ELECTRONICALLY FILED 2020-Jul-31 08:28:48 DIVISION OF WORKERS' COMPENSATION

BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

WILLIAM BAKER, Claimant, vs. MSC INDUSTRIAL DIRECT CO., Employer, and ACE AMERICAN INS. CO., Insurance Carrier, Defendants.	File No. 5063687 ARBITRATION DECISION Head Note Nos.: 1402, 1800, 1803, 1804, 2200, 2600, 4100

STATEMENT OF THE CASE

The claimant, William Baker, filed a petition for arbitration and seeks workers' compensation benefits from MSC Industrial Direct Co., Inc., as the employer, and ACE American Insurance Company, as the insurance carrier. The claimant was represented by Randall Schueller. The defendant(s) were represented by Jean Z. Dickson.

The matter came on for hearing on March 9, 2020, before Deputy Workers' Compensation Commissioner Heather Palmer in Des Moines, Iowa. The evidentiary record closed at the conclusion of the hearing. The hearing transcript was filed with the Iowa Division of Workers' Compensation on March 26, 2020. Post-hearing briefs were filed on April 24, 2020. The case was deemed fully submitted to Deputy Palmer on that date.

The record in this case consists of Joint Exhibits 1-22, Claimant's Exhibits 1-27, and Defendants' Exhibits A-W. Testimony under oath was also taken from the claimant, William Baker and from Kristin Hestness. Amy Pedersen was appointed the official reporter and custodian of the notes of the proceeding. The exhibits were accepted without objection.

Deputy Commissioner Palmer was unavailable to the agency. Pursuant to Iowa Code 17A.15(2), Commissioner Cortese delegated this file to the undersigned for preparation and filing of an arbitration decision.

Pursuant to Iowa Code 17A.15(2), the undersigned inquired of the parties whether they believed demeanor of a witness is a substantial factor in the case. The undersigned offered to hear those portions of the testimony again for which demeanor was considered a substantial factor. The undersigned inquired via e-mail, and requested that the parties reply via e-mail if additional follow-up was necessary. The undersigned has received no response from the parties indicating any objection to the undersigned proceeding to write this arbitration decision without rehearing all or portions

of the testimony to assess witness demeanor. Therefore, pursuant to Iowa Code 17A.15(2) and the Commissioner's Order of Delegation filed on May 13, 2020, the undersigned performs a review of the evidentiary record in this case and issues this arbitration decision at the direction of the Commissioner.

STIPULATIONS

Through the hearing report, the parties stipulated and/or established the following:

1. There was an employer-employee relationship at the time of the alleged injury.

2. Claimant's injury arose out of, and in the course of, employment, on April 14, 2017.

3. The alleged injury is a cause of temporary disability during a period of recovery.

4. The disability is an industrial disability.

5. The commencement date for permanent partial disability benefits, if any are awarded, is September 4, 2019.

6. Claimant's gross earnings were $673.20 per week, and the claimant was single and entitled to 4 exemptions, giving him a weekly rate of compensation of $446.06.

7. Prior to the hearing, the claimant was paid 151.714 weeks of compensation as follows:

    a. Healing period/TTD – April 15, 2017 to January 27, 2019 at $587.34 per week, and January 28, 2019 to September 3, 2019 at $446.06 per week.

    b. Permanent Partial Disability – September 4, 2019, to March 11, 2020, at $446.06.

Additionally, there was no dispute as to the entitlement for temporary disability and/or healing period benefits. Defendants waived their affirmative defenses.

The parties are now bound by their stipulations.

ISSUES

The parties submitted the following issues for determination:

1. Whether the April 14, 2017, injury caused permanent disability, and if so, the extent of claimant's entitlement to permanent disability.

2. Whether the claimant is permanently and totally disabled pursuant to statute or under the odd-lot doctrine.

3. Whether the claimant is entitled to 24/7 care services and whether the claimant is entitled to payment for same.

4. Whether the claimant is entitled to alternate medical care consisting of continued treatment with Farid Manshadi, M.D., DeAnn Fitzgerald, O.D., and James L. Gallagher, M.D., F.A.A.P.

5. Whether the disputed medical expenses are fair and reasonable, the disputed medical treatment was reasonable and necessary, whether the expenses are causally connected to the work injury, and whether the requested expenses were authorized by defendants.

FINDINGS OF FACT

The undersigned, having considered all of the evidence and testimony in the record, finds:

William Baker is a 42-year-old man. He resides in Johnston, Iowa, with his fiancée Kristin Hestness, their young son, and for some time, Kristin's daughter, Caitlyn. Mr. Baker graduated high school and started, but did not finish three degrees at Hawkeye Community College. He took classes related to industrial maintenance, business management and computer science. He was hired by MSC Industrial Direct Co., as a solution sales representative on February 19, 2016. (Def. Ex. G:33). Mr. Baker's duties with MSC Industrial Co. included setting up new job-sites.

On April 17, 2017, Mr. Baker was setting up a new job site in Marshalltown, Iowa. He was stocking cabinets. Upon turning around, the cabinet which is claimed to be anywhere between 750 and 1,000 pounds fell on Mr. Baker, striking him in the head, and pushing him to the ground. He claimed that he needed assistance to get out from under the cabinet. Mr. Baker was on leave from April 17, 2017, through his termination on March 12, 2018. (Def. Ex. G:34; Cl. Ex. 26:117). Mr. Baker's main complaints evolved to involve cognitive, memory, and seizure-like issues. He also had complaints involving his left arm and back pain.

The claimant included records for one date of treatment preceding the work incident stemming from a September 11, 2010, visit to Allen Memorial Hospital in Waterloo, Iowa. (Joint Exhibit 1:1-6). Mr. Baker reported suicidal thoughts including having uncontrollable rage. (JE 1:1). Further, he reported having harmed his girlfriend, causing her bruising. (JE 1:1). Over the few months preceding his visit, he reported

new onset of headaches, which included becoming short-fused and angry. (JE 1:2). He also reported dropping things, memory problems, stuttering, blurry vision, and feeling like he is not himself. (JE 1:1-2). Mr. Baker had a CT scan of his head during this visit, which was normal. (JE 1:4).

On April 14, 2017, Mr. Baker visited the GRU Emergency Department, where he was seen by Jeffrey Curnes, D.O. (JE 2:7-10). He noted that at work, a large cabinet fell onto him. (JE 2:7). He was wearing a hard hat, but that was knocked off and he was knocked to the ground. (JE 2:7). Mr. Baker reported no loss of consciousness, but complained of left knee and elbow pain. (JE 2:7). Mr. Baker's head was noted to be normocephalic and atraumatic. (JE 2:9). Additionally, he was alert and oriented to person, place, and time. (JE 2:9). Swelling and bruising was noted to the left elbow and knee upon examination. (JE 2:9). X-rays showed no evidence of fracture to his left elbow. (JE 2:10). The examining physician noted that Mr. Baker "may have a mild concussion" from when the cabinet hit him, but he has no headaches or residual symptoms. (JE 2:10).

Mr. Baker reported to the GRU Emergency Department again on April 16, 2017, where he was seen by Brian K. Shedek, D.O. (JE 2:11). The chief complaints upon presentation to the emergency department were neck pain and headache. (JE 2:11). Mr. Baker claimed that a 1000-pound cabinet fell on him on Friday, but that he was wearing a hard hat. (JE 2:11). He complained of headaches, has had one episode of emesis and nausea, but denied loss of consciousness. (JE 2:11). Mr. Baker reported memory issues and constantly feeling tired.

On April 27, 2017, Mr. Baker was seen at UnityPoint Clinic Neurology in Waterloo, by Nakita Stephens, M.D. (JE 3:15). Mr. Baker's chief complaint was postconcussive syndrome. (JE 3:15). Since the date of the work incident, he complains of continued headache, which is constant with a tightness from the back of his neck. (JE 3:15). He complained of long and short-term memory issues. (JE 3:15). He was diagnosed with post-concussion syndrome and post-concussion headache. (JE 3:18). It is recommended that he have an MRI of the brain to evaluate any focal or structural changes that may be associated with his symptoms. (JE 3:19). He has cognitive symptoms, and it is noted that he may benefit from cognitive rehabilitation. (JE 3:19).

On May 16, 2017, the claimant visited Cedar Valley Medical Specialists, P.C., for an EMG with Ivo Bekavac, M.D., Ph.D. (JE 4:29-30). Extensive EMG examination and nerve conduction studies were done on Mr. Baker's left upper extremity. (JE 4:29). Dr. Bekavac's findings and impression were that Mr. Baker had ulnar neuropathy distal to the elbow that was mild in degree, and that there was no EMG evidence for cervical motor radiculopathy, polyneuropathy, or myopathy. (JE 4:29).

Eric Neverman, D.O., examined Mr. Baker on May 18, 2017, at UnityPoint Clinic Family Medicine Grundy Center. (JE 5:32-34). Dr. Neverman provided work restrictions for Mr. Baker on May 18, 2017. (JE 5:31). The doctor noted that the claimant complained of headaches, nausea, vision disturbance, and right ankle pain. (JE 5:33). Dr. Neverman assessed Mr. Baker with post concussive syndrome, acute right ankle pain, and decreased peripheral vision of the left eye. (JE 5:33). The work restrictions provided by Dr. Neverman were: desk work without a lot of physical activity

in a quiet environment, frequent breaks, no driving until neuropsychological and PM&R evaluation, and starting at 50 percent work which could increase depending on clinical progress. (JE 5:31).

From July 31, 2017, to August 11, 2017, Mr. Baker visited Cedar Rapids Vision in Motion Occupational Therapy Clinic on a daily basis. (JE 8:122-129). Mr. Baker's noted goals upon entering the program were to improve his vision so that he could return to work and driving, increase his memory function, and decrease or eliminate his headaches. (JE 8:122). On his first day of treatment, he was noted to be taking Keppra and Doxepin, which provided minimal relief of his headaches. (JE 8:122). He noted to the examiner that his left eye had bad tunnel vision and that he had little access to peripheral vision. (JE 8:122). Mr. Baker reported struggling with motion sickness, and issues with depth perception. (JE 8:122). On the second day of treatment, the claimant reported that his headaches were constant throughout the day and sometimes kept him from sleeping comfortably. (JE 8:122). Mr. Baker told his provider that he felt a "a lot of it could be contributed to stress, which may have also been the cause of two seizures he had suffered in the last month." (JE 8:122-123). Mr. Baker also noted that he was having difficulty multi-tasking and carrying on multiple conversations at the same time. (JE 8:123). On the third day of treatment, Mr. Baker reported feeling exhausted after his previous day of treatment. (JE 8:123). On the fourth day of treatment, Mr. Baker shared that he continued to struggle with motion sickness, especially in the car. (JE 8:124). He reported wanting to be able to carry out a nine-hour drive to Indiana so that he could visit his son. (JE 8:124). On the fifth day of treatment, Mr. Baker noted that he had a difficult time remembering what happened after the last session. (JE 8:125). His pain persisted through the night and he reported waking with a headache so bad that he felt the need to vomit. (JE 8:125). He reported a history of having a difficult time remembering conversations that he had earlier in the same day. (JE 8:125). Mr. Baker reported that he would "shut down if he felt overwhelmed." (JE 8:125). On the sixth day of his treatment, Mr. Baker reported feeling more exhausted as of late, and found himself napping more often. (JE 8:125). Prior to attending treatment, Mr. Baker noted that he went to the mall with his wife. (JE 8:126). While at the mall he reported feeling overstimulated because the atmosphere was "too busy." (JE 8:126). By the eighth day of treatment, Mr. Baker reported increased energy. (JE 8:126). Mr. Baker noted that he forgot about a watermelon in his home which rotted and caused an awful odor. (JE 8:126). This frustrated Mr. Baker. (JE 8:126). Around the same time, Mr. Baker found mold in his central air vent, which he then cleaned. (JE 8:126-127). Mr. Baker noted that his stuttering started when he was a child, which improved over time, but then worsened after his injury. (JE 8:127). At the conclusion of his course of treatment, Mr. Baker was given a light box to take home and use on his own. (JE 8:129).

