IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2004 MTWCC 34

WCC No. 2003-0833

BRUCE FUSS

Petitioner

vs.

INSURANCE COMPANY OF NORTH AMERICA and VALOR INSURANCE COMPANY, INCORPORATED

Respondents/Insurers.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

Summary: Claimant, who is developmentally disabled, developed dysphonia (hoarseness) and difficulty breathing in late 1997. After an occupational disease evaluation he was determined by the Department of Labor and Industry (Department) to be suffering from an occupational disease. His employer's insurer – Insurance Company of North America (ICNA) – did not appeal that determination, it therefore became final. In the years thereafter, the claimant had continuing and increasing dysphonia and related breathing difficulties, ultimately leading to a tracheostomy in 2002 and total disability. He submitted an additional claim in 2002 to his employer's new insurer, Valor Insurance Company. Both Valor and ICNA deny liability for his current condition.

Held: While it is clear that psychological factors are substantial contributors to the claimant's continued voice and breathing problems, a preponderance of the evidence shows that those conditions are the same conditions which were determined by the Department to be an occupational disease and that they are causally related to that occupational disease. ICNA is therefore liable for his subsequent and current problems.

Topics:

> **Occupational Disease: Last Injurious Exposure.** Where a claimant is diagnosed with an occupational disease, the insurer at risk at the time of that diagnosis is liable for, and continues to be liable for, the disease even though the disease is materially aggravated by the claimant's continued work for the same employer.
>
> **Judgments: Res Judicata.** Where the Department of Labor and Industry has determined that the claimant suffers from an occupational disease and the insurer

fails to appeal that determination within the time allowed by statute, the determination is final and cannot be contested in a later proceeding.

Judgments: Res Judicata. Where the Department of Labor and Industry has determined that the claimant suffers from an occupational disease and the insurer fails to appeal that determination within the time allowed by statute, the determination is final and may not be challenged on the ground that it was based on a mistake of fact.

Estoppel and Waiver: Equitable Estoppel. The claimant is not estopped from invoking a prior and final decision of the Department of Labor and Industry holding he suffers from an occupational disease where the evidence establishes that he did not deliberately and intentionally misrepresent facts and the insurer has failed to present evidence that the additional facts changed the opinions of the occupational physician upon which the decision was based.

Occupational Disease: Proximate Cause. Where the claimant has been determined to suffer from an occupational disease, the insurer at risk at the time of the determination continues to be liable for the condition unless it wholly resolves and the recurrence of the condition is the result of factors unrelated to his employment.

Occupational Disease: Subsequent Disease. An insurer liable for an occupational disease is not liable for a subsequent new and different disease. However, where a claimant is diagnosed with an occupational disease, the insurer at risk at the time of that diagnosis is liable for, and continues to be liable for, the disease even though the disease is materially aggravated by the claimant's continued work for the same employer.

Occupational Disease: Causation. Liability for an occupational disease extends only to the disease and to conditions and sequella that are caused by the occupational disease.

¶1 The trial in this matter was held on December 9, 2003, in Missoula, Montana. Petitioner, Bruce Fuss, was present and represented by Mr. Rex Palmer. Respondent, Insurance Company of North America, was represented by Mr. Leo S. Ward. Respondent, Valor Insurance Company, Incorporated, was represented by Mr. Joe C. Maynard.

¶2 Exhibits: Exhibits 1 through 19 were admitted without objection.

¶3 Witnesses and Depositions: Bruce Fuss and Michele Fairclough were sworn and testified. The parties also submitted the depositions of Bruce Fuss and Dr. Frederick Kahn for the Court’s consideration. The Court participated by telephone in Dr. Kahn’s testimony on November 25, 2003.

¶4 Stipulations: At trial the parties agreed and stipulated that Valor did not insure Truckers Express, Incorporated.

¶5 Issues Presented: The issues as set forth in the Pretrial Order are:

> ¶5a Petitioner's entitlement to acceptance of his claim and payment of benefits by one or the other Respondents.
>
> ¶5b Petitioner's entitlement to a penalty, reasonable attorney fees and costs from Respondent Insurance Co. of North America for each delay and refusal which the court finds was unreasonable.

(Pretrial Order at 2.)

¶6 Having considered the Pretrial Order, the testimony presented at trial, the demeanor and credibility of the witnesses, the depositions and exhibits, and the arguments of the parties, the Court makes the following.

FINDINGS OF FACT

¶7 The petitioner in this matter is Bruce Fuss and will be referred to as "claimant."

¶8 Some of the facts that follow are taken from my Decision and Order Denying Motion for Partial Summary Judgment, 2003 MTWCC 68 (issued November 25, 2003). The facts I incorporate here were undisputed at the time of the decision and were not disputed at trial.

¶9 As an initial note, the medical records in this case show that claimant's physicians have had great difficulty in identifying and treating his respiratory complaints which are the focus of the present case.

¶10 The claimant is a forty-three-year old developmentally disabled man who resides in Missoula, Montana. His overall IQ is 66. (Ex. 17 at 2). Given his disabilities he has proven to be an extraordinarily hard worker. He has worked mainly in custodial and janitorial jobs for gas stations, bars, restaurants, and convenience stores, often working long hours with few days off.

¶11 While the claimant graduated from high school, he did so in a special education program. Thus, his diploma does not reflect his educational level. Indeed, the claimant has great difficulty reading and writing and cannot balance his own checkbook. I specifically note that he required assistance filling out the questionnaire given him in 1998 by Dr. Headapohl. He did not in fact fill out that form: it was filled out by someone else who posed the questions to him orally and then recorded his answers. The claimant is more probable than not functionally illiterate.

¶12 It is also obvious to me that the claimant has difficulty remembering events. He had to be prompted with respect to significant medical events and even then his recall was poor.

His difficulty in remembering is compounded by a poor appreciation of time, as reflected by his inability to recall dates or to even recall how far in the past events occurred. He was and is an unreliable historian, however, I am persuaded that he has not intentionally misled medical providers or deliberately withheld information from them.

Background Medical Information – Pre-occupational Disease Claim

¶13 Valor urges that the claimant has a long history of multiple, unexplained physical complaints dating back to 1984 which are attributable to psychogenic (psychological) factors, especially stress. I address these contentions in light of the argument by both Valor and ICNA that the claimant's present condition, for which he seeks compensation, is psychogenic in nature and not the result of any occupational disease.

¶14 The first such complaint identified by Valor was on February 13, 1982, when the claimant was twenty-one years old. The claimant was seen on that date at St. Patrick Hospital Emergency Room for a reported "seizure." It was reported at that time that the claimant was suffering from grand mal epilepsy, however, subsequent medical records indicate no evidence or diagnosis of epilepsy and Dr. Frederick W. Kahn, the only physician who testified in this matter, opined that the incident stemmed from psychological, not physical causes. (Kahn Dep. at 8.)

