BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

GARY FERGUSON, Claimant, v. CDA COMPUTUNE, INC., Employer, and IDAHO STATE INSURANCE FUND, Surety, and D & R AUTOMOTIVE, Employer, and IDAHO STATE INSURANCE FUND, Surety, and AUTO TECH NORTHWEST, Employer, and IDAHO STATE INSURANCE FUND, Surety, and STATE OF IDAHO, INDUSTRIAL SPECIAL INDEMNITY FUND, Defendants.	**IC 2001-005778** **IC 2001-021764** **IC 2004-504577** **IC 2004-000161** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** Filed February 25, 2011

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Douglas Donohue. The matter was re-assigned to the Commissioners, who conducted a hearing in Coeur d'Alene, Idaho on March 18, 2010. Starr Kelso of Coeur d'Alene represented Claimant. Alan Hull of Boise represented Defendants Auto Tech Northwest (Employer) and Idaho State Insurance Fund (Surety). Defendants CDA Computune, Inc., D & R Automotive, and State of Idaho, Industrial Special Indemnity Fund did not participate in the

hearing. Post-hearing depositions were taken, and the parties submitted post-hearing briefs. The matter came under advisement on December 3, 2010. It is now ready for decision.

ISSUE

By agreement of the parties at hearing, the sole issue to be decided is: Whether a right shoulder replacement constitutes reasonable medical care pursuant to Idaho Code § 72-432. The parties have stipulated that causation is not at issue.[1]

CONTENTIONS OF THE PARTIES

It is undisputed that Claimant injured his right shoulder in a work-related automobile accident that occurred January 2, 2004. Claimant has had two prior surgeries that failed to alleviate his pain.

Claimant contends that he is entitled to a total shoulder arthroplasty, as recommended by his physician, Dr. Roger Dunteman.

Defendants contend that the proposed treatment is not reasonable, because it is unlikely to improve Claimant's condition.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant taken at hearing;
2. The depositions of Michael Battaglia, M.D.; Roger Dunteman, M.D.; and Edwin Tingstad, M.D.;
3. Exhibits 1-30 admitted into the record at hearing; and
4. The Industrial Commission legal file pertaining to this claim.

All objections posed during the depositions are overruled.

[1] See Hearing Tr. 8, 17.

After having considered the evidence and the briefs of the parties, the undersigned Commissioners make the following findings of fact and conclusions of law.

FINDINGS OF FACT

1. Claimant was born on September 10, 1960. At the time of hearing, he was 49 years old and resided in Post Falls, Idaho.

2. Claimant worked as an auto mechanic for Employer. On January 2, 2004, Claimant was involved in an automobile accident while acting in the course and scope of employment. Claimant was a passenger in a Ford F-150 truck that was struck by another vehicle. He was transported to the emergency room, where he was evaluated for head, neck and back pain, then released.[2]

3. Claimant soon noticed pain in his right shoulder. At the time, Claimant was consulting with Dr. Douglas McInnis for an unrelated condition. Dr. McInnis saw Claimant on January 7, and noted in Claimant's file that Claimant had been involved in an accident and had complaints of headaches, cervical and lumbar strain, and right shoulder strain.

4. Dr. McInnis examined Claimant's shoulder on January 12, after Claimant reported continued shoulder pain. Dr. McInnis found that Claimant had right shoulder impingement and injected the subacromial space in Claimant's right shoulder. The injection failed to provide relief.

5. Claimant continued to work after his injury, though Dr. McInnis imposed restrictions on heavy lifting. Claimant commenced physical therapy for another condition in March 2004. In April, the therapist contacted Dr. McInnis with concerns that Claimant had undiagnosed shoulder instability. Dr. McInnis noted, "At no time has Mr. Ferguson focused any

[2] Claimant was involved in a similar employment-related automobile accident on January 13, 2004. The shoulder injury at issue here resulted primarily from the January 2 accident.

of his concern to the right shoulder, although previously I have suspected him of having some impingement. Review of my records reveals that I have not previously really done any instability testing on him."

6. Dr. McInnis evaluated Claimant and found symptoms of shoulder instability. He ordered an MRI, which was taken on May 10, 2004. The MRI revealed "contrast material underneath the glenoidale labrum diffusely involving the superior aspect." The radiologist interpreted the MRI to show findings "consistent with a superior glenoid labral tear, probably a SLAP lesion," i.e., a superior labral tear from anterior to posterior.

7. After receiving the results of the MRI, Dr. McInnis referred Claimant to Dr. Roger Dunteman, an orthopedic surgeon. In the referral letter, Dr. McInnis observed, "At this point, I expect that Mr. Ferguson probably does have a SLAP tear. However, I am not the least bit convinced that he necessarily will benefit from surgery." Dr. McInnis did not explain his rationale for this statement, though he mentioned earlier in the letter that he had treated Claimant for "ill-defined neurologic complaints."

