BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

WILLIAM MCCLAIN, Claimant, v. VALLEY READY MIX, INC., Employer, and STATE INSURANCE FUND, Surety, Defendants.	**IC 2007-028342** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** **FILED** **DECEMBER 1, 2017**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Alan Taylor, who conducted a hearing in Idaho Falls on October 18, 2016. Claimant, William McClain,[1] was present in person and represented by Andrew A. Adams, of Idaho Falls. Defendant Employer, Valley Ready Mix, Inc. (Ready Mix), and Defendant Surety, State Insurance Fund, were represented by Weston S. Davis and Scott `R. Hall, of Idaho Falls. The parties presented oral and documentary evidence. Post-hearing depositions were taken and briefs were later submitted. The matter came under advisement on April 4, 2017.

ISSUES

The issues to be decided are:

1. Whether, and to what extent, Claimant is entitled to additional medical care received prior to July 15, 2016.

[1] Claimant is also known by the nickname of "Rocky" and is so referenced by his providers in a number of medical records.

2. Whether the medical care for which Claimant seeks benefits was due to the industrial accident.

3. Application of Neel v. Western Construction, Inc., 147 Idaho 146, 206 P. 3d 852 (2009).

CONTENTIONS OF THE PARTIES

All parties agree that Claimant was injured at work on August 10, 2007, when he fell from the top of a cement truck. The parties have settled the indemnity issues and many questions of medical benefits. Claimant presently asserts entitlement to additional medical benefits incurred between January 2009 and July 15, 2016, totaling approximately $1,000,000.00. He seeks full invoiced amounts pursuant to Neel. Defendants contend that Claimant had extensive pre-existing medical conditions, including asthma, diabetes, COPD, hypertension, depression, Agent Orange exposure, and chest injury from a prior motor vehicle accident, and that Claimant sustained injury from several allegedly unrelated post-accident falls. Defendants assert that all medical bills causally related to Claimant's 2007 work accident have been paid and the bills for which Claimant now seeks payment are not related to his industrial accident, thus Neel is inapplicable.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The Industrial Commission legal file.

2. Joint Exhibits 1 through 136, admitted at the hearing.

3. The post-hearing deposition testimony of Michael T. Harris, M.D., taken by Claimant on December 2, 2016.

4. The post-hearing deposition testimony of Anthony Joseph, M.D., taken by Defendants on December 14, 2016.

5. The post-hearing deposition testimony of Nancy Greenwald, M.D., taken by Defendants on January 11, 2017.

All pending objections are overruled and motions to strike are denied.

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

FINDINGS OF FACT

1. Claimant was born in 1951. He is right-handed. He was 65 years old and lived in Idaho Falls at the time of the hearing. Ready Mix is an employer selling and delivering concrete and related products in the Idaho Falls area.

2. **Background.** Claimant graduated from high school and worked at a variety of jobs thereafter, including truck driving jobs.

3. **Prior medical history**. Claimant was exposed to Agent Orange while serving in the military in Viet Nam. From approximately 1967 until 1987, Claimant smoked a pack of cigarettes per day. He then quit smoking. In 1998, Claimant sprained his wrist and in 2000 he sustained an elbow injury and a knee injury. These injuries resolved. In approximately 2001, Claimant was diagnosed with Type 2 diabetes mellitus. Claimant was diagnosed with migraine headaches and pneumonia prior to November 21, 2001. Exhibit 7, p. 3611. In approximately 2004, Claimant was diagnosed with bronchial COPD. Exhibit 3, p. 17. In 2006, he was involved in a dump truck accident in which he hit his chest on the steering wheel. He reported no permanent injury. In March 2007, Claimant began working for Ready Mix driving a concrete mixer truck.

4. In addition to COPD and diabetes, Claimant suffered from asthma and hypertension prior to August 2007.

5. Claimant's wife worked at a day-care from approximately 2006 through 2014 and Claimant was thereby regularly exposed to and became ill with a number of respiratory infections.

6. **Industrial accident and covered medical treatment.** On August 10, 2007, Claimant was working at Ready Mix cleaning his assigned concrete mixer. He climbed on top of the truck flue to break up and remove dried concrete. He has no memory of falling, but he awoke lying on his right side on the ground in a puddle of water amid concrete rubble, his right arm underneath him, and the right side of his head covered with blood. He had been unconscious for approximately 45 minutes.[2] Claimant got up with difficulty, found his glasses broken, and walked into the nearby office. His supervisor drove him to the emergency room. Claimant remembered little of that day, and had no recall of how he got to the hospital.

7. At the hospital emergency room Claimant was attended by Matt Griggs, M.D., and Lindsey Pruyn, P.A.-C., who noted Claimant was very confused and did not remember the accident or how he came to the hospital. The right side of Claimant's head was extremely painful. He had a headache, bloody nose, gash in his forehead, neck pain, right shoulder pain, right side chest pain, and his right eye was swollen shut. His right shoulder and side were bruised and his entire right side was extremely painful. He could hardly move his right arm. His initial exam revealed: "Right pupil 5 mm, round and sluggishly reactive. Left pupil: 3mm, round and briskly reactive. The patient had loss of consciousness of uncertain duration. Patient

[2] Claimant testified that a full water tank on his cement mixer provides enough water for 45 minutes of cleaning. He had filled up the water tank earlier and just commenced cleaning and spraying when he fell. When he awoke the water tank was entirely drained. Therefore Claimant estimated he was unconscious for at least 45 minutes.

was amnesic." Exhibit 3, p. 16J.001. Claimant underwent CT scans of his head, brain, cervical spine, thoracic spine, lumbar spine, chest, pelvis, and maxi-facial region. All CT scans were negative for acute fractures and/or acute disease. Exhibit 3, pp. 16a-16I. Claimant's cervical CT scan showed severe arthritic changes at C3-4, C4-5, C5-6, C6-7, and C7-T1. Claimant's lacerated forehead was sutured, a rock was removed from his right upper lip, he was given a prescription for pain control, and was discharged that same day. He does not recall how long he was at the hospital, what tests were performed, or any conversation with any doctor that day. Claimant's right eye remained swollen shut for a week and a half. He was nauseated for approximately a month after the fall and took anti-nausea medication.

8. On August 14, 2007, Claimant saw family physician Michael Harris, M.D., who diagnosed right chest wall contusion and right shoulder strain. Claimant reported various pains persisting since the accident including sharp neck pain, right shoulder pain with movement, and stabbing right chest wall pain when he breathed. On August 17, 2007, Claimant reported to Dr. Harris that he had stopped "at Albertsons for a cup of soup—walked in—couldn't figure out what [he] was doing, how to get the soup, wandered around x 5-10 min." Exhibit 4, p. 3357. Claimant then had a "hard time" determining how to pay for the soup. Prior to the accident he purchased soup every week. Dr. Harris referred Claimant to Casey Huntsman, M.D., for evaluation of his right shoulder pain.

9. On August 27, 2007, Claimant presented to Dr. Huntsman who examined his right shoulder. Diagnostic imaging revealed a partial tear of the distal subscapularis tendon, medial subluxation of the biceps tendon, and a SLAP lesion.

10. On September 7, 2007, Dr. Huntsman performed arthroscopic repair of Claimant's right shoulder SLAP lesion. On recovery from arthroscopy, Claimant had extended

hypoxia prompting consultation with Brady Cook, M.D. Post-operative chest x-ray revealed elevated right hemidiaphragm but no pneumothorax and was otherwise negative. Exhibit 6, pp. 3468-3469. No rib fractures were identified. Dr. Cook recorded that since Claimant's fall, he had complained of right lower chest pain with deep breaths or coughs. Dr. Cook noted: "He …. complains of no pain with deep breathing. A chest x-ray was done, which is portable in nature, and showed an elevation in his right hemidiaphragm, which is fairly significant and after discussion with anesthesia, is consistent with the nerve block which was used for anesthetic." Exhibit 6, p. 3462. Dr. Cook considered Claimant's abdominal pain complaints with deep breathing since his August 10, 2007 fall and noted that Claimant "may have had a fracture or even a pulled muscle there. Again, I reviewed the scans from his presentation to the emergency room, and they were negative at that time, and I do not feel that is an acute issue now." Exhibit 6, p. 3463.

11. On September 25, 2007, Claimant participated in physical therapy and his therapist recorded: "Pt is still having problems with vertigo and balance with memory loss. Pt related that he bent over to pick something up and stood up and passed out on the lawn." Exhibit 5, p. 3449.

12. On October 29, 2007, Claimant presented to Dr. Huntsman reporting his right shoulder was doing better post-surgery until four days earlier when he "was stretching at home and felt like something popped or tore. The next day he could not move the arm and it was swollen." Dr. Huntsman did not see any evidence of cervical problem and noted: "Everything that I see looks like it is coming directly from his shoulder." Exhibit 7, pp. 3624-3625. Subsequent right shoulder MRI revealed a recurrent SLAP lesion. A December 10, 2007 cervical MRI showed multilevel degenerative spondylosis through the cervical spine.

13. On December 14, 2007, Scott Taylor, M.D., reported that Claimant "incurred an injury after a fall from a truck which required a pain block. Following this, he was found to have a paralyzed right hemidiaphragm. This paralyzation of his right hemidiaphragm and injury may have increased his hypoxia and may have added to or possibly caused obstructive sleep apnea." Exhibit 9, p. 3736.

14. On December 21, 2007, Dr. Huntsman performed arthroscopic repair of Claimant's right shoulder recurrent SLAP lesion and also a right ring finger trigger finger release. Recovery from surgery was uneventful. Claimant later asserted the shoulder surgery solved only part of his right shoulder range of motion and pain problems.

15. On January 16, 2008, Claimant was seen by Dr. Huntsman's assistant, Joel Whiting, P.A.-C., who recorded Claimant was doing well with no sign of infection, no finger triggering, and "fairly normal range of motion" in his right shoulder but "he has also had some headache and neck trouble since his injury this last summer and was hoping to be referred to a neurologist." Exhibit 9, p. 3737. Claimant was referred to neurologist Stephen Vincent, M.D., for evaluation.

16. On February 5, 2008, Claimant presented to Dr. Vincent describing excruciating daily headaches since the accident, accompanied by intermittent diminished vision in his right eye and nausea, but rarely vomiting. Claimant apparently reported to Dr. Vincent that due to the accident "He had fractured ribs and a collapsed lung." Exhibit 15, p. 3892. Claimant did not report any neck injury or complaints. Dr. Vincent prescribed Topamax and also recorded Claimant's reports of reduced cognition in that he "forgot how to play the guitar. He takes his wife to work and has trouble remembering how to go about picking her up. He states he cannot find things in a store (that he knows well)." Exhibit 15, p. 3892. Dr. Vincent believed that if

Claimant had developed central sleep apnea since the fall, this would also substantiate a traumatic brain injury. Dr. Vincent ultimately diagnosed Claimant with traumatic brain injury and posttraumatic headaches.

17. On February 25, 2008, Claimant presented at the hospital emergency room and was reported to have "acted drunk like, dizzy—falling—broke lamp—incoherent—head hurting—went to ER. Did CT-Chest x-ray. Pneumonia." Exhibit 15, p. 3895. No rib fractures were identified and no neck pain was reported. Claimant was scheduled for a psychological evaluation. Clinical psychologist Kenneth Lindsey, Ph.D., evaluated Claimant on February 25, March 31, April 9, 11, and 29, May 8, and June 2, 2008.