¶15 In 1984, when the claimant was twenty-four years old, he was hospitalized for over a week after presenting with symptoms which included difficulty breathing, hyperventilation, left-sided weakness, numbness, tingling, and tremor. (Ex. 14 at 26.) It was noted at the time of admission that he "works 9-10 hours a day, seven days a week and had not had a day off in 2 months," a work schedule very similar to his work at the time his occupational disease arose in 1997. He underwent an extensive physical work-up and no physiological explanation could be found for his complaints. Ultimately, he was diagnosed with a "conversion disorder" (*id*. at 27), which is "a psychoneurosis in which bodily symptoms (such as paralysis of the limbs) appear without physical basis or explanation. The condition is also referred to as "conversion hysteria." Merriam-Webster Medical Dictionary. He was transferred to the Mental Health Unit for treatment. (*Id*. at 26.) During that treatment it was ascertained that the claimant was suffering from stress stemming from betrayal by a friend for whom he had cosigned a promissory note. (*Id*. at 26-27.) Upon discharge he was referred to a psychologist for further counseling.

¶16 The remainder of the instances cited by Valor are principally related to abdominal pain. (See Valor's Proposed Findings of Fact, Conclusions of Law, and Judgment, ¶¶ 16-17, 19, 21-24.) However, the records show that in 1987 he was diagnosed, after an upper GI series, with a peptic ulcer. (Ex. 14 at 42.) He undoubtedly suffers from gastric reflux; thus, his history of abdominal complaints is neither surprising nor particularly significant from a psychological standpoint. However, it may well contribute physiologically to his dysphonia.

Occupational Disease Claim

¶17 During 1997 and 1998 the claimant was employed as a janitor at two businesses - 4B's Crossroads (4B's) and Truckers Express, Incorporated (Truckers Express). The two employers were affiliated. During 1997, 1998, and parts of 1999 both were insured by the Insurance Company of North American which at that time was known as CIGNA but is hereinafter referred to as ICNA. ICNA ceased providing coverage for 4B's on July 1, 1999, and for Truckers Express on August 1, 1999.

¶18 During 1997 and 1998 the claimant was working long hours at his two jobs. He may have had a third job at times. In any event, he liked to work and often worked sixty to eighty hours a week.

¶19 In 1997 the claimant developed hoarseness, which he described as losing his voice. His claim for compensation indicates the condition began in September 1997.

¶20 The only medical records for the last part of 1997 are three slips written by Dr. J. Michael Caldwell. One took the claimant off work for several days in November 1997. A second is a report of a normal chest x-ray on November 10, 1997. The third reflects a phone call to the Western Montana Clinic in which the claimant indicated he was "doing much better." (Ex. 12 at 17- 21.)

¶21 The first medical record of any hoarseness after September 1997 was on February 5, 1998, when the claimant was seen by Dr. Stanley H. Seagraves of the Western Montana Clinic. (*Id.* at 21-22.) At that time the claimant presented with

> laryngospasm symptoms characterized by hoarseness starting about 2 weeks ago again. He has noticed that this seems to follow vacuuming at work or at least in some instances follow that. . . .

(*Id*. at 21.) The claimant's voice was "quite squeaky, particularly if he tries to force his voice at all." (*Id*.) He denied any breathlessness. (*Id*.) Dr. Seagraves diagnosed "laryngospasm, [possible or questionable] allergic etiology" and recommended that he avoid vacuuming at work. (*Id.* at 22.) He prescribed prednisone, a steroid medication. *(Id*.)

¶22 "Laryngospasm" is the "spasmodic closure of the larynx." Merriam-Webster Medical Dictionary. "Spasmodic" means "characterized by spasm" or acting "fitfully." Merriam-Webster Collegiate Dictionary. The "larynx" is the upper part of the airway, lying below the throat at the top of the trachea.

¶23 The claimant was next seen by Dr. Phillip A. Gardner, who also practices with the Western Montana Clinic. At that time the claimant reported

> a six month Hx (history) of dysphonia. He has noted that these symptoms have come on since he has been vacuuming and sweeping and is worried that he is allergic to dust.

(Ex. 12 at 24.) “Dysphonia" is simply a descriptive term for "defective use of voice." Merriam-Webster Medical Dictionary. That definition includes hoarseness.

¶24 Dr. Gardner diagnosed “dysphonia.” His differential diagnosis included gastric reflux, allergy, and spastic dysphonia. (*Id*.) Spastic dysphonia is an older term for the condition now known as paradoxical vocal cord dysfunction, which is a psychogenic or stress-related premature closing of the vocal cords. (Kahn Dep. at 27.)

¶25 Dr. Gardner again saw the claimant on March 11, 1998, and concluded that the “most likely diagnosis” of the claimant’s condition was “spasmodic dysphonia.” (Ex. 12 at 26.) This appears to be a “descriptive” diagnosis.

¶26 Meanwhile, Dr. Gardner had referred the claimant to Dr. Peter G. Von Doersten, an otolaryngologist. (*Id*.) Dr. Von Doersten first saw the claimant on March 2, 1998. His medical record for that date records the following history:

> [The claimant] was initially seen by Dr. Gardner on 2-9-98 with a chief complaint of hoarseness. Patient reported that this began initially after an exposure to a significant amount of dust. It will frequently clear for a period of time, however, with recurrent dust exposure the hoarseness returns. This is characterized by voice breaks with frequent straining or strangling quality to the voice. The straining or strangling typically occurs towards the end of the breath. . . .

(Ex. 9 at 2.) Dr. Von Doersten performed a physical examination of the claimant’s larynx and also had him tested by a speech pathologist. He formed the following impression:

> IMPRESSION & RECOMMENDATION: Dysphonia, likely secondary to true vocal cord irritation. The possibility of allergies must me [sic] entertained as well as the possibility of irritants related to dust exposure. . . .

(*Id*.) He ordered an allergy evaluation and speech therapy. (*Id*.)

¶27 Dr. Von Doersten’s office note for May 6, 1998, noted a change in the nature of the claimant’s hoarseness and suggested the possibility of a functional (psychological) component. His primary impression was as follows:

> Hoarseness with acute laryngitis presently. The patient’s quality of hoarseness has changed considerably since being initially seen. He no longer has the glottic breaks and spasticity that he had initially. He does have hoarseness, which may be related to over straining the voice. It is very unusual to have such a change in the voice

> quality and this lends me to think that there may have been an element of functional dysphonia on the initial visit. . . .

(*Id*. at 3.)

¶28 Dr. Von Doersten also saw the claimant on June 24, 1998, at which time he noted the claimant had been on allergy shots for several weeks and had been “improving generally with this, with regards to his nasal airway and his dysphonia.” (*Id*.)

¶29 Meanwhile, on March 27, 1998, a representative of both 4-B’s and Truckers Express wrote to ICNA reporting a claim for compensation. The enclosed First Report listed Truckers Express as the claimant’s employer. (Ex. 15 at 1.) The accompanying letter stated it would be "acceptable for this occupational disease to be handled through the Truckers Express account." (*Id*. at 2.) The employers did not question the claim.

