BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

KELLY EDENS, Claimant, v. BRUNDAGE-BONE CONCRETE PUMPING, Employer, and LIBERTY MUTUAL INSURANCE CORPORATION, Surety, and BERKSHIRE HATHAWAY HOMESTATE INSURANCE COMPANY, Surety, Defendants.	**IC 2008-035062** **2014-004950** **2014-011138** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** Filed June 7, 2016

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee LaDawn Marsters, who conducted a hearing in Boise on November 19, 2014. Daniel J. Luker represented Claimant Kelly Edens. Joseph M. Wager represented Employer Brundage-Bone Concrete Plumbing ("Brundage-Bone") and Surety Liberty Mutual Insurance Corp. ("Liberty"). Nathan T. Gamel represented Employer Brundage-Bone and Surety Berkshire Hathaway Homestate Insurance Company ("Berkshire"). The Referee admitted oral and documentary evidence at the hearing. The

parties took post-hearing depositions. On July 9, 2015, Referee Marsters granted Claimant's motion to receive additional evidence regarding his right shoulder condition and scheduled a second hearing. Prior to the second hearing, Referee Marsters left the Commission. The Commission reassigned the matter to Referee Alan Taylor, who conducted a hearing in Boise on September 18, 2015. The same legal counsel represented the parties at the second hearing. The Referee admitted additional oral and documentary evidence into the record. The parties took additional post-hearing depositions and submitted post-hearing briefs. The matter came under advisement on March 8, 2016. The undersigned Commissioners have chosen not to adopt the Referee's recommendation and hereby issue their own findings of fact, conclusions of law and order. The Commissioners agree with the Referee's proposed outcome, but give slightly different treatment to the question of whether the risk of injury to which Claimant was exposed was "characteristic of and peculiar to" his employment.

ISSUES

The issues to be decided are as follows:

1. Whether the condition for which Claimant seeks benefits was caused by the 2008 industrial accident, the result of work activity in 2014, neither, or some combination of both;

2. Whether Claimant incurred a compensable occupational disease;

3. Whether Claimant's condition is due in whole or in part to a preexisting injury/condition;

4. Whether and to what extent Claimant is entitled to the following benefits:

   a. Medical care; and

   b. Temporary partial and/or temporary total disability benefits (TPD/TTD);

5. Whether Claimant's shoulder injury is compensable, including his entitlement to medical and temporary disability benefits related to that injury.

6. All other issues are reserved.

CONTENTIONS OF THE PARTIES

On October 27, 2008, Claimant sustained injuries while working for Brundage-Bone on the deck of an interstate bridge that collapsed (the "2008 industrial accident"). At the time of the 2008 industrial accident, Liberty provided the worker's compensation insurance coverage for Brundage-Bone. Liberty accepted the claim, covered Claimant's medical bills, and paid both time-loss and impairment benefits associated with the accident. Claimant received a release to return to work without restrictions and he returned to work full-time for Brundage-Bone. On November 1, 2013, Berkshire became the Surety for Brundage-Bone. Claimant continued to work for Brundage-Bone until February 10, 2014, when he had an onset of pain in his upper extremities while unloading concrete hose line from his truck (the "2014 industrial accident"). Claimant sought medical treatment and has not worked for Brundage-Bone since. Neither Surety has accepted responsibility for Claimant's medical conditions or treatment following the 2014 industrial accident.

Claimant alleges that his work activities on February 10, 2014 constituted a new accident resulting in the onset of bilateral cubital tunnel syndrome ("CTS") and a SLAP tear to his right shoulder. In the alternative, he argues that his bilateral CTS is a compensable occupational disease incurred as a result of his employment with Brundage-Bone. Claimant argues that the medical treatment he has received for both his bilateral CTS and his right shoulder condition, which have included surgeries, are reasonable and causally related to the 2014 industrial accident. He asserts that Defendants are liable to pay

the full invoiced amounts of his medical bills. He further asserts that he is entitled to temporary disability benefits since February 10, 2014 because, as of the date of the second hearing, he was still in a period of recovery. Finally, in the alternative, Claimant argues that if the Commission does not find that the 2014 industrial accident is the most probable cause of his bilateral CTS and his right shoulder condition, then those conditions are the result of his 2008 industrial accident and are still compensable.

Liberty argues that Claimant has not met his burden of proving that his bilateral CTS and right shoulder condition are causally related to the 2008 industrial accident. Thus, Liberty argues that it bears no financial responsibility for those conditions and is not liable for any time loss or medical benefits.

Berkshire argues that there is no medical testimony demonstrating that the 2014 industrial incident caused Claimant's bilateral CTS. Berkshire further argues that Claimant's occupational disease claim for bilateral CTS fails because no physician has offered medical testimony sufficient to satisfy the "peculiarity" element of proof necessary for a compensable occupational disease claim. As for Claimant's right shoulder condition, Berkshire argues that Claimant has failed to sustain his burden of proof that it is causally related to the 2014 industrial incident. Thus, Berkshire argues that it bears no financial responsibility for those conditions and it is not liable for any time loss or medical benefits.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant and his wife Rebecca Edens taken at the November 19, 2014 hearing;

2. The testimony of Claimant taken at the September 18, 2015 hearing;

3. Claimant's Exhibits 1 – 34, Volume I ("CEI") admitted at the November 19, 2014 hearing;

4. Claimant's Exhibits 1 – 21, Volume II ("CEII") admitted at the September 18, 2015 hearing;

5. Defendant Berkshire's Exhibits 1 – 18 ("BE") admitted at the November 19, 2014 hearing;

6. Defendant Liberty's Exhibits 1, 2, 9, and 10 ("LE") admitted at the November 19, 2014 hearing;

7. The deposition transcript of Claimant taken on November 7, 2014;

8. The deposition transcript of David N. Price, DC, taken on January 20, 2015;

9. The deposition transcript of Kevin Krafft, M.D., taken on January 23, 2015;

10. The telephonic deposition transcript of Lance LeClere, M.D., taken on March 19, 2015;

11. The deposition transcript of Jeffrey G. Hessing, M.D., taken on October 2, 2015; and

12. The deposition transcript of Lance LeClere, M.D., taken on October 13, 2015.

OBJECTIONS

All pending objections are overruled, with the exception of the objection to admission of Exhibit 1 offered by Berkshire during the deposition of Dr. LeClere on October 13, 2015, at page 23, lines 8 to 19. Berkshire did not provide notice of the exhibit in compliance with Rule 10(c) of the Judicial Rules of Practice and Procedure, nor was the exhibit in existence at the time of hearing. The objection is sustained.

FINDINGS OF FACT

1. **Claimant's Background.** Claimant was born in 1969. He moved with his family to Idaho in 1979. He attended high school until the ninth grade and later obtained his GED. Prior to his work for Brundage-Bone, his employment history consisted primarily of work in the restaurant and construction industries. He was 46 years old, married and resided in Nampa at the time of the second hearing. Claimant's Dep., 20:2-21; 31:23-36:8.

2. **Brundage-Bone.** Brundage-Bone operates a concrete pumping service business. It employs concrete pump operators who use concrete pump machines mounted on trucks to transfer liquid concrete into concrete forms at construction sites. Brundage-Bone is the largest concrete pumping company in the world and conducts business in Idaho and multiple other states. CEI 29:601.

3. **Claimant's Employment with Brundage-Bone.** Claimant began working as a concrete pump operator for Brundage-Bone in November 2005. His last day of work was February 10, 2014. As of the date of the second hearing, Brundage-Bone still considered Claimant an employee although he had not actually worked for the company since February 10, 2014. Tr. (11/19/2014), 51:11-19.

4. As a concrete pump operator, Claimant drove a concrete pump boom truck to and from construction sites. He was responsible for all aspects of operating a concrete pump mounted on a truck to deliver liquid concrete into concrete forms at construction sites. *Id.*, 51:24-52:1. Claimant summarized his job responsibilities as follows: "To maintain and upkeep the pump and to drive to different job sites and set up – diagnose, set up, and operate the pump truck for whatever contractor we were hired to do it for." Claimant's Dep., 36:18-21.

5. Claimant's workday began with an inspection of his truck, followed by a review of the "job tickets" for the construction sites for which he would provide concrete pumping services that day. Concrete pumping jobs were either "boom jobs," which involved delivering concrete through the truck's extendable metal boom, or "line jobs," which involved attaching lengths of line hose to the pump to deliver the concrete. He used "outriggers," giant metal arms, and "cribbage," material placed underneath the outriggers on the ground, to stabilize the truck in place so that it did not move during concrete delivery. Claimant wore a harness during concrete pumping jobs. The harness had a strap that went over his shoulders. The harness held a "remote box," which weighed approximately 25 pounds. The remote box contained the remote controls that Claimant used to operate the boom and concrete pump. When Claimant performed a line job, he would add as many sections of line hose as necessary to reach the concrete forms. A piece of line hose weighed approximately 95 pounds and the clamps used for attaching the line hose weighed approximately 14 pounds. Claimant was required to lift these items on a daily basis. Once Claimant had all of the line hose set up, he would wait for the concrete mixing truck to arrive to begin pumping the concrete. As the concrete pumping job progressed, Claimant would disconnect each section of line hose one at a time, lift the line hose to empty it of any remaining concrete, and carry it back to the truck to rinse it out. Concrete remaining in the line weighed 150 pounds per cubic foot. Emptying the hose line of concrete had to be done quickly to avoid having the concrete solidify in the hose. One of the methods Claimant used to rinse the line hose was a 55 gallon bucket filled with water. Another method was to use a water-soaked sponge drawn through the line hose by the suction of the pump. He also used a 12 pound hammer to beat the line hose to ensure that it

was clean of concrete. When finished, Claimant would reload all sections of line hose on the truck and move on to the next concrete pumping job at another construction site. At the completion of the workday, Claimant would perform another inspection of the concrete pump truck. Tr. (11/19/2014), 52:24-61:2.

6. The heaviest amount that Claimant was required to lift without the use of lifting aids in the course of performing his duties was 376 pounds. This occurred while lifting line hoses that still had concrete in them. Claimant's Dep., 36:22-37:9. On an average day, Claimant lifted in excess of 50 pounds repetitively throughout his workday. *Id*. at 39:23-40:3.

7. According to Brundage-Bone's Concrete Pump Operator Training Program Manual, concrete weighs approximately 150 pounds per cubic foot. The total weight of line hose with concrete in it is 376 pounds. CEI 29:633.

8. A typical workday for Claimant involved completing one to five concrete pumping jobs. He averaged 60 to 80 hours per week at work. He delivered concrete at construction work sites in the Treasure Valley, eastern Oregon, southern Idaho, and eastern Idaho. On one occasion, Claimant traveled to Texas to work. Tr. (11/19/2014), 61:5-25.

9. **2008 Industrial Accident.** On October 27, 2008, Claimant was performing a concrete pumping job on a new bridge overpass being constructed over Interstate 84 in Nampa. Claimant and coworkers began the morning pumping concrete to a bearing wall on the south side of the bridge. After finishing concrete for the wall, they moved to the north side to pump concrete for the bridge decks. Claimant was standing on the bridge and had begun to pump concrete for the decks when the bridge deck collapsed. Claimant's recollection at his deposition was that he fell 36 feet and landed on his side in concrete

rubble.[1] During the fall, the remote box attached to Claimant's shoulder harness was ripped off. After landing in the rubble, he pried off rebar that was pinning his left leg. Claimant then fell several feet again out of the rubble onto the ground. He crawled towards his truck. He did not lose consciousness. Tr. (11/19/2014), 62:1-25; Claimant's Dep., 43:12-45:15.

10. **Medical Care and Recovery Following the 2008 Industrial Accident.** Canyon County Paramedics found Claimant, who was conscious, lying on his right side in a semi-fetal position, 10 feet away from the collapsed bridge. The paramedic record notes that Claimant had suffered "multiple system trauma" and that his left leg had been pinned during the accident. Claimant complained of pain in his right shoulder, lower back, and left upper and lower leg. The paramedics observed a large abrasion and bulge on Claimant's left lateral mid-thigh. Claimant received morphine for pain at the scene of the accident and during transport to Saint Alphonsus Regional Medical Center in Boise. CEI 4:59-61.

11. Claimant arrived at the emergency department of Saint Alphonsus within one hour of the accident, where he received evaluation and treatment from Frederick J. Klein, M.D. Claimant presented as a "level 1 trauma" patient. He had complaints of right shoulder and left distal femur pain. He also complained of some numbness into the foot. Upon examination, the most significant finding was an abrasion and contusion, with no active hemorrhage, on Claimant's left lateral thigh. Claimant also had abrasions on both anterior tibia. X-rays and CT scans were negative for trauma to his right shoulder and left femur; his left femur was also negative for fracture. All other X-rays and CT scans, including those of his chest, abdomen, and pelvis, were negative for findings of acute trauma or

[1] The medical record for Claimant's post-injury treatment at Saint Alphonsus Regional Medical Center in Boise states that Claimant's fall was twenty feet. CEI 5:62. Paramedic records state Claimant fell thirty feet in a "two stage fall." CEI 4:59.

fractures. Examinations of other bodily systems and areas were unremarkable for findings of trauma. Dr. Klein noted that Claimant had "soft tissue swelling, straining at the distal left lateral femur." Dr. Klein's diagnosis was left leg injury with minor crush injury and right shoulder injury. George Munayirji, M.D., a trauma surgeon, also evaluated Claimant in the emergency room. Dr. Munayirji observed that Claimant's "left lateral thigh showed an area of about 10 x 15 cm of indentation and bruising consistent with soft tissue injury" and that Claimant's "shoulder was negative for any trauma." Dr. Klein released Claimant from work for one week, provided him with crutches, and advised him to elevate his legs and ice sore areas. He discharged Claimant to home with prescriptions for Norco, Flexiril, and Ibuprofen. CEI 5:62-66; 6:72-86.

12. Claimant next received treatment and evaluation from Douglas M. Hill, M.D., of the Saint Alphonsus Medical Group in Nampa. In a report dated October 31, 2008, Dr. Hill noted Claimant's complaints as follows: generalized weakness and soreness; some mild vertigo when rising to standing position; neck pain; low back pain; right shoulder pain; bilateral leg pain, especially left thigh; and bilateral axillary (armpit) pain. His assessment of Claimant's work-related injuries was as follows: contusions and abrasions; crush injury, left leg; cervical sprain; lumbar sprain; right shoulder sprain; and bilateral axillary contusions. Dr. Hill discontinued Claimant's use of crutches due to his axillary pain and ordered a walker instead. He continued Claimant's release from work until November 7, 2008. CEI 7:105-108.

13. Because Claimant had developed fluid accumulation secondary to the hematoma of his left thigh, Claimant received a referral to Mark S. Chown, M.D., a Nampa surgeon. On November 6, 2008, Dr. Chown performed a surgical drainage of the

hematoma. Dr. Chown saw Claimant for two follow-up visits in November 2008, at which he noted Claimant's satisfactory progress with resolution of fluid in the hematoma. CEI 8:198-199.

