rotator cuff tendon, he had what's called positive impingement maneuvers.
>
> He gave way with resistive rotator cuff testing, specifically in the supraspinatus tendon. And I did the injection [*sic*] both diagnostic and therapeutic purposes.
>
> The diagnostic component is the lidocaine component of it. And he had almost immediate relief of his symptoms. He was able to fully resist me to the rotator cuff testing and was actually able to lift his arm up against gravity into a normal position.
>
> . . .
>
> He did not have a tear in the rotator cuff, which could also limit someone from being able to lift it, you know, the tendon is not connected.
>
> But his is more of a pain induced inability to go further. It just caused him that discomfort.

Wathne Deposition, pp. 8-9.

18. Dr. Wathne diagnosed right shoulder impingement syndrome with ongoing rotator cuff inflammation.

19. On December 9, 2010, Dr. Wathne wrote to Claimant's attorney. "I would place work restrictions in regard to Mr. Campos' right upper extremity. I would limit him to 20 lbs. lifting…He should not lift above the shoulder level. I would have him refrain from any repetitive activities in the right upper extremity." JE-30.

20. On January 27, 2010, Claimant returned to Dr. Wathne's office and was examined by Boe Simmons, P.A., Dr. Wathne's physician assistant. Unfortunately, the relief Claimant got from the injection only lasted a few days. "His symptoms are back in full force. He is miserable. He cannot lift his elbow up above shoulder height secondary to pain. He is quite frustrated with this continued pain. He reports that he would like to consider surgical intervention." CE-38. Claimant's findings on exam were essentially

unchanged. Mr. Simmons affirmed Dr. Wathne's diagnosis and opined that Claimant had exhausted conservative treatment measures. "I believe it is reasonable to consider surgical intervention to do an arthroscopy and decompression to the shoulder." *Id.*

21. Dr. Wathne fully agreed with Mr. Simmons' assessment and recommendation for diagnostic arthroscopy. Where, as with Claimant, conservative treatment has failed:

> I'll often recommend an arthroscopic intervention where I can go in, evaluate both sides of the rotator cuff tendon, vacuum out any bursitis tissue, and then usually perform what's called an acromial plasty where I clean the underside of the shoulder blade and essentially create a few more millimeters of room for the rotator cuff tendon to clear underneath the shoulder blade.
>
> And hopefully that does permanently what the injection did temporarily there.

Wathne Deposition, p. 9; *see also,* p. 14.

22. Dr. Wathne also opined that the surgery has a 90% chance of improving Claimant's functionality:

> Q. …in your experience, would that procedural [*sic*] likely lead to an outcome that would allow him to have more function of the shoulder?
>
> A. In my experience, you know, as long as you jump through the hoops of nonoperative treatment where you really, you know, have an understanding of what their pathology is, I would say that that surgery is at least 90 percent successful.

Wathne Deposition, p. 10.

23. Given the time lapse since Dr. Wathne last examined Claimant, he premised his opinions upon the assumption that Claimant would present with the same or substantially similar symptoms on a current exam. He is not surprised that Claimant continues to have difficulty lifting his arm above shoulder-level:

> What I would say [sic] it's hard for me to know without examining him again, but it's not unusual with this type of circumstance. Once - - once this inflammation and this swelling within the tendon starts, it's often a very

difficult thing to eradicate.

> And when - - you know, when those symptoms persist and those - - physical exam findings correlate again with it, then I've had great success in those situations performing arthroscopic decompression and debridement of the shoulder.

Wathne Deposition, p. 15.

24. On May 19, 2011, after reviewing Dr. Wathne's treatment records, Dr. Schwartsman completed a check-the-box letter to Surety indicating that he did not concur with Dr. Wathne's opinion. He added, "The MRI was [negative] with no mass effect on supraspinatus and only mild acromial sloping." JE-46. At his deposition, Dr. Schwartsman explained why he disagrees with Dr. Wathne's assessment:

