BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

MARIA CASASOLA FLORES	)	
Claimant	)	
V.	)	
	)	
NATIONAL BEEF PACKING CO. LLC	)	AP-00-0492-670
Respondent	)	CS-00-0459-055
AND	)	
	)	
AMERICAN ZURICH INS. CO.	)	
Insurance Carrier	)	

ORDER

The claimant, through Stanley Ausemus, requested review of Administrative Law Judge (ALJ) Larry Gurney's Award dated October 7, 2025. Paige Gilmore appeared for the respondent and its insurance carrier (respondent). The Board heard oral argument on February 12, 2026.

RECORD AND STIPULATIONS

The Board considered the same record as the ALJ, consisting of the: (1) regular hearing transcript, held June 2, 2025; (2) stipulation filed March 12, 2025, regarding admissibility of various medical records and reports, including Drs. Pat Do, Terrence Pratt and Pedro Murati; (3) court-ordered independent medical evaluation reports written by Dr. Terrence Pratt dated August 16, 2022, May 1, 2024, July 12, 2024, and August 30, 2024; (4) parties' briefs; and (5) documents of record filed with the Division.

ISSUES

1. What is the nature and extent of the claimant's disability?

2. Is the claimant entitled to future medical treatment?

FINDINGS OF FACT

The claimant has worked in the respondent's meat processing facility for approximately 23 years. On November 27, 2018, the claimant reported an injury while "trimming clefts" – the removal of unwanted fat and bone gristle. Her job was normally performed by ten employees, but there were only six or seven employees in the position. The claimant testified the staffing deficit caused her to perform more repetitive work which brought about her complaints.

The claimant's initial treatment consisted of physical therapy consisting of alternating ice and heat on her right shoulder and wax on her hands. Thereafter, she was referred to Dr. Guillermo Garcia-Ordenes, whose records are not in evidence, but Dr. Terrence Pratt's report, dated August 16, 2022, noted a right shoulder injection was ineffective and Dr. Garcia-Ordenes performed right shoulder surgery in 2019, consisting of debridement of the superior labral tear, anterior to posterior lesion. The claimant testified the surgery did not help and she began having a lot of pain in her right index finger and swelling below her thumb and adjacent to her index finger. She also started having problems in her left shoulder from overcompensating for her right upper extremity.

On November 13, 2019, the claimant began treating with Pat Do, M.D. Dr. Do diagnosed the claimant with right shoulder pain, status-post right shoulder rotator cuff repair, and possible carpal tunnel syndrome/cubital tunnel syndrome. The doctor ordered an MRI of the right shoulder and EMG/NCS of the bilateral upper extremities. Dr. Do continued the prior work restrictions imposed by Dr. Garcia-Ordenes.

On July 19, 2021, the claimant filed an Application for Benefits. She asserted a November 27, 2018, repetitive injury to her neck, shoulders, arms and hands.

The claimant's next visit with Dr. Do was August 5, 2021. Dr. Do noted the MRI showed mild rotator cuff tendinopathy with no high grade or full-thickness tear, a suspected biceps tear with mild retraction into the proximal arm, and a small shoulder effusion. The bilateral EMG/NCS, dated December 9, 2019, was normal. Dr. Do stated the claimant will be at maximum medical improvement today for the right shoulder because the MRI did not show any recurrent rotator cuff tear. The doctor recommended physical therapy for the right wrist and possible right carpal tunnel diagnostic/therapeutic injection in four weeks. On October 7, 2021, the claimant was administered a right carpal tunnel injection. Dr. Do performed a right carpal tunnel release on November 22, 2021.

On April 14, 2022, the claimant returned to Dr. Do's office and was seen by Tamara Harper, APRN, NP-C. The claimant stated her symptoms worsened since the last visit. Ms. Harper prescribed Amitriptyline and Naproxen, placed the claimant at MMI, and indicated the claimant could return to work without restrictions.