14. Claimant returned to Dr. Hill on November 14, 2008. Dr. Hill concluded that all of Claimant's injuries were improving. Claimant was still having discomfort in the axilla and occasional shooting pains in the inner aspect of his upper arms, but not past the elbow. Claimant had greater pain in his right arm than his left. Claimant's left thigh was still bothering him, however there was no visible drainage from his thigh wound. Claimant did not complain of right shoulder pain on this date. Dr. Hill released Claimant to return to work four hours per day, with restrictions limiting him to sedentary work. CEI 7:112-114.

15. At a follow-up visit on November 21, 2008, Dr. Hill noted that Claimant had returned to work, but had experienced reoccurrence of severe left leg pain as well as swelling of his left thigh hematoma. After Claimant saw Dr. Chown again to have his left thigh area re-drained, his symptoms were much improved. Claimant still had discomfort in his right arm axillary area and his left elbow medially. Overall, Dr. Hill found that Claimant was feeling much better, his leg swelling was reduced and his pain had improved. He assessed multiple injuries, recurrent left leg hematoma, and fear of returning to work. He noted that his biggest concern was Claimant's fear of returning to work. For this reason, he believed that a psychological consult was appropriate and referred Claimant to Robert F. Calhoun, PhD, a psychologist. Dr. Hill released Claimant from working for a full week and scheduled him to visit Charlie Frost, PA, in his absence. CEI 7:115-117.

16. PA Frost saw Claimant for follow-up on December 1, 2008. Claimant reported sleep disturbance and anxious reoccurring thoughts of the traumatic fall.

Claimant's most significant concern was his left lateral thigh for which his wound still had daily drainage. Claimant reported that his shoulder pain was much better as well as his right upper arm, but he could feel popping in his right shoulder. Upon examination, Claimant's right shoulder showed no obvious swelling. He had full range of motion without impingement signs. The left elbow showed no obvious signs of swelling. He had full elbow range of motion. The left lateral thigh continued to show an opening but there was no obvious drainage. PA Frost assessed the following: possible posttraumatic stress disorder; right upper arm muscle strain, much improved; right shoulder pain, much improved; crush injury left lateral thigh with reoccurring hematoma, much improved; and insomnia secondary to these conditions. PA Frost prescribed Ambien for sleep, ordered physical therapy, and released Claimant to remain off from work for another two weeks. CEI Ex. 9: 208-210.

17. At Claimant's next visit with PA Frost on December 15, 2008, he was feeling better overall. Claimant described the pain in his right arm as being almost completely resolved. His most significant complaints were left anterior thigh pain and intermittent nightmares of the accident. PA Frost continued all the same medicines, extended Claimant's physical therapy, and released him to return to work four hours per day, sedentary work only. CEI Ex. 9:211-216.

18. Claimant continued to treat with Dr. Hill and associates at Saint Alphonsus Medical Group from January 9, 2009 through May 18, 2010. During this time, the primary focus of Claimant's treatment was his ongoing pain from his left thigh crush injury and posttraumatic stress syndrome as result of the fall in the accident. Claimant did not complain of pain in his upper extremities during this period. Claimant received extensive

physical therapy. He also received psychological treatment by Dr. Calhoun from December 8, 2008 until November 23, 2009, at which point Dr. Calhoun declared that Claimant was "doing very well psychologically" and thus no further psychological treatment was required. Dr. Hill gradually released Claimant to return to work at Brundage-Bone, first with limited, sedentary work at less than full-time, and culminating with a full duty release to return to full-time work with no restrictions. By May 2009, Dr. Hill was treating Claimant solely for chronic left thigh pain secondary to the crush injury. Although Claimant continued to be bothered by chronic left leg pain, Dr. Hill opined that Claimant had reached maximum medical improvement on May 18, 2010. He released Claimant to return to work with no restrictions. CEI 7:118-168; 10:217-289; 11:290-304.

19. After Claimant's return to full-time work with no restrictions, he continued to perform his concrete pumping duties at full-time "plus," meaning that he worked weeks that averaged between 60 and 80 hours, which were common for his job. Nevertheless, he recalled that he "had to adjust everything" he did, primarily in regards to how he carried weight. Claimant, who is right hand dominant, previously carried line hose on his right arm. Following the accident and his return to work, he rotated carrying hose with either arm and sometimes took breaks during this task. Line jobs took longer as a result. Brundage-Bone provided him with a different harness that strapped around his waist instead of his shoulders because Claimant could not handle the pain of carrying a 25 pound remote box with his shoulders. Claimant also requested to be taken off as many line jobs as possible because of the pain it caused him. While performing a line job, it was common for Claimant to begin experiencing bilateral numbness and pain after loading three to four lines of hose. After working long hours, such as an 80 hour week, Claimant would experience

"flare ups" of pain radiating down from his shoulders to his arms. His pain symptoms included pain in his elbows. Tr. (11/19/2014), 65:5-14; 66:13-67:10; 82:13-21; 84:17-22.

20. Claimant also experienced significant changes in his personal lifestyle as a result of the injuries he sustained in the 2008 industrial accident. He could no longer play with his daughter in the yard. He could no longer use a push mower to mow his lawn. He no longer hiked because of the strain on his legs. He could no longer bowl, swim, or engage in similar physical activities. *Id.*, 85:14-86:3.

21. Claimant's wife, Rebecca Edens, testified concerning his condition after he returned to work full time. The "new normal" for the Claimant post-accident and recovery was a much more sedentary lifestyle when Claimant was not at work. Previously, Claimant and Rebecca Edens had enjoyed a vigorous outdoor lifestyle on their time off, which included camping, hiking, fishing, and bike riding. After the accident and his return to work, Claimant could not do any of those kinds of activities due to weakness in his left leg and in his arms. Claimant also used a riding lawn mower, whereas previously he used a push lawn mower. Tr. (11/19/2014), 35:9-37:10.

22. Claimant received pain management treatment from Daniel Marsh, M.D. and Michael J. Eastman, PA-C, of the Saint Alphonsus Pain Management Center from August 14, 2009 through September 25, 2014. On August 14, 2009, Dr. Marsh noted that Claimant's "shoulder pain after injury 100% improved." Claimant received various medications to treat his chronic left thigh pain, including Lidoderm patches, Lyrica, Topomax, Zonegran, and Voltaren Gel. Dr. Marsh prescribed a water circulating heat pad with pump to treat Claimant's thigh pain. Dr. Marsh also recommended that Claimant receive microcurrent therapy to help him with his neuropathic pain. On December 3, 2009,

Dr. Marsh concluded that Claimant had reached maximum medical improvement. CEI 13:308-328; 14:329-389.

23. In a wellness exam on August 13, 2010, performed by Claimant's primary care physician, Brian E. Cothern, M.D. of Saint Alphonsus Medical Group, Claimant complained of both arms going numb for a couple of months, the right arm more than the left. Claimant stated that this occurred at least twice a day. Claimant also complained of neck pain. He believed that these symptoms began when he sneezed and felt an acute pain on the right side of his neck. He did not describe wrist or elbow symptoms. BE 2:36.

24. Lawrence E. Green, M.D., a neurologist, first evaluated Claimant on September 27, 2010, upon referral from Dr. Cothern. He followed Claimant through September 27, 2011. At the first office visit, Claimant reported to Dr. Green that two to three months prior he had a hard sneeze and then felt sudden intense right neck pain, which had remained constant ever since. Claimant also reported that since the sneezing incident, both his arms were going numb, with the numbness a little worse on the right extremity, and that his hands also went numb at night. An MRI of Claimant's cervical spine on August 16, 2010 showed broad based disk bulges at three levels, C3-C4, C4-C5, and C5-C6, with moderate to severe right neuroforaminal narrowing at the C3-C4 level. Dr. Green's impression was that Claimant had two issues, as follows: upper cervical root irritation and possible carpal tunnel syndrome which he opined was "probably job related but not directly due to the accident that happened two years ago." Dr. Green ordered nerve conduction studies and referred his findings to Dr. Hill. CEI 15:390-391.

25. On October 5, 2010, Dr. Green noted that Claimant's upper extremity nerve conduction studies were "really quite unremarkable with no strong evidence for median

nerve compression at the wrists. There are borderline ulnar entrapments at the elbow that I do not think are clinically significant." Dr. Green could not explain the entirety of Claimant's arm going numb more on the right than the left. Because he was concerned that Claimant might have an intracranial abnormality unrelated to his industrial condition, he recommended that Claimant undergo a brain MRI scan. *Id*. at 392.

26. On October 29, 2010, Claimant returned to treat with Dr. Hill, who reviewed Dr. Green's initial findings. Dr. Hill noted that Claimant was "persistent in having constant, unremitting right-sided neck pain and intermittent numbness in his arms, right greater than left." He further noted that there "is an issue of causation here." He referred Claimant for additional physical therapy. His assessment was chronic leg pain secondary to work injury and recent onset of right-sided neck pain with radicular component. CEI 7:172-173.

27. On November 16, 2010, after reviewing Claimant's brain MRI scan, Dr. Green concluded that the scan was unremarkable for significant findings such as MS, stroke, or tumor. He still did not have a good explanation for Claimant's numbness in his right arm. He opined that Claimant's upper cervical pain was "likely" related to his industrial accident trauma. CEI 15:394.

28. In an office consultation chart note dated December 10, 2010, Dr. Hill noted Dr. Green's opinion that Claimant's "upper cervical spine is probably to some degree related to his trauma that he experienced." Dr. Hill stated that he did not disagree with this statement, nevertheless because Claimant's C-spine findings were "diffuse in nature," he could not definitively state that Claimant's current C-spine symptoms were a direct result of his work accident on October 27, 2008. His assessment was as follows: chronic left leg

pain secondary to puncture wound sustained in work incident of October 27, 2008; relative recent onset of cervical pain and upper extremity paresthesias; and diffuse degenerative disease of the cervical spine. CEI 7:176-177.

29. Claimant's neck pain and arm numbness complaints intensified in the summer of 2011. On August 5, 2011, Claimant reported to Dr. Hill that he had an increasing amount of neck and shoulder pain along with numbness in his hands and arms. Dr. Hill believed that Claimant's condition justified a repeat MRI and possible repeat EMG studies. On August 30, 2011, Claimant reported to Dr. Hill that he had woken up two days before with sharp pain in the right arm and also pain in the low cervical, right scapular and right shoulder areas. He also complained of arm numbness with pain in fingers one and two of the right hand. Dr. Hill reviewed a repeat cervical MRI and noted no significant changes from the last study. He noted that there was a persistent abnormality at C3-4, impacting the right neural foramen. He assessed cervical and upper extremity pain with known MRI abnormality and previous negative neurological workup. Dr. Hill expressed his concern about the apparent increase in the frequency and intensity of Claimant's cervical and upper extremity problems. He recommended a reevaluation by Dr. Green with repeat upper extremity EMG study. He also noted a "causation issue here, apparently in dispute by the carrier." CEI 7:182-189.

30. Claimant returned to Dr. Green on September 1, 2011. He reported the pain and numbness symptoms that he had reported to Dr. Hill. Dr. Green wrote a letter to Dr. Hill stating in pertinent part as follows:

> Recently he [Claimant] switched on his concrete control from a shoulder harness to a waist harness. Upon discussing this a bit more with him it turns out that he was black and blue across the neck and shoulder right where the harness was when the original injury happened. His story really is more of a

brachial plexus type of injury since the repeat MRI scan is unchanged.

Dr. Green's plan was to repeat nerve conduction studies to rule out carpal tunnel syndrome, order an EMG of the right arm, and order a brachial plexus MRI scan to look for scar tissue that could account for Claimant's symptoms. He opined that Claimant "very likely had bleeding within the tissue spaces in the brachial plexus area which could have left him with some persistent scar tissue producing some of his current symptoms." CEI 15:395-396.

31. On September 16, 2011, Dr. Green wrote again to Dr. Hill. He noted that an EMG of Claimant's right arm was negative. There was insufficient evidence from the EMG to diagnose carpal tunnel syndrome. Overall, the nerve conduction study was unremarkable except for the possibility of mild median nerve compression at the left wrist. Dr. Green continued to adhere to the theory that the 2008 industrial accident injured Claimant's brachial plexus. He theorized "that there could have been bleeding in that vicinity and now he is getting some scar tissue as a result although it is a little peculiar to be this long out after the injury." He stated that a brachial plexus MRI was still indicated and noted that Claimant would have to use his private health insurance to cover it. CEI 15:397-399.

32. Claimant followed up with Dr. Green on September 27, 2011 after his right brachial plexus MRI. This was Claimant's last consultation with Dr. Green. Dr. Green wrote to Dr. Hill that Claimant's right brachial plexus MRI "looks normal," nevertheless he opined that Claimant either had a brachial plexus residual injury with some scar tissue or soft issue inflammation as a result of trauma. He stated that "[e]ither way I think it is directly or indirectly related to his injury." CEI 15:402.

33. Claimant also saw Dr. Hill on September 27, 2011. In an office progress note, Dr. Hill observed that Claimant's EMGs, nerve conduction studies and brachial

plexus MRI were all normal, with the exception of a mild median nerve compression at the left wrist. His assessment was cervical and upper extremity pain of uncertain etiology and MRI documented cervical disk abnormalities. CEI 7:190.

34. Claimant returned to Dr. Hill for two more office consultations in November 2011. On November 11, 2011, Claimant told Dr. Hill that he continued to have pain in the left thigh, neck and right arm. He expressed frustration with his ongoing symptoms and the lack of definitive etiology for his neck and upper extremity symptoms. On November 29, 2011, Claimant reported waxing and waning pain symptoms in his leg and neck. Dr. Hill's assessment was as follows: neuropathic pain, left leg secondary to a puncture wound; "presumed" brachial plexus injury; and mild degenerative disk disease of the cervical spine. CEI 7:192-195.[2]

35. In 2012 and 2013 Claimant's treatment related to his 2008 industrial accident came primarily from PA Eastman of the Saint Alphonsus Pain Management Center and David N. Price, D.C. of Price Chiropractic Center. The focus of this treatment was pain management of Claimant's left leg neuropathic pain and brachial plexus injury pain. In an office consultation note dated February 21, 2012, PA Eastman noted that Claimant reported a pain level of five on a 10 point scale in his lower left extremity. He also reported increasing symptoms of pain and numbness and tingling in his upper extremities, with the right arm worse than the left. PA Eastman's assessment including the following industrial-related diagnoses: soft tissue trauma to the left lateral thigh area following an industrial accident with neuropathic pain; bilateral brachial plexus injury from a work-related injury

[2] There are no more medical records of Dr. Hill after November 2011. At hearing it was noted that Dr. Hill passed away, however there is no evidence of when this occurred. Tr. (11/19/2014), 95:21-23. In any event, Claimant did not re-establish care with an occupational medicine specialist until his treatment by Kevin Krafft, M.D., beginning in February 2014.

with bilateral upper extremity neuropathic symptoms; and post-traumatic stress disorder following work-related injury. Claimant's prescribed pain medications included Voltaren Gel, Ibuprofen, and Norco. PA Eastman referred Claimant to Price Chiropractic Center for frequency specific microcurrent therapy ("FSM"). CEI 14:357-398.