¶30 On June 1, 1998, ICNA denied the claim. It informed the claimant that "*the information we have received indicates that your condition cannot be directly related to your occupation*." (*Id*. at 3, italics in original.)

¶31 On August 4, 1998, Dr. Dana Headapohl performed an independent medical examination (IME) at the request of the Department of Labor and Industry (Department). (Petitioner's Statement of Uncontroverted Facts, ¶ 11; ICNA's Opposition to Partial Summary Judgment, ¶ 1, Ex. 1.) She concluded:

> Mr. Fuss has pre-existent atopy as manifested by asthma as a very young child and positive allergy testing to a variety of exposures. However, he had been asymptomatic until high occupational dust exposures in the fall of 1997.
>
> His upper airway irritation, nasal and sinus congestion and dysphonia meet the proximate causation criteria for occupational disease.
>
> He continues to work at his job in a modified capacity. He should be able to continue his job with the use of a dust mask and a HEPA filter vacuum cleaner.
>
> Allergy shots for dust mites and pollen (likely contaminants in the dust at work) is recommended on an ongoing basis.
>
> With regard to apportionment, 50% of his symptoms are occupationally related and 50% for his underlying pre-existent atopic condition.

(Ex. 6 at 28.) The occupationally-related symptoms addressed by Dr. Headapohl were upper airway irritation, nasal and sinus congestion, and dysphonia.

¶32 Based on Dr. Headapohl's report, on September 9, 1998, the Department issued an Order of Determination concluding that "claimant is suffering from an occupational disease and is entitled to benefits under the Occupational Disease Act." (Ex. 5 at 1.) The

Department determined that the claimant was entitled to fifty percent of his "total disability benefits if they [sic] suffer a total wage loss as a result of the occupational disease" and was also entitled to "medical and hospital expenses directly related to their [sic] occupational disease." (*Id*.)

¶33 ICNA did not appeal the Department's Order of Determination and paid various benefits relating to the claimant's condition.

¶34 Following Dr. Headapohl's examination and the Department's determination, the claimant continued to experience hoarseness and loss of voice. He had other complaints as well.

¶35 During the remainder of 1998 his medical records reflect the following:

> ¶35a On August 24, 1998, the claimant was seen by Dr. Seagraves, who recorded that the claimant was "continuing to have the same complaints of hoarseness, intermittent weak voice, squeaky voice, occasional cough and wheezing" and was "requesting [a] change in his allergy treatment protocol." (Ex. 12 at 31.)
>
> ¶35b On October 15, 1998, the claimant was seen by Dr. Gardner for "problems with his voice." (*Id*. at 33.) Dr. Gardner noted that his condition has been "difficult to diagnose, but c**ertainly gastric reflux has a participation in this problem** and there is a question of whether allergy is also a possible contributing factor." (*Id*., emphasis added.) He examined the claimant and diagnosed, "Dysphonia with incomplete closure of the true vocal cords and premature closure of the false vocal cords." (Id.) He prescribed speech therapy.

¶36 The year 1999 was far less eventful than 1998. The following information is taken from the claimant's medical records:

> ¶36a The claimant saw Dr. Gardner on January 6, 1999, and had the "same complaints of intermittent hoarseness and intermittent complete voice loss . . . [with] a squeaky quality of his voice." (*Id*. at 34.) The claimant was also suffering from left ear pain, which Dr. Gardner diagnosed as otitis externa (*id*.), which is "inflammation of the external auditory canal." Merriam-Webster Medical Dictionary.
>
> ¶36b Six months later, on June 24, 1999, the claimant was hospitalized for abdominal pain. (Ex. 14 at 73.) While the etiology of his pain was never determined, there were objective findings related to his complaints. (*Id*.)
>
> ¶36c The claimant then developed torticollis (a "wryneck") in July 1999 and suffered an atypical reaction of shakiness, shortness of breath, and flushing to a narcotic medication he was given. (Ex. 13 at 3; Ex. 14 at 74-75, 78.)

¶37 The claimant's first medical intervention in 2000 was on June 12, 2000, nearly a year and a half after his last report of hoarseness and dysphonia. On that date he saw Dr. Seagraves, complaining of a cough. (Ex. 12 at 39.) Dr. Seagraves noted his prior history of "intermittent hoarseness" but recorded, "Today, though, I think the problem is a routine tracheal bronchial infection." (*Id*.) Thus at that time there was no indication of any continuing significant problem with hoarseness or dysphonia.

¶38 On August 31, 2000, Dr. Seagraves saw the claimant to go over routine blood lab work. At that time he noted, without further explanation, that the claimant "continues to be plagued by his mild hoarse voice but has no other problems on review of systems today." (*Id*.) It is not clear whether the claimant was suffering from mild hoarseness on that date or whether he simply reported he had continued to suffer from mild hoarseness. In any event, taken in light of the claimant's failure to seek medical attention for hoarseness over the prior year and a half, the office note indicates that any continuing hoarseness was mild.

¶39 On October 26, 2000, the claimant was hospitalized at St. Patrick Hospital for abdominal pain with vomiting and diarrhea. (Ex. 14 at 79-85.) Dr. Seagraves suspected "mild viral gastroenteritis." (*Id*. at 85.) The claimant was discharged October 31, 2000. (*Id*.)

¶40 On the same day of his discharge from St. Patrick Hospital, the claimant went to the Community Medical Center complaining of extreme epigastric (stomach) pain, as well as some difficulty breathing. (Ex. 13 at 10.) A CT scan was done to rule out a perforated ulcer and the claimant was discharged. (*Id*. at 11.)

¶41 Dr. Seagraves saw the claimant in follow-up on November 7, 2000. His office note states that the results of all of the tests done at both St. Patrick Hospital and Community Medical Center were normal. (Ex. 12 at 41.) Dr. Seagraves concurred with a conclusion of Dr. Diane Yahn that "a lot of his [claimant's] features were anxiety related." (*Id*.) Of some significance, Dr. Seagraves noted:

> He [claimant] says he has gone back to work a couple of times and has felt weak and tired. He says he has occasional episodes of "shaking." He demonstrates this when I ask him by holding his arms up and he has a very odd non-physiologic appearing total arm coarse, wobbling type tremor. When he is distracted though or talking to me or waving his arms about to describe symptoms, there is no tremor whatsoever. . . .

(*Id*.) Dr. Seagraves "felt," and told the claimant, "that some of his symptoms were due to anxiety and/or depression . . . ." (*Id*.) Nonetheless, Dr. Seagraves ordered a battery of further testing, including a CT scan of the head and an EEG. (*Id*.)

¶42 Dr. Seagraves saw the claimant again on November 14, 2000. (*Id*. at 42.) The tests he had ordered were negative. (*Id*.) He explained the results to the claimant and his stepmother, who accompanied him. (*Id*.) His office note goes on to record, "[B]oth Dr. Yahn

and I have confronted him and his stepmother about the roles that depression and stress, overwork, etc., are playing in all of this." Dr. Seagraves' note of his physical examination of the claimant on that date reflects:

> On exam today, Bruce comes in feeling, he says, a little bit better and frankly looking more relaxed, but he still persists and in this very unusual head and upper extremity tremor.
>
> On at least one occasion, I am fairly sure I caught him not shaking and again the frequency and distribution of this tremor is most nonphysiologic in my experience.