On October 4, 2017, Mr. Baker again presented to the GRU Emergency Department. (JE 2:12). He was seen by Allison Schoolman, ARNP with complaints of daily headaches. (JE 2:12). Mr. Baker reported constant nausea without vomiting. (JE 2:12). He was noted to take Depakote due to seizures that developed after the head injury. (JE 2:12). No acute change in the patient's symptoms were reported, other than radiation of the pain down the spine. (JE 2:12). He also complained of seizure-like activity including unresponsiveness and eye fluttering, which are noted as typical symptoms of seizures. (JE 2:12).

Mr. Baker visited Farid Manshadi, M.D., for the first time on June 2, 2017. (JE 6:35-36). Dr. Manshadi outlined the alleged facts of the incident, and again noted that Mr. Baker experienced no loss of consciousness. (JE 6:35). Dr. Manshadi reviewed the imaging done, including x-rays of the left elbow and knee, which showed no acute issues. (JE 6:35). He reported to the doctor that he still had difficulty finding words and that his wife would have to finish sentences for him. (JE 6:35). He continued to report short and long term memory issues, peripheral vision loss, anxiety, and light-headedness. (JE 6:35). Dr. Manshadi's impression/diagnoses were: traumatic brain injury with left-sided weakness and loss of sensation in left upper extremity and left lower extremity, peripheral vision loss, post-concussive headaches, myofascial pain involving the neck, cognitive deficits with memory issues, and episodic symptoms. (JE 6:36). Dr. Manshadi recommended Mr. Baker see a neuropsychologist and Dr. Fitzgerald for vision loss. (JE 6:36). Dr. Manshadi recommended the claimant take Keppra with a follow-up of fascial distortion treatment. (JE 6:36). Physical therapy was also recommended. (JE 6:36).

Dr. Manshadi saw Mr. Baker again on June 9, 2017, to commence fascial distortion treatment for neck pain and reduced neck range of motion. (JE 6:37). Dr. Manshadi discussed some delays with payments to Mr. Baker, and indicates that he felt that Mr. Baker was receiving inadequate care. (JE 6:37). Fascial distortion treatment was completed. (JE 6:37).

Mr. Baker followed-up with Dr. Manshadi again on June 16, 2017. (JE 6:38). He was taking Keppra with no untoward side effects. (JE 6:38). The last fascial distortion treatment provided some relief before the pain came back. (JE 6:38). His neck range of motion was improved, but was not 100 percent. (JE 6:38). Another round of fascial distortion was completed. (JE 6:38).

Mr. Baker was examined by optometrist DeAnn Fitzgerald, O.D., on June 22, 2017, due to his trouble with memory, speech, and balance. (JE 8:121). Dr. Fitzgerald's diagnoses were that structurally, the eyes were doing well, but that there was a severely constricted field of vision. (JE 8:121). Dr. Fitzgerald also noted left cerebellar dysfunction, and right parietal lobe dysfunction. (JE 8:121). Dr. Fitzgerald's plan was to commence multisystems therapy noting the therapy would be "vision, vestibular, auditory and proprioception to stimulate the brain to recognize where he is in space and open up the visual fields for better memory, speech, cognition and balance." (JE 8:121).

Dr. Manshadi examined Mr. Baker on June 23, 2017, due to continued issues with peripheral vision loss, and neck issues. (JE 6:39). Mr. Baker noted that the treatment for his neck has been helpful for his range of motion. (JE 6:39). He noted being examined by Dr. Fitzgerald, and that he was working on scheduling a neuropsychological evaluation. (JE 6:39). His neck range of motion was now considered to be full. (JE 6:39). It was noted that he had quite a bit of stuttering. (JE 6:39).

Mr. Baker returned to Dr. Manshadi's office on July 7, 2017. (JE 6:40). His history of traumatic brain injury, neck pain, peripheral vision loss, memory changes, cognitive deficits difficulty with word finding and stuttering were noted. (JE 6:40). It was

noted that he had improved to some extent, but that he had left-sided weakness and poor balance. (JE 6:40). He also reported continued headaches, for which he took Keppra. (JE 6:40). Dr. Manshadi recommended physical therapy and occupational therapy for Mr. Baker. (JE 6:40). The doctor recommended that he remain off of work for the next two months. (JE 6:40).

Dr. Manshadi saw Mr. Baker again on July 19, 2017, with complaints of continued headaches. (JE 6:41). The headaches were not as consistent as they were in the past. (JE 6:41). His wife, who was present at the examination,

> [R]eported an episode this past Friday where she found him on the kitchen floor with the refrigerator door open and she had to shake him to wake him up. She reports he had a blank face and he could not remember that his kids were at home or if they'd left for Indiana. . . .

(JE 6:41). He continued to have issues with stuttering and expressing what he wants to say. (JE 6:41). Speech therapy and continued follow-up with Dr. Fitzgerald were recommended, in addition to a visit with a neuropsychologist, physical therapy and occupational therapy. (JE 6:41). Mr. Baker was told to be careful if he cooks, and to avoid driving for the next six months. (JE 6:41).

Mr. Baker began occupational therapy with Taylor Physical Therapy Associates, LLC, on July 20, 2017. (JE 9:188-194). During his initial evaluation, it was noted that Mr. Baker had complaints to the head, neck, shoulders, mid-back, and left hand. (JE 9:189). Mr. Baker noted headaches, difficulties with vision and coordination and "episodes." (JE 9:190). He was referred to occupational therapy for left upper extremity strengthening and coordination treatment. (JE 9:190). It was noted that his left hand had apraxic movements, and that Mr. Baker also had difficulty with tasks such as fastening or snapping shirt snaps on his baby's outfits. (JE 9:190). He was noted to have issues with grip strength. (JE 9:190). The assessment upon the initial treatment was left upper extremity weakness, including grip and pinch impairments, apraxia and limited coordination with gross and fine motor tasks. (JE 9:191).

On August 16, 2017, Mr. Baker followed-up with Dr. Manshadi. (JE 6:42). Mr. Baker reported no changes to his headaches, which remained fairly intense on a daily basis. (JE 6:42). He had 12 sessions of light therapy with Dr. Fitzgerald, which helped him sleep, but as soon as the therapy stopped, his sleep quality deteriorated. (JE 6:42). His wife reported several episodes of him having a blank stare on his face. (JE 6:42). Dr. Manshadi recommended a serum Keppra level, adding Gabapentin for seizure prophylaxis, and that Mr. Baker continue not to drive. (JE 6:42). Interestingly, Dr. Manshadi notes, "[a]lso, on account of him, his wife has to stay home to take him to his appointments for his work injury and also needs to be there to supervise if he has a seizure." (JE 6:42). Dr. Manshadi issued a letter stating that Kristin Hestness is required to be with Mr. Baker to drive him to his medical appointments. (JE 6:43). Additionally, he stated that Mr. Baker should not be left alone to care for his children or allowed to drive to medical appointments, and as a consequence, Ms. Hestness is unable to work outside of the home, "at least until Bill is able to resume driving." (JE 6:43).

Mr. Baker had an initial neuropsychological evaluation by Derek Campbell, Ph.D. at Campbell Neuropsychological Services, PC on August 17, 2017. (JE 10:195). Mr. Baker reported forgetting conversations, events and sequences in familiar procedures. (JE 10:195). He also had difficulty finding words, and trouble multitasking. (JE 10:195). Mr. Baker's significant other described his memory as progressively worsening. (JE 10:195). Dr. Campbell opined that Mr. Baker was experiencing mild post-concussion symptomatology, and significant clinical improvement should be expected in the next few months. (JE 10:197). Dr. Campbell further opined, "[u]nfortunately, his suggested response bias characterized by modest symptom magnification seriously constrains clearly detecting deficits referable to the injury with this exam." (JE 10:197). Dr. Campbell recommended antidepressant medication, psychotherapy to improve coping and relaxation, and a consultation with a speech-language pathologist. (JE 10:198).

Mr. Baker had another follow-up with Dr. Manshadi on September 13, 2017. (JE 6:44). Mr. Baker's vision, including his peripheral vision, was noted to be improved since he saw Dr. Fitzgerald. (JE 6:44). Mr. Baker was noted to have also visited Dr. Campbell for a neuropsychological evaluation where it was noted that he had evidence of a mild traumatic brain injury. (JE 6:44). Mr. Baker was to discontinue occupational therapy. (JE 6:44).

From September 19, 2017, to November 7, 2019, Mr. Baker saw Patricia Munson, MA, CCC-SLP for speech therapy. (JE 11:204). Mr. Baker had 8 visits of speech therapy. (JE 11:204). Mr. Baker was able to complete many tasks at 100percent, but reported experiencing many instances when he is unable to recall information at home during daily interactions. (JE 11:204). Ms. Munson noted that goals were difficult to establish for Mr. Baker. (JE 11:204). Mr. Baker had continuing difficulty with working memory, attention (especially with background distractions), and executive function. (JE 11:204).

Kristin Hestness called Dr. Manshadi's office on October 4, 2017, and noted that Mr. Baker experienced a terrible headache since the previous Monday. (JE 6:46). Therapy worsened his headache, and was so severe that it caused him to be in tears. (JE 6:46). Ms. Hestness called a second time and noted that she went to the pharmacy to fill a prescription. (JE 6:46). When Ms. Hestness returned home, she found the claimant lying half-on-and-half-off the couch with his eyes fluttering and a lack of response. (JE 6:46). He reported no memory of the event, and still had a terrible headache. (JE 6:46).

On October 11, 2017, Dr. Manshadi once again examined Mr. Baker. (JE 6:47). Mr. Baker was noted to have had a seizure about one week prior, as noted from the October 4, 2017, phone message(s) from Ms. Hestness. (JE 6:47). He was also having significant issues with anxiety and not sleeping well. (JE 6:47). Mr. Baker's vision was improved with prescription glasses. (JE 6:47). Dr. Manshadi recommended a 24-hour EEG to be done in his home. (JE 6:47).

Mr. Baker was seen by WLA Neurodiagnostics on October 24, 2017. (JE 3:20-21). He had an outpatient EEG due to daily headaches after a head injury in April. (JE 3:20). He reported having two seizures in July. (JE 3:20). A digital EEG was done,

and was considered to be relatively normal in the waking and drowsy states. (JE 3:21). Neither epileptiform discharges, nor electrographic seizures were noted. (JE 3:21).