On May 4, 2022, Dr. Do performed an evaluation at the respondent's request for the claimant's neck, shoulders, arms and hands. The doctor noted the claimant's left hand began hurting recently, she had on and off neck pain, and she had no complaints of any left shoulder problems. Dr. Do opined her work was the prevailing factor for the right shoulder and right wrist carpal tunnel syndrome and stated:

> Within a reasonable degree of medical probability with prevailing factor being the primary factor in relationship to any other factor, any kind of neck pain could be just the muscles going into spasm to help protect [the] injured right shoulder. This is not a separate neck injury Today, she has no complaints of left shoulder problems. Regarding her left hand, this is only more recently subjectively causing some triggering, but there is no triggering today.
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> Any kind of neck complaints and left hand complaints is not causally related to any kind of November 27, 2018 work injury.[1]

Dr. Do imposed permanent work restrictions of no use of a hook or knife with the right hand, no lifting greater than 15 pounds, and no overhead use of the right shoulder. He opined no future medical treatment was anticipated for the claimant. Dr. Do stated:

> Utilizing a reasonable degree of medical probability and the AMA Guides to the Evaluation of Permanent Impairment Sixth Edition, along with my training, education, and experience, her rating for her right shoulder rotator cuff repair and her right carpal tunnel release is as follows. Using table 15-34 page 475 there is 3% upper extremity impairment for the lack of shoulder flexion, 2% upper extremity impairment for the lack of shoulder internal rotation, 3% upper extremity impairment for the lack of shoulder abduction, 1% upper extremity impairment for the lack of shoulder adduction, and 1% upper extremity impairment for the lack of shoulder extension. Using the combined values chart on page 604 there is 10% upper extremity impairment. Using table 15-23 page 449 the testing is classified as grade modifier 1, the history is classified as grade modifier 1, and the physical examination is classified as grade modifier 1. The average of the three grade modifiers is 1. Using table 15-23 page 449 and the grade modifier of 1 there is 2% upper extremity impairment. Using the combined values chart on page 604 there is 12% upper extremity impairment.[2]

The claimant testified Dr. Do wanted to perform a second right shoulder surgery, but she declined because Dr. Do only told her the surgery "could or could not help."[3] The medical records in evidence do not confirm an offer of additional surgery.

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[1] Stipulation (filed Mar. 12, 2025) at 18-19.

[2] Stipulation (filed Mar. 12, 2025) at 19.

[3] R.H. Trans. at 14.

On June 14, 2022, Pedro Murati, M.D., performed an evaluation at the claimant's attorney's request. The claimant complained of right shoulder pain, right shoulder blade pain, right hand and elbow pain, limited range of motion of the right shoulder, left shoulder soreness, bilateral hands swelling with numbness and tingling, bilateral finger pain, and neck pain on the right with limited range of motion. Dr. Murati diagnosed the claimant with status post right carpal tunnel release; status post right shoulder surgery; left carpal tunnel syndrome; tenosynovitis of the right 1st, 2nd, 3rd, 4th and 5th digits and of the left 1st, 3rd and 4th digits; right lateral epicondylitis; myofascial pain syndrome of the bilateral shoulder girdles extending into the cervical and thoracic paraspinals; and right occipital neuralgia. The doctor opined his diagnoses were within all reasonable medical probability a direct result from the work-related injury on November 27, 2018. Dr. Murati recommended additional medical treatment and additional work restrictions.

On August 16, 2022, the claimant saw Terrence Pratt, M.D., for an independent medical examination pursuant to an Agreed Order issued by the prior ALJ, Pamela Fuller. The claimant's chief complaints were cervical, right elbow and right exceeding left-hand discomfort. She reported her symptoms started with the right shoulder and right hand. Soon after, she developed symptoms in her left upper extremity. Dr. Pratt diagnosed the claimant with a history of debridement of the right superior labral tear anterior to posterior in 2019, possible right biceps tear, left shoulder syndrome, bilateral hand discomfort with reported right carpal tunnel release procedure and diminished motor amplitudes for the left median nerve, cervicothoracic syndrome, and right elbow discomfort. Dr. Pratt opined the prevailing factor for all of the claimant's conditions, with the exception of the neck, was the claimant's repetitive work activities. Dr. Pratt noted the claimant did not complain of neck involvement until 2021, and he could not relate such complaints to her work activities in November 2018. The doctor recommended MRIs of both shoulders and EMG/NCS of the bilateral upper extremities. The doctor also added a work restriction of no overhead work.

On May 1, 2024, Dr. Pratt authored an addendum report after receiving the MRI results. Dr. Pratt indicated the claimant's left shoulder study was unremarkable, while the right shoulder MRI showed an intact labrum, intact rotator cuff/proximal long head biceps tendon and mild acromioclavicular changes. The doctor opined the claimant did not need additional treatment for either shoulder because there was no significant evidence of internal derangement. Dr. Pratt reiterated his previous recommendation of an EMG of the claimant's bilateral upper extremities. He also repeated his opinion there was no evidence of cervical involvement from a prevailing factor standpoint.