18. On March 25, 2008, Claimant presented to the hospital emergency room for dizziness and moderate confusion. Chest x-ray showed small infiltrate in the left lung, consistent with pneumonia, but no fractures. Exhibit 3, p. 16J.007. Chest x-rays also showed "some minimal bibasilar atelectasis." Exhibit 3, p. 16J.011. Edwin Wells, M.D., assessed dizziness, concussion, and mild pneumonia. No chest pain was reported.

19. On April 28, 2008, Claimant presented at Channing Physical Therapy reporting he had "issues over the weekend … and felt like someone put a corset on him and crushed down his chest." Exhibit 13, p. 3836. The therapist expressed concern about a possible heart problem and directed Claimant to see his personal physician immediately. Claimant missed his next physical therapy appointment but called later reporting he had a heart attack and stint placement. Claimant does not assert his heart attack was related to his 2007 accident.

20. On May 8, 2008, Dr. Huntsman examined Claimant and noted some right shoulder stiffness but 5-/5 strength to abduction, internal and external rotation and negative impingement sign. He recorded: "I am pleased with how the patient is doing. He has not been

doing his exercises much because of his heart attack." Exhibit 7, p. 3637. Claimant did not show for his final scheduled appointment and never returned to Dr. Huntsman.

21. On June 2, 2008, Dr. Lindsey completed his psychological evaluation of Claimant and diagnosed cognitive disorder and depression. Describing the injuries from the 2007 accident, Dr. Lindsey recorded that Claimant: "states that he suffered a right frontal traumatic brain injury, 'blew out' his right shoulder, broke several ribs, and suffered a collapsed right lung." Exhibit 16, p. 3910. Claimant did not assert any neck injury. Dr. Lindsay found Claimant showed slowed processing speed, difficulty with attention and concentration manifesting in "complaints of memory problems, problems with route finding, and difficulties in recalling and implementing work routines, as well as his disorientation in busy noisy situations." Exhibit 16, p. 3913. Dr. Lindsey recorded Claimant's complaints of post-concussive headaches and recurrent dizziness.

22. On June 12, 2008, Claimant presented at EIRMC complaining of a cough. Chest x-rays were essentially unremarkable except for very slight lung densities that "might raise the possibility of a very early development of bronchiolitis." Exhibit 3, p. 16J.015.

23. On June 24, 2008, Claimant was examined by Nancy Greenwald, M.D. She noted that since the accident his symptoms included headaches, memory loss, and dizziness but not vertigo; and difficulties with reading, multitasking, and driving. She assessed traumatic brain injury with loss of consciousness and recommended an outpatient brain injury program. Dr. Greenwald noted Claimant's very large abdominal girth. He did not report chest, rib, or neck pain.

24. In July 2008, Claimant participated in the outpatient brain injury program supervised by Dr. Greenwald at the Idaho Elks Rehabilitation Hospital to improve his balance

and memory difficulties resulting from his accident. Claimant underwent memory training to find his way back from his lodging to the hospital and to the grocery store. This helped him overcome panic attacks when he entered the grocery store but could not find his way out of the store. The training also helped improve his balance and reduced his dizziness and falls. As part of the brain injury rehabilitation program, Claimant met with clinical psychologist Craig Beaver, Ph.D.

25. On August 5, 2008, Dr. Greenwald found Claimant had reached maximum medical improvement for his shoulder injuries. She rated Claimant's permanent impairment at 7% of the whole person due to his right shoulder injury and deferred to Dr. Beaver to rate Claimant's impairment due to his traumatic brain injury. Dr. Greenwald reported that Claimant had "done extremely well in the Outpatient Brain Injury Program. …. The patient had some falls over the weekend. He states he gets dizzy. He fell two times but was somewhat vague about how he fell; there are not any bruises or focal findings from his falls." Exhibit 17, p. 3931. She recorded Claimant's problems with climbing stairs and listed his issues, including headaches, dizziness, vision complaints, hearing loss on the right side, and traumatic brain injury with loss of consciousness. Dr. Greenwald noted Claimant had daily right-sided headaches and reported: "It is my medical opinion that the headaches are part of his traumatic brain injury." Exhibit 17, p. 3932. She recorded that post-concussive headaches can be muscle tension type headaches and can also mimic migraines. Regarding Claimant's reports of dizziness, she noted that "the patient can do his activities of daily living. The team found he did quite well on higher level testing. They did not find any focal abnormalities so therefore the patient does not qualify for a vestibular disorder rating." Exhibit 17, p. 3933.

26. Concerning Claimant's pulmonary function, Dr. Greenwald recorded:

> The patient was diagnosed with a right hemi diaphragm paralysis and also was diagnosed with obstructive sleep apnea. I request the Workers[’] Compensation carrier to have a pulmonologist evaluate the patient’s medical records as well as perform a physical examination and include pulmonary function tests. Questions that need to be answered include: is the right hemidiaphragm directly related to this injury and what was the mechanism? Is the obstructive apnea directly related to his fall versus body habitus or due to the right hemidiaphragm?

Exhibit 17, p. 3933. Significantly, Claimant apparently did not complain of chest, rib, or neck pain.

27. On August 7, 2008, Claimant presented to the Hearing and Balance Center at the Elks reporting “a decrease in hearing sensitivity in his right ear that began after his accident last year. …. Mr. McClain also reports occasional tinnitus …. He also reports experiencing dizziness which began after his accident which includes occasional lightheadedness when getting up from a sitting position and when in the dark.” Exhibit 19, p. 3977. Following otoscopy, tympanometry, and pure tone testing, Jenna Hoffman, Au D., concluded Claimant had a moderate to severe, high frequency sensorineural hearing loss in his left ear and a mild to severe sensorineural hearing loss in his right ear. She recommended binaural amplification. Dr. Greenwald reviewed the report of Claimant’s hearing loss and concluded: “There seems to be just as prominent hearing loss in his left side as his right. …. We believe that this is a typical hearing abnormality from loud noise exposures throughout his life.” Exhibit 17, p. 3937.

28. On September 1, 2008, Dr. Beaver completed his neuropsychological evaluation of Claimant finding a 2% whole person impairment due to cognitive dysfunction from his industrial accident. Dr. Beaver reported:

> His validity scale configuration on the Minnesota Multiphasic Personality Inventory-2 indicates that considerable caution is needed interpreting the profile. His validity scale configuration is indicative of somebody who is significant [sic] exaggerating their current difficulties and problems. He had endorsement of a highly unusual number of psychological symptoms and was quite inconsistent in his responding to the items.

> In examining the clinical scales of the Minnesota Multiphasic Personality Inventory-2 he had significant elevations on multiple scales with a 1-2-3 clinical profile. These patients are often reporting a mixture of significant depression and physical complaints. These patients typically have a significant interaction between their emotional distress and their physical complaints. These patients are very prone for psychophysiology difficulties. They often feel a need to greatly overstate their difficulties in order to get others to understand "how sick" they are. ….
>
> Test results are variable. In general Mr. McClain functions in the average range of abilities. He showed difficulties in motor speed, attention, language, memory, and executive skills. However, there is evidence that he did not put forth his best effort. While I do not think he is malingering I do not feel he put forth good effort which clouded the results.
>
> Of noteworthy concern is that his performance is variable in comparison to the recent testing also done by Dr. Lindsay [sic]. He is also questionable to failing some of the motivational measures although he did pass the majority of them.

Exhibit 18, pp. 3971-3972.

29. On October 13, 2008, Dr. Taylor re-examined Claimant's pulmonary function at Defendants' request and was unable to definitively attribute Claimant's right hemidiaphragm paralysis or his obstructive sleep apnea to his 2007 accident. Dr. Taylor opined that Claimant's sleep apnea was not related to his traumatic brain injury, finding that "he is no longer hypoxic. …. His hypoxia has definitely changed to normal since his initial injury." Exhibit 9, p. 3748.

30. On December 4, 2008, Claimant presented to pulmonologist Richard Kanner, M.D., at the University of Utah for pulmonary testing as requested by Dr. Greenwald. Dr. Kanner recorded Claimant's report of his 2007 accident and subsequent shoulder surgery:

> He was told that during the procedure he stopped breathing and that he had a collapsed right lung and an elevated right hemidiaphragm. However, they never put a chest tube in place. He was kept in the hospital for about a week and was told his right lung would never fully recover. Then he had a sleep apnea study and was diagnosed with obstructive sleep apnea or the sleep apnea syndrome. He was put on CPAP for sleeping and oxygen.

Exhibit 21, p. 3987.

31. Dr. Kanner recorded that Claimant's elevated right hemidiaphragm returned to its normal position after about three and a half months. Dr. Kanner noted Claimant had served in Vietnam and then weighed about 140 pounds. He smoked cigarettes for 20 years but had not smoked in 20 years. At the age of 35 he was advised he had asthma and subsequently had pneumonia twice. After starting long-haul truck driving he weighed as much as 265 pounds but since his accident was down to 229 pounds. Claimant reported he slept on two pillows to help his breathing.

32. Pulmonary testing included a six-minute walk wherein Claimant walked only 1363 feet. Claimant described the effort as very hard and his dyspnea as being very severe. He was dizzy at the end of the walk. Dr. Kanner noted that Claimant was five feet four inches tall, weighed 229 pounds and his abdomen was very obese. His diaphragms moved normally, although chest radiographs showed both diaphragms were slightly elevated secondary to Claimant's abdominal obesity. No rib or chest pain was reported and no rib fractures were noted.

33. Dr. Kanner concluded that Claimant was at maximal medical improvement and his primary respiratory problem was obstructive sleep apnea due to his significant weight gain. Dr. Kanner concluded: "From his history and from the records, apparently he did have an elevated right hemidiaphragm, indicating there may have been some damage to the right phrenic nerve. However, this has resolved. From a respiratory point of view, he no longer suffers problems from the accident." Exhibit 21, p. 3998.

34. Having received reports from Dr. Greenwald, Dr. Beaver, and Dr. Kanner that Claimant had reached maximum medical improvement, Defendants ceased providing further medical treatment except for several prescription medications.

35. On April 24, 2010, Claimant suffered a left ankle sprain as a passenger in a motor vehicle accident when his wife struck a horse while driving. He was taken by ambulance to the hospital. Claimant did not report any chest, rib, shoulder, or neck pain or injury from or at the time of the motor vehicle accident. Claimant does not allege this injury was related to his 2007 industrial accident.

36. **Disputed medical treatment.** On December 28, 2010, Claimant presented to the triage nurse at the hospital emergency room with "Chief Complaint: COUGH. …. Onset (1 months [sic] ago)." Exhibit 3, p. 16J.028. Claimant reported to the emergency room physician, Edwin Wells, M.D., cough and abdominal and chest pain: "This started several weeks ago and is still present. It is described as sharp and it is described as located in the right chest and the right upper quadrant and radiating to the right upper back." Exhibit 3, p. 16J.025. CT scans ruled out possible aneurysm or dissection. Dr. Wells noted Claimant's COPD and assessed cough, abdominal pain of undetermined cause, and pleuritic chest pain with likely pleurisy. Dr. Wells' notes indicate he independently reviewed the x-rays and observed no rib fractures. However, radiologist John Strobel, M.D., recorded his impression of the chest x-rays as: "Focal pleural thickening on the right which appears to be related to rib fracture deformity." Exhibit 3, p. 16J.033.[3] Claimant did not report any neck or shoulder pain. He was given pain medication and oxygen in the emergency room to increase his oxygen saturation to 91% on nasal cannula at two liters per minute. He was discharged home with prescriptions for Doxycycline, Albuterol, Decadron, and Ultram.