8. On May 18, 2004, prior to Claimant's first meeting with Dr. Dunteman, Claimant presented to T. Daniel Dibble, M.D., for a full pain management evaluation. Claimant reported sharp, constant pain in his shoulder. Dr. Dibble noted in Claimant's social history that Claimant smoked a pack of cigarettes per day, and drank two or three six-packs of beer per week. Dr. Dibble tested Claimant's shoulder range of motion, but did not further examine the shoulder, as Claimant had an upcoming orthopedic evaluation with Dr. Dunteman. Dr. Dibble thought it best to wait for the evaluation before determining a course of action.

9. Claimant presented to Dr. Dunteman on June 9, 2004. Dr. Dunteman observed X-rays of Claimant's shoulder, as well as the MRI. Dr. Dunteman noted degenerative changes

about the AC joint, but no degenerative changes about the glenohumeral joint. He also noted that Claimant had a mesoacromion, a congenital anomaly that can become symptomatic. Dr. Dunteman diagnosed Claimant with a SLAP tear of the right shoulder and ordered a bone scan to rule out other problems. The bone scan came back normal.

10. On June 23, 2004, Claimant met with Dr. Dunteman to discuss options for treatment. Claimant was experiencing a "severe amount of shoulder pain" and agreed to surgery, specifically, an arthroscopic superior labral repair, which was performed on July 29. Dr. Dunteman repaired the labral tear, as well as a partial rotator cuff tear discovered during surgery. While operating, Dr. Dunteman observed that Claimant had mild glenohumeral joint arthritis.

11. At hearing, Claimant testified that he felt no relief after this surgery, and that, in fact, the surgery made his shoulder worse. The medical records present a more nuanced picture. Claimant initially seemed to be doing well. He reported that his pain had improved to both Dr. Dunteman and to John Bartoo, Claimant's physical therapist. On November 5, 2004, Mr. Bartoo noted that Claimant's pain was continually improving and that he was doing well in his exercises. Dr. Dunteman also observed that Claimant was "much improved."

12. To Dr. Dibble, however, Claimant reported constant pain, which varied between sharp and dull. Claimant initially indicated that his pain medications were working well. But on September 9, 2004, he reported to Dr. Dibble that he believed his doses should increase. On September 28, he reported that the medications were only "fair" in treating his pain. He continued to report only "fair" effectiveness in December. In January, he reported that his pain was "worsening" and again requested an increase in dosage. Claimant then reported worsening pain to Dr. Dunteman. An MRI was taken, which revealed degenerative changes in both the AC joint and the glenohumeral joint, as well as fluid in the subacromial space and subdeltoid bursa.

Mark Fickert, physician's assistant for Dr. Dunteman, gave Claimant a cortisone injection, which provided no relief.

13. On February 4, 2005, Claimant met with Dr. Dunteman to discuss treatment options. After viewing the MRI, Dr. Dunteman suspected a re-tear of the labrum and proposed a second surgery, to which Claimant consented. Dr. Dunteman performed arthroscopic surgery on March 3, 2005. He repaired a recurrent superior labral tear and excised Claimant's mesoacromion.

14. At hearing, Claimant testified that the second surgery did nothing to improve his pain. Again, the medical records present a somewhat more ambiguous picture. In post-surgery consultations with Dr. Dunteman and Mr. Fickert, Claimant reported that he was doing well. Throughout March, April, May, and June, he consistently represented that, while he still had some pain on top of his shoulder, he had no pain "deep inside" his shoulder, as had been the case before surgery.

15. Claimant was again referred to physical therapy and continued his pain management sessions with Dr. Dibble. On March 29, Claimant informed Dr. Dibble that his shoulder pain remained constant. On April 26, Dr. Dibble noted that it had been almost two months since surgery, that Claimant continued to have pain, and that it was unclear whether Claimant's pain was due to the shoulder surgery or to pre-existing radicular symptoms related to a cervical condition. On May 10, Claimant reported sharp, constant pain in his right shoulder. Dr. Dibble administered suprascapular nerve blocks on May 17, May 24, May 30, and June 14, but Claimant said the blocks worked poorly and only lasted long enough to get him through his physical therapy sessions.

16. Dr. Dibble then attempted to relieve Claimant's pain through a bursa injection.

Claimant indicated that this injection relieved his pain for several days. Dr. Dibble decided that another bursa shot should be administered, rather than a nerve block. The second injection apparently worked, and on June 28, Claimant reported that he was able to be more active with the injections. However, Claimant's treatment with Dr. Dibble was halted in order for Claimant to undergo an IME at Defendants' request. The IME was scheduled for August 5, 2005.

17. Three days before the IME, Claimant was admitted to the emergency room at Kootenai Medical Center for an intentional drug overdose. Admission notes indicate that Claimant had attempted suicide because of depression. He was treated by Dr. Lorene H. Lindley, who noted that Claimant had overdosed on Avinza, a drug prescribed for Claimant's shoulder and neck pain. Claimant could not recall how many pills he took, but admitted that he had taken them with alcohol. Claimant's blood alcohol level upon admission was 0.25. Drug screen was negative, except for opiates. Dr. Lindley diagnosed Claimant with intentional overdose, depression, and chronic pain in the neck and shoulder area.