(*Id*.) The last paragraph of Dr. Seagraves' record on this date is significant. It reads:

> Bruce and his stepmother are most insistent about further consultation and a neurologic evaluation will be arranged with Dr. Russo for later this week. With the constellation of negative reports that we have turned up thus far, I am fairly comfortable that this problem too will resolve. In some ways, it could be a new version of Bruce's symptom of the mid to late 1980s, namely very unusual chronic hoarseness and cough, but it was extensively worked up here and I believe in Seattle to no avail. I do not believe he has Munchausen's characteristics, but probably does have a strong psychophysiologic predisposition. FU with me in two weeks.

(*Id*.)

¶43 I do not have Dr. Russo's records for his evaluation following Dr. Seagraves' referral, however, Dr. Seagraves' note of November 29, 2000, refers to his evaluation. (*Id*. at 43.) Dr. Seagraves' note of that date also indicates his continued belief that many of the claimant's symptoms were psychogenic. His office note in pertinent part says:

> Bruce is here to follow-up on his problems, including an usual functional tremor, hypothyroidism and abdominal discomfort. He has seen Dr. Russo who concurs with my assessment and recommended a visit with Laurie Bogart at VRI, as well as an OT assessment. Laurie and "Shelly" (?) Are also baffled by his presentation. Bruce thinks he is making a little headway. He is working less in that he has cut back his hours by not working at the 4-Bs but is continuing his other 2 jobs. When I observed him walking about the room doing finger-to-nose testing, reading some appointment cards, etc., his tremor seems to almost completely abate. I am still suspicious of the strong functional component. His nausea and abdominal pain have almost completely resolved. . . .

(*Id*.)

¶44 Significantly, the claimant's complaints in the year 2000 were unrelated to hoarseness or dysphonia. He continued to work as a janitor during much of that year.

¶45 Medical records for 2001 do not indicate complaints of hoarseness or dysphonia during that year. The claimant's medical visits, which were few, were for a continuation of his tremors in early 2001 and for a rash. (Ex. 12 at 45-47; Ex. 14 at 90.) He also had an anxiety reaction following his father's funeral and was seen at St. Patrick Hospital for "shaking." (Ex. 14 at 90; Ex. 12 at 47.)

¶46 Things changed dramatically in 2002. On May 26, 2002, the claimant was hospitalized at Community Medical Center because of wheezing and difficulty breathing. (Ex. 13 at 14.) The history taken at that time indicates he had "a several-day illness of progressive respiratory illness." (*Id*. at 15.)

¶47 The claimant demanded ICNA pay for the May 2002 hospitalization. ICNA refused, stating that the hospitalization was "unrelated to your Occupational Disease of September of 1997." (Ex. 15 at 6.) Apparently, its adjuster believed the claimant's employment after 1997 and 1998 aggravated his condition and relieved ICNA of further liability. At least the adjuster wrote:

> The limited medical records I have been able to review indicate that you experienced a significant material worsening of your respiratory condition as a result of your employment at the 4B's Crossroads on May 20, 2002.

(*Id*.)

¶48 During May 2002 the claimant was still working for 4B's and Truckers Express, however, by that time 4B's was insured by Valor Insurance Company (Valor) which is also a respondent in this action. Valor did not insure Truckers Express. A claim for benefits was submitted to Valor. Valor denied liability for the claimant's 2002 hospitalization and his current condition.

¶49 In this action, both insurers deny liability for the claimant's dysphonia and related conditions. Valor asserts that the claimant's condition is unrelated to his employment. Secondarily, it alleges that liability, if any, should rest on ICNA since it was the earlier insurer of the claimant's employer.

¶50 ICNA proffers four defenses. First, it argues that the claimant's medical conditions are unrelated to any occupational disease. Secondly, it asserts that the diagnosis of an occupational disease in 1998 was based on an inaccurate medical history and that it should be allowed to rescind its acceptance of liability based on fraud or mutual mistake of fact. Third, it alleges that the claimant should be estopped from pursuing his claim because he misrepresented his medical history to Dr. Headapohl. Fourth, and finally, it says, in the alternative, that Valor should be liable because the claimant's condition materially worsened during that time.

¶51 During his May 2002 hospitalization claimant underwent an extensive medical work-up. Dr. T. Shull Lemire, a pulmonologist, evaluated the claimant on May 30, 2002. His assessment at that time was, "Acute bronchitis with possible hyperactive airway disease versus a vocal cord dysfunction – it is hard to say which of these is contributing, or whether it is a combination of both." (Ex. 13 at 20.) He bronchoscoped the claimant and noted that the claimant's "vocal cords appear unremarkable other than adducting significantly with expiration." (*Id*. at 21.) The Discharge Summary, which was authored by Dr. Seagraves, indicates that the claimant had "a lot of bronchospasm" and that the episode was similar to one "in 1998 of dysphonia, wheezing, cough, etc." (*Id*. at 22.) Dr. Seagraves also noted the claimant's "suspicion that some of this is triggered by a lot of fumes and chemicals at work." (*Id*.)

¶52 Dr. Seagraves saw the claimant on June 6, 2002, in a follow-up visit. At that time he noted that the claimant was doing better but had "a little bit of wheeze" and slight hoarseness. (Ex. 12 at 50.) Dr. Seagraves recommended that he stay off work for another two to three weeks and commented:

> He works three jobs, 60 hours a week, and is in a lot of fumes and chemicals. I told him, ideally, he should find another line of work, but the options are limited for Mr. Fuss, and he likes to work hard and wants to continue if he can. Did discuss some mask devices he could employ. . . .

(*Id*.)

¶53 Dr. Lemire saw the claimant on June 27, 2002, in follow-up to his hospitalization. (Ex. 13 at 24.) At that time he ordered a methacholine challenge to determine if the claimant in fact had asthma. (*Id*.) The test was positive and Dr. Lemire made a diagnosis of asthma. (*Id*.)

¶54 On July 12, 2002, the claimant was again seen by Dr. Seagraves. The doctor's office note for that visit indicates that the claimant had been back to work for two or three days and was experiencing a recurrence of his symptoms. He wrote:

> He is here today with recurring hoarseness and breathing symptoms that recurred after 2-3 days back at work. He works 3 jobs and the biggest trouble he seems to have is at the 4Bs where there is a lot of smoke exposure.

(Ex. 12 at 55.) Dr. Seagraves took him off work once more and suggested that he find a new occupation.