Dr. Manshadi re-examined Mr. Baker on November 1, 2017. (JE 6:48). Dr. Manshadi notes that Mr. Baker's EEG was regular and did not show any active seizure activity; however, Dr. Manshadi noted that there was background beta activity. (JE 6:48). Dr. Manshadi was unsure as to the significance of the beta activity, but noted Mr. Baker was scheduled for a 72-hour EEG monitoring at home. (JE 6:48). Dr. Manshadi wrote a follow-up note at the end of the visit notes wherein he stated that Ms. Hestness reported that "one time she left the patient for about 45 minutes to go shopping and he apparently burned the fish and he wasn't even aware of it, that he had the fish in the oven." (JE 6:48). When Mr. Baker was reminded of this during the visit, he had no memory of the incident. (JE 6:48). Additionally, Dr. Manshadi noted, "[t]here is also a question of the issue of the patient being left alone for too long whether he would be able to function. There is a lot of concern about this by his wife and she is the breadwinner for this family now. Eventually he may need to have people stay with him in case she is not there." (JE 6:48).

On November 2, 2017, Mr. Baker commenced visits with Jon Towley, LISW. (JE 12:211). Mr. Baker was noted to have sustained a "major concussion." (JE 12:211). Mr. Baker was depressed and anxious, could not surf or skateboard, and had some depth perception issues. (JE 12:211). He noted having a good childhood, and that he had three children who live in Indiana. (JE 12). He was diagnosed with anxiety, and a head injury. (JE 12:215). He also had "severe" psychological stressors. (JE 12:215).

Mr. Baker visited Mr. Towley again on November 9, 2017, for treatment of his anxiety. (JE 12:216). He was stable and his treatment compliance was average. (JE 12:216). Mr. Baker noted continued sleep disturbance, and missing the last two REM cycles of sleep. (JE 12:216). The plan developed is to sleep from 10 p.m. to 1 a.m., and then remain calm or utilize ear buds for binaural sound. (JE 12:216).

On November 30, 2017, Mr. Towley met with Mr. Baker again. (JE 12:217). Mr. Towley noted, "[c]hange is afoot and that scares Bill more than a bit." (JE 12:217). Mr. Baker is noted to have difficulty trusting others, and the possibility of having someone come into his home as an aid is something that cause him to have questions. (JE 12:217). Additionally, Mr. Baker's partner, Kristin serves as his advocate with providers, and he will need someone to advocate for him. (JE 12:217).

Mr. Baker returned to Dr. Manshadi's office on December 5, 2017. (JE 6:50). His headaches were improved, but there were days where he still has to take Imitrex. (JE 6:50). He continued to have treatment for balance issues and peripheral vision problems. (JE 6:50). Dr. Manshadi's impression continued to be: TBI with left hemiparesis with loss of sensation in left upper extremity and left lower extremity with apraxia, word finding problems with stuttering, peripheral vision lost, post-concussive headaches, myofascial pain involving the neck, cognitive deficits with memory loss and memory issues and concentration issues, and seizure activity. (JE 6:50). Mr. Baker's wife again reported him doing odd things, including as Dr. Manshadi notes, "[f]or example, one day the grandma left some submarine sandwiches and when he was gone, he had the sandwich standing on four knives." (JE 6:50). When Ms. Hestness

asked him why he did this, he was unsure and reported not being able to remember doing it. (JE 6:50). His wife also requested additional speech therapy and physical therapy. (JE 6:50). Dr. Manshadi felt that Mr. Baker will be unable to return to any kind of work until March of the next year. (JE 6:50). It is finally noted that Mr. Baker continues to need 24-hour supervision, along with transportation to and from medical appointments. (JE 6:50). This will be needed “until further notice.” (JE 6:50). Around the same time, Ms. Hestness contacted the home health agency who was supposed to complete an evaluation on Mr. Baker. (Def. Ex. H:38). She informed them not to come to the home, as she did not want them in her home. (Def. Ex. H:38). Kristen Cooper, LPN, a nurse liaison testified in her deposition that she arranged for an aide to visit Mr. Baker’s home to assess his needs and confirm capability of an agency to assist with 24-hour supervision. (Def. Ex. R:107). The aide informed Ms. Cooper that Mr. Baker’s significant other had called the aide and informed her that she was not wanted in the Baker home. (Def. Ex. R:109). This was confirmed by Candy Diercks, the prospective provider via her deposition. (Def. Ex. S). Additionally, Ms. Diercks clarified that Ms. Hestness told her “we do not need anybody, and no, you are not coming to my home.” (Def. Ex. S:119). Ms. Diercks estimated that these services would cost $320.00 per day, as her agency charged $20.00 per hour for 16-hours per day. (Def. Ex. S:120). Normally, for a 24-hour shift, there would be three different shifts for the day. (Def. Ex. S:122). Ms. Diercks would also not recommend that one caregiver do all of the work for one person. (Def. Ex. S:122). Additionally, Ms. Dierck’s noted that a caregiver or aide would not be allowed to leave the client’s house during their shift. (Def. Ex. S:124). Ms. Hestness was asked during her deposition about bringing someone into her and Mr. Baker’s home to help take care of him. (Def. Ex. T:134). Her answer was a bit convoluted, but she ended by saying that her concern is Mr. Baker’s comfort, and he is comfortable with her being in the home. (Def. Ex. T:135). Further, she wanted to be his caretaker because she felt like she knew him, his signals and his comfort. (Def. Ex. T:135). Ms. Hestness indicated that she considered caring for Mr. Baker to be her work, and that she was no longer looking for employment. (Def. Ex. T:135). Ms. Hestness stated in her deposition that Ms. Dierck and Ms. Cooper mischaracterized the situation, and that she and Mr. Baker did not object to anyone coming to do an assessment. (Def. Ex. T:138). Mr. Baker’s deposition testimony conflicts with this, as he stated that he had concerns about a stranger coming into his house because he believed that the best person to “notice the things that need to be noticed is Kris.” (Def. Ex. V). He also noted the anxiety of not knowing the person coming into their home. (Def. Ex. V). Also of interest, Ms. Hestness was not helping Mr. Baker dress, use the bathroom, or shower. (Def. Ex. V).

In contrast to Dr. Manshadi’s recommendation, Mr. Baker notes that he hopes to get back to work sooner, rather than later. (Def. Ex. V). He noted that he loved what he did before, and would like to get back to doing that; however, he felt he could not do so efficiently at the time of the deposition. (Def. Ex. V).

Dr. Manshadi saw Mr. Baker again on January 8, 2018. (JE 6:52). Dr. Manshadi recounted the results of a 3-day continuous monitoring EEG that Mr. Baker underwent. (JE 6:52). The 3-day EEG showed no observable epileptic seizures. (JE 6:52). His wife reported that Mr. Baker continues to have episodes where he is completely out and will not respond to her when she calls his name. (JE 6:52). Dr. Manshadi reported that

while Mr. Baker was in the office, his head went down and his eyes began to flicker. (JE 6:52). After about 30-seconds, Mr. Baker woke up and did not know what happened. (JE 6:52). He noted having incidences where he is extremely anxious. (JE 6:52).

Dr. Stephens at Allen Radiology examined Mr. Baker for his complaints of seizure-like activity on January 22, 2018. (JE 3:22-28). The claimant was previously evaluated for postconcussion syndrome and headaches, but was later referred to Dr. Manshadi for continued follow-up. (JE 3:22). Dr. Manshadi referred Mr. Baker back to Dr. Stephens due to seizure activity. (JE 3:22). Mr. Baker's wife describes the episodes, including an alleged seizure on July 14. (JE 3:22). During this episode, Mr. Baker was reported to be on the floor unresponsive, and needed to be awakened by his wife. (JE 3:22). When awakened, he was confused and unsure of his location. (JE 3:22). During other episodes, Mr. Baker reportedly stares off and has a blank expression on his face. (JE 3:22). Dr. Stephens details several other incidents relayed to her by Mr. Baker's wife regarding his alleged seizure activity. (JE 3:22). During this encounter, Dr. Stephens reports being concerned about being recorded by Mr. Baker's roommate. (JE 3:23). This caused Mr. Baker to become offended, immediately stand-up, and gather his things to leave and not return. (JE 3:23). This incident is confirmed by Jean Youngblut, R.N., who noted that Dr. Stephens exited the exam room, stating that Mr. Baker's roommate appeared to be recording the appointment on her cell phone. (JE 13:221). Nurse Youngblut noted that Dr. Stephens began the exam again after she and another nurse entered the room, but Mr. Baker became angry, and stated "I think we were just accused of something" and left. (JE 13:221). After the examination, Dr. Stephens reports contacting Dr. Manshadi to report her opinions. (JE 3:26). Dr. Stephens notes that the videos reviewed do not show typical seizure-like activities, however, frontal lobe seizures "can present in an atypical manner." (JE 3:26). Dr. Stephens notes:

> Video EEG did not capture any abnormal seizure activity or discharges between events to suggest seizures.
>
> This would be suggestive that these episodes are not epileptic seizures.
>
> Other possible causes include possible cardiac dysfunction with blood pressure changes and resultant loss of consciousness, or can also be seen as a stress response.
>
> Continue at the higher dose of Depakote as previously prescribed by Dr. Manshadi. Should the events continue may would [sic] suggest that hospitalization for prolonged review EEG.
>
> Also recommend that he discuss with Dr. Manshadi a cardiology evaluation and continue with referral for stress induced events.

(JE 3:28).

Mr. Baker followed-up again with Dr. Manshadi on February 6, 2018 for continued care. (JE 6:53). It was noted that Mr. Baker had improved markedly with treatment and therapy by Dr. Fitzgerald. (JE 6:53). Mr. Baker still had episodic symptoms like completely blacking out. (JE 6:53). Dr. Manshadi noted a disagreement with Dr. Stephens regarding Mr. Baker's alleged seizures. (JE 6:53). Mr. Baker was still having memory issues and lacked motivation along with mood problems, anxiety and difficulty sleeping. (JE 6:53). He continued to have issues with weakness in the left-side, which caused him to avoid contact with his son, since he alleged his left hand would not do the things that he wanted it to. (JE 6:53).

On February 14, 2018, Mr. Baker returned to see Dr. Manshadi for further fascial distortion treatment for his neck pain and headaches. (JE 6:55). Mr. Baker continued to get headaches, which he described as sharp pain from his right ear to the middle of his head. (JE 6:55). He also continued to report decreased mental function. (JE 6:55). On February 15, 2018, Mr. Baker's significant other contacted Dr. Manshadi's office and noted that Mr. Baker had another episode where "he was awake but not responding to her for about 20 seconds." (JE 7:118). She further stated that she had to slap Mr. Baker in the face in order to get him to respond. (JE 7:118).

Dr. Manshadi re-examined Mr. Baker on February 21, 2018, for continued complaints of neck pain and reduced range of motion. (JE 6:56). Mr. Baker reported improvement after undergoing fascial distortion therapy during the prior week. (JE 6:56). He reported another episode where he did not reply to his wife when she was calling his name during a car ride. (JE 6:56). A myofascial distortion treatment was done while in the office. (JE 6:56).