36. FSM is the use of a very low amperage current to influence the function of tissue by changing the cellular permeability, decreasing inflammatory chemicals, and increasing healing proteins, especially ATP, which is an energy molecule that helps in cellular healing. The focus of FSM is to isolate the specific frequency that different tissues have to stimulate healing of those tissues. Price Dep., 6:18-7:8.

37. Dr. Price first evaluated Claimant on March 7, 2012. He noted that Claimant had pain findings "that will be difficult to rehabilitate." After a physical exam, he observed that Claimant had the following conditions:

> 1. Residuals from a cervicothoracic sprain/strain injury with posttraumatic biomechanical dysfunction, muscular spasming and cervicothoracic myfascitis.
> 2. Upper extremity paresthesias present bilaterally but dominant to the right that appears to be a combination of thoracic outlet syndrome etiology, and probable nerve root irritation etiology, although there does not appear to be a clear mechanism of nerve root compression that he does not seem to have hard or progressed neurologicals. It also appears to be referred sclerogenic pain from fibrotic soft tissue changes.
> 3. Residuals of a left hip sprain/strain injury with TFL and IT band fibrotic changes and knotted trigger point reactivity/spasming.
> 4. The patient appears to have underlying chronic nerve irritation on the left side causing decreased sensitivity and also chronic underlying deep aching pain.
> 5. Bilateral shoulder sprain/strain injury residuals.

CEI 18:445-446. Dr. Price's plan of care was to focus first on Claimant's left thigh and lower back with FSM and muscle exercise release techniques, and then proceed to treat his cervicothoracic region and upper extremities. Thereafter, Claimant received a series of

FSM treatments and muscle exercise releases performed by Dr. Price until September 2012. On September 13, 2012, Dr. Price noted that Claimant had responded favorably, although slowly, to treatment, with major progress in reduction of pain in Claimant's left lower extremity. He further noted that Claimant had made less progress with reduction of pain involving his brachial plexus injury and upper right extremity paresthesias. On September 17, 2012, Dr. Price advised in a letter to PA Eastman that he had released Claimant from his active planned care and had determined that Claimant had reached maximum therapeutic value from the FSM and other treatment. At this point, Claimant was authorized by Liberty to receive an FSM home unit, for which he received instructions from Dr. Price. Claimant began using the FSM home unit thereafter to treat left leg, lower back and upper extremity pain. CEI 18:443-488.

38. Meanwhile, PA Eastman continued to oversee pain management care for Claimant, which included continued pain medication prescriptions for Norco, Ibuprofen, and Voltaren Gel. On March 11, 2013, PA Eastman noted in pertinent part as follows:

> The patient has been doing Frequency Specific Microcurrent. He started off going to Dr. David Price here in Boise, then he purchased a machine through his insurance company and has been doing it at home. In his legs, he [is] 85% to 90% better. His right arm still goes numb, he does not feel the microcurrent has helped with his right upper extremity. He feels that Dr. Price has been great in helping him with all of those issues. He definitely feels that it is improved. He no longer limps. He continues to work 60+ hours a week. He has no restrictions at work. They do try to put him on job [sic] where he does not have to always carry a 150-pound hose, but that really is the only restriction … His brachial plexus injury is still there, that is the only thing that the microcurrent has not seemed to help.

CEI 14:370.

39. At hearing, Claimant testified that "the microcurrent treatment was a great help. It did a great job on my leg. I don't limp anymore, which is huge. It helped me somewhat with my arms. It was able to calm down – what I would call flare ups or the problems working the extensive hours that we were working." When Claimant experienced severe flare ups of pain due to working long hours, he would return to Dr. Price for FSM treatments, in addition to using his home FSM unit. Tr. (11/19/2014), 64:22-65:2; 88:12-18.

40. On April 25, 2013, Claimant underwent an independent medical exam by Timothy E. Doerr, M.D., at Liberty's request. Dr. Doerr physically examined Claimant and also reviewed the extensive medical records of his treatment following the 2008 industrial accident, including X-rays, MRIs, and neurodiagnostic studies. Dr. Doerr diagnosed Claimant with bilateral upper extremity dysesthesias, likely secondary to brachial plexus injury. He opined that due to the "extensive swelling and ecchymosis in the axilla after the patient's industrial injury that his brachial plexus symptoms are medically more probably than not related to his industrial injury of 10/27/08." He assigned a six percent (6%) whole person impairment to Claimant's upper extremity, based upon the Sixth Edition of the *Guides to Evaluation of Permanent Impairment.* Dr. Doerr further diagnosed Claimant with a left thigh contusion with neurogenic pain, which he causally related on a more probable than not basis to Claimant's industrial accident. For this injury, he assessed a two percent (2%) whole person impairment, per the *Guides.* Combining both impairments without apportionment for preexisting injuries, Dr. Doer concluded that Claimant had sustained an eight percent (8%) whole person impairment as a result of the 2008 industrial accident. He further opined that Claimant had reached maximum medical improvement for all injuries.

Dr. Doerr stated that Claimant's medical treatment to date had been reasonable, appropriate and medically necessary for the injuries caused by the industrial accident. He did not detect any signs of functional interference, magnification of symptoms or secondary gain in Claimant. He opined that it was reasonable for Claimant to receive further treatment to manage his pain related to both injuries, including his home FSM unit and prescription medication. Finally, Dr. Doerr stated that Claimant could work without restrictions. BE 12:453-461.

41. On May 7, 2013, PA Eastman advised Liberty by letter that he agreed with Dr. Doerr's IME report. CEI 14:373.

42. Claimant followed up with Dr. Price on July 20, 2013. Dr. Price noted that Claimant was having a "gradual intensification" of his usual pain and paresthesia in the right upper extremity, pain throughout the cervicothoracic region on the right side, and into the superior medial scapula and along the border of the right scapula. He also had pain and restriction down the left sacroiliac and lumbopelvic regions. He noted that Claimant "has essentially the same findings that we have previously treated him for except that his symptoms have exacerbated with the passage of time." Dr. Price treated Claimant's symptoms through gentle adjustment procedures, exercise and myofascial protocols. He attributed Claimant's symptoms to his work injury. Claimant was to return on a "call as needed" basis. This was Claimant's last treatment with Dr. Price until February 2014. CEI 18:493.

43. PA Eastman continued to manage Claimant's pain through November 25, 2013. PA Eastman refilled Claimant's pain medication prescriptions but otherwise there were no significant changes in Claimant's pain treatment plan. CEI 14:374-379.

44. **2014 Industrial Accident.** Claimant continued to work his regular schedule for Brundage-Bone, which included 60 plus hour weeks, until February 10, 2014. On that date, Claimant received a job ticket to perform a line job, for which he initially had another employee helping him. He estimated that the job would require approximately two hundred feet of line hose. At the worksite, the other employee began pulling the line that they would need for the job, while Claimant began readying the concrete pump truck for the day's work. Claimant then began helping the other employee with unloading the line. At this point, he noticed that his arms and elbows were "feeling different." As Claimant was unloading the line, his "elbows just started burning and everything just progressed to get worse." The pain that he experienced was mainly in his elbows, but it radiated throughout his entire arms. Claimant's prior upper extremity pain radiated down from his shoulder, but the pain on this occasion was primarily in his elbows, to the point where he could not bend his arms. Nevertheless, he continued to perform the concrete pumping job. Due to his symptoms, the job took an hour beyond the normal time to set up because Claimant "just couldn't move any faster." Claimant felt his arms go completely numb, combined with pain in his arms that would come and go. He called his dispatcher and stated that he did not think he was going to be able to make it through the entire workday. Meanwhile, the fellow employee who had been assisting Claimant left the worksite, presumably to go to another job assignment. Claimant's supervisor, Parnell Green, instructed that Claimant was to finish the job on his own. Claimant continued to perform the job, which included taking back the line hose as the job progressed, picking up the line, and emptying it of concrete. Claimant recalls that the contractor on the site began helping him with lifting the line because it was taking too long to complete. Claimant recalls crying due to the pain he was

experiencing. Parnell Green then showed up at the job site and relieved Claimant of his duties. Claimant recalls that Green told him "to get off the F'ing job and not come back until I was a hundred percent." Claimant called his wife to pick him up because he was in too much pain to drive. Tr. (11/19/2014), 68:17-72:16.

45. At his deposition Claimant recalled that the pain he experienced on February 10, 2014 "was more intense to where I could not even cope with dealing finishing the job." He rated the pain as 10 on a 10 point scale. The pain was a severity that he had not experienced before. The numbness in his arms was also different. Prior to this occasion he had experienced waxing and waning symptoms of numbness that came on gradually. On February 10, 2014, the numbness started immediately and then "just instantly went from being numb to pain." These symptoms began when he was unloading line from the truck. Claimant's Dep., 93:25-100:14.

46. Upon cross examination at hearing, Claimant stated his belief that he suffered an accident on February 14, 2014, as follows:

> Q. Had you ever felt pain exactly like that prior to February 10, 2014?
> A. Not that I can recall.
> Q. In your subjective opinion did – do you think you had an accident that day?
> A. Yes.
> Q. And why is that?
> A. Because the pain was different. At first I thought it was just a flare up, that it was going to be a bad day or that it was going to be something that I'd have to go see Dr. Price about and get the microcurrent and calm it down and at this point it just kept getting worse to the point where before I could work through it and that day I could not work through it. That day it literally put me beyond the scope of what I could handle.

Tr. (11/19/2014), 123:13-124:3.

47. Rebecca Edens received a telephone call from Claimant on February 10, 2014. Claimant told her that he was not really sure that he had a job anymore, that he may have just gotten fired. He told her that Parnell Green took him off work because he got hurt and told him that he would not be allowed to return unless he was a "hundred percent better." When Rebecca Edens arrived to pick up Claimant, he was crying from pain and "would not let go of his arm." She then drove him to Dr. Price's office. *Id.*, 37:23-38:14.

48. **Medical Care Following the 2014 Industrial Accident.** Dr. Price's office notes for February 10, 2014 reflect that Claimant presented to him for evaluation and treatment of an "exacerbation" that occurred to his ongoing workers' compensation injury. Until this date, Claimant felt that his pain symptoms had been somewhat improving with Topomax prescribed by PA Eastman. Dr. Price recounted Claimant's work incident as follows:

> However this morning he had to do "line work." In this case the patient had to assemble long lines of hose that cement travels through and then after he had done so he had to disassemble them. These could weigh anywhere from 200 up to 400 pounds and he would have to drag things around. The patient indicates that he called his boss and told him that his hands and arms were "completely asleep and numb." He indicates that the numbness was so intense that it was painful. In presenting to the office, he feels deep aching pain in his cervical region and upper thoracic area bilateral but clearly dominant to the right. He also has soreness and achiness in the low back but not as substantial as his cervical thoracic and right shoulder and upper extremity symptoms. The left side upper extremity is also problematic but not as intense.

CEI 18:496.

49. Dr. Price concluded that Claimant "appears to have sustained an exacerbation of his work injuries from the collapsed bridge." His treatment plan was to treat Claimant with "gentle adjustment procedures" and FSM "to calm down the upper extremity paresthesia especially on the right and the irritation in the brachial plexus that we had

worked with previously." He concluded by noting as follows: "Certainly, what happened today would strongly indicate that doing that type of 'line work' is simply too heavy for this patient to be able to do without him having a high risk of exacerbation." CEI 18:497.

50. Dr. Price shared his dictation with PA Eastman and advised Liberty of his examination findings. He recommended that Claimant be evaluated by an occupational medicine specialist and specifically recommended Kevin Krafft, M.D., a physiatrist with Northwest Physical Medicine and Rehabilitation in Boise. Dr. Price wrote to Liberty on February 13, 2014 in pertinent part as follows: "I believe this patient's injuries and symptoms are essentially the same as those for which I initially treated him for when he was first sent to me for his bridge related injury. This intensity of this and nature of it would most probably be considered a significant aggravation. In my best judgment, at least at this point, I do not see that they are new areas of injury … At this point, I do not believe the patient can safely work." Dr. Price's plan was to continue FSM treatments and chiropractic adjustments to mitigate Claimant's pain. CEI 18:495,498,500.

51. PA Eastman evaluated Claimant on February 11, 2014. He recorded that Claimant had "an increase in his pain from his work. He pours cement. When he does line jobs his pain level goes up significantly. One of the job duties that he has just requires a significant amount of lifting heavy amounts of weight. It is getting to the point where he just cannot do that job anymore." PA Eastman noted that Claimant no longer had established care with an occupational medical specialist because Dr. Hill had passed away. He further noted that Brundage-Bone had taken Claimant off the job and would not allow him to return to work until a health care provider could certify that he could do the job. PA Eastman did not diagnose any new injuries. He recommended that Claimant establish care

with an occupational medicine specialist. He provided Claimant with a shot of Toradol 60 mg for pain. CEI 14:380-381.

52. Claimant proceeded to establish care with Dr. Krafft.[3] In a letter to Dr. Price on February 28, 2014, Dr. Krafft noted that on February 10, 2014, Claimant "was standing on his truck lifting hoses and his pain in the right arm worsened with stabbing, tingling and loss of all feeling in the right arm." Claimant reported numbness in both arms but greater on the right, with the numbness and tingling in his whole arm and shoulders. Claimant rated his pain between two and 10 on a 10 point scale, with greater pain occurring with activity on the job. Dr. Krafft recommended a follow-up nerve conduction EMG study. He noted that these studies "have been negative in the past, but he has increasing symptoms without previous cervical neurological impingement on previous review." Dr. Krafft continued Claimant's Norco and Topomox prescriptions for pain. He held off making further decisions regarding Claimant's plan of care pending the nerve study. CEI 21:550-553.

53. Dr. Krafft conducted the electrodiagnostic study of Claimant on March 17, 2014. In a report dated March 18, 2014, he noted the study impression as follows: "Abnormal study. Today's examination is consistent with moderately severe bilateral cubital tunnel syndromes. There is no evidence of other entrapment, neuropathy, plexopathy or radiculopathy. This is a change compared to his 09/27/11 study which was normal. This is not likely related to his injury of 10/28/08." Dr. Krafft prescribed bilateral

[3] Dr. Krafft is board certified in the following specialties: physical medicine and rehabilitation; independent medical examination; and electrodiagnostic medicine. At the time of the first hearing he was an associate/partner in the Boise Physical Medicine and Rehabilitation Clinic. He was also the Clinical Assistant Professor, Department of Rehabilitation, University of Washington, Medical Director of the Occupational Medicine Work Hardening Program of Saint Alphonsus, and Medical Consultant to the Idaho State Insurance Fund. CEI 33:698.

elbow pads (splints) and ordered a Functional Capacity Assessment ("FCA") for Claimant. CEI 20:546.