18. Later in the day, Dr. William Miller conducted a psychiatric evaluation of Claimant. Dr. Miller reported that Claimant admitted to significant, even daily, drinking, and acknowledged a chronic problem with alcohol abuse. Claimant minimized his suicide attempt, representing that he had wanted to sleep, not die. Claimant also spoke to Dr. Miller about his shoulder injury and his impending IME. Dr. Miller recorded his impressions in a lengthy note:

> I think there is a risk of self harm in a person who most likely has a chronic alcohol problem…[H]e states that he has never had a problem with his prescriptions, but clearly he is on some significant amounts of medications. I spoke with Dr. Dibble and reviewed the situation with him, and voiced my concerns about the narcotic use with his history of substance abuse…[Claimant] is denying suicidal ideation. He states that he is just, I think, worried about his situation. I think his independent medical

> examination, which is pending for Friday, is a major issue for him. Dr. Dibble felt that most likely the case will be closed, and he will not be getting any further resources regarding that. He clearly, at this time, is dependent upon the narcotics, and that will create some difficulties for him. His risk for suicide … is present just because of his history with the chronic pain, alcohol abuse, being unemployed with middle-aged male risk factors.

19. Claimant was further evaluated by Dr. James Osmanski on the evening of August 2. Dr. Osmanski noted that Claimant had a history of substance abuse and alcoholism, and diagnosed Claimant with a polysubstance overdose and an acute intentional suicide attempt, acute hypercapneic and hypoxemic respiratory failure, and chronic pain syndrome. Dr. Osmanski determined that Claimant should remain in the intensive care unit and should not be allowed to leave the hospital.

20. On August 3, Dr. Lindley spoke with Claimant about counseling. Claimant was not willing to consider in-patient counseling, but indicated that he might be willing to consider out-patient counseling. Dr. Lindley left a message with Surety inquiring about whether counseling could be covered under Claimant's workers' compensation claim.

21. The staff at Kootenai Medical recommended psychological treatment for Claimant, but Claimant refused, and the state medical examiner released Claimant from a psychological hold on August 4. Claimant was discharged from the hospital.

22. On August 5, Claimant reported for his IME as scheduled. He was examined by Dr. Linda Wray, a neurologist, and Dr. Joel Cleary, an orthopedic surgeon. Claimant represented to the IME physicians that his alcohol use was only "social" and denied that he had used any alcohol lately. Claimant did not mention his suicide attempt or hospitalization. However, Surety informed the IME physicians of the hospitalization and attendant circumstances.

23. After examining Claimant, Dr. Wray and Dr. Cleary concluded that Claimant was not yet medically stable. Dr. Cleary found it more probable than not that Claimant had posterior and posterior inferior subluxation of the right shoulder, and that physical therapy alone would not resolve it. Surgery might be warranted to correct the instability, perhaps an "aggressive salvage surgery such as a right shoulder fusion." Dr. Cleary recommended that Claimant consult with an expert in shoulder instability, as Claimant's condition was "complex" and "difficult to evaluate and treat." Claimant had not been working since his surgeries, and Dr. Cleary recommended that, if Claimant did return to work, his activity be limited to "very light or sedentary" work with "minimal or no use of the right upper extremity." The IME panel also recommended that Claimant be weaned from potentially addicting medications.

24. In a letter to Surety dated September 30, 2005, Dr. Dunteman stated that he generally concurred with the IME panel's findings but wanted to obtain a second opinion before proceeding with any kind of surgery. Claimant was referred to Dr. Adam Olscamp, who evaluated Claimant on October 20, 2005. He found that Claimant had shoulder instability, with "clicking" inside the shoulder, weakness in the rotator cuff, and positive impingement signs. However, Dr. Olscamp concluded that the most appropriate course of action for Claimant would be "benign neglect." Though Claimant might be a future candidate for surgery, Dr. Olscamp did not believe surgery, at present, would give Claimant significant improvement in function or pain. Dr. Olscamp thought Claimant's shoulder should be given time to rest and recover on its own. If that did not work, then he should be re-evaluated by Dr. Dunteman at some point in the future.

25. Throughout the rest of 2005, Claimant continued his pain management program with Dr. Dibble. After Claimant's overdose, Dr. Dibble began to wean Claimant off his medications and recommended that Claimant see a psychologist. Claimant refused, though Dr.

Dibble stated that counseling was part of Claimant's treatment plan. Dr. Dibble's notes indicate that he was frustrated with Claimant's refusal, but he nevertheless continued to work with Claimant. Dr. Dibble also concurred with the findings of the IME and deferred to Dr. Olscamp's opinion on possible surgery.

26. Claimant's sessions with Dr. Dibble continued through much of 2006. Claimant reported constant pain to Dr. Dibble as well as to Dr. Dunteman. In February 2006, Dr. Dunteman ordered a CT scan, which revealed a degenerative glenohumeral joint. Dr. Dunteman concluded that Claimant's degenerative changes were progressing at a "fairly significant" rate and recommended that Claimant continue to see Dr. Dibble for pain management.