¶55 The claimant did not heed Dr. Seagraves' advice to stay off work. On July 21, 2002, he was back at the Community Medical Center ER with an acute attack of "respiratory distress" occurring at work. (Ex. 13 at 26, 28.) The ER report provides the following information:

> This is a 41 year old, white male, with a history of asthma with exacerbations possibly related to chemical fumes at work, where he works as a janitor, who came in by private care when an employee brought him in with acute respiratory distress that started a couple hours ago. He states it was very sudden in onset. The patient could not really offer any history immediately at the time. There is no description of recent cold-like symptoms or any bee sting. . . .

(*Id*.) His symptoms at the time included high rates of respiration (48-60) and heart beat (130), wheezing and stridor. (*Id*. at 26-27.) Stridor is "a harsh vibrating sound heard during respiration in cases of obstruction of the air passages." Merriam-Webster Medical Dictionary. The degree of his respiratory distress is evident from the fact that he was admitted to the ICU. (*Id*. at 27.) Dr. Lemire saw him upon admission and diagnosed, "Dyspnea with stridor – I suspect that this is mostly due to laryngeal spasm with his vocal cords dysfunction." (*Id*. at 29.)

¶56 The claimant was hospitalized for seven days. (Ex. 13 at 32.) As related to his breathing problems, his discharge diagnosis was:

1. Laryngospasm.
2. Severe anxiety disorder.
3. Asthma
4. Vocal cord dysfunction.

(*Id*.) Dr. Lemire, who wrote the discharge summary, noted the claimant's anxiety and said, "It is uncertain whether the anxiety came first or the laryngospasm." (*Id*.) During his hospitalization the claimant was taught relaxation techniques and prescribed Paxil to reduce his anxiety. (*Id*.)

¶57 The claimant's employment ceased entirely thereafter. (Fuss Dep. at 74-75; Ex. 12 at 56.) He applied for social security disability benefits. (Fuss Dep. at 72.) On July 26, 2002, the claimant filed his claim against Valor. (Ex. 3.)

¶58 Dr. Lemire saw the claimant on July 30, 2002, in follow-up to his July 2002 hospitalization. Dr. Lemire indicates in his office note that the claimant's primary problem was laryngospasm but that it had a component of asthma. (Ex. 13 at 34.) He commented: "I feel that his work environment is causing a lot of his symptoms due to the strong solvent odors, etc." (*Id*.) However, he went on to comment that "anxiety is playing a big part in his disease state." (*Id*.)

¶59 Dr. Seagraves, who is the claimant's regular treating physician, saw the claimant on July 29, 2002. He also saw a link between the claimant's employment and his breathing difficulties. He wrote:

> Bruce seems to have vocal cord dysfunction triggered by an element in his environment, seemingly his work environment, which we have not yet identified. . . . I have told Bruce to stay off work until this is further sorted out and have advised him to pursue vocational rehab so that he can get the training he will need to function in work environments that do not involve repetitive exposure to seemingly provocative chemicals.

(Ex. 12 at 57.)

¶60 On August 6, 2002, the claimant was hospitalized again for breathing difficulties, this time after visiting Wal-Mart. (Ex. 13 at 37-38.) Dr. Seagraves, who was the admitting physician, wrote:

> I am not quite sure what is going on with Mr. Fuss. I think there is a considerable anxiety overlay to his problem. What has triggered this event is not certain. . . .

(Ex. 13 at 39.)

¶61 Dr. Seagraves saw the claimant in follow-up on August 14, 2002. At that time he noted a return of the claimant's "curious head tremor." (Ex. 12 at 62.) Regarding the claimant's latest breathing problems, he commented, "We are increasingly convinced that there is a strong anxiety component to this." (Id.) Because of the anxiety component, Dr. Seagraves referred the claimant to "Dr. Cheatle's program." (*Id*.) Dr. Cheatle is a Ph.D. psychologist who is the director of the Montana Pain Treatment Center in Missoula. (Ex. 14 at 92.)

¶62 The claimant saw Dr. Cheatle on August 20, 2002. Dr. Cheatle confirmed Dr. Seagraves' assessment that the claimant was suffering from an anxiety disorder. (Ex. 14 at 94.) He also diagnosed panic attacks. (*Id*.) He recommended a referral to a psychiatrist for purposes of prescribing appropriate medications. (*Id*.)

¶63 On August 25, 2002, the claimant was again at the ER of Community Medical Center complaining of breathing difficulties. His respiration rate was "60-70 times a minute with extremely noisy strider . . . ." (Ex. 13 at 42.) He was admitted to the hospital. The admitting impression was "Asthma exacerbation with stridor." (Id. at 45.) I do not have the discharge summary or further records of the hospitalization.

¶64 Following that hospitalization, the claimant's vocal cords were examined by videostroboscopy. The impression from that examination was, "Severe vocal cord dysfunction due to high level of vocal cord tension and intermittent paradoxical motion." (Ex. 13 at 47.)

¶65 Dr. Seagraves saw the claimant on September 4, 2002. His office note addresses the claimant's respiratory problems and its causes:

> At this point Bruce is labeled with vocal cord dysfunction. **I suspect this is irritant associated and Dr. Gardner was kind enough to forward me an article, which is enclosed in the front of Bruce's chart, which interestingly notes that this is quite a common problem particularly in custodial workers.** It is not that this is the only circumstance in which it occurs, but it may exacerbate the problem and is only further worsened by Bruce's anxiety and difficulties comprehending the association between his straining and anxiousness and worsening. . . .

(Ex. 12 at 65, emphasis added.)

¶66 The claimant was re-hospitalized on September 10, 2002, this time at St. Patrick Hospital, for breathing difficulty. Dr. Seagraves was the admitting physician and noted:

> This is Bruce Fuss's first admission to St. Patrick Hospital but he has been admitted multiple times this summer at Community Medical Center, the most recent being about 2 weeks ago for symptoms that we think are due to vocal cord dysfunction. **It is thought that there is a strong functional component to his symptoms but the possibility of occupationally induced or worsened symptoms from his janitorial work has been entertained. . . .**

(Ex. 14 at 96, emphasis added.) In his admission note, Dr. Seagraves expressed concern over psychological factors which could be contributing to his attacks and recommended a psychiatric consultation. (*Id*. at 98.) I set out Dr. Seagraves' comments because it illustrates the difficulty the physicians were having in treating the claimant.

> We have to somehow get through to Bruce that only he can ultimately control the frequency of his attacks and how he responds to slight wheeze, breathlessness or coughing and will determine whether he gets into these escalating cycles of panic, increasing anxiety, tremor, stridorous breathing, etc. Will speak with Dr. Haller about his recommendation from the speech standpoint. I think psychiatric consultation will be in order. The difficulty with Mr. Fuss is his comparative lack of insight and difficulty comprehending and putting into effect these treatment plans.

(*Id*.)

¶67 The next event was on September 29, 2002, when the claimant went to the ER at St. Patrick Hospital complaining of respiratory distress. The notes for this visit are handwritten and barely legible. (*Id*. at 104-7.) The claimant was examined and discharged. (*Id*. at 107.)