On July 12, 2024, Dr. Pratt authored an additional addendum report after reviewing the nerve conduction studies. The doctor noted the claimant's nerve conduction studies were normal and stated, "I could not state to a reasonable degree of medical certainty that

there are additional treatment options in relationship to [the claimant's] reported vocationally related activities."[4]

On August 30, 2024, Dr. Pratt authored a final addendum report on the claimant's impairment and permanent work restrictions. Using the *Guides*, 6th edition, as a starting point, the doctor stated:

> There were some limitations on the examination with findings which were not a consistent indication of her functional abilities including variations in range of motion. For the upper extremities with areas of involvement which are related to the injury: Starting with the elbow involvement, I considered table 15-4, page 3/99; she would be considered to have a class I abnormality with a midlevel of 1. For the functional history, table 15-7, page 406, I would consider it as a grade modifier 2. For the physical examination, table 15-8, page 408, a grade modifier 1. I did not consider clinical studies. The net adjustment formula is 1-1+1-1 or 0. Permanency remains at 1% of the extremity. For the left shoulder involvement without specific findings, table 15-5, page 401, a class I abnormality with a midlevel of 1. Utilizing the same tables that were utilized for the elbow, functional history would be a grade modifier 2 and physical examination a grade modifier 1. Clinical studies, table 15-9, page 410, a grade modifier 0. Net adjustment formula, 1-1+2-1+1-1+0-1 is 0. Permanency remains 1% of the extremity. For the right shoulder, I considered table 15-5, page 404, with labral involvement with a class I abnormality and midlevel of 3. Utilizing the same tables that were utilized for the left shoulder, functional history a grade modifier 2, physical examination a grade modifier 1 and clinical studies a grade modifier 2. Net adjustment formula, 2-1+1-1+2-1 is 2. Permanency changes to grade E and 5% of the extremity. For the history of peripheral nerve entrapment on the right with a carpal tunnel release, I considered table 15-23, page 449. Test findings are a grade modifier 0, history is a grade modifier 3 and physical findings a grade modifier 2. The total is 5, 5 divided by 3 would result in a grade modifier 2 with a mid-level of 5. The functional scale is 2 as well and permanency would not change. She has 5% permanency of the extremity for the peripheral nerve entrapment.
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> Combining the permanency, 5% for the right shoulder with 5% for the right wrist and 1% for the elbow results in 11% of the extremity or 7% of the whole person. For the left upper extremity, 1% for the extremity at the shoulder is 1% of the whole person. She has a total of 7 and 1% of the extremity combining for 8% of the whole person.
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> I would utilize the Fourth Edition of the Guides as competent medical evidence and could not modify the assessment for the left shoulder 1% extremity, 1% of the whole person. I also could not modify the assessment for the right elbow 1% extremity. For the right wrist involvement with a carpal tunnel release procedure and residual symptoms with no significant electrodiagnostic evidence of residual symptoms, I considered table 12, page 349 and table 15, page 3/54, also table 16, page 3/57.

[4] Stipulation (filed Mar. 12, 2025) at 28.

> The findings would be less than 10%, and I would consider it as 7% of the extremity. The right shoulder involvement with a procedure and residual symptoms, I would consider after considering table 18, page 3/58, her to have 10% impairment of the extremity. The degenerative type changes on imaging would not relate to the event. For the right upper extremity, the total would change after combining 10, 7 and 1% with the Combined Value Chart to 17% of the extremity which is equivalent to 10% of the whole person. Combining 10% right upper extremity with 1% for the left upper extremity results in a grand total of 11% permanent partial impairment of the whole person.
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> To a reasonable degree of medical certainty in relationship to the alleged injury on November 27, 2018, she has 11% permanent partial impairment of the whole person.[5]

Dr. Pratt imposed permanent restrictions to avoid overhead activities and no lifting in excess of 15 to 20 pounds or pushing-pulling in excess of 30 to 40 pounds.