37. On January 10, 2011, Claimant presented at the hospital emergency room reporting: "Injury to right foot and right ankle. The injury happened today. Fell down several

[3] This is the earliest objective imaging located in the record indicative of rib fracture.

stairs. Occurred at home. Patient is experiencing moderate pain. Patient also notes injury to the head. No other injury." Exhibit 3, p. 16J.037. Physical examination revealed mild scalp tenderness, small leg abrasion, moderate tenderness and ankle swelling. Claimant's neck was supple with no decrease in range of motion. X-rays of the tibia, fibula, and foot were negative. The medical record contains no mention of dizziness; however, Claimant asserted at hearing that "I got dizzy and fell down the steps on my house." Transcript p. 170, ll. 17-18. The record contains no report of chest, rib, shoulder, or neck pain and no chest or rib x-rays were taken.

38. On January 24, 2011, Claimant reported right upper quadrant pain and underwent gall bladder ejection testing. Exhibit 3, p. 16J.041. He does not assert this condition was related to his 2007 accident.

39. On April 6, 2011, Claimant presented at the hospital emergency room and was hospitalized with exacerbation of COPD due to viral infection, likely influenza. He was treated by Dr. Harris and thoracic surgeon Michael Denyer, M.D. CT scans revealed old appearing rib fracture deformities of right posterior lateral seventh and eighth ribs, and new appearing fracture deformities of the ninth rib. In consultation on April 10, 2011, Dr. Denyer recorded:

> Review of CT scan from December 2010 shows a couple of right posterolateral rib discontinuities. On that scan there does seem to be any [sic] lung herniation through the chest wall. …. He is quite clear in his impression that something new has recently occurred. …. His chronic lung disease and coughing have doubtless made whatever chest wall instability he has worse.

Exhibit 3, p. 41.

40. On April 14, 2011, Dr. Harris recorded of Claimant:

> On the last weekend, about midnight, he was up to the sink, had a severe cough and instant pain in the right side of his right lateral chest associated with bulging out of the chest wall, upper abdominal wall. He was subsequently seen in consultation by Dr. Denyer. A CT scan and CT 3-D reconstruction showed 2 old fractures and 1 new fracture, all 3 bones again fractured with significant separation between ribs, consistent with all the muscular attachments having been

> torn off, and consequent flail chest. Whenever he would cough the chest with [sic] flail out. He would have an acute episode of pain and what was interpreted as a vasovagal response, wherein he would pass right out. On one occasion if the nurse had not been right there, he would have fallen.

Exhibit 3, p. 29. Dr. Harris later testified that flail chest is "typically an intensive-care-unit situation. It's very dangerous." Harris Deposition, p. 46, ll. 7-8.

41. While hospitalized, Claimant was examined by Brady Cook, M.D., who noted Claimant had "some syncope-type symptoms in the hospital because of pain from the cough." Exhibit 3, p. 56. He was also examined by neurologist Erich Garland, M.D., for his dizziness. Dr. Garland noted that Claimant suffered from two types of dizziness: the first when arising quickly from sitting down, and the second related to his coughing and sneezing that may take him half an hour to recover from. Exhibit 3, p. 58.

42. Claimant was referred to pain specialist Jason Poston, M.D., for chest pain management. On May 4, 2011, Dr. Poston recorded: "William reports pain in the right side of his chest. When the patient coughs, it radiates around into his back and shoulder and he gets dizzy." Exhibit 27, p. 4238. There was no other report of shoulder or neck pain. Dr. Poston recommended injections to reduce Claimant's rib cage pain. Dr. Poston administered one thoracic transforaminal epidural steroid injection and recorded Claimant's response:

> There was no pain with injection. The patient tolerated the procedure poorly and was discharged to the recovery room where the patient was monitored for respiratory and hemodynamic stability for over 30 minutes. Complications: William started to complain of right sided chest pain. He was hemodynamically stable …. He began to have a tremor in the right hand. The patient has had interesting reactions attributed to anxiety previously with intercostal nerve blocks reported to me by Dr. Denyer. Given that the potential complication with this injection is pneumothoraax [sic] I did call the ambulance and had him taken to the EIRMC emergency department. He ambulated with assistance to the gurney and was taken to the ED in stable condition. I did talk to the physician on call who reported that there was no pneumothorax and that this reaction was likely anxiety related.

Exhibit 27, p. 4239.

43. On June 1, 2011, Dr. Denyer performed right thoracotomy with excision of seventh, eighth, and ninth rib malunions and chest wall reconstruction with PTFE patch. Claimant developed Staphylococcus aureus wound infection and bacteremia. On June 9, 2011, Dr. Denyer removed the patch due to wound infection. Claimant remained hospitalized until July 5, 2011, and was treated with intravenous antibiotics. He was taken to the operating room repeatedly to drain and treat the infection.

44. On September 14, 2011, Claimant presented again to Dr. Poston reporting sharp and stabbing pain post-surgery from right rib fracture and seeking a spinal cord stimulator. Claimant also reported dizziness, high blood pressure, and back pain. All upper extremity reflexes were normal and there was no mention of shoulder or neck pain.

45. In November 2011, Claimant underwent a spinal cord stimulator trial and on December 2, 2011, Dr. Poston surgically implanted a spinal cord stimulator which Claimant reported relieved approximately 80% of his rib pain.

46. On February 9, 2012, Dr. Poston recorded Claimant's complaints of rib, back, and right shoulder pain, as well as chest pain from a cold. There was no mention of neck pain. Claimant reported coughing, wheezing and shortness of breath. He ambulated with a cane.

47. On April 23, 2012, Claimant presented to Dr. Poston's assistant, Matthew Nelson, PA-C, who recorded: "William is here today to follow-up with neck and low back pain. He complains of inability to turn his head to the left. This started about 6 weeks ago. He states the pain radiates down his neck, right shoulder, and back." Exhibit 27, p. 4269.[4] Claimant also reported coughing and trouble breathing. He requested a cervical MRI.

[4] After December 2008, this is the earliest reliable documented report of neck pain that has been located in the

48. On April 24, 2012, Claimant underwent a cervical CT scan that revealed: "no appreciable interval change in the appearance of the cervical spine since the previous exam of August 10, 2007 with the exception that disk space narrowing has mildly progressed at C3-C4 through C7-T1 levels." Exhibit 27, pp. 4271-4272.

49. In May 2012, Claimant underwent a total thyroidectomy for two neck tumors. In July 2012, he was admitted to the hospital for kidney stones and related complications. Claimant does not assert that these conditions were related to his industrial accident.

50. On July 10, 2012, Claimant presented to Dr. Denyer at the request of Dr. Harris "having again injured the right chest wall, this time in a fall when his lawn chair collapsed and he landed on his water jug, impacting the surgical area." Exhibit 28, p. 4346. Claimant was eventually fitted with an external corset type thoracolumbosacral orthosis to stabilize his right chest wall.

51. On December 26, 2012, Claimant presented to Matthew Nelson, PA-C, complaining of increased neck pain. Claimant was referred to Brandon Kelly, M.D., for consultation regarding cervical surgery. There was no mention of shoulder pain.

52. On January 17, 2013, Claimant presented to Dr. Kelly who diagnosed cervical spondylosis and cervical pain. He discussed and offered Claimant anterior cervical decompression and fusion surgery. There was no mention of shoulder pain.

53. In January 2013, Claimant underwent surgical repair of an abdominal aortic aneurism. Claimant does not assert that this condition was related to his industrial accident.

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medical records.

54. On March 28, 2013, Claimant presented to Matthew Nelson, PA-C, complaining of worsening neck pain. Claimant was preparing for cervical surgery by Dr. Kelly. There was no mention of shoulder pain.

55. On April 2, 2013, Dr. Kelly performed C3-C7 anterior cervical diskectomy and fusion as treatment for Claimant's refractory cervical spondylosis with intractable axial neck pain as well as bilateral radicular arm pain. During his hospitalization, he was maintained on nasal cannula oxygen for his chronic hypoxia. Claimant was discharged from the hospital on April 7, 2013. His discharge was delayed due to three days of postoperative nausea and vomiting. Dr. Kelly noted that Claimant already had home oxygen and a walker. Claimant testified the cervical surgery helped reduce his neck pain and increase his range of motion.

56. On April 18, 2013, Dr. Kelly saw Claimant in followup and recorded that his right shoulder pain was reduced. Upon further followup on June 28, 2013, he recorded Claimant "has some stiffness and right sholder [sic] pain. Exhibit 35, p. 4476.

57. On July 5, 2013, Claimant presented at the hospital emergency room complaining of left knee pain. "Pt was at the Hilton Inn last night, tripped over the edge of a fireplace, fell and hit L knee. …. The patient complains of pain on weight bearing. No chest pain …. All systems otherwise negative …." Exhibit 3, p. 3010. There is no mention of shoulder or neck pain.

58. On April 2, 2014, Dr. Kelly examined Claimant and recorded "He was doing well until about a month ago when he had a hard fall. He landed on his right shoulder. …. Physical exam …. Significantly increases pain in right shoulder with internal and external rotation compared to last exam." Exhibit 35, pp. 4482-4483. Plain radiographs showed a broken screw with likely pseudoarthrosis at C6-C7. Dr. Kelly advised Claimant that the majority of his

symptoms were likely due to his right shoulder injury. He also discussed revision cervical surgery for C6-C7 pseudoarthrosis.

59. On July 21, 2014, Dr. Kelly again examined Claimant and noted his increasing cervical pain since he fell four months earlier, as well as significant increase in right shoulder pain with internal and external rotation. CT scan showed solid fusion of C3-6, with C6-7 pseudoarthrosis, and C7 screw fracture. Claimant desired revision cervical surgery.

60. On September 8, 2014, Claimant tripped over his dog and fell with his right arm under his body.

61. On September 25, 2014, Edward Yee, M.D., performed a Gore-Tex mesh reconstruction of Claimant's right chest wall and repair of severe diaphragmic herniation.

62. On October 27, 2014, Dr. Kelly examined Claimant who reported continued neck pain since his fall several months earlier. Dr. Kelly also recorded Claimant's report that "He had a spontaneous diaphragm rupture. He underwent urgent thoracotomy for this. He denies any trouble after the surgery. He states that a suture 'split out' last week." Exhibit 35, p. 4486. Dr. Kelly again noted Claimant's significant increase in right shoulder pain with internal and external rotation. He agreed to perform cervical revision surgery but only after further healing of Claimant's recent diaphragm repair.

63. On December 22, 2014, Claimant reported to EIRMC for chest pain and cough.

64. On January 5, 2015, Dr. Kelly performed revision cervical surgery with placement of new hardware. The second cervical surgery reduced Claimant's neck pain by 90%. In follow-up, Dr. Kelly recorded limited range of motion in Claimant's right shoulder.

65. On January 24, 2015, Claimant presented to the hospital emergency room reporting disorientation and confusion following his cervical surgery. "His wife reports she's

[sic] been having trouble walking and has had falls." Exhibit 3, p. 3085. Cervical CT scan showed no acute fracture and all anterior and posterior cervical fusion hardware intact, with large posterior lower neck post-operative seroma. Brain CT showed no evidence of acute intracranial hemorrhage but mild loss of cerebral fluid volume.