¶68 The claimant was then admitted to St. Patrick Hospital on October 2, 2002, for "recurrent vocal cord dysfunction" which caused breathing difficulty. (*Id*. at 110.)

¶69 On October 7, 2002, the claimant was admitted to the Community Medical Center for trouble breathing. Dr. Lemire was the admitting physician and was unsure at the time

whether the claimant's major problem was his vocal cord dysfunction or asthma, although he suspected the former. (Ex. 13 at 51.)

¶70 On October 15, 2002, a tracheostomy was performed on the claimant. (Id. at 55.) A tracheostomy is a surgical incision in the trachea below the larynx, thus bypassing the larynx for purposes of inhalation and expiration. The discharge summary reflects the reasons for the surgery:

> HISTORY OF PRESENT ILLNESS/HOSPITAL COURSE: 42 year old male with history of asthma and vocal cord dysfunction who has had numerous admissions over the last six months with dyspnea. Although a couple of these have been due to his asthma, the majority are due to vocal cord dysfunction and occasionally laryngospasm. . . .

(*Id*. at 70.)

¶71 The tracheostomy interrupted but did not put an end to the claimant's emergent breathing difficulties. He was referred to a psychiatrist to address his anxiety, which was deemed a factor in his respiratory difficulties. (*Id*. at 83.)

¶72 On January 27 and 29, 2003, the claimant saw Dr. Seagraves for an "episode of wheezing and breathlessness," and apparently had an upper respiratory infection. (Ex. 12 at 74.) The claimant did not improve and was thereafter hospitalized twice in February and put in a nursing home. Upon the second hospital admission, Dr. Seagraves summarized the history as follows:

> He seemed to improved after the tracheostomy, or at least for some time he did, but starting in January of this year he re-presented with stridorous breathing, wheezing, shortness of breath. He was treated with antibiotics and a Prednisone burst and then ultimately he was rehospitalized by Dr. Lemire. He was hospitalized, seen by Speech Pathology for his vocal cord dysfunction and because of ongoing weakness and trouble with breathing and an inability to care for himself at home, he was admitted to Village Health Care. Since he has been there, we have been fielding calls from his family members on repeated occasions about his breathing, stating that he was still having some trouble with breathing and that he was increasingly weak in the lower extremities. He was ambulating with a walker and evidently inconsistently at least had been falling down. I went out and saw Bruce last week and indeed on two or three short walks across the room he collapsed to his knees. He says he has been having some knee pain as well and it turns out that a recent MRI of the knee was done that shows a meniscal tear.

(Ex. 14 at 115.)

¶73 Dr. Seagraves admitted the claimant on February 24, 2003, to St. Patrick Hospital for a further work up, apparently because "recent rediscovery historically of sarcoidosis raises

questions about not only the possibility that sarcoid is contributing to his upper airway problems but whether or not he might have central nervous system sarcoid which can manifest in a number of different ways." (*Id*. at 117.) Dr. Seagraves described the claimant as a "diagnostic dilemma" and an "enigma." (*Id*. at 115, 117.) The hospital work up was essentially negative except for thalamic lesion of questionable significance; the claimant was discharged back to the nursing home. (*Id*. at 126-27.) In his discharge summary, Dr. Seagraves commented,

> There is still the strong suspicion among most of his care givers that there is a supratentorial overlay to his symptoms and this, combined with his lack of insight and lack of a long term life plan, makes it difficult for him to work towards recovery.

(*Id*. at 126.)

¶74 The claimant was discharged from the nursing home in late March but told Dr. Seagraves on April 1, 2003, that he would like to go back "so that they will prepare his meals for him and keep an eye on him." (Ex. 12 at 77.)

¶75 On August 27, 2003, the claimant was again hospitalized for complaints of wheezing, stridous breathing, and breathlessness. (Ex. 14 at 128.) He was discharged September 4, 2003. (*Id*. at 135.) The discharge diagnosis was "[r]ecurrent vocal cord dysfunction." (*Id*.)

¶76 On November 3, 2003, Dr. Gardner opined that the claimant's ongoing respiratory condition was the same condition he suffered in 1998 and agreed with Dr. Headapohl's 1998 assessment that fifty percent of his symptoms were occupationally related. (*Id*. at 80.)

¶77 In addition to the previously mentioned psychological evaluation by Dr. Cheatle, the claimant has had psychological evaluations by Dr. Noel L. Hoel, a psychiatrist and Drs. Patricia L. Webber and Joseph McElhinney, both psychologists. Dr. Hoel's evaluation was in the course of the claimant's treatment at the request of Dr. Seagraves. Dr. McElhinney's examination was at the request of Valor. Dr. Webber examined claimant in connection with his application for social security disability benefits.

¶78 Dr. Hoel saw the claimant in late 2002 and during the first four months of 2003. (Ex. 11.) On November 25, 2002, he summarized the claimant's medical problems as follows:

> He has a history of asthma, laryngospasm, vocal cord dysfunction, had to undergo a tracheostomy at that time. Other identified medical problems include hypertension, hyperthyroidism, upper GI reflux problems, as well as his cognitive and learning difficulties and anxiety.

(Ex. 11 at 1.) He noted, "During his more recent hospitalizations, there has apparently been "[a] question as to the role of anxiety in causing or aggravating some of his problems." (*Id*.)

¶79 Dr. Hoel diagnosed the claimant with an anxiety disorder. With respect to the claimant's breathing problems, he wrote, "To what extent these problems are aggravated by anxiety is unclear on first contact." (*Id*. at 3.) In subsequent visits he noted both depression and anxiety and prescribed medications to treat those conditions. (Ex. 11.) Other than the quoted language from the first office note, Dr. Hoel never indicated any additional opinion concerning the role of anxiety in the claimant's breathing problems and dysphonia.

¶80 Dr. Webber examined and tested the claimant in connection with his social security disability claim. She confirms that the claimant is "mildly mentally retarded" but her report is otherwise not noteworthy. (Ex. 17.)

¶81 Dr. McElhinney evaluated the claimant on September 22, 2003. His evaluation noted that the claimant "is functioning in the mentally retarded range when it comes to verbal knowledge and probably has a significant auditory-verbal learning disability." (Ex. 8 at 5, 6.) His comments are helpful in understanding the potential role of anxiety in the claimant's medical conditions. Initially, he noted that the claimant

> has a well documented history of anxiety disorder. According to a review of the records, it is more probable than not that his anxiety has adversely affected his medical status on a number of occasions over the years. First of all, he is more prone than the average individual for anxiety-type reactions because of his cognitive style. His ability to communicate is limited, as well as his ability to understand a variety of psychosocial circumstances. Similar individuals become easily overwhelmed in a variety of situations and experiencing anxiety-type reactions at those times would not be unusual given the circumstances. Anxiety-type symptoms, especially sympathetic nervous system symptoms, can confound medical diagnoisis and treatment. Fortunately, Mr. Fuss's physicians observed the "functional overlays" precipitated by his anxiety years ago, but it still remains a challenge to separate anxiety-related physical symptoms and actual physical pathology.