> There is absolutely no evidence on any of his prior examinations of either impingement syndrome or rotator cuff inflammation. The source of the patient's pain when I examined him was his trapezius muscle insertion on the scapular border and his lateral deltoid. He was not complaining of rotator cuff pain, and he had neither the clinical, nor the radiographic manifestations of impingement syndrome.
>
> And, specifically, I would state that on the MRI arthrogram of November 2nd, 2010, the acromion and the AC joint, which are the sources of impingement in this case, or potential sources of impingement in this case, are described as having no mass effect on the supraspinatus. That means the bony structures around the shoulder are not pushing on the rotator cuff, which is the understanding of impingement.
>
> In other words, there is no radiographic evidence - - there is no objective radiographic evidence to support Dr. Wathne's assertion in this case. Furthermore, this is inconsistent with the patient's initial presentation in his initial complaints, and, also, his subsequent complaints on follow-up examinations in my office.
>
> In other words, the patient's representation of his pain seems to be changing all the time and has become inconsistent here. Again, there's a note from Dr. Wathne's PA, a Mr. Simmons, dated January 27th, 2011, in which the assertion that the patient has impingement syndrome and ongoing rotator cuff inflammation following an on-the-job injury is stated as the impression.
>
> Again, this would contradict the patient's earlier presentations while in my

> office, and also contradicts the one bit of objective evidence we have in this case, which is the MRI arthrogram.
>
> In other words, I would have to say that the diagnosis here is incorrect. It is inconsistent with the patient's earlier presentation, and that surgery in this case is not warranted, since the patient does not meet either clinical or radiographic criteria for surgical intervention in this case.

Schwartsman Deposition, pp. 12-14.

25. Dr. Schwartsman went on to testify that Claimant underwent the highest-quality imaging available which neither he nor the attending radiologist, whom he highly trusts, detected any inflammation on Claimant's MRI films. "In Boise, and in this instance in particular, this is a magnet that I frequently utilize for interpretation in difficult cases where black-and-white answers are needed." Schwartsman Deposition, p. 21. Further, the accuracy of MRI imaging has supplanted the need for diagnostic arthroscopy. "In other words, the diagnostic accuracy of MRI arthrograms and the improved interpretation provided by better trained radiologists over the past five and, possibly, ten years has really eliminated the need for diagnostic arthroscopy." *Id.* at p. 21.

26. On May 26, 2011, after reviewing Dr. Wathne's treatment records and Dr. Schwartsman's documentation disagreeing with Dr. Wathne's opinion, Dr. Johns completed a check-the-box letter to Surety indicating that he concurred that Claimant is medically stable. (*See* JE-61.)

CLAIMANT'S CREDIBILITY

27. There is no dispute that Claimant experiences severe right shoulder pain, that he seeks relief from his pain, and that he desires to return to work. Claimant is a credible witness.

DISCUSSION AND FURTHER FINDINGS

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).

REASONABLE MEDICAL CARE

Claimant carries the burden of proving, to a reasonable degree of medical probability, that the injury for which benefits are claimed is causally related to an accident arising out of and in the course of employment. *Wichterman v. J.H. Kelly, Inc.,* 144 Idaho 138, 158 P.3d 301 (2007). It is clear that in order to recover medical benefits, the injured worker must prove both that the need for medical care is causally related to the accident and that the medical care is "reasonable." See *Henderson v. McCain Foods, Inc.,* 142 Idaho 559, 130 P.3d 1097 (2006).

Idaho Code § 72-432(1) obligates an employer to provide an injured employee reasonable medical care as may be required by the treating 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 the treatment is reasonable. See*, Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989).

The Idaho Supreme Court has held that medical treatment is reasonable when three circumstances exist: 1) the claimant made gradual improvement from the treatment

received; 2) the treatment was required by the claimant's physician; and 3) the treatment received was within the physician's standard of practice, and the charges were fair, reasonable and similar to charges in the same profession. *Id.* However, the *Sprague* standard anticipates a situation in which treatment has already been rendered, and the *Sprague* analysis is not readily applicable to care, like that at issue in the instant matter, that is prospective in nature. See, *Richan v. Arlo G. Lott Trucking, Inc.,* IC 2007-027185 (Feb. 2011); and *Ferguson v. CDA Computune, Inc.*, *et. al*., consolidated case numbers IC 2001-005778, IC 2001-021764, IC 2004-504577 and IC 2004-000161 (filed Feb. 2011).