66. On February 12, 2015, Claimant presented to Terry Thompson, NP-C, with non-healing abdominal surgical incisions. Claimant also reported "a fall a few weeks ago and he sustained abrasions to his limbs." Exhibit 3, p. 3109.

67. In May 2015, Claimant underwent surgery for a deviated septum. Claimant apparently does not assert this condition was related to his industrial accident.

68. On September 17, 2015, Claimant presented to Dr. Poston who recorded:

> William McClain … presents to the clinic today complaining of neck and right shoulder pain. Patient also states that he has pain radiating into his right upper extremity. He underwent a cervical fusion with Dr. Kelly in January 2015. He states that about 5 months ago he was walking and fell on an outstretched each [sic] outstretched right arm. He said he felt a pop in his shoulder and has had decreased range of motion and pain in his shoulder since.

Exhibit 27, p. 4326. Cervical CT imaging showed the cervical fusion intact. Right shoulder CT imaging showed mild degenerative changes in the glenohumeral joint; however, a rotator cuff tear was considered likely but no MRI was possible given Claimant's spinal cord stimulator. Subsequent right shoulder CT arthrogram showed no rotator cuff or labral tears although Claimant complained of increasing right shoulder pain.

69. In January 2016, Claimant was referred to Nathan Richardson, M.D., for evaluation of his painful right shoulder. Shoulder injections were not helpful. On March 15, 2016, Dr. Richardson performed total right shoulder arthroplasty. After recovering from the surgery, Claimant reported pain reduction and improved range of motion in his right shoulder.

70. **Condition at the time of hearing.** At the time of the hearing, Claimant continued to notice persistent right chest, neck, and right shoulder symptoms. Claimant used a portable oxygen tank at hearing and on multiple occasions during his testimony coughed forcefully and continuously for more than 60 seconds before he could speak to answer a pending question.

71. **Credibility.** Having observed Claimant at hearing, and compared his testimony with other evidence in the record, the Referee finds that Claimant is not a reliable witness. As previously noted he suffered a traumatic brain injury from his 2007 accident and his perception and memory were noticeably unreliable in many instances at hearing. Furthermore, it was apparent at hearing and in the medical records that Claimant is imprecise in some of his descriptions, is occasionally prone to overstatement,[5] and has limited familiarity with medical terminology.[6] Comprehensive evaluation of Claimant's medical records substantiates Dr. Beaver's above-noted caution after reviewing Claimant's performance on Minnesota Multiphasic Personality Inventory-2 testing.

72. Moreover, in a few instances during Claimant's testimony at hearing he was seemingly initially evasive in responding to Defendants' counsel's questions. Two illustrations will suffice. The first regarding Claimant's pre-existing COPD:

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[5] After being admitted to EIRMC on July 17, 2012, for an unrelated condition, a pain comment note recorded:

> NO BEHAVIORAL S/S PAIN. WHEN ASKED ABOUT THE PAIN PATIENT STATES "OH THE PAIN. TERRIBLE PAIN. OH THE PAIN." BUT THEN RETURNS TO WATCHING TELEVISION. UNSURE IF PATIENT IS JOKING OR SERIOUS. DOES RATE PAIN AT A 8/10. ASKED PATIENT IF HE WAS SERIOUS OR KIDDING. PATIENT LOOKED AT THE RN AND STATED HE DOESN'T KNOW.

Exhibit 3, p. 2051.

[6] At hearing when responding to a question regarding a May 2015 surgery Claimant received from Dr. Hinckley for deviated septum, Claimant asked: "Is that the diaphragm?" Transcript, p. 91, l. 13.

Q. …. You were diagnosed with COPD prior to the industrial accident, weren't you?

A. Not that I know of.

Q. Okay. You are sure?

A. Like I said, not that I know of.

Transcript, p. 155, l. 25 through p. 156, l. 4.

Q. Okay. Let's talk about COPD. You had mentioned before that you had not had COPD—that you had not been diagnosed with COPD prior to this accident; is that correct?

A. That's what I said, correct.

Q. Is that still correct?

A. At least that's what I recall.

….

Q. This is a report from EIRMC. …. Can you read that, please?

A. "He was diagnosed with COPD seven years ago."

Q. What is the date of that report?

A. 4/6 of '11.

Q. Okay. So seven years prior would have been about 2004, 2005?

A. Yeah.

Transcript, p. 162, l. 10 through p. 163, l. 7

Q. And you had been diagnosed with COPD prior to this accident; right?

A. That's true.

Transcript, p. 184, ll. 17-19.

73. The second illustration concerns Claimant's pre-existing chronic headaches:

Q. Okay. Talking about your head injuries, your headaches and your dizziness, isn't it true that you suffered from chronic headaches prior to the industrial accident?

A. No.

Q. You are sure?

A. I didn't have chronic migraines prior to the accident.

Q. What about chronic sinus infections?

A. I had some sinus infections.

Q. Okay. In fact, when you reported to that—to East Idaho Ear Nose and Throat, ENT, you reported that you have suffered from chronic sinus infections over the last 10 years. Does that sound right?

A. That's true.

Q. So in 2005, you were suffering from chronic sinus infections; right?

A. That's true.

Q. They stated your symptoms include sinus headaches, thick green yellow discharge, nasal congestion, and facial pain; is that accurate?

A. That's true.

Q. So that would mean that you were suffering from chronic sinus infections, including headaches, two years prior to this accident?

A. That's true.

Transcript, p. 152, l. 20 through p. 154, l. 1. Furthermore, Dr. Harris testified in his post-hearing deposition that when he examined Claimant on August 14, 2007—just four days after his accident—Claimant reported:

> He's had migraines …. Discussing migraine. He reports that he does tend to have periods without migraines, that he had four to five migraines in the last two months, and he had one for about a week before he fell. And in the past, he reported those have been diagnosed as cluster migraines.

Harris Deposition, p. 18, ll. 2-15.

74. To the extent Claimant's testimony and/or his reports to his treating or consulting physicians are inconsistent with other evidence of record, especially prior documented objective medical records; those records will be relied upon rather than Claimant's statements or medical records or opinions founded upon Claimant's uncorroborated representations.

DISCUSSION AND FURTHER FINDINGS

75. The provisions of the Idaho 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).

76. **Medical care and causation.** The first two issues presented are intertwined in that Claimant is entitled to additional medical benefits only if the medical care for which he seeks benefits is related to his industrial accident. In this regard, Idaho Code § 72-432 provides in pertinent part:

> the employer shall provide for an injured employee such reasonable medical, surgical or other attendance or treatment, nurse and hospital services, medicines, crutches and apparatus, as may be reasonably required by the employee's physician or needed immediately after an injury or manifestation of an occupational disease, and for a reasonable time thereafter. If the employer fails to provide the same, the injured employee may do so at the expense of the employer.

An employer is only obligated to provide medical treatment necessitated by the industrial accident, and is not responsible for medical treatment not related to the industrial accident. Williamson v. Whitman Corp./Pet, Inc., 130 Idaho 602, 944 P.2d 1365 (1997). A claimant must provide medical testimony that supports a claim for compensation to a reasonable degree of

medical probability. Langley v. State, Industrial Special Indemnity Fund, 126 Idaho 781, 785, 890 P.2d 732, 736 (1995).

77. Claimant herein asserts that his 2007 accident at Ready Mix caused his need for medical treatment of the following issues: 1) right chest wall injury including right hemi-diaphragm paralysis, rib fractures, and flail chest necessitating a thoracotomy; 2) traumatic brain injury resulting in recurring dizziness and falls; 3) cervical injury necessitating two cervical fusion surgeries; and 4) right shoulder injury necessitating total right shoulder arthroplasty in March 2016. Defendants maintain Claimant reached maximum medical improvement by approximately December 2008 and deny responsibility for costs of medical treatment for any and all of these conditions after December 2008. The causation of each condition is evaluated below.

78. Right chest wall injury. Claimant asserts his industrial accident caused right hemi-diaphragm paralysis, right rib fractures, and ultimately resulted in a flail chest.

79. *Hemi-diaphragm paralysis.* Claimant asserts that his right hemidiaphragm paralysis is related to his 2007 accident.

80. In her post-hearing deposition, Dr. Greenwald opined that Claimant's initial right hemidiaphragm paralysis was related to his 2007 accident. Greenwald Deposition, p. 24. She noted that September 7, 2007 x-rays revealed an elevated right hemidiaphragm with a non-fully-expanded lung. She testified that Claimant's right hemidiaphragm was initially likely caused by a scalene nerve block administered as part of his first shoulder surgery on September 7, 2007. However, within a few months thereafter the paralysis resolved and the right hemidiaphragm normalized. She noted that Claimant's subsequent March 25, 2008 x-rays showed resolution of his elevated right hemidiaphragm. Greenwald Deposition, pp. 27, 29. Thus this was only a temporary condition resulting from his September 2007 shoulder surgery.

81. On April 7, 2011, Dr. Harris recorded: "During his first shoulder surgery, he had trouble with anesthesia and was found to have right lung collapse. It has been collapsed now for the 6 weeks [sic] and has not re-inflated. The left lung had also had collapse but it largely reinflated on its own subsequent to the initial injury." Exhibit 3, p. 17. The source of Dr. Harris's note is unspecified, unknown, and not substantiated in the record.

82. In her September 30, 2016 report Dr. Greenwald addressed both Claimant's initial and subsequent right diaphragm injuries. She stated:

> Right hemidiaphragm. Yes, this was related to the accident. The good news is, in 2013, a chest x-ray demonstrated resolution of the right hemidiaphragm. In addition, Dr. Kanner performed a pulmonary report and stated the patient did have resolution of the right hemidiaphragm. He feels the smoking has probably interfered more with his pulmonary issues. He believes his weight has most likely caused his sleep apnea. However, there is discussion of a right hemidiaphragm repair due to a fall. I could not find the actually [sic] injury of the fall, but the patient appears to have had a reinjury when he was in his lawn chair and it collapsed on that right side as well. There is a note stating that he had that diaphragm repaired on 09/25/14. From the medical records I have presently, it appears that the right hemidiaphragm was repaired, and if there was a rupture, it was sometime after the accident of 2007 and therefore not related to the 2007 accident.

Exhibit 17, p. 3937D.

83. Claimant also maintains that his 2007 accident contributed to the progression of his COPD. Claimant's pre-existing COPD and attendant coughing may have been temporarily aggravated by his right hemi-diaphragm paralysis which resulted from his September 2007 shoulder surgery necessitated by his 2007 accident. However, even assuming Claimant's coughing may have been due solely to his temporary right hemidiaphragm injury, no objective imaging documents any rib fractures on or before March 25, 2008—the date upon which x-rays documented that Claimant's previously elevated right hemidiaphragm had resolved. Furthermore, as Dr. Greenwald noted, Dr. Kanner performed extensive pulmonary testing in

December 2008 and recorded that Claimant's right hemidiaphragm paralysis had "resolved. From a respiratory point of view, he no longer suffers problems from the accident." Exhibit 21, p. 3998.

84. Claimant has not proven that any need for treatment for his right hemi-diaphragm after December 2008, was caused by his 2007 accident.