On October 9, 2024, the claimant returned to Dr. Murati for an evaluation at her attorney's request. The claimant complained of bilateral shoulder pain, bilateral hand swelling with numbness and tingling, neck pain on the right with limited range of motion and difficulty sleeping. The only additional diagnoses from his earlier report were right wrist sprain and bilateral rotator cuff tear versus strain with probable labral involvement on the right. Dr. Murati opined, beyond reasonable medical certainty, the claimant will require at least yearly follow-ups on her bilateral upper extremities, right occipital neuralgia and myofascial pain syndrome, including physical therapy, injections, radiological studies, anti-inflammatory and pain medications and need for surgical intervention. The doctor stated the claimant "needs a diagnostic arthroscopy of both shoulders."[6]

Using the *Guides*, 6th edition, as a starting point, Dr. Murati stated:

> It deviates from it when assessing all of the damaged anatomical structures which have been injured and assessed separately using 6th edition tables. The reasoning behind this is that multiple injuries to a regional area result in higher percentage of disability and impairment than just a single injury. This is based off of my medical experience, education, and expertise. Also, failure to find any peer reviewed literature that states that multiple injuries to a single regional area result in similar outcomes as a single type of injury would produce. This is also based on the extent of interference of activities of daily living as evident in the ADL document filled out by the examinee and consistent with the expected loss of ability known to be caused by the injuries suffered which will result in this examinee being unable to perform her job. And finally, my own experience in treating similar types of patients in my

[5] Pratt Report (filed Sep. 25, 2024) at 1-2.

[6] Stipulation (filed Mar. 12, 2025) at 55.

chronic pain clinic. This clinic will no longer be utilizing table 15-23 and its associated section to rate entrapped upper limb nerves. The reasons are as follows: first this section relies on NCS/EMG findings which are directly reliant on local electrodiagnosticians. Most of these are not Board Certified by the American Association of Neuromuscular & Electrodiagnostic Medicine. Even if they were, there is approximately 10% of studies that are false negatives. This means that fully 10% of cases will be mis-impaired. Second, there are no known peer reviewed medical treatises that explain that the location of the injury to a nerve fiber has an effect in the end pathology. The only thing that matters is which particular nerve fibers are involved, not the exact location of the injury. Third, there are no known peer reviewed medical treatises that show that if a second entrapped nerve is found in the upper limb, then the impairment is reduced by half. Having one injured nerve does not make the second healthier. It is the experience of this examiner that this relationship is at least additive if not multiplicative. Certainly no subtractive. And lastly, the maximum rating for any entrapped nerve in this table is 9% upper extremity. This number is a clear deviation from all the preceding editions of the guides. This examiner has direct knowledge in his experience that a severe entrapment of the Median or Ulnar nerve will lead to a nonfunctional hand. There are no known peer reviewed medical treatises that show that severe entrapment do not lead to minor functional loss. For the tenosynovitis of the right 1st digit, using table 15-2, this examinee is placed in Class 1 for 6% digit impairment, which converts to 2% right hand impairment. For the tenosynovitis of the right 2nd digit, using table 15-2, this examinee is placed in Class 1 for 6% digit impairment, which converts to 1% right hand impairment. For the tenosynovitis of the right 3rd digit, using table 15-2, this examinee is placed in Class 1 for 6% digit impairment, which converts to 1% right hand impairment. For the tenosynovitis of the right 4th digit, using table 15-2, this examinee is placed in Class 1 for 6% digit impairment, which converts to 1% right hand impairment. For the tenosynovitis fo the right 5th digit, using table 15-2, this examinee is placed in Class 1 for 6% digit impairment, which converts to 1% right hand impairment. These hand impairments add for a total of 6% right hand impairment, which converts to 5% right upper extremity. For the right carpal tunnel syndrome s/p release, using table 15-21, this examinee is placed in Class 2 for 14% right upper extremity impairment. For the right wrist sprain, using table 15-3, this examinee is placed in class 1 for 2% right upper extremity impairment. For the right lateral epicondylitis, using table 15-4, this examinee is placed in Class 1 for 1% right upper extremity impairment. For the loss of range of motion of the right shoulder, using table 15-34, this examinee receives 10% right upper extremity impairment. With a functional modifier, using tables 15-7, 15-35, and 15-36, this impairment does not increase and remains at 10% right upper extremity impairment. For the right labrum involvement, using table 15-5, this examinee is placed in Class 1 for 3% right upper extremity. For the right AC joint injury, using table 15-5, this examinee is placed in Class 1 for 3% right upper extremity. The right upper extremity impairments combine for 33% right upper extremity which converts to 20% whole person impairment. For the tenosynovitis of the left 1st digit, using table 15-2, this examinee is placed in Class 1 for 6% digit impairment, which converts to 2% left hand impairment. For the tenosynovitis of the left 2nd digit, using table 15-2, this examinee is placed in Class 1 for 6% digit