27. On October 26, 2006, Claimant was evaluated by Dr. Edwin M. Tingstad, an orthopedic surgeon. Dr. Tingstad examined Claimant's shoulder and took X-rays. Dr. Tingstad found that Claimant had "post-traumatic degenerative changes of the right shoulder with static posterior/inferior instability symptoms and neural irritation about the shoulder." Dr. Tingstad believed there were multiple causes of Claimant's shoulder pain and that no intervention would "give him a normal shoulder." Dr. Tingstad recommended that Claimant undergo a complete physical examination in an attempt to isolate the factors causing the pain. After this was done, Dr. Tingstad planned to administer an injection of local anesthetic into Claimant's glenohumeral joint in order to assess how much of Claimant's pain was "coming from the glenohumeral interface." The result of this diagnostic test would guide Claimant's treatment.

28. Claimant did not undergo a comprehensive physical, and he did not return to Dr. Tingstad for the diagnostic injection. On November 14, 2006, Dr. Dibble discussed Dr. Tingstad's findings with Claimant, and Claimant indicated that he had no primary care physician to conduct the physical exam. When Dr. Dibble asked Claimant how Claimant would like to go

about finding a primary care physician, Claimant replied that it was a workers' compensation problem and "they could deal with it." Dr. Dibble considered this approach "unacceptable." He informed Claimant that he would not continue treating Claimant and would only refill Claimant's medications until Claimant had obtained a primary care physician. Claimant did not do so, and Dr. Dibble ceased treating Claimant, though he continued to refill Claimant's medications until early 2008.

29. At the request of Defendants, Claimant was examined by Dr. Larry K. Lamb on March 22, 2007. Dr. Lamb also reviewed Claimant's medical records. He reported his impression that Claimant had an "overwhelming sense of disability conviction" and seemed "absolutely sure that he is completely and totally disabled with regard to usage of the right arm." Dr. Lamb did not think that Claimant was engaging in deliberate deception but believed Claimant's conviction was not supported by the "organic pathology" identified in Claimant's medical records. Dr. Lamb recommended that Claimant be evaluated by a psychologist for somatoform pain disorder or conversion hysteria.

30. On June 13, 2007, Claimant, on his own accord, presented to Dr. H. Graeme French, an orthopedic surgeon. After reviewing Claimant's records and examining Claimant, Dr. French recorded his impression that Claimant had "multidirectional traumatic instability with hereditary laxity of the right shoulder" and a recurrent SLAP lesion. Dr. French noted that Claimant would probably need a right shoulder "reconstruction," because physical therapy and prior surgeries had failed.

31. Claimant saw Dr. French again on December 31, 2007. Dr. French ordered an MR arthrogram of Claimant's right shoulder, which revealed an intact rotator cuff with mild tendinopathy of the distal infraspinatus tendon, a partial-thickness intrasubstance tear of the

distal subscapularis tendon with subluxation of the superior aspect of the long head of the biceps tendon, a partial-thickness tear of the biceps anchor with degenerative irregularity of the free margin of the adjacent superior glenoid labrum, and articular cartilage thinning and surface irregularity throughout the glenohumeral joint with marginal spurring. Dr. French reviewed the MRI with Claimant on January 14, 2008, and noted that he would "start working on getting him [Claimant] authorized for right shoulder reconstruction and possible rotator cuff repair." What Dr. French meant by "shoulder reconstruction" was not the total shoulder arthroplasty currently being proposed, but a diagnostic and operative arthroscopy to carry out a bicipital tenodesis and ligamentous reconstruction of the capsule, as well as repair of a rotator cuff tear, if one was found.

32. At Defendants' request, Claimant underwent an IME by Dr. Bradley Billington on November 28, 2007. Dr. Billington was asked to evaluate Claimant and to opine on Dr. French's proposed treatment plan. After conducting an orthopedic examination of Claimant and reviewing Claimant's medical records, including those that post-dated the November 28 exam, Dr. Billington concluded that Claimant had a "deep-seated disability syndrome" that could "doom any surgical attempt to failure." Dr. Billington did not state that such a surgery would be unreasonable in principle. Rather, he believed that before undergoing any surgery, Claimant should undergo a thorough psychological or psychiatric examination. All possible etiologies of Claimant's shoulder pain needed to be ruled out before surgery could be performed. Otherwise, the surgery might not address the primary sources of Claimant's pain. Dr. Billington believed it was unlikely that Claimant could obtain relief from any surgical procedure prior to a thorough psychological evaluation. Similar to Dr. Tingstad, Dr. Billington also recommended a diagnostic injection into Claimant's glenohumeral joint to determine if that was the primary cause of

Claimant's symptom complex.

33. On February 11, 2008, Dr. Dibble formally discharged Claimant from his care, as Claimant was now receiving prescriptions from another provider, Dr. French.

34. On February 28, 2008, Claimant reported to Kootenai Medical Center with multiple rib fractures and a laceration of his right shin. Dizzy from Lyrica, a pain medication prescribed by Dr. French, Claimant had fallen and hit his ribs on a dresser. He was treated and released. On February 29, March 2, and March 21, Claimant also presented to Kootenai Medical Center for follow-up care. On April 4, Claimant returned to Kootenai Medical Center, this time reporting shortness of breath and significant chest pain. He was admitted into the hospital and received care over the course of several days, including surgical treatment for a large left hemothorax and pericardial effusion, which were caused by his rib fractures.