On February 28, 2018, Dr. Manshadi saw Mr. Baker again for a repeat fascial distortion treatment. (JE 6:57). Dr. Manshadi noted that Mr. Baker was present with "a person who drove him here today." (JE 6:57). Mr. Baker reported his neck being much improved. (JE 6:57). On the same day, Dr. Manshadi filled out a form provided by defendant MSC Industrial Supply Co., entitled "ADA Accommodation Request Form." (JE 6:58-61). On this form, Dr. Manshadi recounts the diagnoses previously discussed. (JE 6:58). Dr. Manshadi indicated that the claimant's memory issues, chronic headaches, seizure activities and inability to drive prevent Mr. Baker from being at work, as well as preclude assignment of tasks and duties in Mr. Baker's job description. (JE 6:59). Additionally, Mr. Baker was determined to be a significant risk for incapacitation due to sudden worsening of headaches or seizure activities. (JE 6:59). Dr. Manshadi further notes that Mr. Baker is not likely to recover sufficiently to perform the tasks and duties described to the doctor; however, Dr. Manshadi notes that the need for leave is not likely to be indefinite. (JE 6:60).

Taylor Physical Therapy Associates issued a progress note on March 1, 2018, after Mr. Baker completed 23 visits of occupational therapy. (JE 9:192). The therapist recommended that Mr. Baker obtain some simple exercise equipment. (JE 9:192). Mr. Baker's grip strength had improved, but he continued to have daily headaches. (JE 9:192). His progress was noted to be slow and complicated with complicating factors of unrelenting headaches and difficulty processing commands. (JE 9:192). The therapist recommended physical therapy decrease to once weekly over the next month and then

progressing to self management. (JE 9:192). The therapist also recommended work conditioning or work hardening or a functional capacity evaluation when Mr. Baker becomes more work ready. (JE 9:192). Mr. Baker was discharged as instructed by workers' compensation. (JE 9:192).

Mr. Baker returned to Dr. Manshadi's office again on March 6, 2018 for a follow-up and re-evaluation. (JE 6:62-63). During this visit, Mr. Baker had another round of fascial distortion treatment. (JE 6:62). Mr. Baker was previously fitted for musician's earplugs, which improved his ear pressure. (JE 6:62). Dr. Manshadi noted some issues continuing with Mr. Baker's ears, and recommended that he visit an ENT doctor. (JE 6:62). Mr. Baker reported two additional episodes of "being completely out" since his last visit with Dr. Manshadi. (JE 6:62).

On March 12, 2018, Dr. Manshadi saw Mr. Baker again for a botox injection in the head and neck due to his migraine headaches. (JE 6:64). The plan was to see Mr. Baker again in three months for re-evaluation and another injection. (JE 6:66). Mr. Baker's next scheduled appointment with Dr. Manshadi was on April 6, 2018. (JE 6:67-68). Mr. Baker's history is noted, along with his medication list. (JE 6:67). Mr. Baker reports improperly taking certain medications, and that his wife has now taken over the medication process. (JE 6:67). Dr. Manshadi reported, "he is making nice progress…" and that the botox injection helped the headaches to some extent. (JE 6:67). Dr. Manshadi discussed the claimant's continued follow-ups with a myriad of different providers. (JE 6:67).

Mr. Baker began treatment with Darko Zdilar, M.D., on March 21, 2018. (JE 14:222-227). Mr. Baker's chief complaint was depression, "I don't know maybe severe depression, anxiety, massive anxiety, and I guess suicidal thoughts." (JE 14:222). He noted to Dr. Zdilar that he had not previously suffered from depression, but that a few months after his injury he began feeling depressed. (JE 14:222). Mr. Baker noted "when I started to realize I am not going back to normal, whole change in my life, situation to kids, injury, unable to function." (JE 14:222). Mr. Baker felt useless, hopeless, and sad. (JE 14:222). He had daily thoughts of suicide triggered by what ifs. (JE 14:222). Mr. Baker also had complaints of anxiety since this started. (JE 14:222). He noted wanting to "chill," having issues with sleep and spending a lot of time worrying about the worst case scenario. (JE 14:223). Mr. Baker noted having no concept of time, and a change in personality after the accident. (JE 14:224). Dr. Zdilar gives an assessment of depression and anxiety, along with diagnoses of: major depressive disorder (single episode), generalized anxiety disorder, GERD, and postconcussion syndrome for Mr. Baker. (JE 14:226). Treatment was discussed to include medication, continued therapy, and supportive therapy. (JE 14:226-227).

Mr. Baker followed-up with Dr. Fitzgerald again on March 23, 2018. (JE 8:130). Dr. Fitzgerald's examination and testing revealed that since the accident, Mr. Baker's brain is unable to shift out of the "foggy brain" where he "feels behind himself." (JE 8:130). Mr. Baker was utilizing an app known as Brain Tap three times per day for a month in order to try to get the brain out of the "sleep like state". (JE 8:130). Dr. Fitzgerald recommends that Mr. Baker continue to utilize the app to improve his brain function. (JE 8:130).

Taylor Physical Therapy Associates issued a discharge summary on March 29, 2018. (JE 9:193). At that time, Taylor Physical Therapy discharged Mr. Baker from formal therapy after 28 visits. (JE 9:193). Mr. Baker continued having daily headaches, but had full and functional range of motion in the upper and lower extremities. (JE 9:193). Mr. Baker's grip strength improved to 60 pounds on the left and 65 pounds on the right. (JE 9:193). Outside of some initial improvements, Mr. Baker was unable to demonstrate significant functional improvements over the past two to three months of therapy. (JE 9:193). Mr. Baker reported concerns about going backwards should he cease physical therapy. (JE 9:193).

In a letter dated, March 31, 2018, Michael Kitchell, M.D., of the McFarland Clinic PC, performed a records review regarding Mr. Baker's alleged head injury. (Defendants' Exhibit A:1-3). Dr. Kitchell summarized some of the records reviewed and noted that Mr. Baker was injured when a large cabinet fell and caused him to fall on the ground. (Def. Ex. A:1). Dr. Kitchell noted that Dr. Curnes from the Grundy Center Emergency Department noted no loss of consciousness, and no indication of significant head trauma. (Def. Ex. A:1). Dr. Kitchell also noted that Dr. Curness never ordered a brain scan or head and neck imaging studies. (Def. Ex. A:1). Dr. Kitchell recounted the subsequent emergency room visit where no loss of consciousness was noted. (Def. Ex. A:1). During that visit, Dr. Kitchell noted Mr. Baker complained of headaches. (Def. Ex. A:1). Mr. Baker also reported memory lapses. (Def. Ex. A:1). During that visit, Mr. Baker underwent CT scans of the brain, cervical spine and thoracic spine, all of which were normal. (Def. Ex. A:1-2). Dr. Kitchell noted Mr. Baker's subsequent claims of neurologic symptoms. (Def. Ex. A:2). Dr. Kitchell recounted Dr. Campbell's records indicating a response bias characterized by symptom magnification. (Def. Ex. A:2). Dr. Kitchell also noted the two normal EEGs, even with the second EEG having six reported "seizure like" episodes. (Def Ex. A:2). Dr. Kitchell's final impression is as follows:

> Mr. Baker did have a minor head injury on 04/14/17, but there is no evidence that he had any significant injury. It is difficult to say whether he even had a minor 'concussion' or not. There is certainly no evidence that he had any brain damage from this injury. These symptoms that he had subsequently, including his visual loss, the left-sided weakness and numbness, and these pseudo seizures, are all three consistent with a psychogenic cause. They are not a result of his accident or head injury on 04/14/17. These 'treatments' that he has had are not necessary as a result of his accident. Mr. Baker, I believe, could have more neuropsychological testing, which I think would confirm that there is no brain injury or brain dysfunction as a result of this accident, and that he is suffering from psychological problems that are not related to any injury on 04/14/17. I do not believe he will need any further treatment as a result of the incident on 04/17/17, but he may need more psychiatric or psychological treatment because of his multiple psychogenic symptoms.

(Def. Ex. A:3).

On April 10, 2018, Mr. Baker visited Mark Zlab, M.D., of The Iowa Clinic Ear, Nose and Throat. (JE 15:228-230). Mr. Baker's chief complaint was a history of head

injury with concussion, right ear pain with possible old blood in the right ear. (JE 15:228). Mr. Baker felt that his hearing was down in his right ear. (JE 15:228). Dr. Zlab performed testing on Mr. Baker, including a normal tympanometry test. An audiometry test showed moderate to severe right ear sensorineural hearing loss and moderate left ear sensorineural hearing loss. (JE 15:229). He had a partial wax obstruction of the auditory canal. (JE 15:229). Cranial nerve abnormalities were also noted. (JE 15:229). Dr. Zlab assessed Mr. Baker with asymmetrical sensorineural hearing loss, and smell disorder. (JE 15:229). A loss of smell and taste could be the result of the head injury. (JE 15:229). Mr. Baker had a left hearing loss of 4 percent and a right hearing loss of 43 percent for an age corrected binaural hearing loss of 10 percent, but this could not be connected to the head injury definitively. (JE 15:230).

Mr. Baker visited CR Vision in Motion on April 30, 2018, with complaints of having a stressful event over the weekend. (JE 16:231). Mr. Baker felt he handled the event well. (JE 16:231). Light therapy and a driving simulator were completed. (JE 16:231). The therapist's recommendation was to continue treatment. (JE 16:231).

Mr. Baker followed-up with Dr. Manshadi again on May 9, 2018. (JE 6:69-70). Dr. Manshadi once again notes the claimant's history. (JE 6:69). Since his last visit, Mr. Baker noted that he had a stressful month with increased headaches. (JE 6:69). He noted having a blackout episode when he experienced some of this stress. (JE 6:69). Overall, it was noted that he was making progress. (JE 6:69). It was noted that his neck pain still caused some irritation and headaches, but his stuttering was improved, as well as his blackout episodes. (JE 6:69). He reported still having issues with his left hand. (JE 6:69). He also reported to Dr. Manshadi that he was having issues with his handwriting – at times, it appears as that of a 2nd or 3rd grader, but at other times it is "very good." (JE 6:69). On May 25, 2018, Mr. Baker followed up with Dr. Manshadi for a repeat botox injection. (JE 6:71-73). He reported that his headaches had decreased in severity. (JE 6:72).

Mr. Baker had a psychiatric progress visit with Shawn Plunkett, ARNP on May 15, 2018. (JE 17:234). Mr. Baker followed-up for depression and anxiety. (JE 17:234). Mr. Baker took Klonopin, Depakote, Cymbalta, and Lexapro. (JE 17:234). Mr. Baker described frequent headaches and severe neck and shoulder pain. (JE 17:234). His speech has continued to improve, and he reported a decrease in seizure activity. (JE 17:234). His current depression symptoms included sadness, isolation, intermittent suicidal thoughts, irritability, impaired memory and decreased focus. (JE 17:234). Mr. Baker noted being forgetful on a regular basis which irritated him. (JE 17:234). He also noted that he either had no reaction to a situation or complete overreaction to a situation. (JE 17:234). Mr. Plunkett diagnosed Mr. Baker with moderate episode of recurrent major depressive disorder, generalized anxiety disorder, post-concussive syndrome, and injury of head, subsequent encounter. (JE 17:234). A treatment plan was discussed for Mr. Baker. (JE 17:235).