> impairment, which converts to 1% left hand impairment. For the tenosynovitis of the left 3rd digit, using table 15-2, this examinee is placed in Class 1 for 6% digit impairment, which converts to 1% left hand impairment. For the tenosynovitis of the left 4th digit, using table 15-2, this examinee is placed in Class 1 for 6% digit impairment, which converts to 1% left hand impairment. These hand impairments add for a total of 6% left hand impairment, which converts to 5% left upper extremity. For the left carpal tunnel syndrome, using table 15-21, this examinee is placed in Class 2 for 14% left upper extremity impairment. For the loss of range of motion of the left shoulder, using table 15-34, this examinee receives 6% left upper extremity impairment. With a functional modifier, using tables 15-7, 15-35, and 15-36, this impairment does not increase and remains at 6% left upper extremity impairment. For the left AC joint injury, using table 15-5, this examinee is placed in Class 1 for 3% left upper extremity. These combine for a 25% left upper extremity which converts to 15% whole person impairment. For the myofascial pain syndrome affecting the cervical paraspinals using table 17-2, this examinee is placed in Class 1 for 2% whole person impairment. For the myofascial pain syndrome affecting the thoracic paraspinals, using table 17-3, this examinee is placed in Class 1 for 2% whole person impairment. For the occipital neuralgia, using table 13-20, this examinee is placed in Class 2 for 2% whole person impairment. These combine for a 35% whole person impairment.[7]

The claimant continues to work for the respondent. She testified about pain and discomfort affecting her upper extremities, right hand and neck. She has increased pain in her neck with movement towards her right side. She has to use her left hand and arm more because of her work injuries. She rates her pain as a 6 on a 1-10 pain scale. The claimant testified she is unable to sleep on either side because of pain and has difficulty driving a vehicle and performing household chores. She believes the problems affecting her bilateral shoulders and bilateral upper extremities are getting worse.

The ALJ did not adopt Dr. Do's rating because it was more than three years old and concluded the evidentiary record did not support the 35% whole person rating provided by Dr. Murati, which the ALJ called "excessive."[8] The ALJ found the claimant sustained 11% whole person impairment based upon Dr. Pratt's rating opinion, stating: "This rating seems to be the most reasonable assessment available to the Court for the conditions about which Claimant testified and for which she was treated. Dr. Pratt was also a neutral physician, not hired by either party, and was someone that the parties agreed to for a Court-ordered evaluation."[9] The ALJ further found the claimant failed to prove entitlement to an award of future medical and failed to overcome the presumptions and statutory provisions.

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[7] Stipulation (filed Mar. 12, 2025) at 55-57.

[8] ALJ Award at 7.

[9] *Id*.

PRINCIPLES OF LAW AND ANALYSIS

The claimant argues she is entitled to 35% whole person impairment and future medical treatment based on Dr. Murati's opinion. The claimant asserts Dr. Murati's opinion is more credible because he considered all of her injuries. The respondent argues the claimant is entitled to 12% to the right upper extremity based on Dr. Do's opinion as the treating physician. In the alternative, the respondent requests the Board adopt the 6th edition rating provided by Dr. Pratt, the court's neutral examiner. The respondent further requests the Board uphold the Award on the issue of future medical treatment.

An employer is liable to pay compensation, including medical treatment, to an employee incurring personal injury by accident or repetitive trauma arising out of and in the course of employment.[10] The burden of proof is on the claimant.[11]

Board review of an order is de novo on the record.[12] A de novo hearing is a decision of the matter anew, giving no deference to findings and conclusions previously made by the judge.[13] On de novo review, the Board makes its own factual findings.[14]

1. The claimant sustained 11% functional impairment to the body as a whole as a result of her repetitive work injuries.

K.S.A. 44-508 states, in part:

> (e) "Repetitive trauma" refers to cases where an injury occurs as a result of repetitive use, cumulative traumas or microtraumas. The repetitive nature of the injury must be demonstrated by diagnostic or clinical tests. The repetitive trauma must be the prevailing factor in causing the injury. "Repetitive trauma" shall in no case be construed to include occupational disease, as defined in K.S.A. 44-5a01, and amendments thereto.
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> . . .
>
> (g) "Prevailing" as it relates to the term "factor" means the primary factor, in relation to any other factor. In determining what constitutes the "prevailing factor"

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[10] See K.S.A. 44-501b(b).