35. On May 16, 2008, Claimant underwent a neuropsychological IME, conducted by Craig Beaver, Ph.D., a licensed psychologist. Dr. Beaver interviewed Claimant and reviewed the medical records. Claimant also took a neuropsychometric test battery. Dr. Beaver diagnosed Claimant with: 1) polysubstance dependency (opiates and possibly alcohol), 2) pain disorder associated with psychological factors and general medical condition, and 3) major depressive disorder or substance-induced mood disorder with depressive features. Regarding the last diagnosis, Dr. Beaver leaned more toward major depressive disorder, but found Claimant hard to diagnose with accuracy because of the substance addictions. Dr. Beaver opined that Claimant had become "very entrenched in being disabled" and was "extremely focused on his chronic pain and ensuring he will get narcotics." Importantly, though, Dr. Beaver thought there was "no question" that Claimant had a painful shoulder condition. The problem lay in parsing out how much of Claimant's pain had an actual organic cause, versus how much was due to psychological

factors. According to Dr. Beaver, patients with psychological profiles similar to Claimant's "often are reporting multiple physical problems and difficulties. They have a strong tendency to develop physical complaints under periods of stress. Their complaints are often excessive and vague, with a particular emphasis on weakness and pain." Again, while such individuals might have an organic component to their complaints, the "intensity of their symptom complaints and the level of disability they perceive from their complaints are clearly affected by their psychological status." Such individuals, Dr. Beaver reported, have a "strong tendency toward somatization." He recommended that Claimant participate in a pain management program with a psychological component.

36. Surety referred Claimant to the LifeFit Chronic Pain Management Program. Dr. Michael H. McClay, a licensed clinical psychologist, conducted a psychological evaluation of Claimant prior to Claimant's admission into the program. Dr. McClay's findings were largely consistent with Dr. Beaver's evaluation. Dr. McClay found that Claimant was appropriate for the program, and recommended that Claimant receive both personal and vocational counseling during the course of the program.

37. Claimant enrolled in the LifeFit Program in October 2008 and was overseen by Robert H. Friedman, M.D. During the program, Claimant worked on his functional capacity and improved by over 40%. His pain, however, did not improve. Dr. Friedman judged that Claimant's pain was chronic in nature, and believed that Claimant was medically stable. On November 19, 2008, Dr. Friedman opined in a letter to Surety that Claimant had reached maximum medical improvement. Dr. Friedman reported that Claimant was "narcotics and benzodiazephines free," and should remain so, as the medications had not "assisted and/or improved him in any fashion" and had caused him to fall and injure himself. Having performed a

functional evaluation of Claimant, Dr. Friedman reported that Claimant could return to work, but not to his time-of-injury position. Claimant was able to work at the light-to-medium level, with lifting restrictions of 30 pounds occasionally and 20 pounds repetitively. Claimant's strength and function had shown continuous improvement during his participation in the program, and he should be allowed access to an athletic facility so that he could continue his exercises. Dr. Friedman anticipated that Claimant would eventually be able to lift 25 pounds repetitively and 50 pounds occasionally, but that he should not do any repetitive above-the-shoulder activity greater than 20 pounds. Dr. Friedman did not believe that Claimant required further treatment for his "reactive depression" beyond two to three months' time from the date of the letter.

38. On December 4, 2008, Claimant presented to the emergency room at Kootenai Medical Center, reporting shoulder pain. X-rays were taken, which revealed moderate to severe glenohumeral arthritis. Dr. Nickol, the emergency room physician, prescribed Claimant Motrin and recommended follow-up with Dr. Dunteman. Dr. Nickol also ordered an MRI.

39. The MRI was taken on December 7, 2008. It showed moderate to severe glenohumeral arthrosis, recurrent SLAP tear, medial subluxation of the long head of the biceps, and postoperative changes.

40. Surety asked Dr. Friedman to review Claimant's most recent medical records, including the MRI. In a letter dated December 26, 2008, Dr. Friedman concurred with the radiologist that the MRI showed severe degenerative disease with a probable recurrent SLAP tear. However, Dr. Friedman did not believe that Claimant would benefit from surgery. He maintained that Claimant had reached maximum medical improvement and that his pain would best be managed by "nonsurgical conservative treatment" and an exercise program. Dr. Friedman again emphasized that Claimant had been weaned off narcotic medications and should remain off

them, as the medications had not helped his pain and had caused significant injuries.

41. Claimant presented to Dr. Dunteman on March 23, 2009 for the follow-up evaluation recommended by Dr. Nickol. Dr. Dunteman reviewed Claimant's most recent X-rays and MRI and noted moderate to severe glenohumeral arthritis. He diagnosed osteoarthritis and discussed treatment options with Claimant, including NSAIDs (non-steroidal anti-inflammatory drugs), intra-articular cortisone injections, and surgery, specifically, a total shoulder replacement. Claimant indicated he preferred the surgical option.