(*Id*. at 6.) Regarding the claimant's breathing difficulties, he said:

> I cannot determine, with a degree of psychologic certainty, if his reactive airway disease is initiated primarily by psychologic underpinnings. Nonetheless, his psychologic symptomatology will adversely affect his experience of physical symptoms, as well as continue to make medical treatment complex.

(*Id*.)

¶82 Dr. Kahn, who conducted an IME at the request of Valor, was the only physician to testify in this matter. I would have liked to have heard from at least some of the claimant's treating physicians, especially Drs. Seagraves, Gardner, and Lemire, as well as Dr. Headapohl, in this terribly difficult case.

¶83 Dr. Kahn is board certified and specializes in pulmonary medicine, which encompasses respiratory and lung disorders. (Kahn Dep. at 4.) He reviewed the claimant's extensive medical records and also examined the claimant.

¶84 Dr. Kahn confirmed that the claimant's current respiratory condition is the same condition which surfaced in 1997 and was diagnosed in 1998. (*Id*. at 43.) I find no substantial contrary evidence. It is therefore the same condition that Dr. Headapohl opined was fifty percent attributable to the claimant's occupation and for which ICNA accepted liability.

¶85 Valor's counsel spent a significant amount of time in his examination of Dr. Kahn on the claimant's abdominal complaints over the years in an attempt to show that those complaints were due to anxiety or psychological factors, which Valor contends should in turn support a conclusion that the claimant's respiratory problems have a psychological cause. I was not impressed by that effort. Dr. Kahn testified that no physician had ever found any other cause for the claimant's abdominal complaints. (Kahn Dep. at 24.) My review of the medical records, however, shows that the claimant was diagnosed with a bona fide ulcer in 1987 as shown in an upper GI series. (Ex. 14 at 42.) Undoubtedly, as Dr. Kahn testified, the claimant has gastroesophogeal reflux disease (GERD), but so what. It is a common condition among Americans.

¶86 Dr. Kahn ultimately testified that the claimant's dsyphonia and respiratory problems were due to psychogenic factors, "including learning disorder, anxiety, and depression." (Kahn Dep. at 43.) He testified that the claimant's respiratory problems were neither caused nor aggravated by any exposure at work. (*Id*.) This testimony puts him in direct conflict with Dr. Headapohl's 1998 opinion and the Department's 1998 finding that the claimant suffers from an occupational disease since he specifically conceded that the claimant's current respiratory condition is the same condition from which he was suffering in 1997 and 1998. (*Id*.) Dr. Kahn conceded only that the claimant's exposure to dust in 1997 could have caused a "temporary or transitory irritation." (*Id*. at 48.) Finally, Dr. Kahn testified that the claimant's need for a tracheostomy in 2002 was the result of psychological, not occupational, factors. (*Id*. at 44.)

¶87 Dr. Kahn, however, made one very important point, which cannot be overlooked, regarding the 1997 and 1998 exposures. Referring to the claimant's May 2002 hospitalization, he testified:

> Q. . . . Why did we see this change in May of 2002 that we get into this serious situation all of a sudden?
>
> A. The root cause is largely psychogenic, and I would have to believe that it was just an acceleration of that stress response, as virtually no other factor was identified. There was no testing done, however, for something like reflux, which was another

> contributor. So within reasonable accuracy, I believe it was simply an acceleration of the underlying process related to stress, and once the pattern was established of the vocal cord dysfunction syndrome, it's very like – or it's common, let me say, for this to accelerate to the just like we saw here. So this is a fairly common pattern.

(*Id*. at 50-51, emphasis added.)

Resolution

¶88 This case is governed by the 1997 and 2001 versions of the Montana Workers' Compensation Act since that was the law in effect at the time of claimant's occupational disease claims. *Buckman v. Montana Deaconess Hospital,* 224 Mont. 318, 321, 730 P.2d 380, 382 (1986).

¶89 The claimant's attorney has taken a very simplistic view of this case, urging that since ICNA accepted liability for the claimant's dysphonia and associated respiratory problems, it is liable for the claimant's current respiratory problems since they are the same problems for which ICNA accepted liability. I wish it were that simple.

¶90 Initially, as I determined in my Decision and Order Denying Motion for Partial Summary Judgment, *Fuss v. Insurance Co. of North America and Valor Ins. Co.,* 2003 MTWCC 68, ICNA's failure to appeal the 1998 determination of the Department is conclusive as to its liability for the claimant's dysphonia and attendant respiratory condition so long as subsequent instances of the condition are causally related to his 1998 condition. In my prior decision I found that it was not clear that the claimant's current condition was the same condition as that diagnosed in 1998 and I denied summary judgment on that basis. However, it is now clear that the claimant's 2002 hospitalization, his subsequent tracheostomy, and his current breathing problems are the result of the same medical condition diagnosed in 1998 and which was determined to be an occupational disease.

¶91 ICNA and Valor, however, have presented evidence that the claimant's condition is largely or entirely due to stress and anxiety, not to any exposure to dust or chemicals at work. When I thought about this case, I wondered if it were analogous to one in which the claimant contracted a work-related bacterial infection causing a sore throat, was successfully treated with antibiotics, and then suffered a subsequent sore throat due to a new bacterial or viral infection unrelated to his work. In this hypothetical, an insurer is clearly not liable for the subsequent sore throat and infection because it is unrelated to the original one, i.e, there is no causal connection between the claimant's original occupational disease and his subsequent condition. See §§ 39-72-701, -704, MCA (1997). Is the present case analogous?

¶92 I therefore consider the sore throat analogy. Under that analogy, if the claimant's 1997-98 dysphonia totally resolved and thereafter recurred because of anxiety or some other a

non work-related physical cause, then neither ICNA nor Valor is liable for his later condition even though it is the same condition as diagnosed and treated in 1997-98. That is because the later condition would be unrelated to the 1997-98 condition and occupational disease.

¶93 After considering the analogy, I am not persuaded that the claimant's subsequent dysphonia and respiratory difficulties are unrelated to his 1997-98 condition. Dr. Gardner, who was one of the claimant's many treating physicians over the years, opined that the claimant's continued problems are occupationally related; he agreed with Dr. Headapohl that fifty percent of his condition is attributable to occupational factors. All things being equal, the opinions of treating physicians are entitled to greater weight than the opinions of an IME physician. "As a general rule . . . . the testimony of a treating physician is entitled to greater evidentiary weight," although it is not conclusive. *Kloepfer v. Lumbermen's Mut. Cas. Co.*, 276 Mont. 495, 498, 916 P.2d 1310, 1312 (1996).