54. Angela Cluff, PT, CEAS, of Saint Alphonsus Rehabilitation Services, conducted an FCA of Claimant on April 1, 2014. During the evaluation, PT Cluff added an extra component to the test to account for Claimant's particular work activity. This activity tested Claimant's ability to repetitively load 10 foot lengths of four inch pipe, weighed at 65 pounds. Brundage-Bone supplied the equipment for the test. Brundage-Bone indicated that Claimant would need to demonstrate the ability to lift such line overhead a total of 15 times to return to work without restrictions. Claimant performed the task nine times before stating that he needed to stop due to numbness in his right arm. After a short break, Claimant performed three additional repetitions, but stated that he was in too much pain and could not feel his right arm, thus he could not continue. Claimant was unable to complete the remaining KEY testing protocol. PT Cluff concluded that the result of the FCA was conditionally invalid, because it generally reflected levels beyond the safe capability of Claimant. She noted that Claimant exhibited a tendency to perform beyond his safety level. She concluded that Claimant did not demonstrate the ability to perform the critical demands of his job. PT Cluff recommended that Claimant could benefit from a work hardening program with the goal of returning him to his pre-injury work. CEI 22:558; 23:568.

55. Claimant saw Dr. Krafft for a follow-up consultation on April 7, 2014. Dr. Krafft noted that Claimant had "trouble with the work evaluation," and that he continued to have numbness and pain in his arms, with a lot of soreness, numbness and tingling. Claimant continued to take both Norco and Topomax for pain control. The

Toradol shot given by PA Eastman, as well as microcurrent treatment provided by Dr. Price, had helped him control his pain. Upon reviewing the results of Claimant's FCA, Dr. Krafft noted that it concluded that it was unsafe for Claimant to return to his pre-injury position, as he would most likely reinjure himself. He further noted that Claimant continued to have upper extremity symptoms with noted CTS. Dr. Krafft opined that Claimant's bilateral CTS was "not likely related to his original injury but likely related to his work activity." He concluded by stating that once Claimant had his bilateral CTS addressed with surgery, he would recommend pursuing work hardening to prepare Claimant to return to full duty work. CEI 21:556-557.

56. Claimant recalled that Dr. Krafft told him that the bilateral CTS was a new injury, unrelated to his brachial plexus injury, and that it would require surgery to repair, after which he would recommend work hardening after surgery. Thereafter, Claimant had difficulty scheduling a surgeon because Liberty did not approve the claim. He decided to seek treatment for his bilateral CTS through his own insurance. Tr. (11/19/2014), 75:18-77-79.

57. Neither Liberty nor Berkshire accepted Claimant's accident or occupational disease claims for the 2014 industrial accident. Liberty denied coverage on the basis that the condition for which Claimant sought treatment was a new condition unrelated to his 2008 industrial accident. Berkshire contested the claim, asserting that Claimant's injury related to a preexisting condition. Claimant's Post-Hearing Brief, 2-3.

58. On July 29, 2014, Lisa Rendon, M.D., of Idaho Hand and Wrist, evaluated Claimant's condition. She reviewed his medical history, including the EMG which showed findings consistent with bilateral CTS. She noted that Claimant was using elbow splints

prescribed by Dr. Krafft, as well as prescriptions for Hydrocodone, Voltaren Gel, Topomax, and Ibuprofen for pain. Claimant described pain in his right elbow on the back side which was constant and severe, rated as an eight out of 10. He also reported pain in his left elbow that was less severe. Dr. Rendon assessed Claimant as a "45-year old right hand dominant man with bilateral CTS and bilateral elbow pain." She noted that his most severe symptoms appeared to be a posterior elbow pain. She opined that Claimant was a candidate for CTS surgery to treat his numbness and tingling because he had failed splinting. She recommended further evaluation by an orthopedist for Claimant's posterior elbow pain as she found that this was not consistent with bilateral CTS. Dr. Rendon provided Claimant with ulnar nerve gliding exercises. CEI 24:570-571.

59. Claimant obtained a surgery consultation from David Hassinger, M.D., an orthopedic surgeon, on August 6, 2014. Dr. Hassinger noted that Claimant had a "complex bilateral upper extremity history." He noted the 2008 industrial accident and subsequent diagnosis of brachial plexopathy. Dr. Hassinger further noted that Claimant had recently begun having elbow pain worse on the right than on the left and associated numbness and weakness in his right hand. Claimant's pain was moderate in severity, dull in quality, intermittent in timing, and localized in his bilateral elbows, right greater than left. Dr. Hassinger recommended ulnar nerve decompression surgery and Claimant consented. Dr. Hassinger did not record an opinion regarding causation of Claimant's condition. CEI 25:571-572.

60. Dr. Hassinger performed right cubital tunnel decompression surgery on Claimant on September 2, 2014. He then performed left cubital tunnel decompression on Claimant on September 23, 2014. CEI 25:573-577.

61. Claimant followed up with Dr. Hassinger post-surgery in three office visits in 2014. On October 13, 2014 Dr. Hassinger noted that sensation was intact throughout bilateral hands. Claimant denied any problems. On November 11, 2014, Dr. Hassinger noted that Claimant had more pain on the right than on the left postoperatively. There was no numbness in the right hand. He provided Claimant with Voltaren Gel for pain. On December 10, 2014, Dr. Hassinger noted that Claimant was gradually improving, the Voltaren Gel helped somewhat, his incisions had healed, and his elbow range of motion was full. Dr. Hassinger provided Claimant with a prescription for physical therapy. CEII 2:22-24.

62. At Berkshire's request, Lance E. LeClere, M.D., an orthopedic surgeon with Impartial, delivered an independent file review report concerning Claimant on October 31, 2014.[4] Dr. LeClere reviewed Claimant's extensive medical history and records beginning with the 2008 industrial accident through September 23, 2014, including physical therapy notes, chiropractic notes, psychology notes, and pain management notes. Dr. LeClere expressed skepticism regarding all of Claimant's subjective pain complaints due to "minimal to no objective findings to explain them, dating back to his work event of 2008." He observed that Claimant "has had sustained upper extremity subjective complaints including entire extremity numbness and paresthesias despite documentation of numerous normal examinations, normal electrodiagnostic studies until 2014, and MRI findings of the cervical spine and brain that do not explain his widespread subjective sensory complaints."

[4] According to his curriculum vitae, Dr. LeClere graduated from the Loyola University School of Medicine in 2006. He then served an internship with the Naval Medical Center of San Diego from 2006 to 2007. He served a residency in orthopedic surgery from 2007 to 2011, also at the Naval Medical Center in San Diego. From 2011 to 2012 he was a fellow in orthopedic sports medicine at the Massachusetts General Hospital/Harvard Combined Orthopedics Program. BE 17:533. He is board certified in orthopedic medicine and specializes in shoulder and knee arthroscopies, sports medicine injuries, and shoulder injuries. LeClere Dep. (3/19/2015), 6:8-20.

Therefore, Dr. LeClere found it unreasonable to attribute causation of the subjective complaints to any work activities, specifically including the 2008 industrial accident. With regard to Claimant's diagnosed bilateral CTS and ulnar nerve compression surgeries, Dr. LeClere found that they were not related to 2008 industrial accident "as there are no objective findings that delineate causation to that specific event or any subsequent work activities." BE 17:518-532.

63. In a letter to Claimant's legal counsel dated November 10, 2014, Dr. Krafft offered the following opinions:

1) I diagnosed Kelly with bilateral ulnar neuropathies.
2) Kelly's conditions are likely from repetitive activity.
3) His symptoms are the findings of ulnar neuropathies are likely from other activity rather than the bridge collapse.
4) Dr. Hassinger's treatment was reasonable.
5) I recommend asking Dr. Hassinger for his post surgical restrictions.

CEI 21:557(A).

64. Claimant underwent physical therapy for bilateral elbow, ulnar nerve lesion, and joint pain/upper arm, as prescribed by Dr. Hassinger at Saint Alphonsus Rehabilitation Services ("STARRS") from December 16, 2014 until his discharge on January 8, 2015. Claimant's chief complaint upon commencing therapy was pain in bilateral elbows which he rated as a five out of 10. Claimant reported difficulties in activities of daily living, including lifting heavy items, doing yard work, dressing, and cooking. His goal was to return to work without restrictions He wanted help with the pain and to improve the strength and range of motion of both arms. Upon discharge from therapy on January 8, 2015, his clinician, Michelle Bjornson, OT, made the following assessment: Claimant had made improvements in range of motion as well as improved strength in all areas of grip and pinch. He had continued pain but it was mostly located in the lateral

epicondyle areas and in the right shoulder. Ms. Bjornson encouraged Claimant to continue home exercises and recommended that he follow up with Dr. Krafft. She further noted that Claimant would benefit from a work hardening program to meet his goal of returning to work without restrictions. CEII 3:27-62.

65. Claimant recalls having difficulty with his post-surgery physical therapy because he kept having right shoulder pain, of which he complained to his therapist. He recalled the nature of his shoulder pain as follows: "It just doesn't feel right. I had a lot of pain. I couldn't reach behind me." Claimant distinguished his right shoulder pain from shoulder pain prior to the 2014 industrial accident as "a lot more pain. A lot more difficulty doing stuff." Nevertheless, Claimant completed his course of physical therapy and proceeded to enter a work hardening program. Tr. (9/18/2015), 30:25-31:23.

66. On January 27, 2015, Claimant received an evaluation for entry into the work hardening program of STARRS. He participated in work hardening until his discharge on May 12, 2015. During his participation in the program, his therapist noted that Claimant was "guarding and protecting" his right shoulder during exercises. Claimant continued to complain of right shoulder pain. CEII 6:93-151.

67. Both Dr. Price and Dr. Krafft continued to provide treatment and evaluation for Claimant while he participated in the work hardening program. On February 9, 2015, Dr. Price noted as follows: "The patient indicates that he recently started 'work hardening' and has been to several of these classes. In doing so, he has found a major 'flare up' of his cervicothoracic right upper extremity and shoulder pain …" Dr. Price's plan was to continue to use FSM therapy to "calm down" Claimant's symptoms. CEII 7:152. On February 18, 2015, Dr. Krafft noted as follows: "Kelly continues in the work hardening

program. He is having some right shoulder symptoms which we will sort out in therapy." *Id.* at 5:82. On February 25, 2015, Dr. Krafft noted that Claimant rated his right shoulder pain as six out of 10 in the posterior shoulder. Exercises in the work hardening program increased his pain. He concluded in pertinent part as follows: "Kelly continues to have right shoulder pain. It is affecting his sleep and ability to function … I will obtain an MRI arthrogram of the right shoulder, which we also discussed in team conference." *Id*. at 84.

68. Radiologist Shane McGonegle, M.D., of Gem State Radiology performed an MRI right shoulder arthrogram with an intra-articular injection of dilute gadolinium for Claimant on March 2, 2015. The conclusion of the MRI as read by Dr. McGonegle was as follows:

> Nondisplaced SLAP tear extending into the superior quadrant of the posterior labrum. Mild intra-articular biceps tendinosis.
> Intact rotator cuff.
> Abnormal appearance of the inferior glenohumeral ligament in its peripheral portion and adjacent to the anteroinferior labrum suspicious for prior injury with partial tear.
> Intact rotator cuff.
> Fatty atrophy in the teres minor muscle most compatible with chronic quadrilateral space syndrome.

CEII 8:163-164.

69. At a follow-up examination on March 3, 2015, Dr. Krafft noted that Claimant continued to have right shoulder pain. He reviewed the results of the right shoulder MRI, which he noted as showing "a prior GH ligament partial tear. He also has a SLAP tear, biceps tendinosis, and quadrilateral space syndrome, but no rotator cuff tear." Because of Claimant's persistent pain, Dr. Krafft recommended a referral to a shoulder surgeon. He ordered restrictions in Claimant's work hardening program until a shoulder surgeon could evaluate him. CEII 5:86-87.

70. Claimant returned to Dr. Hassinger for a surgical consultation regarding his right shoulder following the MRI. Dr. Hassinger recommended surgery, however he could not perform it for Claimant because his office no longer accepted Claimant's health insurance for reimbursement. Instead, he received a referral to Jeffrey G. Hessing, M.D., an orthopedic surgeon. Tr. (9/18/2015), 36:19-38:4.

71. Dr. Hessing[5] saw Claimant in a first office visit on March 18, 2015. Claimant told Dr. Hessing that he did not want him to "to review old records or talk to other treating physicians." Dr. Hessing thus understood that he was to review Claimant's shoulder and recommend treatment without determining causation at this time. Dr. Hessing's progress note nevertheless shows that he had knowledge of the 2008 industrial accident, but does not mention the 2014 industrial accident.[6] Claimant told Dr. Hessing that as his elbows seemed to improve following his cubital tunnel decompression surgeries, he began having more pain in his right shoulder, despite work hardening. Claimant complained of pain diffusely about the right shoulder joint which radiated down the arm. He had difficulty bringing the arm up over his head or behind him. Dr. Hessing obtained the MRI arthrogram of the right shoulder from March 2, 2015. He reviewed the MRI and advised Claimant that he agreed with the reading by the radiologist. He advised Claimant that he had SLAP tear in the superior posterior labrum with resulting rotator cuff impingement syndrome. He further advised Claimant that there were degenerative AC joint changes present with underlying impingement. Dr. Hessing recommended conservative treatment with a

[5] During his deposition, counsel for both Liberty and Berkshire stipulated to Dr. Hessing's competency to give expert witness testimony. Hessing Dep., 6:5-7. His curriculum vitae shows that he has practiced in orthopedic surgery in Boise since 1985. He is board certified in orthopedic surgery. CEII 18:309-311. He also testified in his deposition that he had practiced as shoulder subspecialist for thirteen years. Hessing Dep., 6:12-13.

[6] In his deposition, however, Dr. Hessing testified that his nurse made a handwritten note on Claimant's medical history form that he had suffered an accident on February 10, 2014 "doing a line job, right arm went numb, painful and grip was weak," that did not make it into his dictation for his patient progress notes. Hessing Dep., 31:3-25.

cortisone injection into Claimant's right shoulder as both a therapeutic and diagnostic test. He then gave Claimant the cortisone injection, encouraged him to continue exercise while avoiding any heavy lifting with the right arm. He scheduled Claimant for follow up in three to four weeks. CEII 9:165-166.