28. Dr. Wathne recommends exploratory arthroscopic surgery based upon Claimant's continuing right shoulder pain and associated weakness. His opinion is supported by Claimant's consistent complaints of pain and tenderness in the supraspinatus region, as well as his interpretation of Claimant's MRI as demonstrating inflammation in this area. Dr. Schwartsman disagrees[1] because, as he interprets the MRI, Claimant has no rotator cuff or labral pathology and no significant loading on the supraspinatus.

29. To determine whether arthroscopic surgery is "reasonable," the Commission must ascertain whether the required care is likely to be efficacious. In other words, if, from the medical evidence adduced by Claimant, it appears more probable than not that the care required by Dr. Wathne will improve Claimant's condition, then the care is "reasonable." The Commission recently addressed the weight to be given to MRI evidence that is seemingly inconsistent with a credible claimant's persistent pain symptomatology:

The Commission is aware that the MRI is not a perfect diagnostic tool; both

[1] Dr. Johns also disagrees; however, Dr. Johns did not examine Claimant after November 4, 2010, at which time he continued to assess restrictions and provide treatment. Thereafter, he concurred in Dr. Schwartsman's opinion via a check-box letter, but the reason(s) for his concurrence are not found in the record. Therefore, Dr. Johns' opinion carries less weight than Dr. Wathne's or Dr. Schwartsman's.

> false positive and false negative results are obtained from time to time. Therefore, it is always important to correlate such studies with clinical findings on exam, and the patient's history. Here we have accepted, as true, Claimant's testimony that he experienced a sudden and significant worsening of his pain following the subject accident. Under facts similar to those at bar, the commission has, in the past, found that a compensable injury has occurred, even in light of pre- and post-injury radiology studies which show no interval change in an injured workers condition. In such cases, we have been persuaded by medical testimony tending to establish that an injury has occurred, notwithstanding negative radiology studies.

Davis v. U.S. Silver-Idaho, Inc., IC 2008-031273, filed July 3, 2013.

30. The guidance provided by the *Davis* decision is directly applicable. Claimant is a credible witness and Dr. Wathne's opinions are based upon a sound foundation. Therefore, it is appropriate in this case to allocate more weight to Dr. Wathne's opinion even though Dr. Schwartsman is convinced that the MRI demonstrates no evidence to support Claimant's claims. The Referee recognizes that Dr. Schwartsman saw Claimant on one more occasion than did Dr. Wathne and his assistant (three versus two). However, this is offset by the fact that Dr. Wathne has more experience performing diagnostic arthroscopy in cases such as Claimant's. After considering Claimant's continuing pain, his imaging studies and his clinical presentation (which Dr. Johns also believed warranted continued treatment shortly following Dr. Schwartsman's discharge of Claimant from care), Dr. Wathne opined that arthroscopic surgery is likely to improve Claimant's condition. Dr. Schwartsman's contrary opinion is insufficient to establish that Dr. Wathne's recommendation is unreasonable.

MAXIMUM MEDICAL IMPROVEMENT

31. Dr. Schwartsman and Dr. Johns opined that Claimant reached maximum medical improvement (MMI) as of November 2, 2010. However, Dr. Wathne's opinion that Claimant is likely to improve with further treatment, was determined, above, to be

more persuasive. The Referee finds Claimant has not reached MMI since his industrial accident and injury on August 2, 2010.

TEMPORARY DISABILITY BENEFITS

32. Idaho Code §§ 72-408 and 409 provide time loss benefits to an injured worker who is temporarily totally disabled. Here, it has been determined that Claimant's right shoulder condition will likely improve with arthroscopic surgery. In addition, the record establishes that Claimant has never been capable of returning to work, where he is required to be capable of lifting at least 50 pounds repetitively.

33. Dr. Schwartsman's opinion that Claimant reached MMI on November 2, 2010, and the concurrence of Dr. Johns therein, are unpersuasive. The Referee finds Claimant has never achieved medical stability since his industrial accident on August 2, 2010. Under *Malueg v. Pierson Enterprises*, 111 Idaho 789, 727 P.2d 1217 (1986), once a claimant establishes by medical evidence that he is within a period of recovery from the industrial accident, he is entitled to TTD benefits *unless* and *until* evidence is presented that he or she has been medically released for light work and (1) that an employer has made a reasonable and legitimate offer of suitable employment to her or that (2) there is employment available in the general labor market which claimant has a reasonable opportunity of securing, and which is consistent with her physical abilities.