Mr. Baker began treatment with Marc Hines, M.D., at Covenant Clinic CPO on May 17, 2018. (JE 18:241-256). Mr. Baker presented with a chief complaint of a traumatic brain injury due to being hit in the back of the head with an over 1,000 pound steel cabinet. (JE 18:241). Dr. Hines reviewed the patient history to-date. (JE 18:241-

249). Since his botox treatment in March, he noted improvement in severity and duration of headaches. (JE 18:250). His short term memory was still problematic, but improving. (JE 18:250). Mr. Baker indicated to Dr. Hines that he had more mood difficulties than even his wife knew about. (JE 18:250). Mr. Baker expressed a desire to have a working relationship and possibly additional treatment with Dr. Hines. (JE 18:250). Dr. Hines discussed switching to another medication if his headache or mood did not improve. (JE 18:251). His anxiety caused him the most difficulty, and made him intolerable in response to anything. (JE 18:251). His lack of activity was not consistent with his previous activity levels, according to evidence presented by his wife to Dr. Hines. (JE 18:251). Dr. Hines' assessed Mr. Baker as having a closed head injury with post-traumatic stress reaction, post-traumatic anxiety, post-traumatic depression, cervical myofascial dysfunction, post-traumatic migraine, and possible post-traumatic partial seizures with complex symptomatology. (JE 18:256). Dr. Hines' plan of care was to continue Mr. Baker's current therapies, perform trigger point injections, follow his memory and other cognitive disturbances, and continue EMDR (eye movement desensitization and reprocessing therapy). (JE 18:256).

Mr. Baker followed-up with Dr. Hines for trigger point injections on June 1, 2018. (JE 18:256-258). Mr. Baker noted that botox helped, but that it wears off after about 1.5 months. (JE 18:257). He also reported no seizure-like spells since his last visit, but his headaches have continued. (JE 18:257). Dr. Hines directed him to follow-up in one month and continue his medications as-is. (JE 18:258).

On June 12, 2018, Dr. Manshadi examined Mr. Baker for his continued complaints. (JE 6:74-75). Dr. Manshadi's impressions regarding Mr. Baker's complaints remained essentially unchanged. (JE 6:74). It was noted that he still has cognitive deficits and issues that need to be worked on. (JE 6:74). It was also noted that he still is having issues with blanking stares and difficulty multitasking. (JE 6:74). Dr. Manshadi opined that it is not reasonable to have a trained person on-site to care for Mr. Baker when his wife is not there; however, Dr. Manshadi noted that Mr. Baker's wife should be compensated for caring for or being with Mr. Baker since she was not working. (JE 6:74). Dr. Manshadi reported the findings of the ENT Dr. Zlab who found 40 percent hearing loss in the right ear and 10 percent hearing loss of the left ear. (JE 6:74). At the time of the examination, Dr. Manshadi would not release Mr. Baker to work due to ongoing issues. (JE 6:74).

Mr. Baker saw Ms. Munson for additional speech therapy on June 14, 2018. (JE 11:205-208). Mr. Baker made progress on his goals, and was able to complete tasks with improved speed and accuracy. (JE 11:208). He required less episodes of re-direction, including being interrupted and returning to the task at hand. (JE 11:208). Ms. Munson noted that speech therapy should continue to focus on cognitive tasks with multiple background distractions. (JE 11:208).

On July 3, 2018, Mr. Baker returned to Mr. Plunkett for a follow-up appointment due to his depression and anxiety, as well as sleeping poorly. (JE 17:237-240). Ever since starting duloxetine, he noticed subtle improvements in his depression. (JE 17:237). Mr. Baker expressed frustration about his continued medical concerns and the number of appointments that he attends. (JE 17:237). He struggled with the fact that

his sons returned to Indiana. (JE 17:238). The main diagnoses remained unchanged. (JE 17:238). On this same date, Mr. Baker visited Dr. Hines for a one-month follow-up. (JE 18:258). Mr. Baker noted only nominal improvement after the trigger point injections. (JE 18:258). He had one episode of "staring" two-days prior to this visit. (JE 18:258). His anxiety and depression were noted to be "brutal," but that he was following-up with psychiatry. (JE 18:258). Dr. Hines' assessment remained a closed head injury, chronic post-traumatic headaches, and cervicalgia. (JE 18:261). The plan proposed was ice for his head, Topamax at bedtime, a trial of Amiovig, and to follow-up in 4-6 weeks. (JE 18:261).

Dr. Manshadi responded to a letter from defendants' counsel dated July 11, 2018, wherein he agreed that the following were his conclusions:

1. I have recommended that Mr. Baker be provided 24 hour supervision. Such supervision may be provided by way of a home health care aide as long as that person is adequately trained to identify Mr. Baker's episodes and how to care for him. That Mr. Baker's significant other be the sole provider of that supervision is not necessary or required.

2. Mr. Baker is scheduled to be evaluated on July 13, 2018. The attendance of a home health care aide at that appointment (or a subsequent one) will provide the opportunity for that person to be trained on identifying Mr. Baker's episodes and how to care for him.

3. Once a home health aide has been trained at the July 13, 2018 (or a subsequent appointment), having Mr. Baker's significant other at home will not be necessary. Mr. Baker's significant other may go to work and/or otherwise leave the house while the aide is providing supervision.

(Def. Ex. B:6).

Dr. Manshadi re-examined Mr. Baker on July 13, 2018. (JE 6:76-78). Mr. Baker's history was noted, and it was also noted that besides the history, Mr. Baker was within normal limits and unremarkable. (JE 6:77). His treatment with other doctors was noted, along with adjustments made to his medications. (JE 6:77). He continued to have headaches but was stabilized. (JE 6:77). Mr. Baker had his sons visiting for about a month, and "did ok" but by the time they left, he noted having an episode where "his eyes were moving around and his wife had to shake him to get him to come out of it…" (JE 6:77). At the time of his examination, Dr. Manshadi diagnosed Mr. Baker with: apraxia of the left hand, chronic migraine without aura intractable, headaches with improvement, myofascial pain involving the neck and upper back, neck pain with reduced range of motion with improvement, neuropraxia of the left hand, complex partial seizures, peripheral vision loss close to resolution, post-concussive headaches with improvement, seizure activities improved with Depakote, TBI with left hemiparesis and loss of sensation, word finding problems and stuttering. (JE 6:77-78). Dr. Manshadi's recommendation was to continue with current medications and hire an aide to help when Mr. Baker's wife was unavailable and upgrade physical therapy for home exercise plan. (JE 6:78). Dr. Manshadi issued a letter on July 30, 2018, recommending that Ms.

Hestness be the “best and most reasonable option for 24/7 supervision.” (JE 6:79). The letter continued, “Ms. Hestness is the person that understands and knows Mr. Baker’s medical history.” (JE 6:79). Dr. Manshadi closed his letter by indicating that supervision has been needed since the date of injury. (JE 6:79).

Mr. Baker followed-up again with Mr. Towley on July 19, 2018, wherein the record noted that he was stable with an average treatment compliance. (JE 12:218). Mr. Baker was struggling with resistance to people coming into his home to provide care because it felt like an invasion. (JE 12:218). Mr. Baker felt the need to resist due to his anger. (JE 12:218).

On July 24, 2018, Mr. Baker restarted physical therapy with Taylor Physical Therapy Associates, LLC. (JE 9:194). The referral was to upgrade therapies for Mr. Baker’s home exercise program. (JE 9:194). Mr. Baker continued to have a constant headache, but noted improvements in strength, balance, and smaller improvements with memory. (JE 9:194). Mr. Baker explicitly noted that his legs and left upper extremity have improved. (JE 9:194). However, he experienced numbness and tingling to the left hand. (JE 9:194). Mr. Baker did well with the maintenance of his home exercise program. (JE 9:194). The therapist opined Mr. Baker should increase load with activities to increase functional strength. (JE 9:194).

Mr. Baker returned to Dr. Manshadi’s office on August 7, 2018, for a follow-up botox injection. (JE 6:80-82). Mr. Baker reported improvement in migraine headaches since starting botox injections. (JE 6:81). He also reported that he has a positive outcome from the botox injection for about eight weeks before it wears off. (JE 6:81).

On August 9, 2018, Mr. Baker was evaluated by James L. Gallagher, M.D., F.A.P.A., based on a referral from Dr. Manshadi. (JE 19:302-311). Dr. Gallagher noted the alleged facts of loss, and that it was unclear whether Mr. Baker ever lost consciousness during the incident. (JE 19:302). Since the work incident, Mr. Baker reported considerable pain in his neck, headaches, reduced range of motion in his neck, diminished peripheral vision, and loss of hearing in his right ear. (JE 19:302). Dr. Gallagher noted that Mr. Baker’s depression and anxiety were clearly present. (JE 19:303). Dr. Gallagher interviewed Mr. Baker, and reviewed his medical records and history. (JE 19:302-311). Dr. Gallagher noted that Mr. Baker sustained a head injury, which caused some cognitive and emotional symptoms. (JE 19:306). Dr. Gallagher recounted Dr. Campbell’s note of mild impairment of short-term memory. (JE 19:306). This included Mr. Baker’s fiancée reporting that he needs continued supervision at home, and previous attempts to involve home health care in place of his fiancée have been resisted by Mr. Baker and his fiancée. (JE 19:306). Dr. Gallagher opined that it appeared as though Mr. Baker’s fiancée was “running interference” for Mr. Baker (JE 19:306). Dr. Gallagher further opined that Mr. Baker appeared to be withdrawing from social contact as a natural result of his depression and anxiety. (JE 19:307). Mr. Baker’s thoughts were “fairly clear and organized,” however, Dr. Gallagher did note some issues with math during the examination. (JE 19:308). Dr. Gallagher opined, “[i]n sum, this is a man who suffered a head injury, is unhappy, seems to have some memory deficits, and has responded to various therapies, but not so much that he can return to work.” (JE 19:308). Dr. Gallagher’s impression was that Mr. Baker had an

emotional component to his injury, but that his pain was the most vexing limitation and barrier for him. (JE 19:309). Dr. Gallagher recommended an increase in certain medications. (JE 19:309). Dr. Gallagher thought it would be of assistance to Mr. Baker if help were brought in via a home health aide to give Ms. Hestness a break from her duties. (JE 19:310). Ms. Hestness resisted that idea when proposed by the doctor. (JE 19:310). Dr. Gallagher concluded his report by indicating he agreed with Dr. Manshadi's findings and diagnosis of a mild traumatic brain injury. (JE 19:310). Dr. Gallagher also noted that Mr. Baker exhibited significant depressive disorder that had not adequately responded to antidepressants. (JE 19:310).