72. On April 8, 2015 Claimant returned to Dr. Hessing to follow-up. Claimant stated that his right shoulder pain had subsided after the injection. It was not as stiff and was moving better. Nevertheless, he still had pain and numbness. Dr. Hessing then discussed causation with Claimant. He recorded the following history recounted by Claimant: "By his recollection his right shoulder began to bother him in February 2014. He says he was lifting a heavy hose full of concrete during February 2014 on the job. He says he felt something pop in the shoulder with immediate pain. He continued to work, however, and the shoulder remained painful."[7] Dr. Hessing told Claimant that he had a "partial response" to the injection, and that this confirmed an intra-articular source for his pain. He doubted that the pain was related to his "old brachial plexus issues." Dr. Hessing opined that Claimant was symptomatic because of his superior labral tear, which was unresponsive to conservative care. He further opined that Claimant likely tore his labrum in a work injury in February 2014. He noted that this impression was based solely upon Claimant's history. Dr. Hessing recommended surgical intervention by means of an arthroscopic decompression of his right shoulder and an excision of his distal clavicle. The rotator cuff and labrum could then be repaired. Claimant consented to the surgery. CEII 9:167.

[7] The history recounted in this record, and in three subsequent medical records (CEII 9:168, 170, 191) generated by Dr. Hessing, was the subject of cross examination of Claimant by counsel for Berkshire at the second hearing. Under cross examination, Claimant denied that he told Dr. Hessing or anyone at any time, that he felt a "pop" in his right shoulder on February 14, 2014. Claimant recalled only that he told Dr. Hessing that he had "pain in my shoulder, that it was different than what I had ever felt before." Tr. (9/18/2015), 50:4-53:4.

73. Claimant saw Dr. Hessing on April 20, 2015 for a pre-operative physical examination. Dr. Hessing summarized Claimant's medical history beginning with the 2008 industrial accident. The history recounted by Claimant was that his right shoulder was initially injured at work in 2008 when a bridge he was working on collapsed. Claimant told Dr. Hessing that he had brachial plexus injuries in both his shoulder. Dr. Hessing again recorded that he "felt something pop in the shoulder with immediate pain" in February 2014. Dr. Hessing obtained X-rays of Claimant's right shoulder, which he read to demonstrate subacromial calcification and spurs, a type three acromion with underlying impingement, and narrowing in the AC joint. Dr. Hessing assessed a right shoulder impingement with DJD of the AC joint and possible rotator cuff and labral tearing. He scheduled Claimant for surgery. CEII 9:168-171.

74. Dr. Hessing performed the arthroscopic surgery of Claimant's right shoulder, with subacromial decompression, distal claviculectomy, and labral and joint debridement, on April 27, 2015. His postoperative diagnosis was as follows: impingement syndrome, right shoulder, with hypertrophic change of right AC joint and labral tearing only. Dr. Hessing found that Claimant had superior labral tearing with flap formation, which he repaired. He excised the distal clavicle. He did not find Claimant's rotator cuff in need of repair. He noted that although the cuff was "frayed up, it was not torn through partially or completely." He smoothed down the superior surface of the cuff and debrided the subacromial space. There were no surgical complications identified. CEII 9:172-175.

75. Claimant returned to Dr. Hessing for post-operative follow-up visits on May 12 and June 9, 2015. Dr. Hessing found that Claimant had recovered well from the surgery. On May 12, 2015, Claimant could flex forward with his shoulder to about 120

degrees actively. He displayed a good pendulum exercise. His incisions were healing well. Dr. Hessing prescribed four weeks of physical therapy and encouraged him to continue with his exercise program. He noted that Claimant could not return to work in any capacity at that time. On June 9, 2015, Dr. Hessing recorded that Claimant's physical therapist reported that he was progressing well. Claimant agreed that he was making good gains and that his pain had subsided. Dr. Hessing reviewed X-rays completed on June 9, 2015. He found that Claimant's right shoulder had a "satisfactory appearance" and no complicating factors were apparent. He continued Claimant's full release from work. He encouraged Claimant to continue exercises to strengthen his rotator cuff. He opined that Claimant might be able to return to work hardening within four weeks. *Id.* at 176-179.

76. Claimant participated in physical therapy for his recovery from his shoulder surgery at RehabAuthority in Nampa from May 16 until August 17, 2015. His final assessment was that he had progressed well with therapy, but that further therapy was indicated. CEII 10:194-223.

77. Claimant testified at the second hearing that he had to stop going to physical therapy because he could no longer afford it. Tr. (9/18/2015), 39:23-24.

78. In two letters, dated March 25, 2015 and June 4, 2015, respectively, Claimant's counsel requested that Dr. Hessing provide a medical opinion concerning the etiology of Claimant's right shoulder condition. Counsel provided Dr. Hessing with relevant medical records for review, including records beginning with Claimant's 2008 industrial accident through his 2014 industrial accident and recovery. Dr. Hessing also received the independent record review report of Dr. LeClere, Claimant's deposition, the

hearing transcript of November 19, 2014, and the deposition transcripts of Dr. Price and Dr. Krafft. CEII 9:180-188.

79. Dr. Hessing responded to the correspondence of counsel in a letter dated June 22, 2015. He summarized Claimant's medical history and treatment to date. With regard to causation of Claimant's shoulder condition, Dr. Hessing repeated the same history that appears in his previous medical records, as follows:

> I had extensive discussion with him [Claimant] about causation of his right shoulder problem. By his recollection his right shoulder began to bother him in February 2014. He says he was lifting a heavy hose full of concrete during February 2014 on the job. He says he felt something pop in the shoulder with immediate pain. He continued to work, however, and the shoulder remained painful.

Dr. Hessing stated that it remained his opinion that, on a more probable than not basis, the cause of Claimant's superior labral tear in his right shoulder was the February 10, 2014 injury. He opined that after an extensive review of the medical records, he believed that they supported the fact that Claimant's right shoulder symptoms related to the presumed brachial plexus injuries had "pretty well resolved by the end of 2009." He noted, in particular, that Dr. Marsh stated on August 10, 2009 that Claimant's "shoulder pain after injury was 100% improved." Dr. Hessing stated that on February 10, 2014, "something changed." Claimant felt a pain in his right shoulder so severe that he had to leave work and go directly to Dr. Price's office. He stated further as follows: "Because of his positive MRI he was referred for my evaluation. I felt and remain convinced that a new injury occurred in his right shoulder at this time. The stress of repetitive lifting of the heavy concrete hoses torn [sic] his labrum." Dr. Hessing stated that Claimant was progressing well, but would need another six weeks of physical therapy for range of motion and strengthening. He advised that at three months out from surgery Claimant would be ready for work hardening.

He limited Claimant to lifting five pounds and opined that he may be able to lift 50 pounds when he was three months postoperative. CEII 9:189-193.

80. **ICRD Rehabilitation Efforts**. Rehabilitation Consultant Sara Statz of the Industrial Commission Rehabilitation Division ("ICRD") worked with Claimant from February 20, 2014 through August 19, 2015. CEII 1. On February 25, 2014, Statz confirmed with Brundage-Bone that Claimant's pre-injury job was preserved, however no light duty work was available. Brundage-Bone required a full duty release to return to work. *Id*. at 1:2. As of July 15, 2015, Dr. Krafft stated to Ms. Statz that Claimant's restrictions were pending completion of a work hardening program. *Id*. at 1:20.

81. **Claimant's Status at Second Hearing**. At the time of the second hearing, Claimant had not worked since February 10, 2014. Brundage-Bone still considered him an employee, although he was not on active, working status. Claimant was not currently scheduled to go to work hardening because he could not afford it. He was still unable to mow his lawn. He had not returned to any of his pre-injury physical activities. Tr. (9/18/2015), 42:12-43:12.

82. **Claimant's Credibility.** Having observed Claimant testify at the second hearing, and compared his testimony to the other evidence in the record, the Referee found Claimant to be a credible witness. The Commission finds no reason to disturb the Referee's findings and observations on Claimant's presentation or credibility.

DISCUSSION AND FURTHER FINDINGS

83. **Causation**. This case presents a complex medical history. There is no dispute that Claimant suffered a traumatic industrial accident in 2008 when he fell from a collapsed bridge and sustained multiple injuries. Liberty accepted that claim and paid substantial medical

expenses as well as indemnity benefits pertaining to that accident. The key dispute is whether two conditions, bilateral CTS, diagnosed in 2014, and a right shoulder SLAP tear and related pathology, diagnosed in 2015, were causally related to either the 2008 industrial accident or 2014 industrial accident, or whether the bilateral CTS was the result of an occupational disease incurred in the employment of Brundage-Bone.

84. Claimant bears the burden of proving that the condition for which compensation is sought is causally related to an industrial accident. *Callantine v. Blue Ribbon Supply*, 103 Idaho 734, 653 P.2d 455 (1982). There must be medical testimony supporting the claim for compensation to a reasonable degree of medical probability. A claimant is required to establish a probable, not merely a possible, connection between cause and effect to support his contention. *Dean v. Dravo Corporation*, 95 Idaho 958, 560-61, 511 P.2d 1334, 1336-37 (1973).

85. As in industrial accident claims, an occupational disease claimant must prove a causal connection between the condition for which compensation is claimed and the occupation to a reasonable degree of medical probability. *Langley v. State of Idaho, Special Indemnity Fund*, 126 Idaho 781, 786, 890 P.2d 732, 737 (1995).

86. No special formula is necessary when medical opinion evidence plainly and unequivocally conveys a doctor's conviction that the events of an industrial accident and injury are causally related. *Paulson v. Idaho Forest Industries, Inc.*, 99 Idaho 896, 901, 591 P.2d 143, 148 (1979). The Industrial Commission, as the fact finder, is free to determine the weight to be given to the testimony of a medical expert. *Rivas v. K.C. Loggin*g, 134 Idaho 603, 608, 7 P.3d 212, 217 (2000). "When deciding the weight to be given an expert opinion, the Commission can certainly consider whether the expert's reasoning and methodology has been sufficiently

disclosed and whether or not the opinion takes into consideration all relevant facts." *Eacret v. Clearwater Forest Industries*, 136 Idaho 733, 737, 40 P.3d 91, 95 (2002).

87. **Bilateral Cubital Tunnel Syndrome.** For his bilateral CTS, Claimant argues in the alternative that either the 2008 industrial accident or the 2014 industrial accident caused this condition. He further argues in the alternative that the condition was an occupational disease incurred in the employment of Brundage-Bone. Each theory and the relevant medical evidence will be examined below.

88. **Accident.** On the basis of a positive EMG that he conducted on March 17, 2014, Dr. Krafft diagnosed Claimant with moderate to severe bilateral CTS. Krafft Dep., 11:11-14. Dr. Krafft defined CTS as "the slowing of the nerve conduction across the elbow accompanied by numbness and tingling in the ulnar nerve distribution, potentially weakness." Krafft Dep., 11:15-18.

89. The only physician who came close to relating Claimant's bilateral CTS to one of the accidents was his chiropractor, Dr. Price. He did not diagnose Claimant with the condition; rather he received a report back from Dr. Krafft that Dr. Krafft had diagnosed Claimant with bilateral CTS. At the time that Dr. Price examined Claimant on February 10, 2014, his assessment was that Claimant sustained "some type of flare-up and aggravation" that day; Dr. Krafft's report indicated that the aggravation was bilateral CTS. Price Dep., 33:19-25. "Looking back" at the time of his deposition, Dr. Price testified that he believed that Claimant "actually had some type of trauma that may even have been a new trauma. I hadn't dealt with that before, but some kind of new trauma to his elbows" in "February of 2014." Price. Dep., 34:1-7.

90. Dr. Price admitted on cross examination that he did not have experience in treating or dealing with CTS, did not perform nerve conduction studies, and did not review Claimant's nerve conduction studies. *Id*. at 65:17-67:15. He further testified that based on his knowledge at the time of deposition, Claimant might have had a preexisting "mild case" of bilateral CTS, but on February 10, 2014 Claimant "either significantly aggravated it with new trauma or was a brand new trauma in the first place." *Id*. at 69:11-15.

91. Dr. Price's testimony as described above is insufficient medical evidence to establish a probable causal link between Claimant's bilateral CTS and the 2014 industrial accident. He conceded that he was inexperienced in treating the condition, did not review Claimant's nerve condition studies, and qualified his causation opinion by conceding that the condition may have predated the 2014 industrial accident.

92. The only other physician's testimony to look to for a positive accident causation opinion is that of Dr. Krafft, who diagnosed the condition. Nevertheless, he did not testify that condition was the result of one discreet event such as either the 2008 industrial accident or the 2014 industrial accident. Rather, he testified that the condition resulted from Claimant's repetitive "work activity," namely "lifting and using his arms on a repetitive basis." Krafft Dep., 20:12-16.

93. There is no medical testimony in the record that causally related Claimant's bilateral CTS to the 2008 industrial accident.

94. Because the evidence shows that Claimant's bilateral CTS was not the result of either the 2008 or 2014 industrial accidents, his claim for compensation of the condition on the basis of an industrial accident must fail. His claim for compensation for the

condition thus rests on whether it was the result of an occupational disease that he incurred while in the employment of Brundage-Bone.

95. **Occupational Disease.** I.C. § 72-102(22) provides the following relevant definitions for occupational disease claims:

> (a) "Occupational disease" means a disease due to the nature of an employment in which the hazards of such disease actually exist, are characteristic of and peculiar to the trade, occupation, process, or employment, but shall not include psychological injuries, disorders or conditions unless the conditions set forth in section 72-451, Idaho Code, are met.
>
> (b) "Contracted" and "incurred" when referring to an occupational disease, shall be deemed the equivalent of the term "arising out of and in the course of" employment.
>
> (c) "Disablement," except in cases of silicosis, means the event of an employee's becoming actually and totally incapacitated because of an occupational disease from performing his work in the last occupation in which injuriously exposed to the hazards of such disease, and "disability" means the state of being so incapacitated.

I.C. § 72-437 defines the right to compensation for an occupational disease:

> When an employee of an employer suffers an occupational disease and is thereby disabled from performing his work in the last occupation in which he was injuriously exposed to the hazards of such disease, or dies as a result of such disease, and the disease was due to the nature of an occupation or process in which he was employed within the period previous to his disablement as hereinafter limited, the employee, or in case of his death, his dependents shall be entitled to compensation.

I.C. § 72-439 limits the liability of an employer for any compensation for an occupational disease to cases where (1) "such disease is actually incurred in the employer's employment," and (2) for a non-acute occupational disease, where "the employee was exposed to the hazard of such disease for a period of 60 days for the same employer."