85. *Right rib fractures and flail chest*. Claimant asserts he had continuing right rib and chest pain all along after his 2007 accident. Thus he attributes all of his right rib fractures to the 2007 accident. However, CT scans of most of his body, including his chest and rib cage, were read as showing no acute fracture at the time of his 2007 accident. Specifically, chest CT scan with intravenous contrast on the day of the accident August 10, 2007, showed: "Review of the bone windows demonstrates no acute fractures. IMPRESSION: NEGATIVE CT SCAN OF THE CHEST FOR ACUTE CHANGES." Exhibit 3, p. 16G. These scans were reviewed by radiologist John Stobel, M.D., on August 10, 2007, by the emergency room physician Dr. Griggs, and later reviewed by Dr. Cook and Dr. Greenwald—all of whom confirmed the CT scans showed no rib fracture. Claimant had further chest x-rays on September 7, 2007, chest CT scan and x-ray on February 25, 2008, chest x-ray on March 25, 2008, chest x-rays on June 12, 2008, and chest radiograph on December 4, 2008—none of which were reported to show rib fracture. Thus Claimant underwent at least six imaging scans at various intervals within 18 months of his 2007 accident and none showed rib fractures.[7]

86. The very earliest objective imaging showing rib fractures was December 28, 2010—more than three years after Claimant's 2007 accident—when he presented at the hospital

[7] The May 14, 2009 Impairment Rating report of Gary Cook, M.D., does not mention or discuss chest or rib pain or respiratory difficulties as a condition reported by Claimant at that time. Exhibit 22, pp. 4013-4037.

emergency room complaining of a cough and sharp right chest pain commencing one month earlier. Exhibit 3, pp. 16J.025, 16J.028, 16J.033. Dr. Denyer later confirmed the December 28, 2010 imaging showed "a couple of right posterolateral rib discontinuities." Exhibit 3, p. 41. Additional diagnostic imaging revealed a third—and new—rib fracture on April 6, 2011. Exhibit 3, p. 29.

87. Dr. Harris recorded in his April 14, 2011 notes after CT scanning showed one new and two old right rib fractures, that Claimant had developed flail chest shortly prior to his admission to the hospital and that:

> The impression remained chronic obstructive pulmonary disease until the above PFT with current diagnosis being recurrent, severe bronchospasm bronchitis with viral infection. Of note, he has typically had 3 episodes of bronchitis per year for the last 3 or 4 years, each of them quite severe, resulting in recurrent fracture of the right-sided ribs that initially occurred during and after the 17 foot fall off a concrete mixer but he would heal in between times, then refracture and have pain, but this most recent is the first time he had flail chest.

Exhibit 3, p. 30.

88. Claimant testified at hearing that his wife worked at a daycare for approximately 10 years and he was thus frequently exposed to viruses. Claimant asserted that he had three episodes of bronchitis per year for three or four years prior to April 2011. Transcript p. 178, ll. 9-13. However, the source of Dr. Harris' above-quoted note, that Claimant initially fractured his right ribs in the 2007 accident and then suffered recurrent rib fractures during three episodes of bronchitis each year for the prior three or four years, is unidentified, unknown, and not substantiated or corroborated by the medical record. To the extent the source of Dr. Harris' note is Claimant's self-report, it is unreliable and unpersuasive.

89. Dr. Harris testified that x-rays in general, and particularly from a portable x-ray machine, are a notoriously poor diagnostic tool for rib fractures and unless the rib fracture is

displaced the x-ray may well not show a rib fracture even when it is present. Harris Deposition, pp. 37-38.

90. In his post-hearing deposition, Dr. Harris opined:

> Q. I guess my question for you is more likely than not, did all those recurring—are all those recurring fractures related to his August 10th, 2007 injury?
>
> A. Given that it was the right side of his chest, which was what was injured in the fall, I think it's more probable that not that these recurrent fractures were related to the fall. It's complicated, of course, and brought on by the bronchitis.

Harris Deposition, p. 56, ll. 2-11.

91. Dr. Harris testified that broken ribs usually manifest themselves with pain, especially pain with a deep breath, and that Claimant described pain with deep breathing on his first visit, August 14, 2007. Harris Deposition, pp. 81-82. Dr. Harris testified that once ribs have broken there is a propensity toward the lungs not expanding properly and that broken ribs make bronchitis more severe, and that bronchitis can cause or contribute to rib refracture. Harris Deposition, pp. 108-109.[8]

92. Dr. Joseph practices sports medicine and frequently treats concussion and sports orthopedic injuries. He reviewed Claimant's medical records at his request. Defendants assert Dr. Joseph could not recall which of Claimant's medical records he reviewed and thus his conclusions should be given no weight. Dr. Joseph testified he reviewed two banker boxes plus two additional three-ring binders full of Claimant's medical records. Although the full basis for Dr. Joseph's opinion is not detailed, his conclusions are not thereby entirely invalidated. His

[8] Relying upon the opinions of Dr. Harris and Dr. Joseph, Claimant's briefing argues that he suffered "damage" to the right chest wall from the 2007 accident, which "damage" rendered him more susceptible to significant respiratory infections. However, the foundation of the opinions of Dr. Harris and Dr. Joseph is that Claimant suffered rib fractures at the time of his 2007 accident, not merely contusion or other less significant form of chest wall damage. The opinions of Dr. Harris and Dr. Joseph are unpersuasive without evidence of rib fractures relating to the time of the 2007 accident.

report demonstrates familiarity with numerous aspects of Claimant's post-accident treatment and cites to post-accident medical records of Claimant's treating physicians. Dr. Joseph concluded that Claimant's chest wall complications including rib injuries were related to his 2007 accident. Dr. Joseph explained:

> A. Well, when you look at initial X-rays of the chest, when patients report for trauma, a portion of those fractures are not evident on a CAT scan or—but especially on a chest X-ray.
>
> And so, unless there was some other subsequent injury or preceding injury that would have caused what was described as old rib fractures, my assumption from reviewing the records is that rib fractures from the–and this is based on the distance that he fell—were more probable—probably caused by this accident. ….
>
> Q. …Why are X-rays right after the fact? What are they—why sometimes do they not show up on broken ribs?
>
> A. Because it's under the resolution of the X-ray, that is it's a hairline crack, and then only after some time can you see what we call the callus formation, the thickening around the ribs suggestive of a fracture.
>
> I'm a case in point. I had a mountain bike fall, went back into my office. I was working at the university at the time, had an X-ray, didn't show up, and I'm thinking why do my ribs hurt so much? So I had the luxury of having my tech do another X-ray in six weeks and lo and behold I had a callus formation.

Joseph Deposition, p. 16, l. 6 through p. 17, l. 8.

93. Dr. Joseph's explanation fails to account for the fact that Claimant underwent CT and/or x-ray imaging on August 10, 2007, September 7, 2007, February 25, 2008, March 25, 2008, June 12, 2008, and December 4, 2008—none of which showed any rib fracture or callus formation.

94. Michael O'Brien, M.D., provided a neurological consultation for Claimant and on September 5, 2012, reported concerning his injuries from the 2007 accident:

> His injuries were quite severe at that time. Subsequent to the fall, there were four elements of severe injury that are undisputed at this time. They include the

> concussion to the head, the shoulder injury, multiple fractures of the ribs on the right side, and a collapsed lung on the right side.
> ….
>
> The third problem involves the discovery of multiple fractures of the ribs on the right side. Unfortunately, his history from that point on is rather tragic in a sense that portions of the ribs were removed and then a mesh was placed in the area. The patient had a reaction to the mesh and had to have further surgery in the area to remove that mesh and now there are spaces between the ribs that are mal-joined and probably will continue in definitely [sic]. ….
>
> The next problem involves the lung that collapsed. This was associated with rib fractures and, therefore, is associated with the trauma of the patient falling. It became more of a problem during surgery for his shoulder when a catastrophic event occurred causing breathing difficulties which have been taken care of conservatively at this point. The patient still has significant residuals in that region. They involve problems with breathing on a daily basis.

Exhibit 33, pp. 4434-4435. Dr. O'Brien does not clearly identify the source of his information regarding rib fractures or a collapsed lung at the time of the 2007 accident other than to refer to having "the opportunity to review volumes and volumes of records of follow up medical care on this patient." Exhibit 33, p. 4434. To the extent the source of Dr. O'Brien's opinion is Claimant's self-report, it is unreliable and unpersuasive. Dr. O'Brien's unsupported conclusory opinions of rib fractures and a collapsed lung at the time of the August 10, 2007 accident are contrary to the objective imaging records at the time of and for three years following the 2007 accident and are unpersuasive.

95. Dr. Greenwald opined that Claimant's rib fractures and thoracotomy were not related to his 2007 accident. She reviewed Claimant's record after the 2007 accident and "that did not demonstrate any fractured ribs. And if you have a trauma, you would see off—CAT scans are the gold standard, and he had CAT scans done, and there was no mention of any rib fractures." Greenwald Deposition p. 25, ll. 19-23. She noted that Claimant's subsequent September 7, 2007, March 25, 2008, and June 12, 2008 x-rays did not show any rib fractures,

and that the first evidence of rib fractures was December 28, 2010—three full years after his 2007 accident. Dr. Greenwald reasoned that the appearance of rib fractures three years later cannot be directly related to the 2007 accident. She testified that Claimant's hard coughing could cause fractured ribs and also that his post-accident falls could have caused cracked ribs. Greenwald Deposition, p. 30.[9]

96. Dr. Greenwald concurred in Dr. Denyer's conclusion that Claimant's "chronic lung disease and coughing has doubtless made whatever chest wall instability he has worse" and also agreed with Dr. Harris' note that a week prior to April 14, 2011, Claimant "had an acute cough with further rib fracture which led to the significant flail that was not present before." Greenwald Deposition, p. 32, ll. 3-5, 9-11.

97. Claimant's counsel cross-examined Dr. Greenwald specifically about Claimant's rib fractures, noting his complaints of right chest pain at the emergency room on August 10, 2007 the day of his accident, on August 14, 2007 during his visit with Dr. Harris, and on August 16, 2007 at Ellis Physical Therapy. Claimant's counsel reiterated Claimant's report of broken ribs to Channing Physical Therapy on January 3, 2008, and the following exchange ensued:

> Q. And I'm just wondering here—it says, "The patient states on August 10, 2007 he was up about 20 feet on a mixer truck and fell off the truck landing on his head and shoulder. He had a bruise on his brain and injured his right shoulder. He broke three ribs and had a collapsed lung and possibly a neck injury."
>
> We've already talked about it, but I want to ask you: Did you see any record in your review that verified that he had three broken ribs?
>
> A. No, I did not. Nor did I see anything that said he had a bruise on his brain.

[9] However, the record does not indicate that Claimant complained of any chest pain after a fall between December 4, 2008—when imaging showed no rib fractures and pulmonary function testing showed full resolution of any respiratory difficulty relating to the 2007 accident—and December 28, 2010, the earliest date when objective imaging documented rib fracture.

> Q. So here is my question: As you go through the records, he continues to—and as we went through there—would it be a fair assessment that even though there was no x-rays or CT scans demonstrating that he had fractured ribs, would it be fair to say that he continued to complain about right chest pain?
>
> A. No. Because, again, it's his subjective response. And as we have figured out with Rocky, that, you know, sometimes his recall and what he tells you what's going on doesn't make sense. Like no one told him he bruised his brain, but he told me the same thing.