Dr. Hines examined Mr. Baker again on August 14, 2018, for a follow-up related to his head injury. (JE 18:262-266). Topamax helped with headaches, but he had pain of 5 out of 10 all day long. (JE 18:263). Mr. Baker was taken off of Lexapro, which helped his irritability. (JE 18:263). He did odd things like leaving the refrigerator open, or leaving milk out. (JE 18:263). He also described disequilibrium, which was "not clearly a vertigo." (JE 18:263). Cognitively, he had trouble with sequencing. (JE 18:263). Botox injections helped for about 8 weeks. (JE 18:263). Dr. Hines felt Mr. Baker was making progress, but also noted that Mr. Baker had "some fairly clear partial complex seizures." (JE 18:263). Dr. Hines made changes to his anticonvulsants. (JE 18:263). Dr. Hines' assessment was partial symptomatic epilepsy with complex partial seizures – intractable without status epilepticus, anxiety, cervical myofascial pain syndrome, cervicalgia, chronic post-traumatic headache – not intractable, closed head injury, and post-traumatic stress. (JE 18:266). Dr. Hines' plan was to continue Topamax, check Topamax and Depakote levels, follow-up in October, and obtain a repeat neuropsychological examination with Dr. Campbell. (JE 18:266).

Dr. Campbell examined Mr. Baker again on September 13, 2018, for a re-evaluation. (JE 10:199-203). The claimant perceived mild improvement in cognitive processing since the last examination. (JE 10:199). He noted instances of forgetfulness which pose a threat to personal safety. (JE 10:199). Mr. Baker's wife described a significant disconnect between his perception and reality. (JE 10:199). Dr. Campbell noted that in comparison to the exam of August 17, 2017, Mr. Baker had a mild improvement in auditory delayed recognition performance, moderate improvements in visual delayed recall, constructional praxis, and visuomotor speed performances, and mildly worse verbal fluency performance at present. (JE 10:202). Dr. Campbell noted moderate cognitive improvement over the last year, and prominent psychiatric overlay plus a degree of symptom magnification in this case. (JE 10:202). Dr. Campbell opined that there is a discrepancy between mild compromise in aspects of learning and Mr. Baker's claimed lapses in memory. (JE 10:202). The results of the exam suggested that the claimant had recovered sufficient cognitive capabilities to return to work; however, Dr. Campbell opined that there is a suspicion that at least some of his spells are psychogenic non-epileptic seizures, and a grossly abnormal psychological profile indicate that an immediate return to work would be unsuccessful. (JE 10:202). Dr. Campbell recommends that Mr. Baker continue to regularly participate in psychotherapy, continue consulting his psychiatrist to optimize his pharmacotherapy, and consult with his psychiatrist, psychotherapist and physiatrist to determine when he reaches MMI. (JE 10:202-203).

Dr. Manshadi saw Mr. Baker again on October 5, 2018, for continued follow-up and re-evaluation of chronic pain and a brain injury. (JE 6:83-85). While in the shower on the morning of the appointment, Mr. Baker fell, striking his head. (JE 6:84). Mr. Baker described feeling light headed after the fall. (JE 6:84). Mr. Baker's wife reported no episodic symptoms since July 31, 2018. (JE 6:84). His medications were unchanged, and a referral was made for physical therapy for craniosacral treatment. (JE 6:84). A repeat botox injection was done on October 12, 2018, at Dr. Manshadi's office. (JE 6:86). On the same day, Mr. Baker visited CR Vision in Motion noting that he fell in the shower that morning. (JE 16:232). He had a vestibular workout with light visualization. (JE 16:232).

On October 11, 2018, Mr. Baker saw Dr. Gallagher for a follow-up visit. (JE 19:312-313). Mr. Baker reported that his therapy with Mr. Towley was helpful. (JE 19:312). His usage of Cymbalta was noted to make him feel better. (JE 19:312). Mr. Baker was noted to be stuck in the present, so Dr. Gallagher emphasized thinking about the future and setting goals. (JE 19:313). Mr. Baker was noted to be easily frustrated and ashamed of his current predicament. (JE 19:313). After therapeutic discussion, Mr. Baker was "intrigued by the thought of eventually accepting his limitations and not wasting energy on experiencing shame." (JE 19:313).

Mr. Towley met with Mr. Baker again on October 25, 2018. (JE 12:219). Mr. Baker noted that Dr. Gallagher is encouraging him to "spread his wings socially." (JE 12:219). Mr. Baker noted his embarrassment at not being the social driving force that he once was. (JE 12:219). Mr. Baker avoided crowds due to anxiety, and old friends, lest they ask him questions. (JE 12:219).

On November 13, 2018, Mr. Baker returned to Dr. Manshadi's office. (JE 6:89-91). His history was again noted, and his systems were otherwise within normal limits and unremarkable. (JE 6:90). He recounted some of the treatment that he was seeking for his complaints. (JE 6:90). He noted continued vestibular issues which have been causing episodes making him confused and tired for a time. (JE 6:90). He also noted that unfamiliar roads or environments can make him easily confused. (JE 6:90). Mr. Baker was noted to be stable, and noted to Dr. Manshadi that he wanted to visit family in Indiana for Thanksgiving. (JE 6:91). Dr. Manshadi noted, "I feel this should fulfill the social reintegration and patient also wants to try to do some volunteer work…" (JE 6:91). On December 12, 2018, Mr. Baker had a repeat botox injection. (JE 6:92-94). Mr. Baker reported moderate improvement in his headaches. (JE 6:93).

Mr. Baker visited Mr. Towley again on November 15, 2018. (JE 12:220). Mr. Towley noted, "Bill is caught in his 'what I could do then' phase." (JE 12:220). Mr. Baker used to swim and wanted to paddle board around Oahu, Hawaii. (JE 12:220). Mr. Baker was noted to have "big-big dreams" which inevitably leads to the conclusion of "but never again." (JE 12:220). Mr. Towley worked with the claimant on "new ways to be extraordinary," as that was important for him." (JE 12:220).

Dr. Gallagher examined Mr. Baker as a follow-up on December 7, 2018. (JE 19:314-315). Mr. Baker had not been as reclusive during the previous two months, which included several trips with his wife. (JE 19:314). Mr. Baker's mood was improved, and he was smiling. (JE 19:314). Mr. Baker reported looking forward to

Christmas. (JE 19:314). Overall, Dr. Gallagher felt Mr. Baker's mood was more positive. (JE 19:315).

Mr. Baker was seen at the emergency department of the Grundy County Memorial Hospital on December 13, 2018. (JE 2:13-14). Mr. Baker was at the emergency department with his infant son. (JE 2:13-14). While an IV was being placed into his son, he laid his head on the bed and his wife noted he was having a possible seizure. (JE 2:14). Mr. Baker's wife states that eye fluttering, and decreased levels of consciousness happen quite frequently. (JE 2:14).

Mr. Baker visited with Dr. Gallagher on December 20, 2018. (JE 19:316-317). Mr. Baker continued to be in a better mood as he had reached out to people that he formerly worked with. (JE 19:316). The goal continued to do more of what he was already doing. (JE 19:316).

Dr. Hines examined Mr. Baker again on January 7, 2019, for a five-month follow-up. (JE 18: 267-272). He had a new issue with his right hand being unable to make a closed fist. (JE 18:267). His fingers would freeze up, especially in the morning. (JE 18:267). His word finding issues were stable, and "do not seem related." (JE 18:267). Mr. Baker noted that his headaches never go away, and described them as his brain being in a vice. (JE 18:268-269). Dr. Hines opined, "[h]e has had a head injury but it is highly likely that the anxiety component of his difficulties is causing accumulated concerns." (JE 18:269). His diagnoses were essentially unchanged. (JE 18:272). The plan from Dr. Hines involved medications, re-checking his blood levels in three weeks, and consideration of a prolonged EEG. (JE 18:272).

Mr. Baker followed-up with Dr. Gallagher on February 8, 2019. (JE 19:318-320). Mr. Baker indicated he was frustrated of his lost physical ability, including not being able to play the guitar. (JE 19:318). Dr. Gallagher told Mr. Baker that he should adapt his expectations and goals to what he can do. (JE 19:318). Dr. Gallagher called into doubt the reliance of the Vision in Motion test results. (JE 19:319-320).

On February 20, 2019, Mr. Baker had his eighty-eighth visit for speech therapy services with Ms. Munson. (JE 11:209). Mr. Baker had not attended therapy in the past two weeks due to illness, difficulty with transportation and storms. (JE 11:209). Mr. Baker worked quickly through a deductive reasoning task, did better on a working memory task, and only missed one on the calculation/reasoning task. (JE 11:209).

Mr. Baker had another botox injection on February 22, 2019. (JE 6:95-97). He reported that his headaches have been more frequent, but that they have been under control since starting the botox injections. (JE 6:96). Ms. Hestness also reported that he was not complaining of headaches as much. (JE 6:96). Also on February 22, 2019, Mr. Baker had an office visit with Dr. Manshadi. (JE 6:98-99). He reported having continued mental health issues including short-term memory issues. (JE 6:98). He also reported frustration while trying to play guitar, as he could not do it. (JE 6:98). Dr. Manshadi recommended no work for the next three months. (JE 6:98).

Dr. Gallagher visited with Mr. Baker again on February 27, 2019; however, due to weather, the visit was done over the phone. (JE 19:321-322). Mr. Baker complained of a terrible headache. (JE 19:321). Dr. Gallagher thought that Mr. Baker had trouble managing his expectations. (JE 19:321). Mr. Baker got frustrated with his family from time to time. (JE 19:321). At some point in time, it was mentioned to Mr. Baker that his medical care would be wrapped up around the two-year point, which caused him great distress. (JE 19:322).

Mr. Baker followed-up with Dr. Gallagher on March 15, 2019 for continued care. (JE 19:323-325). Dr. Gallagher felt that Mr. Baker was doing well. (JE 19:323). Mr. Baker felt that his mood dropped a little since his Cymbalta was reduced. (JE 19:323). Mr. Baker's headaches and pain remained persistent. (JE 19:323). Mr. Baker verbalized his frustrations. (JE 19:324).

On April 10, 2019, Mr. Baker returned to Dr. Manshadi. (JE 6:100). Mr. Baker's history was reviewed, and it was noted that the craniosacral treatment was not helping much with his headaches. (JE 6:100). He was given a prescription for a low to the ground rowing machine. (JE 6:100). His wife reported giving him tasks around the house, but that he does not finish the tasks. (JE 6:100). Mr. Baker claimed to Dr. Manshadi that he does not have any sense of time. (JE 6:100). Sixteen days later, on April 26, 2019, Mr. Baker had a follow-up botox injection at Dr. Manshadi's office. (JE 6:101-103). He reported that for seven weeks, his headaches were kept under control by the injection, but that for the last two weeks they worsened. (JE 6:102).

Mr. Baker followed-up with Dr. Gallagher on April 13, 2019, for continued psychiatric care. (JE 19:326-328). Mr. Baker's appointment with Dr. Manshadi wherein the doctor informed him that he had plateaued in terms of improvement, and that competitive employment would be a longshot was a "crushing blow" to Bill. (JE 19:326). His therapy with Dr. Gallagher continued, with Dr. Gallagher noting that he was pleased with what Bill was doing and that he was motivated. (JE 19:328).

On April 29, 2019, Mr. Baker returned to Dr. Gallagher's office. (JE 19:329-330). Mr. Baker struggled with obtaining some of his medications, which caused him to have migraine headaches. (JE 19:329). Dr. Gallagher noted that the overall goal was to get Mr. Baker as healthy as possible and be certain of his limitations or abilities. (JE 19:330).