42. On April 6, 2009, Dr. Dunteman wrote a letter to Surety, in which he stated that Claimant had osteoarthritis of the right shoulder and "will require total shoulder arthroplasty to relieve his symptoms. Any other treatment such as physical therapy will most likely only exacerbate his symptoms."

43. Surety asked Dr. Michael J. Battaglia, an orthopedic surgeon, to conduct a medical records review. After reviewing Claimant's records, including the imaging studies, Dr. Battaglia opined that, while Claimant did have postoperative glenohumeral arthrosis, a total shoulder arthroplasty was not warranted "at this particular time." Dr. Battaglia noted that a total shoulder replacement was "not an unreasonable option." However, when Claimant's psychological profile, addiction issues, and failed prior surgeries were taken into account, Dr. Battaglia did not believe that Claimant's pain would be alleviated by a shoulder replacement. He proposed more conservative care, such as simpler surgeries or steroid injections into the glenohumeral joint.

44. Surety asked both Dr. Dunteman and Dr. Friedman for their opinions of Dr. Battaglia's analysis. Dr. Friedman concurred with Dr. Battaglia's report with one exception: Dr. Friedman did not think Claimant should undergo any surgeries at all. Prior surgical intervention

had failed to help Claimant, and further surgeries could put Claimant at risk for complications, such as infections, or could even worsen Claimant's shoulder condition. The potential risks, according to Dr. Friedman, outweighed the potential benefits. Dr. Dunteman informed Surety that he would try glenohumeral joint injections, but believed any surgical options other than the total replacement would be a "waste of time."

45. On March 9, 2010 — less than two weeks before hearing — Claimant received a therapeutic injection into his glenohumeral joint. The injection failed to relieve Claimant's pain. At deposition, Dr. Tingstad testified that if Claimant failed to obtain relief from such an injection, he was unlikely to obtain relief from shoulder surgery on the glenohumeral joint, and that shoulder replacement surgery was therefore unlikely to give Claimant "any sustained benefits."

46. Claimant testified at hearing that he desired a total shoulder replacement to relieve pain and improve his function. It is evident from Claimant's testimony that he is frustrated by his condition and perhaps depressed by it. In response to a question posed by Mr. Kelso, Claimant testified that he "can't live with it [his shoulder] this way." He stated that his shoulder constantly hurts, that he is unable to move without experiencing pain, and that his daily activities are extremely limited.

DISCUSSION, FURTHER FINDINGS, AND CONCLUSIONS OF LAW

The sole issue before the Commission is whether the proposed shoulder replacement surgery constitutes reasonable medical care. Pursuant to Idaho Code §72-432(1), an employer shall provide an injured employee with reasonable medical treatment as may be required by the employee's physician. 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. *Sprague v. Caldwell Transportation*, 116 Idaho 720, 722-723, 779 P.2d 395, 397-398 (1989). However, the *Sprague* standard anticipates a situation in which treatment has already been rendered. The Court has announced no comparable standard for cases, as here, in which the treatment has been proposed but not yet rendered. In the absence of such an enunciated standard, we will look to *Sprague* for guidance, but judge the case based on the totality of the circumstances.

47. Claimant argues that the shoulder replacement surgery is reasonable because it is required by Dr. Dunteman, and because more conservative treatment has failed to alleviate Claimant's pain. His condition is unlikely to improve without surgical intervention. Defendants argue that Claimant is a poor surgical candidate and that surgery will likely be a "disaster" for Claimant.

48. Since his accidents in 2004, Claimant has been seen by numerous physicians. His condition is quite complex. It is clear that he suffers from osteoarthritis and that his shoulder is in poor condition. What complicates this case is Claimant's history of ultimately ineffective treatments, his psychological condition, and the risk of surgical and post-surgical complications.

Dr. Dunteman

49. Claimant relies primarily on the opinion of Dr. Dunteman in support of his claim. Dr. Dunteman treated Claimant from 2004 to 2006 and resumed treating Claimant in 2009. Dr. Dunteman is board-certified in orthopedic surgery and specializes in knee and shoulder injuries. He performs approximately twenty shoulder replacements each year. Having performed two prior surgeries on Claimant, as well as provided follow-up care, he is the physician most familiar

with Claimant's shoulder condition.

50. Dr. Dunteman testified at deposition that Claimant's shoulder is in "horrible" shape. He also characterized Claimant's range of motion as "horrible." He testified that shoulder replacements have an 85-90% success rate in improving pain and function. He acknowledged, however, that in order for surgery to succeed, the patient has to be compliant. The patient should not smoke, as smoking has a poor effect on the blood and can increase the failure rate to almost 50%. Dr. Dunteman was also clear that a failed shoulder replacement is a "disaster" — that it could leave the patient in even worse pain, or with even more limited function; that the patient could become infected; or that there could be a "major catastrophic event," including a shoulder that is essentially non-functional. Failed surgery could also cause stiffness, weakness, and nerve damage.