Greenwald Deposition, p. 61, l. 25 through p. 62, l. 22. She emphasized that even when Claimant reported on January 3, 2008 that he fractured three ribs when he fell on August 10, 2007, he did not report continuing chest pain that day, nor did he report any continuing chest or rib pain to Dr. Greenwald when she examined him on multiple occasions in July and August 2008. Dr. Greenwald observed that Claimant had a right chest contusion—but not fractures—as a result of his 2007 accident.

98. Claimant had chest CT scans taken the day of his 2007 accident which were ultimately read by at least four physicians as showing no rib fractures. CT scans are the gold standard for diagnosing rib fractures. All of the physicians who commented on this question confirmed that CT scans are more sensitive and reliable in diagnosing rib fractures than x-rays. Dr. Greenwald testified that "CAT scans would definitely capture a rib fracture." Greenwald Deposition, p. 57, ll. 1-2. Dr. Joseph indicated that even CT scans may not always detect rib fractures; however, using himself as an illustration, he testified that within four to six weeks a fractured rib will show bone callus on x-ray, thus providing a somewhat delayed documentation of the earlier rib fracture. In Claimant's case there are no x-rays or CT scans until more than three years after his 2007 accident showing ribs with bone callus indicative of prior fracture. There are at least six x-rays and/or CT scans between August 10, 2007, and December 2008 that

do not show any rib fracture or bone callus. There is no objective evidence of rib fracture prior to the objectively documented resolution of Claimant's right hemidiaphragm by December 2008.

99. Between December 2008 and April 2011, Claimant reported only one significant fall due to dizziness. That occurred on January 10, 2011 when he fell on the stairs to his home. He reported ankle pain, but there was no report of chest or rib cage pain.

100. Claimant has not proven that his rib fractures are directly caused by his 2007 accident. Claimant has also not proven that his rib fractures were caused by any post-2007 accident fall resulting from dizziness due to whatever cause. Claimant has not shown that his coughing persisting after the resolution of his right hemidiaphragm in 2008 was caused by his 2007 accident. The weight of the evidence indicates that Claimant's initial rib fractures were most likely caused by his coughing no earlier than December 2010.[10] The weight of the evidence indicates that Claimant's further rib fractures and flail chest were most likely caused by his coughing due to his COPD and viral infection in April 2011. Claimant has not shown that his post-accident falls even if due to his 2007 accident, caused his fractured ribs or flail chest.

101. Claimant has not proven that his need for medical treatment of his right chest condition after December 2008 is related to his 2007 accident.

102. Traumatic brain injury and recurring dizziness. Reasonable estimates indicate Claimant fell approximately 14 feet from the top of a cement truck, landed on his head and right shoulder in concrete rubble, and was unconscious for approximately 45 minutes. He could not remember how he fell, how he arrived at the hospital, who he talked to at the hospital or much of

[10] One reasonable explanation of the May 2011 CT-3D reconstruction showing two old and one new rib fracture is that Claimant initially fractured two ribs approximately one month prior to his December 28, 2010 emergency room visit wherein he reported cough and sharp chest pain for the previous month and his chest x-ray showed rib fracture deformity and "a couple of right posterolateral rib discontinuities." Exhibit 3, p. 41. The rib fractures would have been approximately one month old at that time, with sufficient callus formation to be visible on x-ray. These two

anything that occurred that day. Dr. Harris classified this as a category three concussion with loss of consciousness.

103. Defendants provided substantial treatment including rehabilitation for Claimant's traumatic brain injury and ensuing memory loss, dizziness, nausea, and headaches. He required rehabilitation initially to be able to find his way around the grocery store and back to the rehabilitation hospital. Claimant did well in his brain injury rehabilitation program. However, he asserts that he has persisting difficulty recalling information and is otherwise forgetful. Defendants acknowledged Claimant's traumatic brain injury and Dr. Beaver rated Claimant's permanent impairment due to his traumatic brain injury from the 2007 accident at 2% of the whole person. The remaining dispute between the parties is whether Claimant's traumatic brain injury caused recurring dizziness after approximately December 2008, which resulted in multiple falls and further injury.

104. Dr. Harris testified that it was general information that head injuries and concussions are known to cause balance problems, whereas diabetes does not necessarily cause balance issues unless it results in severe peripheral neuropathy. Harris Deposition, pp. 25, 32-33. Dr. Joseph testified similarly that post-concussive symptoms include cognitive difficulty in thinking and reasoning and somatic symptoms including dizziness.

105. Dr. Greenwald examined Claimant on June 24, July 28, and August 5, 2008 and reported Claimant's injuries, including dizziness causing him to fall, and noted that Claimant reportedly fell as recently as three weeks earlier. However, on September 30, 2016, Dr. Greenwald issued a report wherein she considered the effect of Claimant's pre-existing conditions on his continuing balance issues persisting several years after his 2007 accident:

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fractures then healed in the four months between December 2010 and May 2011 when they refractured and another

> the patient complains of issues with loss of balance when he ambulates. His blood pressure and heart rate have been significantly raised and he is noted to be quite deconditioned. The patient also has hypertension and diabetes. The recreational therapist noted that the patient has a history of myocardial infarction, cerebral vascular accident by his report, and is in poor health with obesity, diabetes, increased blood pressure, hypertension, and general deconditioning.

Exhibit 17, p. 3937. Dr. Greenwald reviewed approximately 4,000 pages of Claimant's medical records and noted his multiple post-accident falls including: January 11, 2011 fall down the stairs at his home, July 2012 fall onto his right chest on a water jug when his lawn chair collapsed, July 2013 trip and fall over a hotel fireplace, March 3, 2014 hard fall on his right shoulder, July 2014 fall, September 8, 2014 fall with his right arm under his body when he tripped over his dog, and multiple falls in 2015 including a fall with outstretched arm five months prior to September 2015.

106. Dr. Greenwald testified that some of Claimant's pre-existing conditions created a risk of falls, including poorly controlled diabetes with blood sugar level fluctuations causing dizziness, vision decline, and polyneuropathy making it more difficult for Claimant to feel his feet and thus less stable. She noted that on several occasions when Claimant sought medical treatment post-accident, his blood sugar level was noted to be very elevated. She testified that Claimant's hypertension may also contribute to his dizziness. Dr. Greenwald summarized her final conclusion that Claimant's continued falls after 2008 are not related to his 2007 accident:

> Certainly, when I came and met with him in 2008 and went through my program we were working a lot with his dizziness, which can be commonly found after a concussion.
>
> However, it was a little unusual to see that someone was having such significant falls after—this far out of this type of accident, which was a mild traumatic brain injury or concussion, so I did start spending a little bit more time on trying to figure out why is he still falling.

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rib also fractured due to Claimant's coughing from his COPD aggravated by his viral infection.

> And it's my medical opinion that I don't think it's related to this accident anymore. I believe it's related to multiple medical conditions that he currently has.
>
> Polyneuropathy is one of the main things to cause falls. Also with COPD you get short of breath, and that can cause issues. Diabetes can cause, also, some vision issues, and that can also add into a high risk for falls.

Greenwald Deposition, p. 17, l. 20 through p. 18, l. 13.

107. In December 2008, Dr. Kanner examined Claimant and, as previously noted, concluded: "From a respiratory point of view, he no longer suffers problems from the accident." Exhibit 21, p. 3998. Dr. Kanner's examination corroborates Dr. Greenwald's concerns regarding Claimant's COPD, deconditioning, and shortness of breath. Dr. Kanner recorded that Claimant in his 20s weighed about 140 pounds. He smoked cigarettes for 20 years. At age 35 he was diagnosed with asthma, thereafter had pneumonia twice, was diagnosed with COPD in 2004, and by the time of his 2007 accident was five feet five inches tall and weighed approximately 250 pounds. Dr. Kanner noted that Claimant's abdomen was very obese and chest radiographs showed both diaphragms were slightly elevated due to Claimant's abdominal obesity. In routine pulmonary testing, Claimant walked only 1363 feet on level ground in six minutes, which Claimant described as "very hard" and his dyspnea as being "very severe." Dr. Kanner recorded that upon completing this walk Claimant was dizzy.

108. At hearing, Claimant repeatedly testified of his understanding that his recurring dizziness is due to oxygen deficiency:

> Q. …. Do you remember [Dr. Harris] telling you got dizzy because of your coughing?
>
> A. Lack of oxygen.

Transcript, p. 139, ll. 13-15.

> Q. Do you recall what Dr. Harris told you about why you were having headaches?
>
> A. Having headaches or dizziness?
>
> Q. Okay. One reason—do you recall him talking about getting up and sitting down too quickly?
>
> A. It's called lack of oxygen.

Transcript, p. 154, l. 22 through p. 155, l. 2.

109. Claimant testified he began using oxygen approximately two years after the 2007 accident because of his low blood oxygen levels and that he must be on oxygen for the rest of his life. He testified at his pre-hearing deposition of his balance issues: "Dizziness, not all the time but dizziness. I get dizzy when I bend over. I get dizzy—if I turn my head too quick, I have a momentary dizzy problem." Exhibit 44, p. 4601. Claimant testified of his physical limitations due to oxygen insufficiency:

> Q. What about bending at the waist is that a problem?
>
> A. If I bend over at the waist sitting down—I can't tie my shoe laces because I get winded because it all presses on the diaphragm and all that. I would get a little dizzy if I bend over at the waist standing up.

Exhibit 44, p. 4605. Claimant testified that he can only walk a half a block and can "deal with" a half dozen steps, but would be "winded" and have difficulty with a flight of stairs.

110. Claimant's briefing also asserts his recurring dizziness and post-accident falls are a direct result of his flail chest condition. He emphasizes Dr. Harris' April 14, 2011 note and asserts:

> Dr. Harris' comments regarding Dr. Garland's consultation is that the flail chest was causing Mr. McClain to pass out. Dr. Harris did not opine it was the COPD or the headaches that were causing Mr. McClain to pass out. Dr. Cook noted that on April 14, 2011, that Mr. McClain's sugar levels were "reasonable." (V1, Ex. 3, 77). Therefore, the dizziness related falls after April of 2011 can be attributed to flail chest which causes the intra-thoracic and intra-abdominal pressure.

> Given that Dr. Harris' discussion with Dr. Garland explains the dizziness after the flail chest in April of 2011.

Claimant's Post-Hearing Reply Brief, p. 8.

111. Dr. Garland's April 13, 2011 note states:

> Since his injury, he has had episodic dizziness. He has 2 types of dizziness. The most common and at [sic] least disabling dizziness is when he gets up from lying or sitting too quickly. He will feel lightheaded and may have some initial darkening of his vision, but does not lose consciousness or feel like he will fall. If he gets up slowly this does not occur. His dizziness seems to be definitely postural and has been manageable. A second type of dizziness occurs only when he coughs or sneezes. When this occurs, he has increase in chest wall pain. He described darkening of his vision with a sense of vertigo. He can control some of the dizziness if he tries to fixate on the stationary object in front of him. He will sometimes become pale and may take minutes to as long as a half hour to recover from the exhaustion which occurs afterwards. When he coughs or sneezes he has ballooning out of his right chest wall because of the multiple rib fractures resulting in a flail chest. He report that he has had brain imaging to include carotid ultrasound, cardiac angiogram, and abdominal thoracic angiogram which are [sic] not found a cause for his symptoms. This dizziness and sense of near syncope which occurs with coughing or sneezing is very disabling.

Exhibit 3, p. 58.