Mr. Baker was seen for a discharge visit with Ms. Munson on April 30, 2019. (JE 11:210). Over the course of treatment, he made great progress in most areas, especially with speed/accuracy of completion of any given task. (JE 11:210). He continued to have severe headache pain levels, which caused difficulty in completion of tasks. (JE 11:210). The therapist noted that Mr. Baker should utilize Lumosity to address all areas of cognition. (JE 11:210). If Mr. Baker declined with no intervention, it must be communicated to his physician to consider additional therapy. (JE 11:210).

Dr. Gallagher saw Mr. Baker for a follow-up visit on May 16, 2019. (JE 19:331-332). Mr. Baker was more at ease, and discussed his difficulties with accepting his deficits. (JE 19:331). He reported getting anxious and being hypervigilant since his

injury. (JE 19:331). Coping mechanisms were discussed. (JE 19:332). The overall goal remained progressing Mr. Baker towards independence as much as possible. (JE 19:332).

Mr. Baker returned to Dr. Gallagher's office on June 3, 2019. (JE 19:333-334). Dr. Gallagher reported that he was trying to formulate positive plans for Mr. Baker. (JE 19:333). Dr. Gallagher counseled against having Mr. Baker's wife attend sessions with him because she may overwhelm him with her own issues. (JE 19:333). Dr. Gallagher did note that "she helps out and I think her supervision is still necessary." (JE 19:333). The overall goal remained progressing Mr. Baker towards independence as much as possible. (JE 19:334).

On June 5, 2019, Dr. Hines re-examined Mr. Baker for a six-month follow-up. (JE 18:273-279). Mr. Baker had some episodes of zoning out and blank staring noted by Dr. Hines. (JE 18:273). Dr. Hines reviewed the neuropsychological report from Dr. Campbell, which Dr. Hines noted a suggestion of an element of psychological overlay and was "significant enough to suggest that he may have psychogenic epilepsy." (JE 18:274). The results of the EEG which showed no epileptiform disturbance were noted by Dr. Hines. (JE 18:274). Mr. Baker's wife noted that there were cameras in the house which showed Mr. Baker shaving his head at 1:30 a.m. (JE 18:274). Mr. Baker claimed no memory of shaving his head. (JE 18:274). Mr. Baker noted that Vimpat was useful for pain suppression, which gave him "a wash of relief." (JE 18:275). He continued to complain of issues with sleep habits, and grasp of time spans. (JE 18:275). Dr. Hines' diagnoses remained: partial symptomatic epilepsy with complex partial seizures – intractable – without status epilepticus, anxiety, cervical myofascial pain syndrome, cervicalgia, chronic post-traumatic headache – not intractable, closed head injury, and post-traumatic stress. (JE 18:278). Dr. Hines' plan was to hold Mr. Baker's medications for a potential sleep study, continue his prescription for Emgality, and follow-up in one month. (JE 18:278).

Dr. Gallagher visited with Mr. Baker again on June 19, 2019. (JE 19:335-336). A good deal of the session was spent discussing possible ways to enhance Mr. Baker's independence. (JE 19:335). Mr. Baker was frustrated because it was unclear when his restrictions may change. (JE 19:335). Mr. Baker's wife attempted to enhance his independence by asking him to take over minor duties. (JE 19:335). Mr. Baker's mood was good, as his sons were visiting him. (JE 19:336).

Mr. Baker followed-up with Dr. Manshadi on June 25, 2019. (JE 6:104). Dr. Manshadi noted Mr. Baker's history of complaints, including traumatic brain injury with residual symptomatology as a result of head trauma. (JE 6:104). Mr. Baker's significant other reported that the Sunday before this visit, Mr. Baker had additional seizure activity, which consisted of hearing a thud from the other room. (JE 6:104). When she arrived in the kitchen, Mr. Baker was on the floor and "out cold" for about 30-seconds. (JE 6:104). Mr. Baker reported to his significant other that he could not remember what he was doing prior to being out cold. (JE 6:104). Mr. Baker noted that he had continued headaches, but that his threshold issues improved. (JE 6:104). His significant other noted that she left Mr. Baker to perform some tasks, including tending to his children independently. (JE 6:104). Mr. Baker forgot to feed one child, and forgot

to prepare lunch for the other children. (JE 6:104). The only issue noted to have resolved is an issue with his peripheral vision. (JE 6:104). Dr. Manshadi noted, "I do not believe he is able to return to any type of gainful employment at this point or in the foreseeable future." (JE 6:104). Dr. Manshadi issued a letter to the same effect. (JE 6:105).

On July 10, 2019, Mr. Baker visited CR Vision in Motion, where he indicated "my stress levels have been high because my boys are going back to their mom's." (JE 16:233). He was told to continue neuro rehabilitation. (JE 16:233). Visual therapy was performed. (JE 16:233).

Dr. Gallagher visited with Mr. Baker again on July 20, 2019, to discuss his progress. (JE 19:337-338). Mr. Baker had a better time around the appointment, as his sons were visiting from Indiana. (JE 19:337). His wife kept him pointed in the right direction. (JE 19:337). Pathways which may improve his functionality and enhance his independence were discussed. (JE 19:338). His gains were fairly minimal, which caused him to be discouraged. (JE 19:338).

Mr. Baker visited Dr. Hines on August 12, 2019, for a neurology follow-up. (JE 18:280-285). Mr. Baker reported an episode on June 23, 2019, that took 30-seconds to get him to snap out of it; however, the effects lingered for several hours. (JE 18:280). He was found on the floor after 6:00 p.m., which was triggered by placing a child into time-out. (JE 18:281). Mr. Baker also complained of constant, every-day headaches, the severity of which was unchanged. (JE 18:280-281). A sleep study showed moderate sleep apnea, which will require a CPAP. (JE 18:281). Dr. Hines assessed Mr. Baker as follows: obstructive sleep apnea, partial symptomatic epilepsy with complex partial seizures – intractable – without status epilepticus, cervicalgia, and cervical myofascial pain syndrome. (JE 18:284-285). Dr. Hines' plan was to ask Mr. Baker to return to the sleep clinic to obtain and adjust a CPAP, obtain a CPAP titration, increase lacosamide, and follow-up in two-months. (JE 18:285).

On August 28, 2019, Mr. Baker returned to Dr. Gallagher's office for a psychiatric follow-up visit. (JE 19:339-340). Mr. Baker had been in Des Moines for the previous few days and enjoyed it because there was more stimulation and things to do. (JE 19:339). Mr. Baker was attempting to move to the Des Moines area due to the stimulation and activity in the area. (JE 19:339). Mr. Baker's family did not understand that he sustained a severe injury and disregarded his limitations. (JE 19:340). Mr. Baker was able to discuss and organize thoughts that he was unable to do elsewhere. (JE 19:340).

Dr. Manshadi examined Mr. Baker again on September 4, 2019. (JE 6:106-107). Mr. Baker noted having some seizure activity in August, including while visiting Dr. Fitzgerald. (JE 6:106). His significant other reported that Mr. Baker needed to be shaken 3 or 4 times to get him out of the seizure, and afterwards, Mr. Baker was "very groggy for about 45 minutes." (JE 6:106). Dr. Manshadi noted the continued failure of Mr. Baker to complete household tasks, and volunteer work. (JE 6:106). Dr. Manshadi placed Mr. Baker at maximum medical improvement (MMI) for his head injury, including concussive headaches and chronic migraines, as well as myofascial pain issues involving his back and neck. (JE 6:106). Dr. Manshadi also placed Mr. Baker at MMI

for seizures, word finding issues, peripheral vision issues, and left-sided weakness. (JE 6:106). Dr. Manshadi recommended that Mr. Baker continue to follow-up with several doctors. (JE 6:106). Dr. Manshadi concludes the narrative portion of his record by stating, "I believe that Mr. Bill Baker will not be able to be gainfully employed at this point due to his traumatic brain injury and the seizure activities and cognitive issues, as well as with left-sided weakness and word finding issues." (JE 6:106).

Dr. Fitzgerald replied to a letter from claimant's attorney on September 11, 2019. (JE 8:131-133). Dr. Fitzgerald opined that Mr. Baker suffered a traumatic brain injury, that is permanent as he will continue to have short term memory loss with cognitive issues. (JE 8:132). Dr. Fitzgerald opined that Mr. Baker will need to have continued medical care and cannot be left alone or allowed to care for someone else. (JE 8:133).

Dr. Gallagher responded to a letter from claimant's attorney on September 12, 2019. (JE 19:341-343). Dr. Gallagher agreed that Mr. Baker suffered a traumatic brain injury, anxiety, depression, post-traumatic stress disorder, and a TBI, which were caused by the incident of April 14, 2017. (JE 19:342). Dr. Gallagher also noted that Mr. Baker would need to be continued indefinitely. (JE 19:343). Dr. Gallagher agreed that Mr. Baker has cognitive limitations, cannot drive, and is unable to be gainfully employed as a result of the work incident. (JE 19:343).

Dr. Manshadi responded to a letter from the claimant's attorney on September 20, 2019. (JE 6:108-110). Dr. Manshadi agreed that his diagnoses of Mr. Baker were: post-concussive headaches, chronic migraine headaches, myofascial pain involving neck and upper back, partial complex seizures, seizure disorder, traumatic brain injury with left hemiparesis and loss of sensation, continued word finding problems with memory issues, anxiety, depression, and post-traumatic stress disorder. (JE 6:108). Dr. Manshadi agreed that Mr. Baker would need transportation to and from his medical appointments, as well as for other commitments. (JE 6:109). Dr. Manshadi also agreed that Mr. Baker sustained a permanent head injury and would require 24-hour supervision due to the incident of April 14, 2017. (JE 6:109). Dr. Manshadi opined that Mr. Baker needs continued medical care from a laundry list of providers. (JE 6:110). Finally, Dr. Manshadi agreed that Mr. Baker is unable to be gainfully employed as a result of the work incident of April 14, 2017. (JE 6:110).

Dr. Gallagher saw Mr. Baker again on September 25, 2019, for a psychiatric follow-up visit. (JE 19:344-345). Mr. Baker had moved to Des Moines, for the sake of greater opportunity both in stimulation and his career. (JE 19:344). Mr. Baker struggled with Dr. Manshadi placing him at MMI, which made him realize that further gains may be minimal and unpredictable. (JE 19:344). Dr. Gallagher noted that the goal was to get Mr. Baker to "digest the notion of being at MMI without taking that to mean that he is a hopeless case." (JE 19:344).

Phil Davis, M.S., C.B.I.S., a vocational specialist issued an opinion with regard to the vocational implications of Mr. Baker's accident. (Claimant Exhibit 16:38-45). Mr. Davis reviewed Mr. Baker's medical records, and answers to interrogatories. (Cl. Ex. 16:38). He also conducted a vocational interview with Mr. Baker and Ms. Hestness on August 14, 2019, noting that Ms. Hestness was helpful in assisting Mr. Baker by verifying the accuracy of information provided. (Cl. Ex. 16:38). Mr. Baker reported

having several computers in his home, and that prior to his injury his computer skills were "good/excellent," including writing and developing computer programs. (Cl. Ex. 16:39). However, since his injury, Mr. Baker claimed that he was unsure of his ability to work at a computer due to the adverse effects of viewing the screen and "other reported cognitive issues." (Cl. Ex. 16:39). Mr. Baker and Ms. Hestness made clear during the interview process that Mr. Baker may no longer drive, that he is unable to mow the yard or shovel snow or landscape or perform any activity which requires the climbing of a ladder. (Cl. Ex. 16:43). Mr. Baker also could not perform home repairs, such as electrical work, plumbing, painting, or changing lightbulbs. (Cl. Ex. 16:43). He also could not wake up on time, remember to take his medication, or get to his appointments on time without assistance. (Cl. Ex. 16:43). It was noted that Ms. Hestness had assumed all responsibilities with regard to paying bills, budgeting, finances, and other necessary tasks. (Cl. Ex. 16:43).