96. In summary, to prevail on his occupational disease claim, Claimant must prove as follows: (1) that he was afflicted by a disease; (2) that the disease was incurred in, or arose out of

and in the course of his employment; (3) that the hazards of such disease actually exist, are characteristic of, and peculiar to the trade, occupation, process, or employment in which he was engaged; (4) that he was exposed to the hazards of such non-acute disease for a minimum of 60 days while employed with the same employer; and 5) that as a consequence of such disease, he became actually and totally incapacitated from performing his work in the last occupation in which he was injuriously exposed to the hazards of such disease. *Burrows v. H.J. Heinz Co.*, 2013 IIC 0080.8-9. Claimant's occupational disease claim will be analyzed below in light of these elements.

97. Disease. There is no dispute that Dr. Krafft diagnosed Claimant with bilateral CTS on March 18, 2014. CEI 20:546-549.

98. Causation. There is a disagreement between Claimant's treating physician, Dr. Krafft, who first diagnosed him with bilateral CTS, and Dr. LeClere, Berkshire's independent medical examiner, regarding the cause of Claimant's bilateral CTS.

99. *Dr. Krafft*. When asked to explain how CTS originates, Dr. Krafft offered the following explanation:

> There are a number of different ways. You can get it from pressure on the nerve, itself. You could have a trauma at that level. If you have a fracture, for example, that could cause compression of the nerve, or damage to the nerve. You could get it from repetitive action over time. A lot of people have it, you know, if their arms are flexed for an extended period, sometimes they can get numbness in that distribution and cause denervation to the nerve, and cause some damage in that way. But usually it some sort of pressure or impact to the nerve, either over time, or with trauma.

Krafft. Dep., 18:13-25.

100. When asked to explain the most probable cause of Claimant's bilateral CTS, Dr. Krafft testified as follows:

Q. Do you relate the ulnar condition to the claimant's work at all?

A. Yes, I do.
Q. So it's a result of his work activity?
A. Most likely.
Q. Is that on a more probable than not basis?
A. Yes.

Krafft Dep., 26:22:-27:3. Dr. Krafft further explained the "work activity" that caused Claimant's condition as "his lifting, and using his arms on a repetitive basis." *Id*. at 20:15-16. He specified his understanding of the work activity that Claimant performed repetitively for Brundage-Bone as follows: "He was in construction. I knew he worked with concrete, and he had to move hoses a fair amount, and things of that nature. So it was pretty heavy work." *Id*. at 19:19-21.

101. *Dr. LeClere*. Dr. LeClere testified as to the cause of Claimant's bilateral CTS as follows:

> Q. And what was your impression there?
> A. Based on the nerve conduction studies of 3 – or electrodiagnostic studies of 3/18/14, bilateral ulnar nerve cubital tunnel syndrome, and my conclusion was not related to work activities or previous work injury.
> Q. Okay. Now, you stated that it could be caused from idiopathic causes. What do you mean by that?
> A. Typically, bilateral cubital tunnel syndrome is not attributed to any specific activities or injuries, and it's simply – there's no identifiable cause, so that would be the definition of idiopathic.
> Q. Now, could cubital tunnel syndrome, could you experience symptoms from something as simple as, say, you know, holding your arm in a crux position for a long period of time?
> A. I don't know that that's really well established. I mean, what is a long period of time? I mean, theoretically –
> Q. Well, I guess what I'm getting at is maybe desk ergonomics. Can you get it from just sitting at your desk incorrectly?
> A. There's not any good evidence that sitting at your desk incorrectly can cause cubital tunnel syndrome.
>
> Q. So what are some of the idiopathic causes that you are thinking of?
> A. So age, BMI, gender, smoking, anatomic variations.

LeClere Dep. (3/19/2015), 26:7-27:9.

102. *Weighing the Medical Opinions.* Neither Dr. Krafft nor Dr. LeClere cited to or relied upon any specific medical studies as the basis of their medical opinions on the etiology of CTS. Dr. Krafft's opinion was that the disease may be caused by repetitive pressure on the ulnar nerve or repetitive flexion of the elbow, and that this actually happened in Claimant's case as a result of his work activities. Dr. LeClere believed that there is no known cause of Claimant's CTS, thus it is idiopathic. To determine which physician's opinion has greater credibility, the factual basis and underlying assumptions of their respective opinions must be examined.

103. Dr. LeClere's opinion was based solely upon a medical records review concerning Claimant; he did not conduct a physical examination of Claimant. *Id.* at 33:3-16. Furthermore, he did not review Claimant's deposition. *Id.* at 39:19-40:1. He did not have any information or knowledge of the number of hours Claimant worked before he stopped working on February 10, 2014, nor did he have any understanding of the weightlifting requirements for Claimant's job. *Id.* at 35:24-36:8.

104. While he first testified that the cause of Claimant's CTS is idiopathic, meaning not attributable to any specific cause, nevertheless Dr. LeClere then proceeded to identify specific risk factors, such as age, BMI, smoking, and anatomic variations, as "idiopathic causes" of CTS. He did not opine as to which, if any, of these causes were related to Claimant's condition. *Id*. at 26:12-27:9.

105. Either the cause of Claimant's CTS is truly idiopathic, meaning not attributable to any cause, or it is not. It cannot be both. Thus, there is an inherent logical inconsistency in Dr. LeClere's opinion testimony concerning CTS as an idiopathic disease.

106. Dr. Krafft based his causation opinion on Claimant's specific work activities, i.e., repetitive heavy lifting of line hoses containing concrete. Indeed, substantial evidence in the record concerning Claimant's actual working conditions corroborates Dr. Krafft's causation opinion that Claimant's repetitive heavy lifting at work caused his bilateral CTS. Claimant consistently performed very heavy lifting of line hoses that weighed 95 pounds without concrete in them, but weighed substantially more when containing concrete. He worked in this manner on a work schedule that greatly exceeded a normal full-time occupation – 60 to 80 hours per week. Under these circumstances, it is reasonable to find that Claimant's repetitive work activities caused his condition, as opined by Dr. Krafft. Thus, the Commission finds that greater weight should be given to the opinion of Dr. Krafft, Claimant's treating physician, that his repetitive lifting activities at work caused his bilateral CTS.

107. Peculiar to the Occupation. In addition to proving actual causation, Claimant must also prove that the hazards of the disease are characteristic of and peculiar to his occupation.

> The phrase, "peculiar to the occupation," is not here used in the sense that the disease must be one which originates *exclusively* from the particular kind of employment in which the employee is engaged, but rather in the sense that the conditions of that employment must result in a hazard which distinguishes it in character from the general run of occupations.

Mulder v. Liberty Northwest Insurance Co., 135 Idaho 52, 56, 14 P.3d 372, 376 (2000), *quoting Bowman v. Twin Falls Const. Co., Inc.*, 99 Idaho 312, 323, 581 P.2d 770, 781 (1978), *overruled on other grounds, DeMain v. Bruce McLaughlin Logging*, 132 Idaho 782, 979 P.2d 655 (1999) (emphasis in original).

108. Berkshire argued that Claimant failed to meet his burden on "peculiar to the occupation" as follows:

> He offered no testimony regarding the frequency with which concrete pumper employees develop cubital tunnel syndrome, he offered no testimony as to what aspect of Claimant's job presented a risk for developing the condition, and he offered no testimony to explain why concrete pumper workers and their occupation are somehow different as regard the risk for cubital tunnel from virtually any other occupation Defendants can think of.

Berkshire Post-Hearing Brief at 20.

109. Further review of *Mulder*, 135 Idaho 52, 14 P.3d 372, is enlightening. In *Mulder* the Court examined and approved of the Commission's analysis and application of the "characteristic of and peculiar to" requirement stating:

> Applying the test from *Bowman*, the Commission found the hazards that Mulder was exposed to during his work at Liberty could be distinguished from the general run of occupations. The Commission determined that exposure to long periods of repetitive upper extremity motions, including writing, keyboarding, and gripping of a steering wheel are not characteristic of all occupations. The Commission based its factual determination, in part, on the medical testimony of Dr. Lenzi and upon the description of the job duties peculiar to Mulder's position with Liberty. The Commission determined that those duties necessitated driving, handwriting and keyboarding. Though Liberty presented conflicting testimony from its expert, Dr. Richard Knoebel (Dr. Knoebel), this Court will defer to the Commission's findings as to the credibility of conflicting medical experts. [Citation omitted.] This evidence is substantial and competent, and will not be disturbed on appeal.

Mulder, 135 Idaho at 56, 14 P.3d at 377. It is instructive that the Court approved the Commission's focus on whether the hazard causing the disease was characteristic of and peculiar to the claimant's occupation, not on whether the frequency of the disease was greater in the claimant's occupation than other occupations.

110. Contrary to Berkshire's assertion, there is evidence in the record that identifies which aspect of Claimant's job put him at risk of CTS. Dr. Krafft identified how CTS develops usually from "some sort of pressure or impact to the nerve, either over time, or with trauma."

Krafft Dep., 18:23-25. He explained that the pressure "can occur with a stretch, or it can occur with direct pressure on the nerve itself." *Id.* at 19:3-4. He further explained that flexion of the elbow, meaning bending the elbow, repetitively, such as picking something up repetitively, would be sufficient to impact the ulnar nerve over time to cause CTS. *Id*. at 5-16. Dr. Krafft then related this repetitive activity to Claimant's work as follows: "He was in construction. I knew he worked with concrete, and he had to move hoses a fair amount, and things of that nature. So it was pretty heavy work." *Id*. at 19-21. Dr. Krafft specifically identified Claimant's "lifting, and using his arms on a repetitive basis" as the cause of his CTS. *Id*. at 20:15-16.

111. Dr. Krafft's medical testimony about the cause of Claimant's bilateral CTS must also be understood in the context of the undisputed evidence in the record regarding Claimant's job duties, including his testimony at both hearings and in his deposition. This evidence explains why concrete pump operators are at a peculiar risk for developing CTS. As a concrete pump operator, Claimant was required to repetitively lift (thus flexing his elbows) pieces of line hose weighing 95 pounds per piece empty, but weighing much more when containing concrete. Concrete weighs 150 pounds per square foot. With concrete in the hose, a "full line" could weigh 195 pounds to 250 pounds. Claimant was required to very quickly lift such hoses containing concrete and carry them back to the truck to rinse them out. Claimant performed one to five concrete pumping jobs per day and his work weeks averaged 60 to 80 hours.

112. Claimant's working conditions were partially simulated in his functional capacity examination ("FCE") conducted by STARRS. A job specific component was added to the standardized testing protocol with equipment supplied by Brundage-Bone. In the test, Claimant was required to demonstrate the ability to lift a 10 foot length of four

inch “pipe” (line hose), weighing 65 pounds, overhead a total of 15 times to return to work without restrictions. The task required him to lift the pipe from the floor and carry it for a distance of 40 feet, then lift it to an overhead position, and then carry it back 40 feet and return it to the floor. Claimant correctly argues that this activity was added to his FCE because the regular testing could not address the particular demands of his job duties, which are unique to concrete pumping.

113. The Commission is persuaded by Dr. Krafft’s opinion that the repetitive heavy lifting/elbow flexion required by Claimant’s work is the probable cause of his CTS. Whether that risk of injury can be distinguished from the risks to which workers are exposed in the general run of occupations is hardly a medical question. How a particular risk is distributed among all occupations in more appropriately a question for an engineer, a human factors expert, an ergonomics expert, or the like. No such testimony is before the Commission in this matter. However, common knowledge may sometimes supply an answer where expert testimony is lacking. *Mulder v. Liberty Nw. Ins. Co.*, supra; *Denoma v. Holman Transportation Services*, 2011 IIC 0092. The job requirements described above, i.e., the activities identified as causing Claimant to develop CTS, are patently not risks encountered in the general run of occupations. More so than in *Mulder*, where the risks at issue involved the pencil gripping, driving and keyboarding activities of an insurance adjuster, it can be concluded that while some employments require heavy lifting/elbow flexion of the type performed by Claimant, most do not. We conclude that Claimant has met his burden of establishing that his condition is not only causally related to the aforementioned demands of his employment, but that those demands represent hazards which are characteristic of and peculiar to his employment.

114. Sixty Days Exposure. Both Dr. Krafft and Dr. LeClere agreed that Claimant developed bilateral CTS sometime between September 16, 2011 and March 18, 2014, the dates of two nerve conduction studies. The first study by Dr. Green on September 16, 2011 was negative for any ulnar neuropathy. The second study on March 18, 2014 by Dr. Krafft was positive for bilateral ulnar neuropathy, or bilateral CTS. Brundage-Bone continuously employed Claimant between September 16, 2011 and March 16, 2014, which exceeds 60 days. Therefore, Claimant was exposed to the hazards of bilateral CTS for a minimum of 60 days while in the employ of Brundage-Bone.

115. Disablement. The evidence shows that Claimant became actually and totally incapacitated from performing his work with Brundage-Bone, in which he was injuriously exposed to the hazards of bilateral CTS. Claimant's supervisor, Parnell Green, took him off work on February 10, 2014 and did not allow him to return unless he obtained a full duty release. As of the date of the second hearing, Claimant had not obtained such a release, although Brundage-Bone still considered him an employee.

116. Conclusion. Based upon the foregoing, Claimant has met all five *prima facie* elements required for a compensable occupational disease, bilateral CTS.

117. **Last Injurious Exposure.** I.C. § 72-439(3) provides as follows: "Where compensation is payable for an occupational disease, the employer, or the surety on risk for the employer, in whose employment the employee was last injuriously exposed to the hazard of such disease, shall be liable therefore." This statute is a codification of the "last injurious exposure rule." *Burns v. Western Equipment Co.,* 2011 IIC 0001.10. The rule as codified in Idaho provides that "it is the last such employer, or its surety, who is liable to the claimant." *Sundquist v. Precision Steel & Gypsum, Inc.*, 141 Idaho 450, 456, 111 P.3d 135, 141 (2005).

118. Brundage-Bone employed Claimant when he was last injuriously exposed to bilateral CTS in February 2014. Berkshire was the Surety on risk during that exposure. Therefore, Brundage-Bone and Berkshire are liable for compensation payable to Claimant related to this occupational disease.

119. **Right Shoulder Condition**. Claimant argues that the 2014 incident was an industrial accident that caused a SLAP tear in his right shoulder and related pathology. Whether the claimed shoulder condition is relatable to this accident will be analyzed below. As with his bilateral CTS, two competing medical opinions must be analyzed, that of Dr. Hessing, Claimant's treating surgeon, and Dr. LeClere, the independent medical examiner commissioned by Berkshire.

120. *Dr. Hessing*. Prior to his first consultation with Claimant on March 18, 2015, in which he provided Claimant with a physical exam, Dr. Hessing read Claimant's right shoulder MRI. Based upon that review, he found there was an "obvious tear in the labrum," which Dr. Hessing termed a "SLAP tear," meaning superior labral anterior to posterior. Hessing Dep., 10:13-11:12. Dr. Hessing testified as follows as to the origination of Claimant's SLAP tear:

> Q. And I was going to go into this a little bit later, but since we're having this discussion right now, what kind of things cause a – or what kind of forces cause an injury to that labrum in the location Kelly had?
>
> A. Sure. Well, you know, you just – as I've described what the labrum does, it helps prevent the ball from sliding off the cup, because it's really a very unstable joint. And so any force that would potentially accentuate that push against the rim of the cup would potentially tear the labrum.
>
> And so he had, you know, a tear up top and around towards the front of the ball, and those, you know, basically forces – that would up overhead, potentially displacing the ball superiorly, forces that would push that ball up or out front would do that.