112. Dr. Harris' April 14, 2011 discharge note after Claimant initially developed flail chest, addressed the cause of Claimant's falls and concurred in Dr. Garland's assessment:

> Whenever he would cough the chest with [sic] flail out. He would have an acute episode of pain and what was interpreted as a vasovagal response, wherein he would pass right out. On one occasion if the nurse had not been right there, he would have fallen.
> ….
>
> Because of headaches and episodes of loss of consciousness, he was seen by Dr. Eric [sic] Garland. The patient also in 2007 had significant head injury with consequent traumatic brain injury and some neurological deficits. Therefore, he was seen in consultation by Dr. Garland. His impression was that there might be a dramatic change in intra-thoracic, intra-abdominal pressure is [sic] a result of his flail chest, resulting in him passing out. The change in intrathoracic pressure reflected in a cerebral venous system, producing a change in intracranial pressure and/or cerebral perfusion pressure. One occasion when he was caught by nurse,

> once he was back in bed, his blood pressure was normal; however it is reasonable to conclude that possible drop in blood pressure during the acute event.

Exhibit 3, pp. 29-30.

113. In his post-hearing deposition, Dr. Harris reaffirmed Dr. Garland's assessment:

> Q. …. Is it more likely than not that Rocky McClain's loss of consciousness was caused by his flail chest?
>
> A. Let me answer that by saying that I commented on Dr. Garland's report, and there is—the other question is: Would it have been just some other cause for hypotension or low blood pressure—
>
> MR. DAVIS: I would object. It's nonresponsive.
>
> THE WITNESS: So he commented and made a comment in the record that Mr. McClain felt dizzy even while he was lying in bed suggesting that it wasn't just central blood pressure but another cause for him to pass out which could have been, in this instance, flail chest. Flail chest is a very significant condition.

Harris Deposition, p. 53, ll. 8-22.

114. The above-cited opinions of Dr. Harris and Dr. Garland are well explained and persuasive that Claimant's recurring dizziness after April 2011 is related to his flail chest.

115. Claimant asserts that the pattern of his lack of falls before the 2007 accident and his repeated falls thereafter establish that the 2007 accident caused his subsequent falls. Clearly his 2007 accident was itself a fall. Because Claimant denies memory of falling on August 10, 2007, it is unknown whether the effort required to climb the steps of the cat walk to the top of his cement mixer left him winded and/or dizzy thus precipitating his fall. At the time of his 2007 accident Claimant was five feet five inches tall and weighed approximately 250 pounds—very similar to his body habitus when tested by Dr. Kanner.

116. The pattern of falls demonstrated by the record is that Claimant's falls were initially numerous during the 12 to 16 months following his 2007 accident, then markedly decreased until he developed flail chest in April 2011, and thereafter dramatically increased.

Medical records show at least six falls between August 10, 2007 and September 2008, only one fall between October 2008 and April 8, 2011,[11] and at least seven falls (not including a fall from a collapsing lawn chair) between April 8, 2011 and March 2016. This correlates with Claimant's flail chest developed in April 2011 and his increasing need for supplemental oxygen and provides further indication that his recurring dizziness and resulting falls after April 2011 are more likely due to flail chest and oxygen deficiency rather than to any residual effect of his traumatic brain injury. This corroborates Dr. Greenwald's opinion that Claimant's falls after December 2008, are not due to his traumatic brain injury.

117. The record establishes Claimant's falls after April 2011, are most likely due to his flail chest and/or oxygen deficiency—conditions not proven to be related to his 2007 accident.

118. Claimant has not proven that his dizziness and resulting falls after December 2008 are due to his 2007 accident.

119. Cervical injury. Claimant asserts his 2007 accident caused his need for cervical fusion surgery in 2013 and for revision cervical fusion surgery in 2015, either as a direct result of his 2007 accident and/or as a result of his subsequent falls due to recurring dizziness from his 2007 accident.

120. *2013 cervical fusion.* Claimant contends that from the time of his 2007 accident until his first cervical surgery in 2013, he suffered persisting sharp aching neck pain.

121. Claimant's cervical CT scans the day of the 2007 accident showed no acute injury but "SEVERE DEGENERATIVE DISC DISEASE C3-4, C4-5, C5-6, C6-7, C7-T1." Exhibit 3, p. 16F. His medical records report neck pain after the 2007 accident until approximately December 2008. Claimant testified at hearing that from the time of his 2007 accident and

[11] On January 10, 2011, Claimant fell down the stairs at his home. He reported moderate ankle pain, but no chest,

continuing through April 2012, he had sharp neck pain that restricted his ability to turn his head or look up or down. However, Claimant is not a reliable witness and his professed recollection is inconsistent with the medical record and unpersuasive.

122. On April 24, 2010, Claimant suffered a left ankle sprain as a passenger when his wife struck a horse while driving. Claimant did not report any neck pain or injury when taken to the hospital. Indeed, the emergency room report recorded: "Neck: Normal inspection. Neck supple. C-spine non–tender." Exhibit 3, p. 16J.020. Similarly, on January 10, 2011, Claimant presented at the hospital emergency room reporting he had fallen down the stairs at his home. He reported no neck pain. Indeed, the physical examination notes recorded that Claimant's neck was supple with no decrease in range of motion. Exhibit 3, p. 16J.037.

123. The earliest reliable documented neck pain complaints after December 2008 appear in the April 23, 2012, record of Dr. Poston's assistant, Matthew Nelson, PA-C, who recorded: "William is here today to follow-up with neck and low back pain. He complains of inability to turn his head to the left. This started about 6 weeks ago." Exhibit 27, p. 4269 (emphasis supplied). Claimant's April 24, 2012 cervical CT scan showed: "no appreciable interval change in the appearance of the cervical spine since the previous exam of August 10, 2007 with the exception that disk space narrowing has mildly progressed at C3-C4 through C7-T1 levels." Exhibit 27, pp. 4271-4272.

124. Claimant's medical records do not indicate complaints of neck pain between December 2008 and April 2012—a period of more than three years. The voluminous record establishes that Claimant was not hesitant to seek medical care or to inform his providers of his complaints, thus the absence of reports of neck symptoms in the medical records for more than

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shoulder, or neck pain.

three years post-accident is significant. Dr. O'Brien, who issued a report on September 5, 2012, regarding Claimant's injuries from his 2007 accident, made no mention of cervical complaints. The credible evidence does not show a pattern of persisting cervical symptoms relating Claimant's 2013 cervical surgery to his 2007 accident.

125. Additionally, the credible record does not contain any report of a fall producing complaints of neck pain between the 2007 accident and the commencement of cervical symptoms on April 23, 2012. Similarly, the record does not contain any report of a fall producing complaints of worsening neck pain between April 23, 2012, and April 2, 2013. There is no credible evidence relating Claimant's 2013 cervical surgery to a post-accident fall from whatever cause.

126. *2015 cervical fusion revision.* Claimant underwent C3-C7 anterior cervical diskectomy and fusion on April 2, 2013. He did well until he sustained a "hard fall" and landed on his right shoulder approximately one month prior to April 2, 2014. Exhibit 35, pp. 4482-4483. Thereafter, plain radiographs showed C3-6 fusion, C6-7 pseudoarthrosis, and C7 screw fracture. Claimant underwent revision cervical surgery with placement of new hardware on January 5, 2015.

127. Claimant's 2015 revision cervical surgery might conceivably be related to the 2007 accident if Claimant's hard fall approximately one month prior to April 2, 2014, was caused by his 2007 accident. The record contains few reliable details surrounding Claimant's alleged fall one month prior to April 2, 2014. Claimant alleges all of his post-accident falls, including his fall one month prior to April 2, 2014, were due to his 2007 accident, asserting the accident caused flail chest which resulted in recurring dizziness and subsequent falls. However,

as already determined, Claimant has not proven that his flail chest or recurring dizziness after 2008 were caused by his 2007 accident.

128. Dr. Harris did not opine that Claimant's 2013 and 2015 cervical surgeries were related to his 2007 accident. He testified that he does not do neck surgeries, was not directly involved in Claimant's neck surgeries and had "No specific comments" when asked if he felt comfortable expressing opinions about Claimant's neck surgeries. Harris Deposition, p. 60, ll. 11-18. Similarly, Dr. Joseph readily acknowledged that he "did not have any information" and thus could not opine whether Claimant's neck injuries were related to his 2007 accident. Joseph Deposition, p. 26, ll. 5-13. Dr. Greenwald opined that Claimant's cervical surgeries were not related to his 2007 accident. Dr. Greenwald's opinion is well supported by the reliable record detailed above and is persuasive.

129. Claimant has not proven that his need for cervical treatment after December 2008, including his cervical surgeries in 2013 and 2015, is related to his 2007 accident.

130. Total right shoulder arthroplasty. Claimant has had three right shoulder surgeries. Defendants accepted responsibility for his first shoulder surgery of September 7, 2007, and his second shoulder surgery of December 21, 2007. However Defendants deny responsibility for Claimant's third shoulder surgery—a total right shoulder arthroplasty on March 15, 2016. Claimant asserts this third shoulder surgery is related to his 2007 accident.

131. In Claimant's first right shoulder surgery on September 7, 2007, Dr. Huntsman performed arthroscopic repair of a SLAP lesion. In Claimant's second right shoulder surgery on December 21, 2007, Dr. Huntsman performed arthroscopic repair of a recurrent SLAP lesion after Claimant's right shoulder popped when he was stretching at home. Dr. Huntsman last examined Claimant on May 8, 2008, and was pleased with how Claimant was doing. Dr.

Huntsman noted some right shoulder stiffness but 5-/5 strength to abduction, internal and external rotation, and negative impingement sign.

132. Claimant testified that his right shoulder continued to be symptomatic even after his second shoulder surgery. As repeatedly noted, Claimant is not a reliable witness. His assertion of significant continuing symptomatology is inconsistent with his failure to attend his final scheduled post-surgical appointment with Dr. Huntsman. Claimant thereafter never returned to Dr. Huntsman. Undoubtedly Claimant had some persisting right shoulder symptoms. However, on August 5, 2008, Dr. Greenwald found Claimant medically stable and rated his right shoulder impairment at 7% of the whole person. She did not recommend further right shoulder surgery.

133. Claimant did not report a change in his right shoulder condition to any of his medical providers between September 2008 and April 2011, when he developed flail chest. He did not report any falls resulting in a change in his right shoulder symptoms between September 2008 and April 2011. Claimant reported right shoulder pain on February 9, 2012 to Dr. Poston, as well as rib, back, and chest pain from a cold. On April 23, 2012 he reported neck pain radiating into his right shoulder to Matthew Nelson, PA-C, and shortly thereafter underwent a cervical CT. Claimant underwent his first cervical fusion surgery on April 2, 2013. Thereafter he was "doing well" until about one month prior to April 2, 2014, when he had a "hard fall" and "landed on his right shoulder." Exhibit 35, pp. 4482-4483. X-rays that day showed a fractured C7 screw from his 2013 cervical fusion. From that time onward, Claimant regularly reported increased right shoulder pain and his providers recorded significant increased pain with right shoulder strength and range of motion testing. He subsequently tripped over his dog and fell with his right arm under his body on September 8, 2014. Claimant suffered several further falls,

most notably, he reported to Dr. Poston a fall five months prior to September 17, 2015 when he "fell on an … outstretched right arm. He said he felt a pop in his shoulder and has had decreased range of motion and pain in his shoulder since." Exhibit 27, p. 4326. Thus Claimant had continued increased right shoulder symptoms for at least five months.