¶94 Moreover, it is clear that the 1997-98 condition was a triggering event leading to a cascade of similar events. Plainly, there are psychological factors involved in the claimant's respiratory problems and the claimant's anxiety and diminished intellectual function have made treatment of his condition difficult. But equally as plain, the claimant's dysphonia and breathing problems began in earnest in 1997. His problems at that time were determined to be due in significant part as his work as a janitor, and that determination is conclusive. *Fuss v. Insurance Co. of North America and Valor Ins. Co*., 2003 MTWCC 68. Dr. Kahn testified, and I am persuaded, that the 1997-1999 dysphonia was a triggering event which was then accelerated by stress. In his words, "[O]nce the pattern was established of the vocal cord dysfunction syndrome, it's very like -- or it's common, let me say, for this to accelerate just like we saw here." (Kahn Dep. at 51.) It has always been the rule that an employer takes an employee as is, with all the employee's preexisting conditions. *Ridenour v. Equity Supply Co.*, 204 Mont. 473, 482, 665 P.2d 783, 788 (1983). Thus, the fact that claimant's anxiety and limited intelligence may have contributed to the continuation and cascading of his condition does not relieve ICNA of liability.

¶95 ICNA seeks to transfer its liability for the claimant's condition to Valor. Section 39-72-303 (2), MCA (1993-2003), governs. It provides:

> (2) When there is more than one insurer and only one employer at the time the employee was injuriously exposed to the hazard of the disease, the liability rests with the insurer providing coverage at the earlier of:
> (a) the time the occupational disease was first diagnosed by a treating physician or medical panel; or
> (b) the time the employee knew or should have known that the condition was the result of an occupational disease.

¶96 In this case the statute imposes liability upon ICNA since the claimant's occupational disease was diagnosed under its watch. ICNA accepted liability for the claim by failing to

appeal the determination of the Department. To shift liability to Valor, ICNA must demonstrate that the claimant suffered a new and different occupational disease while Valor was at risk. It is not enough that the occupational disease for which ICNA is otherwise liable worsened during Valor's watch, or even that his work under Valor's watch materially aggravated the underlying disease. I so held in *Abfalder v. Travelers Indemnity Co. of Illinois*, 2002 MTWCC 29, wherein I said:

> Nationwide's argument that the original disease ended upon claimant reaching MMI in 1995 and that a new disease began thereafter makes little sense in the context of this case. Since the disease was a continuous process involving repetitive trauma, under that theory the claimant would reach MMI at the end of each day and a new occupational disease would commence the next morning.

2002 MTWCC 29 at ¶ 53.

¶97 On appeal, the Supreme Court affirmed my reasoning in *Abfalder*. It held that where the claimant's employer has two or more insurers during the employment, "liability rests with the insurer providing coverage at the earlier of the time the occupational disease was first diagnosed or the time that the employee knew or should have known that the condition was the result of an occupational disease." *In Re: Abfalder v. Nationwide Mutual Fire Ins. Co.*, 2003 MT 180, ¶ 18, 316 Mont. 415, 75 P.3d 1246.

¶98 I therefore hold that ICNA is liable for the claimant's dysphonia and breathing difficulties.

¶99 ICNA also argues in its proposed findings fo fact, conclusions of law and judgment that it is relieved of liability for the claimant's occupational disease claim because the claimant, either intentionally or unintentionally, failed to provide a complete medical history to Dr. Headapohl. The argument is without merit. First, the Department's determination regarding the occupational disease was final and cannot be set aside on account of mistake of fact theories. Second, the suggestion that the claimant deliberately misled Dr. Headapohl or deliberately concealed facts is unfounded in light of the level of the claimant's intellectual functioning. Third, the claimant's intellectual limitations were evident from the medical records at the time of Dr. Headapohl's evaluation and ICNA could have more aggressively inquired into the claimant's past medical history had it felt the history it had was inadequate.

¶100 Finally, ICNA contends that the claimant is estopped from claiming it is liable for his current condition. It cites the elements of estoppel as set out most recently in *Wiard v. Liberty Northwest Ins. Corp.*, 2003 MT 295, ¶ 36, 318 Mont. 132, 79 P.3d 281, as follows:

> 1. There must be conduct--acts, language, or silence--amounting to a representation or a concealment of material fact.

2. These facts must be known to the party estopped at the time of his said conduct, or at least the circumstances must be such that knowledge of them is necessarily imputed to him.

3. The truth concerning these facts must be unknown to the other party claiming the benefit of the estoppel, at the time when it was acted upon by him.

4. The conduct must be done with the intention, or at least with the expectation, that it will be acted upon by the other party, or under such circumstances that it is both natural and probable that it will be so acted upon.

5. The conduct must be relied upon by the other party, and, thus relying, he must be led to act upon it.

6. He must in fact act upon it in such a manner as to change his position for the worse; in other words, he must so act that he would suffer what he has done by reason of the first party being permitted to repudiate his conduct and to assert rights inconsistent with it.

The facts set forth previously in this decision should make it obvious that the claimant is essentially incapable of intentionally misrepresenting his prior medical history. If they do not, I so find. Moreover, the medical records show clearly that he was a poor historian. Under these circumstances, any blame must rest on ICNA's shoulders for not digging deeper into the claimant's prior medical records. Finally, ICNA has presented no evidence that Dr. Headapohl would have reached a different conclusion had she had a more complete medical history. She has never repudiated her original opinion.

¶101 I have not been asked to determine the medical and indemnity benefits due the claimant, and I leave that task to the parties, at least initially. Indemnity benefits should be readily ascertainable. Medical benefits are an entirely different matter. The claimant's medical treatment and hospitalizations have involved conditions and complaints unrelated to his breathing difficulties. Thus, not all of his medical expenses are attributable to his occupational disease. I suggest that the parties collaborate in an attempt to determine what is and is not related. I retain jurisdiction to resolve any disputes concerning the amount of disability and medical benefits due the claimant in the event the parties are unable to do so.

¶102 Finally, I address the claimant's request for attorney fees and a penalty. Both requests require proof that the insurer acted unreasonably in denying benefits. §§ 39-71-611, MCA (1987-2001), -2907, MCA (1991-2003). I am unpersuaded that either insurer in this case acted unreasonably in denying benefits. Substantial legal and factual issues were raised. I was able to resolve them only after a comprehensive evaluation of the evidence and a great deal of reflection.

JUDGMENT

¶103 Insurance Company of North America is liable for the claimant's dysphonia and breathing problems and shall pay appropriate medical and indemnity benefits. No determination was requested or is made concerning the specific benefits are due and the Court expects the parties will be able to make that determination. However, the Court retains continuing jurisdiction to determine the specific benefits due in the event the parties are unable to do so.

¶104 The claimant is entitled to his costs and shall file his memorandum of costs in accordance with Court rules. He is not entitled to attorney fees or to a penalty.

¶105 This JUDGMENT is certified as final for purposes of appeal.

¶106 Any party to this dispute may have twenty days in which to request a rehearing from these Findings of Fact, Conclusions of Law and Judgment.

DATED in Helena, Montana, this 8th day of April, 2004.

(SEAL)

\s\ Mike McCarter
JUDGE

c: Mr. Rex Palmer
Mr. Leo S. Ward
Mr. Joe C. Maynard
Submitted: December 9, 2003