51. Despite the risks, Dr. Dunteman believes a total shoulder replacement in Claimant's case would be reasonable because conservative care has failed. He stated that this is the only viable way of treating Claimant, as other methods were unsuccessful. Barring major complications, such as nerve damage or infection, it is unlikely that surgery would make Claimant any worse. Dr. Dunteman opined, on a more probable than not basis, that Claimant would benefit from the surgery, provided that he was a compliant patient, fully participated in the rehabilitation process, and did not smoke.

Dr. Battaglia

52. Defendants rely on the opinion of Dr. Battaglia in opposition to Claimant's claim. Dr. Battaglia is board-certified in orthopedic surgery and subspecialty-certified in orthopedic sports medicine. His practice focuses on shoulder surgery, sports medicine, and general orthopedics. About 5% of his practice involves independent medical evaluations, second

opinions and records review. Dr. Battaglia has never treated Claimant or evaluated him in person. Dr. Battaglia performed a medical records review in this case at the request of Defendants.

53. Dr. Battaglia's report and deposition testimony were at times confusing. He concluded that the "radiographic appearance" of Claimant's shoulder did not warrant a total replacement surgery, and even described Claimant's osteoarthritis as "not significant." However, he also noted that a total replacement would not be "unreasonable," and his recommendations for Claimant's treatment involved a range of treatments, from injections to various forms of surgery. This would indicate that in Dr. Battaglia's opinion, Claimant's shoulder is damaged enough to warrant treatment of some kind.

54. When Dr. Battaglia's report and deposition are considered in their entirety, his opinion appears to be that a total replacement surgery is not unreasonable for patients in similar *physical* condition to Claimant, but that circumstances unique to Claimant would likely prevent the proposed surgery from being successful. Dr. Battaglia highlighted the following areas of concern: 1) Claimant's psychological history, including a suicide attempt; 2) Claimant's history of addiction; and 3) the fact that prior treatments, including two surgeries, were unsuccessful. When asked why Claimant's psychological history is important, Dr. Battaglia explained that a patient's psychological condition can affect his perception of pain. The prior unsuccessful treatments of Claimant's shoulder might indicate that Claimant's pain is primarily psychological in origin. If that is the case, it is unlikely that further surgery would provide the pain relief that Claimant seeks.

55. Dr. Battaglia also appeared to be concerned about Claimant's ability to handle a major surgery. The two prior surgeries, he testified, were relatively minor operations, but the

total shoulder replacement is a "very big" surgery, one Dr. Battaglia likened to an "internal amputation." He believes that such a surgery, in a patient who has not responded well to treatment in the past, would likely do more harm than good. The surgery could result in worse pain and worse function, even without the potential complications that "go along with a surgery of this magnitude." These complications include stiffness, nerve and vessel damage, infection, revision surgery, pulmonary embolism, deep veinous thrombosis, and death from anesthesia.

56. Dr. Battaglia emphasized that Claimant's failure to obtain even temporary relief from the injection he received in March 2010 is indicative that Claimant's glenohumeral joint is not his primary pain generator.

Dr. Tingstad

57. Defendants also rely on the opinion of Dr. Tingstad in support of their argument. Dr. Tingstad is board-certified in orthopedic surgery and orthopedic sports medicine. His practice is focused primarily on shoulder and knee surgery. He conducted an examination of Claimant's shoulder on October 26, 2006, but has not seen Claimant since.

58. When Dr. Tingstad examined Claimant, he found that Claimant had "notable" osteoarthritic or degenerative changes across the shoulder. The shoulder was not centered in the socket, which indicated significant degenerative changes and loss of muscle function. However, Dr. Tingstad did not believe Claimant would benefit from surgery. He was concerned about Claimant's smoking, addiction problems, and psychological condition. At deposition, he explained that smoking "significantly impairs the body's ability to heal, or makes the healing process slower," because it negatively affects the patient's blood supply. He also explained that depression can "significantly affect the ability of the body to recover" from any treatment, either surgical or non-surgical. Pain disorder, too, can significantly decrease the chances that a surgical

procedure would benefit a patient, because the surgery might not address the true source of pain.

59. Dr. Tingstad believes it is important that there be a clear understanding of the pain generators before surgery is undertaken. The fact that Claimant failed to obtain relief from the pre-hearing injection was, to Dr. Tingstad, quite significant. He testified that the failed injection would indicate that Claimant's glenohumeral joint is not the primary pain generator, and that it is therefore unlikely that a shoulder replacement surgery would give Claimant any sustained pain relief or benefits. On the other hand, a failed replacement surgery could leave Claimant with persistent pain, very limited motion, and weakness.

60. The other doctors who have seen or evaluated Claimant did not testify at deposition or hearing, but their records provide some insight as to their opinions of Claimant's condition. Dr. Cleary noted that Claimant's condition was complex and difficult to treat. Dr. Olscamp believed the best way to treat Claimant was through benign neglect. Dr. French proposed a "reconstruction" surgery. Dr. Billington thought all possible etiologies of Claimant's pain should be ruled out before surgery was considered. Dr. Friedman believed Claimant to be medically stable.