[11] See K.S.A. 44-501b(c).

[12] See *Helms v. Pendergast*, 21 Kan. App. 2d 303, 899 P.2d 501 (1995).

[13] See *In re Tax Appeal of Colorado Interstate Gas Co.*, 270 Kan. 303, 14 P.3d 1099 (2000).

[14] See *Berberich v. U.S.D. 609 S.E. Ks. Reg'l Educ. Ctr.*, No. 97,463, 2007 WL 3341766 (Kansas Court of Appeals unpublished opinion filed Nov. 9, 2007).

> in a given case, the administrative law judge shall consider all relevant evidence submitted by the parties.

As an initial matter, two of three physicians, including the court-ordered physician, Dr. Pratt, and the treating physician, Dr. Do, found the claimant's work activities were not the prevailing factor for her cervical spine or neck complaints. While this could be characterized as a wholly-separate issue, the prevailing factor requirement limits what is compensable, and in this case, what is rateable. Only Dr. Murati assigned neck or mid back impairment. The Board finds the claimant did not prove the prevailing factor requirement for her neck complaints or symptoms. The Board also finds the claimant did not prove a thoracic spine or mid back injury or any associated impairment.

Having considered the record as a whole, the Board finds the opinions of Dr. Pratt more credible than the ratings from Dr. Murati and Dr. Do. Dr. Pratt reviewed all of the claimant's treatment records and performed an extensive evaluation of the claimant. Dr. Pratt noted the claimant's symptoms and clinical findings were inconsistent and the claimant displayed signs of symptom magnification. Dr. Pratt was appointed by the court to serve as a neutral physician, while Dr. Murati was hired by the claimant. The Board historically gives some deference to the opinions of treating and neutral physicians, but it is not required to do so.[15] Dr. Pratt's opinions are particularly credible because he was the court-ordered neutral evaluating physician by agreement of the parties.

Under these circumstances, the Board finds Dr. Pratt's determination of the claimant's functional impairment of 11% more accurately represents the claimant's resulting impairment. Accordingly, the award of permanent partial general disability compensation is affirmed.

2. The claimant is entitled to an award of future medical treatment.

K.S.A. 44-510h(e) states:

> It is presumed that the employer's obligation to provide [medical benefits] shall terminate upon the employee reaching maximum medical improvement. Such presumption may be overcome with medical evidence that it is more probably true than not that additional medical treatment will be necessary after such time as the employee reaches maximum medical improvement. As used in this subsection, "medical treatment" means only that treatment provided or prescribed by a licensed healthcare provider and shall not include home exercise programs or over-the-counter medications.

Dr. Pratt's commentary he could not state to a reasonable degree of medical certainty additional medical treatment options are available to the claimant uses the wrong

[15] See *Nasi v. Jimmy's Egg*, No. 1,067,478, 2018 WL 1176258 (Kan. WCAB Feb. 21, 2018).

standard or burden of proof. The claimant need not prove she requires additional medical treatment based on medical certainty. The claimant need only prove she requires medical treatment after reaching maximum medical improvement based on a preponderance of the evidence, i.e., that it is more probably true than not. Dr. Pratt basically said he could not give an opinion. Dr. Do's statement no future medical was anticipated is questionable, at least given the claimant's contention he suggested additional right shoulder surgery.

Dr. Murati provided many medical treatment recommendations. Based on his report, the claimant proved on a more probable than not basis she will require additional medical treatment after having reached maximum medical improvement. The claimant is awarded the right to pursue additional medical treatment.

AWARD

WHEREFORE, the Board modifies the Award. The ALJ's decision on the claimant's permanent impairment of function is affirmed. The ALJ's denial of future medical is reversed. The claimant may pursue additional medical treatment.

IT IS SO ORDERED.

Dated this _____ day of March, 2026.

_____
BOARD MEMBER

_____
BOARD MEMBER

_____
BOARD MEMBER

c: (via OSCAR)
Stanley Ausemus
D. Shane Bangerter
Paige Gilmore
Hon. Larry Gurney