34. Rangen offered, and Claimant accepted, modified-duty work following his industrial accident when his physician allowed him to return to work. On November 5, 2010, however, Rangen laid Claimant off in reliance upon Dr. Schwartsman's November 2, 2010 full release combined with Claimant's actual inability to return to full-duty work. In that regard, Rangen informed Claimant that he could not return unless he could perform

full-duty work. *See* JE-19. Also on November 5, Dr. Johns issued work restrictions including a lifting limit of 10 pounds, which precluded Claimant from returning to full-duty.

35. Claimant has been in a period of recovery since the date of his accident. Therefore, the burden shifted to Defendants to adduce the proof required to curtail the obligation to pay TTD benefits. Here, no such proof has been presented, and the default case is that Claimant is entitled to time loss benefits effective August 2, 2010, through the date of medical stability, with credit for payments already rendered, unless and until Defendants can meet their burden of proof.

36. The record establishes that Claimant's condition is unlikely to improve without additional treatment. Dr. Wathne opined that 90% of his patients that have undergone diagnostic arthroscopy have benefitted, and that he believes Claimant would benefit from this procedure as well. Conservative measures have failed. Implementation of Dr. Wathne's recommendation for exploratory arthroscopy to diagnose and treat Claimant's chronic right shoulder pain is likely to improve his condition. The Referee finds Claimant has proven he is entitled to exploratory diagnostic arthroscopy, as directed by Dr. Wathne.

CONCLUSIONS OF LAW

1. Claimant has proven that he has not yet reached maximum medical stability following his August 2, 2010 industrial injury.

2. Claimant has proven that he is entitled to additional reasonable and necessary medical care for his right shoulder pain, including but not limited to diagnostic arthroscopic surgery, as directed by Dr. Wathne.

3. Claimant has proven that he is entitled to temporary disability benefits from August 2, 2010 through the date of medical stability, or until Defendants satisfy any of the criteria identified in *Malueg* that authorize curtailing temporary disability benefits, with credit for payments already rendered by Defendants.

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 __3rd___ day of July, 2013.

INDUSTRIAL COMMISSION

___/s/_____
Michael E. Powers, Referee

CERTIFICATE OF SERVICE

I hereby certify that on the __2nd___ day of __August___, 2013, 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:

JAMES C ARNOLD
PO BOX 1645
IDAHO FALLS ID 83403-1645

JOSEPH M WAGER
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ge

Gina Espinosa

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

JERRY CAMPOS, Claimant, v. RANGEN, INC., Employer, and LIBERTY NORTHWEST INSURANCE CORPORATION, Surety, Defendants.	**IC 2010-019618** **ORDER** **Filed August 2, 2013**

Pursuant to Idaho Code § 72-717, Referee Michael E. Powers submitted the record in the above-entitled matter, together with his recommended findings of fact and conclusions of law, to the members of the Idaho Industrial Commission for their review. Each of the undersigned Commissioners has reviewed the record and the 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 has proven that he has not yet reached maximum medical stability following his August 2, 2010 industrial injury.

2. Claimant has proven that he is entitled to additional reasonable and necessary medical care for his right shoulder pain, including but not limited to diagnostic arthroscopic surgery, as directed by Dr. Wathne.

3. Claimant has proven that he is entitled to temporary disability benefits from August 2, 2010 through the date of medical stability, or until Defendants satisfy any of the criteria identified in *Malueg* that authorize curtailing temporary disability benefits, with credit for payments already rendered by Defendants.

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

DATED this __2nd___ day of ___August____, 2013.

INDUSTRIAL COMMISSION

___/s/_____
Thomas P. Baskin, Chairman

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

___/s/_____
Thomas E. Limbaugh, Commissioner

ATTEST:

__/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __2nd___ day of __August__ 2013, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

JAMES C ARNOLD
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ge _____/s/_____