61. The picture that ultimately emerges from the evidence in this case is of a Claimant who is unquestionably in pain, with a shoulder in poor condition, but with a history of unsuccessful treatments and psychological difficulties. The question before the Commission is whether the proposed shoulder replacement surgery is reasonable. Under the *Sprague* analysis, treatment is reasonable if 1) the claimant's condition improves, 2) the treatment is required by the claimant's physician, and 3) the physician is qualified to perform the treatment, and the charges are fair and reasonable. As mentioned earlier, *Sprague* concerns treatment that has already been rendered. Nevertheless, the *Sprague* factors are instructive here. Defendants do not

dispute the second and third factors. The focus here, then, is on whether Claimant is likely to improve if the surgery is performed. *See Richan v. Arlo G. Lott Trucking*, IC 2007-027185, ¶¶ 25-26 (filed February 7, 2011).

62. Dr. Dunteman testified that he believes the surgery will likely succeed in improving Claimant's pain, so long as Claimant is a compliant patient. By compliant, Dr. Dunteman means that Claimant should quit smoking and participate in the recovery process, including physical therapy. Dr. Dunteman also believes that Claimant would benefit from post-operative counseling.

63. Dr. Dunteman characterizes Claimant as reasonably compliant after the first two surgeries. Claimant participated in the physical therapy process. However, when he was advised to quit smoking, he did not.

64. Claimant testified that he has quit smoking cigarettes, but that he now smokes cigars. He stated that he "doesn't inhale." Dr. Dunteman testified at deposition that Claimant should not smoke anything, including cigars.

65. Claimant represents that he would be compliant. He argues that he has participated in physical therapy in the past and has been cooperative in various medical, psychological, and vocational evaluations. Evidence in the record tends to support this; Claimant's evaluations and other medical records show that he is generally cooperative. His prior failures to quit smoking are troubling, however. So, too, is his failure to get a complete physical examination on the advice of Dr. Tingstad, and to participate in counseling on the advice of Dr. Dibble.

66. Based on the evidence in the record, we anticipate that Claimant would be somewhat but not totally compliant in the post-surgical rehabilitation process.

67. Dr. Battaglia and Dr. Tingstad testified that Claimant is unlikely to benefit from surgery and that it could, in fact, make him worse. The most compelling support for their opinions is the failure of the March 2010 injection to provide any relief for Claimant's pain. This failure casts doubt on the proposition that Claimant's shoulder is his primary pain generator. The psychological evaluations, which suggest that Claimant has a pain disorder, are troubling, and they lend credibility to the opinions of Dr. Lamb, Dr. Battaglia, and others, who believe that the objective medical evidence does not explain Claimant's extreme pain. Claimant's history of depression is likewise troubling, in light of Dr. Tingstad's testimony that depression significantly affects the body's ability to heal. Perhaps Claimant's depression affected his prior treatments, perhaps not, but the evidence in the record establishes that Claimant has not responded well in the past to either conservative care or to surgery. This calls into question his ability to benefit from major surgery now.

68. Claimant has not presented evidence that would alleviate these concerns. He has submitted no alternative psychological evaluations that challenge the diagnoses of depressive disorder and pain disorder. In the past, he has reacted negatively to suggestions that he seek counseling. In effect, there is no evidence in the record that Claimant's psychological condition has substantially changed since his evaluations by Dr. Beaver and Dr. McClay.

69. While it is clear that Claimant's shoulder is in poor condition, it has not been shown, on a more probable than not basis, that Claimant's condition is likely to benefit from a total shoulder replacement. Claimant's history of not fully complying with post-surgical requirements, his failure to recover or gain even temporary relief from past treatment, and the uncertainty as to the primary source of his pain, all establish that Claimant is not, at present, a good candidate for surgery. The proposed treatment is therefore not reasonable.

70. We note that in the pleadings, the issue to be decided was originally presented as whether Claimant is at maximum medical improvement, or whether he is entitled to additional medical treatment for his right shoulder injury. At hearing, however, the parties requested that the Commission focus on whether the proposed right shoulder replacement constituted reasonable medical care. The briefs of the parties are entirely focused on the issue of whether the right shoulder replacement is reasonable. Therefore, we make no finding as to whether Claimant is medically stable. The narrow holding in this decision is that *at present*, Claimant is not a good candidate for the proposed surgery, and that the treatment is therefore not reasonable.

ORDER

Based on the foregoing analysis, IT IS HEREBY ORDERED That:

1. The proposed right shoulder replacement does not, at present, constitute reasonable medical care.

2. Pursuant to Idaho Code § 72-718, this decision is final and conclusive as to the issue of whether the treatment required by Dr. Dunteman is currently reasonable.

DATED this __25th_____ day of February, 2011.

INDUSTRIAL COMMISSION

_/s/_____
Thomas E. Limbaugh, Chairman

_/s/_____
Thomas P. Baskin, Commissioner

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

ATTEST:

_/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __25th_____ day of February, 2011, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** was served by regular United States Mail upon each of the following:

STARR KELSO
PO BOX 1312
COEUR D'ALENE ID 83816-1312

ALAN K HULL
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BOISE ID 83707-7426

eb/mw __/s/_____