134. Dr. Joseph testified at his deposition that he was aware of Claimant's 2007 shoulder surgeries by Dr. Huntsman, but was not aware that Claimant underwent additional shoulder surgery after March 14, 2016. Dr. Joseph testified that 50-70% of rotator cuff repairs hold; however, a portion subsequently tear following repair. Dr. Joseph did not opine that Claimant's total shoulder arthroplasty was related to his 2007 accident. Joseph Deposition, pp 14-15.

135. Dr. Harris did not opine that Claimant's total right shoulder arthroplasty was related to his 2007 accident. By May 2016, Dr. Harris was aware of Claimant's 2016 right shoulder replacement; however, at the time of his post-hearing deposition Dr. Harris had no information or opinion regarding whether the total shoulder arthroplasty was related to the 2007 accident. Harris Deposition, pp. 57-58.

136. In a September 5, 2012 report Dr. O'Brien opined that Claimant's right shoulder issues were related to his 2007 accident, stating:

> The second problem involves the right shoulder which was surgerized [sic] recently after the accident and then again on another occasion and now the patient tells me that he is facing a third surgery on the right shoulder since it has not taken care of the problem in that area. Portions of the clavicle were excised during his first surgery because of the symptoms. Certainly there is a significant problem there in the shoulder that will now require another surgery. His problems in the shoulder are directly related to the accident of August 2007.

Exhibit 33, pp. 4434-4435 (emphasis supplied). Dr. O'Brien's stated source of information is Claimant. Dr. O'Brien does not specifically identify the "significant problem" in the shoulder or

what surgery is now required. It does not appear that Dr. O'Brien ever reviewed the record of Claimant's 2016 total right shoulder arthroplasty.

137. While Claimant reported right shoulder symptoms to Dr. O'Brien on September 5, 2012, it does not appear that any provider had then recommended or offered additional right shoulder treatment let alone surgery. After Dr. O'Brien's consultation, Claimant suffered a hard fall on his right shoulder, a fall with his right arm underneath him, and a fall onto his outstretched right arm with a pop in his right shoulder resulting in persisting shoulder pain and decreased range of motion—all before undergoing total right shoulder arthroplasty nearly four years later.

138. Dr. Greenwald initially concluded Claimant's third shoulder surgery was related to his 2007 accident. However, at her post-hearing deposition she ultimately revised her conclusion after learning of his multiple post-accident falls:

> Q. As it relates to the third shoulder surgery, could an intervening cause after the industrial accident have caused the need for a third shoulder surgery?
>
> A. And that where I was having a difficult time to understand a third surgery. And the reason why is generally a replacement, a joint replacement, is related mostly to arthritis. We know this well with knee replacements, hip replacements, and shoulders are no different if they get arthritic.
>
> The issue with this is that he mentioned he only had mild arthritis. Certainly trauma within a joint space can cause acceleration of arthritis, but it wasn't clear to me the true reason, besides complaints of pain, that they were going in and performing a total joint.
>
> Q. There was some mention of some falls that had some impact as it relates to his right shoulder. A few that I had mentioned involved a hard fall on the right shoulder in March of 2014. Another in, I think September of 2014. And then in 2015 in May, when he reported to Dr. Poston that he fell on outstretched arms. Could those have had an impact as it relates to his third shoulder surgery?
>
> A. Yes, those could definitely have impact.

> Q. Now, it looks like these three falls that I just mentioned occurred between six months and two years before the third surgery. Is that enough time for that type of an acceleration to occur that may reasonably relate to that third shoulder arthroplasty—well, I guess, it was the first shoulder arthroplasty, but the one that was done in 2015 [sic].[12] Could—
>
> A. Yes. ….
>
> Q. …. Is it possible that that shoulder arthroplasty could have been related to any of these falls even though they were somewhere between six months and two years before that third surgery?
>
> A. Yes, certainly it can, especially with arms outstretched is hard on the shoulder.
>
> Q. And, in fact, there were significant periods of time where the claimant was not complaining of his shoulder at all during this seven- or eight-year period after the injury, right.
>
> A. That is correct.
> ….
>
> In my note that I have here from September and October, I said that, you know, I thought since he had two surgeries that—I thought that this is directly related to the work injury.
>
> However, after reviewing and discussing today with the multiple falls, it's hard to say that these falls are not involved, especially with an outstretched arm that could significantly affect his shoulder.

Greenwald Deposition, p. 20, l. 23 through p. 22, l. 19, p. 24, ll. 3-10.

139. The record does not indicate that Dr. Richardson, who performed Claimant's right total shoulder arthroplasty, opined it was related to Claimant's 2007 accident. No medical expert has persuasively opined that Claimant's 2016 right shoulder arthroplasty is related to his 2007 accident.

140. Claimant notes possible suprascapular neuropathy noted near the time of his March 15, 2016 total right shoulder arthroplasty. Dr. Greenwald did not find evidence of

[12] Claimant's total shoulder arthroplasty was performed March 15, 2016.

suprascapular neuropathy in the form of atrophy when she examined Claimant. Neither Dr. Huntsman nor prior physical therapists reported evidence of such atrophy.

141. Claimant nevertheless cites the comments in Dr. Greenwald's September 30, 2016 report regarding suprascapular neuropathy and possible right shoulder labral cyst wherein she stated:

> The last concern is that right suprascapular neuropathy. I still recommend an MRI of the nerve to see if there is a possible labral cyst. Sometimes, cysts do occur after surgery. As I mentioned above, Dr. Huntsman did not note any initial atrophy at the time; however, perhaps after the third surgery, a cyst appeared or it could be from the nonuse. Therefore, I think it is reasonable to do an MRI related to the work related injury. If there are cysts, I would deter to the surgeon. If it is related to this third surgery, then it is related to the work accident. I do not see any indication this happened at the time of the accident, so I cannot say it is related to the accident in 2007 injury. If there are no cysts, I would defer to the surgeon. If it is related to this third surgery, then it is related to the work accident. I do not see any indication this happened at the time of the accident [sic], so I cannot say it is related to the accident in 2007 from the fall; however, as mentioned several times above, it is possible this could have happened from the third surgery and cyst formation.

Exhibit 17, pp. 3937M-N (emphasis supplied).

142. Based upon Dr. Greenwald's recommendation for an MRI, Claimant "requests that Commission find that the letter to the surgeon regarding the cyst and it's [sic] relationship to the injury, be ordered in this matter." Claimant's Opening Post-Hearing Brief, p. 22. Claimant's request is declined for two reasons.

143. First, Dr. Greenwald's reference in her report to a right shoulder MRI to rule out a possible labral cyst was made based upon her earlier conclusion that Claimant's third right shoulder surgery was related to his 2007 accident. However, after learning of Claimant's multiple post-accident falls on his right shoulder, Dr. Greenwald effectively declined to relate his 2016 shoulder surgery to the 2007 accident. Thus any suprascapular nerve irregularity arising

from Claimant's third right shoulder surgery has not been shown to be related to the 2007 accident.

144. Second, Dr. Greenwald testified a labral cyst can develop due to surgery or due to a labral tear:

> I've read a couple of studies that talk about after surgery a cyst can come after a labral tear or a surgical intervention.
>
> And what's interesting is with one of the falls with his arm stretched out, that's actually a very common labral tear position. And if he had a labral tear in that shoulder, it's possible that that could have caused a cyst formation.

Greenwald Deposition, p. 54, ll. 10-17.

145. Dr. Greenwald affirmed a fall on an outstretched arm is a very common cause of labral tears. Claimant reported exactly such a fall to Dr. Poston. Therefore, even if a future right shoulder MRI revealed a labral cyst, there is no assurance the MRI would identify whether the cause of such a cyst was due to Claimant's September 7 or December 21, 2007 right shoulder surgeries, his fall onto his outstretched right arm five months prior to September 2014, any of his other multiple post-accident falls onto his right shoulder, or his March 15, 2016 total right shoulder arthroplasty.

146. Claimant has not proven that his 2016 total right shoulder arthroplasty is related to his 2007 accident.

147. Claimant has not proven that his need for medical treatment for his dizziness, neck, right shoulder, or right chest conditions after December 2008 is related to his 2007 accident.

148. **Neel v. Western Construction.** Claimant asserts he is entitled to payment of the full invoiced amounts of the medical expenses related to his August 10, 2007 industrial accident pursuant to Neel v. Western Construction, Inc., 147 Idaho 146, 206 P.3d 852 (2009).

149. As noted, Claimant has not proven that medical care for his dizziness, neck, right shoulder, or right chest conditions after December 2008 is related to his 2007 accident. At hearing Surety's adjuster Paul Sears explained two ledgers listing Surety's payment or non-payment of more than 700 medical bills that Claimant alleges or has alleged related to his 2007 accident. Mr. Sears testified credibly that Exhibit 136 is a comprehensive and accurate itemization of payments made pursuant to Dr. Greenwald's express determination of whether the medical costs claimed were related to Claimant's 2007 accident. Transcript, pp. 223-227; Exhibit 17, pp. 3937A-3937B; Exhibit 136, pp. 6033-6047. Dr. Greenwald's causation opinions as extensively discussed above are well explained and persuasive.

150. Having carefully reviewed Exhibit 136, no outstanding unpaid medical bills have been identified which Claimant has proven are related to his 2007 industrial accident, except the bill for Dr. Huntsman's August 27, 2007 examination of Claimant's right shoulder. Exhibit 136, p. 6038. However, Exhibit 135, p. 6023 documents that Surety did in fact acknowledge this bill was related to the 2007 accident and paid this bill via check number 1396905. Claimant has not proven his entitlement to any further medical benefits.

151. Neel is inapplicable.

CONCLUSIONS OF LAW

1. Claimant has not proven he is entitled to additional medical care for treatment received prior to July 15, 2016.

2. Claimant has not proven that his need for medical treatment for his dizziness, neck, right shoulder, or right chest conditions after December 2008 is related to his 2007 accident.

3. Neel is inapplicable.

RECOMMENDATION

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

DATED this __20TH__ day of November, 2017.

INDUSTRIAL COMMISSION

_/s/_____
Alan Reed Taylor, Referee

ATTEST:

_/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the ___1st___ day of _December_____, 2017, 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:

ANDREW A ADAMS
598 N CAPITAL AVE
IDAHO FALLS ID 83402

SCOTT R HALL
WESTON S DAVIS
PO BOX 51630
IDAHO FALLS ID 83405-1630

_/s/_____

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

WILLIAM MCCLAIN, Claimant, v. VALLEY READY MIX, INC., Employer, and STATE INSURANCE FUND, Surety, Defendants.	**IC 2007-028342** **ORDER** FILED DECEMBER 1, 2017

Pursuant to Idaho Code § 72-717, Referee Alan Taylor 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 recommendations 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 not proven he is entitled to additional medical care for treatment received prior to July 15, 2016.
2. Claimant has not proven that his need for medical treatment for his dizziness, neck, right shoulder, or right chest conditions after December 2008 is related to his 2007 accident.
3. Neel is inapplicable.

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

DATED this ___1st_ day of _December_____, 2017.

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 ___1st___ day of _December_____, 2017, a true and correct copy of the foregoing **ORDER** was served by regular United States mail upon each of the following:

ANDREW A ADAMS
598 N CAPITAL AVE
IDAHO FALLS ID 83402

SCOTT R HALL
PO BOX 51630
IDAHO FALLS ID 83405-1630

sc _/s/_____