Hessing Dep., 11:13-12:6.

121. Dr. Hessing injected Claimant's shoulder with a cortisone shot on March 18, 2015 to gather information for the following reason: "If you have a patient with lots of arm and shoulder complaints, if it's coming from inside the shoulder, I believe if you put numbing medicine and cortisone inside that shoulder, they should at least get some change in their pain pattern if their problem is in their shoulder …" *Id.* at 13:8-13. Claimant had a "partial response" to the injection, meaning that his pain was somewhat better, which confirmed for Dr. Hessing that Claimant had "an intra-articular problem, a problem inside the shoulder, as a source for his pain." Hessing Dep., 14:20-15:9.

122. Based upon his reading of Claimant's MRI, physical examination, and the results of the cortisone injection, Dr. Hessing diagnosed Claimant with a "symptomatic labral tear and that was driving his pain complaints at that time more than this history of an old brachial plexus injury that he had." *Id*. at 15:14-17. He also diagnosed Claimant with an "impingement in his shoulder related to his labral tear." *Id*. at 18:12-13.

123. Pursuant to his diagnosis, Dr. Hessing recommended decompression or acromioplasty, an arthroscopic surgery, to repair Claimant's SLAP tear and impingement. He performed that surgery on April 27, 2015. In surgery, Dr. Hessing found what he expected to find in Claimant's right shoulder based upon his previous diagnosis. Claimant had a "tear in the cartilage rim up front … what we call an 'anterior labral tear,' you can see it pretty frayed up, pretty nasty tear." *Id*. at 19:23-20:3. After removing the tear, Dr. Hessing "cleaned out a lot of calcium and debris from up underneath the bony roof and opened up that space, pretty much found what I thought we would find, and did exactly what I thought we would do. There's nasty calcium, yeah." *Id*. at 20:13-17.

124. Dr. Hessing testified that a patient does not need to feel a "popping sensation" to have a SLAP tear. He testified that "you can certainly tear the labrum without a popping sound." *Id.* at 20:18-21:8.[8] Nevertheless, upon cross examination, he confirmed that he documented in his medical records beginning on April 8, 2015 that Claimant felt something pop in his shoulder during the 2014 industrial accident. *Id*., 32:12-23.

125. Dr. Hessing testified as to how a SLAP tear could occur as follows: "Well, I – anything that would drive the ball towards the front or upward could do that. And certainly that's often, you know – forces tending to push the ball forward, upward motions, heavy lifting, those kinds of things." Hessing Dep., 22:1-5.

126. Following the surgery, Dr. Hessing reviewed Claimant's past medical records supplied by Claimant's counsel, which led to his opinion letter dated June 22, 2015. Based upon that records review, his physical examination of Claimant, and the treatment he provided to Claimant, Dr. Hessing concluded that by 2009, Claimant's "shoulder and arm pain had pretty well resolved … and when I say 'resolved' he still has episodic pain and numbness, but it wasn't nearly, you know, as bad as it had been." He noted that Claimant was "living with it, had returned to his job on a cement pumping truck and seemed to be doing okay." Dr. Hessing then noted that "the record demonstrated that they [his shoulders] were functional for him and he was working, you know, until he had this episode in February 10, 2014, when something changed. He was lifting heavy hoses on the job, filled with concrete, and experienced a severe stabbing pain in the shoulder like nothing he'd felt before." Based upon that mechanism of injury, Claimant's response to the

[8] Counsel for Claimant did not ask Dr. Hessing if Claimant had not in fact experienced a popping sound in his right shoulder on February 10, 2014, whether that would have changed his opinion as to causation. Nevertheless, a negative answer to that question is readily inferred from the testimony provided.

cortisone injection, and his positive response to surgery, Dr. Hessing opined that Claimant's SLAP tear and related pathology was "a new problem that had happened when he was lifting these heavy hoses on the job, and it was consistent." Thus, Dr. Hessing concluded that "there was a new injury in February 2014 and that at this point, you know, he was getting better after appropriate treatment for that isolated injury." *Id*. at 24:13-26:3.

127. Dr. Hessing acknowledged that his first causation opinion stated on April 8, 2015, that Claimant likely had torn his labrum in a work injury in February 2014, was based upon Claimant's subjective history only. Hessing Dep., 33:17-22. Nevertheless, he also indicated that Claimant's medical records were very helpful to him in forming and firming up his causation opinion. *Id*. at 42:23-25.

128. Dr. Hessing acknowledged that he first evaluated Claimant 13 months after the 2014 industrial accident. *Id*. at 38:4-9. Nevertheless he disagreed that proximity in time made a difference to his causation opinion. He explained that "If I have some good records, I think that's – works well for me." *Id*. at 38:16-17.

129. Dr. Hessing agreed that Claimant had "other issues" in his right shoulder, but disagreed that those were primarily degenerative changes. He explained his opinion as follows: "[T]he labral tear is a significant aggravation of any wear and tear findings that, you know, could have potentially been in this gentleman's shoulder. I have no idea what his shoulder would have been like without the labral tear." *Id*. at 35:2-13. He acknowledged that "there was likely some wear and tear in a gentleman who uses his arms as vigorously for a long time." He explained further as follows: "I do believe that all this stuff, the spurring, those changes were certainly aggravated – if not initially caused –

maybe there is some wear and tear, but they aggravate those findings … degenerative findings that you'll find in anybody's shoulder." *Id*. at 37:5-25.

130. *Dr. LeClere*. By the time of his second deposition on October 13, 2015, Dr. LeClere had reviewed additional relevant medical records concerning Claimant, including Dr. Hessing's medical records. LeClere Dep. (10/13/2015), 8:5-8. In reviewing Dr. Hessing's operative report of April 27, 2015, Dr. LeClere concluded that the findings at the time of that surgery were chronic degenerative changes. *Id*. at 9:4-5. He described the surgery as a "cleanup of the shoulder. Debridement is basically taking a shaver and smoothing out the frayed edges." LeClere Dep. (10/13/2015), 9:23-25. He explained further as follows: "Typically, if there's degenerative free edge fraying of the labrum, then you'd just do a debridement as is described here." *Id*. at 10:9-11. He noted that Dr. Hessing performed an acromioplasty to remove a bone spur and a claviculectomy to remove arthritic joint surface that is at the edge of the clavicle. *Id*. at 10:12-11:13.

131. Dr. LeClere disagreed with Dr. Hessing's opinion that the need for surgery was due to an inflammatory process created by the torn labrum. He opined as follows:

> No. I – I don't think that the two are causally related, and I don't think there's any established link in any of – with any of the orthopedic literature between a labrum tear causing AC joint arthritis, nor am I aware of any link between a labrum tear and an acromial spur.
> So, no, I've never made that diagnosis and I don't think the two are – I don't think those three diagnostic entities are related.

Id. at 12:2-10.

132. Dr. LeClere opined that Claimant's shoulder diagnoses at the time of surgery and the surgeries performed were not related to either the 2008 industrial accident or the 2014 industrial accident. *Id*. at 13:17-19. He explained the basis of his opinion in pertinent part as follows:

> I say this for a number of reasons. Number one, from his – from the standpoint of his subjective complaints, this claimant's subjective complaints, number one, changed over time and, two, to include at points the upper extremity. Labral fraying, subacromial impingement or bursitis and the acromial spurring and AC joint arthritis would not be expected to cause entire upper extremity pain and numbness in the subjective complaints that – that he has outlined on and off over the several years following the 2008 injury and they don't match the subjective complaints after his 2014 injury – claimed injury.
> …
> From an objective standpoint and from the findings at the time of surgery, I would characterize all the findings at the time of surgery as chronic degenerative conditions. I would not expect a traumatic event to cause any of the findings that are described at the time of surgery.

LeClere Dep. (10/13/2015), 13:25-14:25.

133. Upon cross examination, Dr. LeClere admitted that he did not review the MRI film that formed the basis of Claimant's shoulder diagnosis. Rather, he only reviewed the MRI report. *Id*. at 15:24-16:1. He also did not physically examine Claimant, but rather based his opinion on medical records. *Id*. at 16:5-14. He did not review any of the hearing transcripts. *Id*. at 17:2-3. Dr. LeClere admitted that his knowledge of Claimant's job duties and working conditions was limited to what he read in his medical records, and prior to his second deposition he had not reviewed any additional information about Claimant's employment. *Id*. at 17:23-18:3. He did not review records related to Claimant's work hardening program. *Id*. at 18:20-19:11.

134. *Weighing the Medical Opinions*. Both Dr. Hessing and Dr. LeClere delivered well-articulated opposing medical opinions as to the etiology of Claimant's right shoulder condition. Dr. Hessing found that Claimant's SLAP tear and related pathology were due to an identifiable injury on February 10, 2014, while Dr. LeClere attributed Claimant's right shoulder condition to chronic degenerative changes that had no specific industrial origin.

These contrasting opinions are evaluated based on both the recognized extent of injury and causation.

135. Dr. Hessing opined that Claimant's right shoulder condition included both degenerative and traumatic components. Dr. Hessing physically examined Claimant and also examined the right shoulder MRI films as well as the MRI report. The MRI report described Claimant's labral tear as a: "Nondisplaced SLAP tear undermining the superior labrum along the biceps tendon origin and extending into the superior quadrant of the posterior labrum." CEII 8:163. The MRI also described ligament fraying. Dr. Hessing actually visualized the SLAP tear and his operative findings describe both fraying and labral tearing with flap formation: "arthroscopic exam of the glenohumeral joint did reveal *significant* anterior superior labral *tearing with flap formation*. This was debrided back to a stable rim. There was some circumferential fraying that was also smoothed down." CEII 9:172 (emphasis supplied).

136. In his post-hearing deposition, Dr. Hessing apparently displayed to counsel images taken during the procedure. He described the surgical repair of the tear and particularly the removal of the labral flap formation as follows:

> I'm looking right at the pictures today, and I know I can't show you those because we're not on video. But he did have a tear in the cartilage rim up front. It's *a piece*—it's *a fragment that flips around, hangs up in the joint*, what we call an "anterior labral tear," you can see it *pretty frayed up, pretty nasty tear*. And so with that, we put this roto-rooter device in, and we *trim it up* and shave it down. And *where his tear was we just remove it, just like we do in the knee when people have a cartilage tear, and so we remove that*. When we were all done, this little rim looked a whole lot better than when we started. Yeah, it's not normal, but *it no longer flips around and catches and pops* in the shoulder.

Hessing Dep., 19:22-20:11 (emphasis supplied). Dr. Hessing observed and described labral damage beyond mere degenerative fraying.

137. Dr. LeClere's causation opinion is critical of Claimant's changing subjective shoulder complaints but seemingly fails to acknowledge that Claimant suffered at least three medically documented conditions simultaneously: permanent brachial plexus impairment, bilateral cubital tunnel syndrome, and right shoulder SLAP tear. To discount the validity of Claimant's complaints because they encompassed his entire upper right extremity and cervicothoracic region is to ignore his multiple conditions.

138. Dr. LeClere never addressed the flap formation described by Dr. Hessing in his surgical findings. Instead, Dr. LeClere testified that "In the finding section, if I could briefly summarize, I would just say that the finding[s] at the time of that surgery are chronic degenerative changes. He describes circumferential fraying of the labrum." LeClere Dep. (10/13/2015), 9:3-6. Dr. LeClere continued: "From an objective standpoint and from the findings at the time of surgery, I would characterize all the findings at the time of surgery as chronic degenerative conditions." *Id*. at 14:20-23. Certainly, Dr. Hessing described circumferential fraying; however, Dr. LeClere's characterization of all of the findings at surgery as degenerative ignores the most significant finding—"significant anterior superior labral tearing with *flap formation.*" CEII 9:172. There is no indication Dr. LeClere reviewed the images taken by Dr. Hessing during surgery or reviewed Dr. Hessing's deposition. Indeed it appears that Dr. LeClere did not review Dr. Hessing's deposition wherein Dr. Hessing indicated clearly that the flap requiring removal was: "a piece … a fragment that flips around and hangs up in the joint." Hessing Dep., 19:22-20:11. Dr. LeClere's understanding of the extent and nature of Claimant's SLAP tear is open to serious question and is not persuasive.

139. While not disputing that Dr. Hessing correctly diagnosed the extent of Claimant's right shoulder pathology, Berkshire nevertheless asserts that Dr. Hessing

initially formed his opinion that Claimant injured his shoulder, causing a labral tear and related pathology, on an inconsistent and factually unsupported subjective account of Claimant's symptoms that occurred on February 10, 2014. Berkshire emphasizes Claimant's denial that he told anyone he felt a pop in his right shoulder on February 10, 2014, even though Dr. Hessing recorded that Claimant reported a pop in his shoulder. Significantly, Dr. Hessing testified a labral tear can occur without a popping sound, thus whether or not Claimant noticed a pop or told Dr. Hessing he felt a pop in his right shoulder that day does not eviscerate his claim of an accident. There is no dispute that Claimant was repetitively lifting lines weighing from 95 to as much as 195 pounds the morning of February 10, 2014, until he became incapacitated by pain and weakness. Claimant affirmed he had an onset of pain in his arms and shoulder that was worse than anything previously and that prevented him from finishing the line job that day and caused his supervisor to order him off the job site. This is ample evidence to support Dr. Hessing's conclusion that something changed that day in Claimant's shoulder functioning.

140. Additionally, Claimant's worsening shoulder symptoms over time were not unexpected. Dr. Hessing testified that symptoms from a labral tear may not be limited to the involved shoulder and may not be immediately apparent. He observed that some SLAP tear symptoms may take from 72 hours to several weeks to develop after the occurrence of the tear:

> A. ... [P]eople with labral tears have pain down the arms, they have pain clear into the hand, and so I'd have to go back and really look at exactly what you're talking about if you want me to really comment.
>
> Q. I get that, okay, that's fine. Now, just in general, when folks have this particular labral tear, the types of symptomatology that you normally would expect to see and would be helpful to you as part of your examination process in making a diagnosis would be limitation in range of motion, limitation in raising the arm, things like popping, crepitus, as you pointed out, complaints of that nature, would they not?

> A. Not necessarily within the first few days. Labral tears get worse with swelling—
>
> Q. Yeah.
>
> A. –and it takes 72 hours for a lot of the symptoms to be manifest, even a few weeks. So again, I could go back and look at exactly that, over again, but I—I wouldn't say that it necessarily would be—appear like a full-blown, you know, locking, popping episode early on.

Hessing Dep., 41:2-24. Dr. Hessing affirmed that he had indeed considered all these circumstances in arriving at his causation opinion.

141. As noted previously, Claimant denied that he told Dr. Hessing that he felt a "pop" in his right shoulder on February 10, 2014. Claimant recalled and affirmed, however, that he told Dr. Hessing that he had "pain in my shoulder, that it was different than what I had ever felt before." Tr. (9/18/2015), 50:4-53:4. Claimant testified that the most severe pain was in his elbows, but that his whole arms hurt. On February 10, 2014, Dr. Price recorded that Claimant's most intense pain was on the right. Given the severity of Claimant's bilateral arm pain from his CTS that brought him to tears on February 10, 2014, it is not surprising that he did not focus on the details of his right shoulder symptoms except to recall pain like he had never had before.

142. In arriving at his causation opinion, Dr. Hessing had an accurate understanding of the extent and nature of Claimant's SLAP tear, including both the fraying and flap formation components, and Claimant's onset of shoulder pain different than what he had ever experienced before. Furthermore, it is significant that Dr. Hessing's conclusion that Claimant suffered a SLAP tear on February 10, 2014, is consistent with Claimant's history of right shoulder symptoms.

143. After the 2008 accident, Claimant was off work and gradually returned to sedentary, then progressed to full duty work without restrictions. Dr. Hessing noted that

Dr. Marsh at Saint Alphonsus pain clinic on August 10, 2009, stated that Claimant's shoulder pain after his 2008 injury was 100% improved. CEI 13:310 On February 21, 2012, Dr. Sladich examined Claimant's right shoulder and found full range of motion. BE 10:353. On April 25, 2013, Dr. Timothy Doerr, M.D., examined Claimant at Defendants' request and recorded no finding of right shoulder labral pathology. BE 12:453-461. On October 4, 2013, Stephen Martinez, M.D., examined Claimant in connection with Claimant's fall from a ladder while working on his concrete pump truck on September 16, 2013. Dr. Martinez recorded no right shoulder complaints and released Claimant to full work without restrictions. BE 13:476-477.

144. On February 10, 2014, Claimant experienced the onset of such severe upper extremity pain while lifting lines that he testified he was crying as he attempted to complete the job before the pain and his supervisor compelled him to stop working. He believed he suffered an accident because the severity of the pain was greater than he had experienced before, such that he could not continue working and could not complete the line job. Claimant did not return to work thereafter. Tr. (11/19/2014), 68:17-72:16.

145. Dr. Hessing testified that heavy lifting could cause the shoulder injury Claimant suffered. Dr. Hessing also testified that an elbow condition causing someone to favor their elbows would put more stress on their shoulders. Hessing Dep., 22:6-10.

146. On February 10, 2014, Claimant went immediately from his work site to treat with Dr. Price, who recorded Claimant's report of deep aching pain in his cervical thoracic and right shoulder areas. CEI 18:496-497. Claimant testified that the most severe pain was in his elbows, but that his whole arms hurt. Claimant's Dep., 93:25-100:14. Claimant was off work from February 10, 2014, through the time of hearing. Tr. (9/18/2015), 42:12-43:12.

147. On February 28, 2014, Claimant presented to Dr. Kevin Krafft, M.D., complaining of right greater than left arm numbness and tingling in his whole arm and shoulders, and that "the more he puts on his shoulders the more his symptoms increase. ... He notes burning with lifting overhead now." BE 14:485. On March 18, 2014, Dr. Krafft reported abnormal EMG studies documenting moderately severe bilateral CTS. CEI 20:546-549.

148. As noted previously, the physical therapist testing Claimant's ability to return to work by lifting 65 pound sections of pipe 15 times overhead, noted that Claimant tended to perform beyond his safety level, but increasing pain forced him to stop the test. CEI 22:558.

149. On April 7, 2014, Dr. Krafft examined Claimant and noted continued pain in his arms which would require surgery. CEI 21:556. Surgery, however, was delayed when both sureties denied treatment and Claimant was forced to make his own arrangements for surgery with Dr. Hassinger.

150. On July 14, 2014, Dr. Price examined Claimant and recorded in pertinent part as follows:

> [T]he patient has a feeling of pain tightness and soreness in his right shoulder. This bothers him with laying on the right side it bothers him with use of the upper extremity on the right at chest level or above.
> ….
> Circumduction of the right shoulder is painful in the superior posterior aspects of movement and restricted about 10% but can be forced through to full mobility with pain intensification and also increasing his right upper extremity symptoms. Abduction is decreased about 20% but can be forced through to near full motion with pain intensification ….

CEI 18:512 and 514.

151. On September 2, 2014, Claimant underwent right ulnar nerve decompression followed by left ulnar nerve decompression with partial transposition on September 23, 2014. CEI 25:573-577. He recuperated and finally commenced physical therapy on December 16,

2014. His physical therapy generally included dynamometer grip and pinch testing, elbow flexion and extension, shoulder overhead pulleys for flexion and abduction, and overhead elbow extensions. Significantly, shortly after commencing overhead exercises, he again began reporting right shoulder symptoms. Tr. (9/18/2015), 30:25-31:23.

152. On January 6, 2015, the physical therapist recorded Claimant's report: "Pain: Current Severity: 5/10 pain my right shoulder was bothering me and the left elbow was sore but I don't want to reduce anything." CEII 3:58. On January 8, 2015, he was discharged from physical therapy with the therapist noting: "4.5 pain in the extensors of the right through the shoulder." *Id.*, at 3:61.

153. On January 13, 2015, Claimant returned to Dr. Krafft prior to commencing the work hardening program. Dr. Krafft recorded: "He reports his whole right arm is painful but the pain is mainly in the elbow with radiation up to the shoulder." CEII 5:76. His right shoulder discomfort continued and on March 2, 2015, a right shoulder MRI confirmed a SLAP tear. CEII 8:163-164. On March 18, 2015, Dr. Hessing noted popping and catching in Claimant's right shoulder with difficulty bringing the arm up overhead. CEII 9:165-166. Dr. Hessing performed right shoulder arthroscopy on April 27, 2015. CEII 9:172-174.

154. Commencing with Dr. Price's February 10, 2014 notes, the post-accident medical, physical therapy, and work hardening records show a general pattern of right shoulder symptoms that corroborates Dr. Hessing's causation opinion. As noted, Dr. Hessing examined Claimant, his right shoulder MRI images, his SLAP tear, and his pre and post February 10, 2014, medical records. In contrast, Dr. LeClere never examined Claimant, his right shoulder MRI or arthroscopic images, his medical records after his CTS release surgeries, and acknowledged he was not familiar with Claimant's work requirements. LeClere Dep. (3/9/15), 35:11-36:8.

Dr. Hessing's opinion is more persuasive than Dr. LeClere's opinion. Claimant has proven he suffered an industrial accident on February 10, 2014, causing right shoulder SLAP tear.

155. In addition to Claimant's SLAP repair, Dr. LeClere opined that Claimant's need for acromioplasty and claviculectomy were due to preexisting degenerative changes. However Dr. LeClere's conclusion arises from an incomplete understanding of the extent and nature of Claimant's SLAP tear. Dr. Hessing carefully described the shoulder anatomy and the development of shoulder impingement. He opined that Claimant's labral tear caused an inflammatory response that created swelling and irritation deep in the shoulder resulting in Claimant's right shoulder impingement. Hessing Dep., 18:6-13. Dr. Hessing testified that Claimant's labral tear "is a significant aggravation of any wear and tear findings" and "certainly aggravated" the degenerative changes in Claimant's right shoulder. Hessing Dep., 35:l and 37:21. Dr. Hessing's opinion that Claimant's SLAP tear aggravated his degenerative right shoulder conditions and caused shoulder impingement is persuasive.

156. It is well settled that an employer takes an employee as he finds him. *Wynn v. J. R. Simplot Company*, 105 Idaho 102, 666 P.2d 629 (1983). The aggravation, lighting up, or acceleration of a preexisting disease or weakened condition by an industrial accident is compensable:

> The rule is well established in this jurisdiction that injury, resulting partly from accident and partly from a pre-existing disease, is compensable if the accident aggravated or accelerated the ultimate result; and it is immaterial that the claimant would, even if the accident had not occurred, become totally disabled by reason of the disease.

Woodbury v. Arata Fruit Company, 64 Idaho 227, 239, 130 P.2d 870 (1942); *see also*, *Spivey v. Novartis Seed Inc.*, 137 Idaho 29, 34, 43 P.3d 788, 793 (2002).

157. Based upon the foregoing findings, Claimant has proven he suffered an accident at work on February 10, 2014, causing his right shoulder labral tear, aggravating his degenerative conditions, causing impingement, and necessitating the right shoulder surgery performed by Dr. Hessing on April 27, 2015.

158. **Medical Care**. Idaho Code § 72–432(1) requires an employer to provide an injured employee such reasonable medical, surgical or other attendance or treatment, nurse and hospital service, 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. In *Neel v. Western Construction, Inc.*, 147 Idaho 146, 206 P.3d 852 (2009), the Idaho Supreme Court held that "when a surety initially denies an industrial accident claim which is later determined to be compensable, it is precluded from reviewing medical bills for reasonableness under the workers' compensation regulations from the time such bills are initially incurred until the claim is deemed compensable, but once the claim is deemed compensable a surety may review a claimant's medical bills incurred thereafter for reasonableness in accordance with the workers' compensation regulatory scheme." *Neel*, 147 Idaho at 149, 206 P3d at 855.

159. Claimant has proven that his bilateral CTS was the result of a compensable occupational disease. Claimant has also proven that his right shoulder labral tear and impingement, resulting in the need for right shoulder SLAP repair, acromioplasty, and claviculectomy, were caused by his February 10, 2014 industrial accident. Based on *Neel*, 147 Idaho at 149, 206 P3d at 855, Claimant is entitled to reimbursement of the full invoiced amount of the medical bills related to his bilateral CTS and his right shoulder labral tear and

impingement, up to the date of the decision in this case. After the date of the decision, any such medical expenses may be reviewed for reasonableness.

160. **Temporary Disability Benefits**. I.C. § 72-408 provides for temporary disability benefits during an injured worker's period of recovery. A claimant becomes disabled and thus eligible for temporary disability benefits in an occupational disease case when the claimant can no longer perform the job tasks required of the time-of-injury employment. *See, Simmons v. Winco Foods, Inc.*, 2009 IIC 0435.36; *Morris v. U.S. Bank*, 2012 IIC 0044.21.

161. Once a claimant is medically stable, the claimant is no longer in the period of recovery and total temporary disability benefits cease. *Jarvis v. Rexburg Nursing Center*, 136 Idaho 579, 586, 38 P.3d 617, 624 (2001). Furthermore, the Idaho Supreme Court in *Malueg v. Pierson Enterprises*, 111 Idaho 789, 727 P.2d 1217 (1986), held as follows*:*

> [O]nce a claimant establishes by medical evidence that he is still within the period of recovery from the original industrial accident, the claimant is entitled to total temporary disability benefits unless and until evidence is presented that the claimant has been medically released for light work and that (1) his former employer has made a reasonable and legitimate offer of employment to him which he is capable of performing under the terms of his light duty work release and which employment is likely to continue throughout his period of recovery, or that (2) there is employment available in the general labor market which claimant has a reasonable opportunity of securing and which employment is consistent with the terms of his light duty work release.

Maleug, 111 Idaho at 791-792, 727 P.2d at 1219-1220.

162. Claimant's supervisor suspended him from work on February 10, 2014 and told him that he could not return without a full duty release. Tr. (11/19/2014), 70:25-71:2. Dr. Price evaluated Claimant on that date and concluded that it was unsafe for Claimant to return to his job as a concrete pump operator because performing line work was "too heavy" for him. CEI 18:497. The reason for Claimant's disablement was an occupational disease, bilateral CTS, which Dr. Krafft diagnosed on March 18, 2014. CEI 20:546.

Claimant was also disabled by his right shoulder labral tear and impingement, confirmed by MRI on March 2, 2015, which Dr. Hessing surgically repaired on April 27, 2015. Following Claimant's suspension from work, Brundage-Bone indicated that although his job was preserved, no light duty work was available and Claimant would need a full duty release to return to work. CEII 1:2. On July 15, 2015, Dr. Krafft stated that Claimant's work restrictions would remain in place until Claimant had completed a work hardening program. CEII 1:20. At his post-hearing deposition, Dr. Hessing indicated he last examined Claimant's shoulder on August 17, 2015, and recommended "a few more therapy visits." Hessing Dep., p. 27, 18-19. As of the date of the second hearing, Claimant had not obtained alternative employment and had not completed a work hardening program or physical therapy for his right shoulder because Defendants had denied further treatment and he could not afford to pay for it. Tr. (9/18/2015), 42:21-43:12.

163. Based upon the foregoing facts, the evidence shows that Claimant became disabled on February 10, 2014 and as of the date of the second hearing was still in a period of recovery. Claimant is therefore entitled to total temporary disability benefits from February 10, 2014 until he reaches medically stability, or Brundage-Bone offers him work within his limitations, or shows there is employment in the general labor market within his limitations that Claimant has a reasonable opportunity of obtaining.

CONCLUSIONS OF LAW AND ORDER

Based on the foregoing, the Commission hereby ORDERS the following:

1. Neither the 2008 industrial accident nor the 2014 industrial accident was the cause of Claimant's bilateral CTS.

2. Claimant's bilateral CTS is a compensable occupational disease.

3. As the Employer and Surety at the time of Claimant's last injurious exposure, Brundage-Bone and Berkshire are liable for worker's compensation benefits payable due to his occupational disease.

4. The 2014 industrial accident was the cause of Claimant's right shoulder labral tear and impingement which are therefore compensable.

5. Claimant is entitled to reimbursement of the full invoiced amount of the medical bills that he has incurred related to his bilateral CTS, up to the date of the decision in this case. Claimant is also entitled to reimbursement of the full invoiced amount of the medical bills that he has incurred related to his right shoulder labral tear and impingement, up to the date of the decision in this case. After the date of this decision, any such medical expenses may be reviewed for reasonableness and Claimant is entitled to such further reasonable medical expenses necessitated by his bilateral CTS or his right shoulder labral tear or impingement.

6. Claimant is entitled to total temporary disability benefits from February 10, 2014 until he reaches medical stability, or Brundage-Bone offers him work within his limitations or shows there is employment within his limitations in the general labor market which Claimant has a reasonable opportunity of obtaining.

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

DATED this 7th day of June, 2016.

INDUSTRIAL COMMISSION

___/s/_____
R.D. Maynard, Chairman

___/s/_____
Thomas E. Limbaugh, Commissioner

___/s/_____
Thomas P. Baskin, Commissioner

ATTEST:

___/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 7th day of June, 2016, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** was served by regular United States Mail upon each of the following:

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