Mr. Davis took note of the opinions of Dr. Manshadi that: 1. Mr. Baker cannot drive due to the work incident; 2. Mr. Baker requires 24-hour supervision due to the work incident; and, 3. Mr. Baker is unable to be gainfully employed as a result of the work incident. (Cl. Ex. 16:42). Mr. Davis also noted the opinion of Dr. Gallagher, which concurred with the opinion of Dr. Manshadi that Mr. Baker is unable to be gainfully employed as a result of the work incident. (Cl. Ex. 16:42). Mr. Davis finally noted the opinion of Dr. Fitzgerald which noted Mr. Baker's continued short term memory loss issues, and that Mr. Baker requires 24-hour care. (Cl. Ex. 16:43). Mr. Davis noted,

> When taking into consideration the physical and cognitive restrictions set forth by Dr. Manshadi, Dr. Gallagher and Dr. Fitzgerald (all of which agreed that Mr. Baker is unable to be gainfully employed as a result of his injury of 4/14/17). I would opine that Mr. Baker is currently incapable (100%) of returning to his past employment activities when taking into consideration the physical demands of any of his past employment, as well as the concerns for his safe ability to perform any job based upon his cognitive and psychological diagnosis. Based on the same opinions of his treating and evaluating physicians, Mr. Baker is 100% precluded from performing any gainful employment activity.

(Cl. Ex. 16:44).

Following the vocational report, Shelly Kinney, MSN, RN, CCM, CNLCP, a nurse life care planner, prepared a life care plan. (Cl. Ex. 17:46-54). Ms. Kinney met with Mr. Baker and Ms. Hestness in September of 2019 in preparing her report. (Cl Ex. 17:47). Ms. Kinney cites several studies and resources as to the burden that caregiving can be on families. (Cl. Ex. 17:51). Ms. Kinney recommended steps outlined by the U.S. Department of Health and Human Services to "prevent or relieve caregiver stress including seeking help from respite services or adult day programs, taking caregiving classes, asking for help from friends or family members, joining a support group, daily routines, taking time for yourself, taking care of personal health needs." (Cl. Ex. 17:51). The life care plan goes on to list a litany of services and prices for said services to be provided for Mr. Baker. Ms. Kinney opined that if Ms. Hestness were to be compensated for Mr. Baker's 24-hour care, she would be paid for anything from 13 to

24 hours of care per day. (Cl. Ex. 17:63). Ms. Kinney also recommends respite care services in order to provide Ms. Hestness with a break. (Cl. Ex. 17:63). If a professional were to provide in-home supervision for Mr. Baker, it would be for 10-hours per day and five days per week. (Cl. Ex. 17:64). There was also respite care and pay recommended for Ms. Hestness during the non-professional periods. (CL. Ex. 17:64).

Ernest Preston Goss, Ph.D. submitted a report dated October 1, 2019, estimating the claimant's lost earning capacity. (Cl. Ex. 18). I do not find this relevant.

On October 15, 2019, Mr. Baker returned to Dr. Hines' office for a follow-up examination. (JE 18:286-291). Mr. Baker reported having a seizure in late August, wherein he was shaking and having eye movements. (JE 18:286). It took him 45 minutes to return to normal after the incident. (JE 18:286). Mr. Baker informed Dr. Hines that he had left sided weakness. (JE 18:286). He continued to have daily headaches, but Emgality helped. (JE 18:286). His wife informed Dr. Hines that Mr. Baker had great difficulty getting out of bed, and has had continued cognitive problems. (JE 18:287). Communication was an issue in that he does not get statements, and did not recall portions of the conversation. (JE 18:287). He reported trouble getting and staying asleep, and the doctor opined that his depression appeared to play a role in this. (JE 18:290). His diagnoses remained unchanged from his prior visit with Dr. Hines. (JE 18:291). The treatment plan by Dr. Hines was to begin his CPAP the next week, and taper/discharge from his Vimpat. (JE 18:291).

On October 21, 2019, Mr. Baker saw David Visokey, D.O., due to obstructive sleep apnea. (JE 20:358-363). His history of a traumatic brain injury was noted. (JE 20:358). According to Mr. Baker's wife, since the injury, it took Mr. Baker several hours to fall asleep. (JE 20:358). His sleep study was positive for obstructive sleep apnea. (JE 20:358). Before his visit, when he was in the bathroom, Mr. Baker fell and hit his head on the sink with a mild headache. (JE 20:362). After the visit, he returned to the bathroom with his son, and fell again. (JE 20:362). Mr. Baker was unsure as to whether it was a syncopal episode seizure since it was unwitnessed. (JE 20:362).

After falling on October 21, 2019, Mr. Baker reported to the emergency department at Wheaton Franciscan Healthcare-Waterloo, where he was seen by Stuart Feldman, D.O. (JE 21:364- 367). Mr. Baker presented to the emergency department due to syncope. (JE 21:364). He recounted the events from Dr. Visokey's office. (JE 21:364). Mr. Baker had another episode later on that date, which caused his family to become concerned, as he had not had two episodes in the same day previously. (JE 21:364). Mr. Baker noted that he had similar seizure episodes four times per year. (JE 21:364). Dr. Feldman discharged Mr. Baker. (JE 21:366).

Mr. Baker followed-up with Dr. Gallagher for another session on October 23, 2019. (JE 19:346-347). Mr. Baker's move to Des Moines went better than anticipated. (JE 19:346). Mr. Baker's wife was quite happy, and there was less tension. (JE 19:346).

On November 5, 2019, Mr. Baker reported for a neuropsychology consultation with Robert Jones, Ph.D., at the University of Iowa Hospitals & Clinics. (Def. Ex. D:9-14). Mr. Baker recounted his history including his head symptoms and seizure-like

symptoms. (Def. Ex. D:9). He denied problems with activities of daily living, but noted that he does not often shower, brush his teeth or change clothes. (Def. Ex. D:9). Mr. Baker attributed these issues to problems with his concept of time, noting that the days "run together." (Def. Ex. D:9). Dr. Jones noted that Mr. Baker described difficulties with memory, attention, concentration, speech, language, vision, motor skills, and mood. (Def. Ex. D:9). Mr. Baker recalled being struck by the cabinet, and "then losing memory for the subsequent 11 months." (Def. Ex. D:9). He also described increased anger and irritability. (Def. Ex. D:9). At the end of the performance validity testing, a clinician asked Mr. Baker if he put forth maximum effort. (Def. Ex. D:10). This angered Mr. Baker, and caused him to try to discontinue testing, claiming he had been called a "liar." (Def. Ex. D:10). Dr. Jones found Mr. Baker with fluent, well-articulated, speech. (Def. Ex. D:10). A battery of tests were run on Mr. Baker. (Def. Ex. D:11). Mr. Baker's performance on embedded measures of performance validity were within normal limits, but his performance on direct measures of performance validity suggested less than optimal effort in response. (Def. Ex. D:12). Dr. Jones noted that the results of the exam must be interpreted with caution due to the lack of effort. (Def. Ex. D:12). Mr. Baker's overall intellectual function was estimated to be in the low average range. (Def. Ex. D:12). Dr. Jones noted that there were questions about Mr. Baker's effort during the examination, and thus the results of the assessment should be viewed with some caution. (Def. Ex. D:13). Dr. Jones noted that they would not diagnose post-concussive syndrome or a traumatic brain injury. (Def. Ex. D:13). Dr. Jones and his team came to that conclusion because the contemporaneous medical records found no evidence of confusion, disorientation or difficulties with cognition that would represent a concussion. (Def. Ex. D:13). In general, Dr. Jones found Mr. Baker's performances to be within expectations given Mr. Baker's educational and occupational background. (Def. Ex. D:13). Dr. Jones noted some areas of mixed results, but the meaning of these performances is "unclear." (Def. Ex. D:13). Dr. Jones opined that "the most salient aspect of the patient's neuropsychological profile is his severe psychological distress." (Def. Ex. D:13). The reason behind the psychological disruption was unclear to Dr. Jones, "but it would not be expected from the April 2017 accident." (Def. Ex. D:13). Dr. Jones recommended continued treatment of Mr. Baker's complaints as recommended by his treating providers, especially continued psychiatric or psychological care. (Def. Ex. D:14).

Dr. Gallagher visited with Mr. Baker again on November 18, 2019, for a psychiatric follow-up. (JE 19:348-349). Mr. Baker was calm and his mood improved. (JE 19:348). His move to Des Moines was a "good thing for him and his wife." (JE 19:348). Mr. Baker had issues with maintaining sleep. (JE 19:348). Dr. Gallagher's goal was to prevent regression. (JE 19:349).

On December 3, 2019, Mr. Baker had a follow-up visit with Dr. Manshadi. (JE 6:111-112). Mr. Baker claimed to have had another seizure episode when visiting another medical provider, which caused him to fall. (JE 6:111). Mr. Baker recounted a fall from the summer prior which caused some numbness in his right thigh. (JE 6:111).

Mr. Baker visited Dr. Hines for a follow-up on December 16, 2019. (JE 18:292-301). The reasons for his visit were seizures, a head injury, headaches, and PTSD. (JE 18:292). Dr. Hines noted that Mr. Baker had an episode after his last visit, and had

some minor “spaced out” episodes since that time. (JE 18:292). His headaches continued to be daily and were “horrible.” (JE 18:292). Dr. Hines noted it was clear that Mr. Baker had more fogginess without his medications, and that he was especially worse without Vimpat. (JE 18:293). On physical examination, it was noted that he had lateral femoral cutaneous nerve distribution with decreased sensation. (JE 18:298). Mr. Baker was irritable and frustrated. (JE 18:298). Dr. Hines’ diagnoses of Mr. Baker remained unchanged. (JE 18:298). The plan proposed by Dr. Hines was an MRI of the cervical and thoracic with and without contrast due to pain and episodic numbness, an EMG-NCV, and follow-up in about two-months. (JE 18:299).

Dr. Gallagher followed-up with Mr. Baker on December 18, 2019, for a psychiatric session. (JE 19:350-351). The goal continued to be increasing self-sufficiency as much as possible. (JE 19:350). There were issues with Mr. Baker not receiving medications in a timely and consistent manner, which caused him to enter withdrawal periods. (JE 19:350). Dr. Gallagher noted therapy should continue. (JE 19:351).

Dr. Kitchell issued a supplemental record review and opinion on December 19, 2019. (Def. Ex. A:4-5). This review included additional medical records not reviewed during Dr. Kitchell’s previous record review. Dr. Kitchell noted, “[i]t is my impression from reviewing these records that Mr. Baker did not have any significant head injury, even though he reported a large cabinet fell on him and hit his helmet, causing the helmet to fall off.” (Def. Ex. A:4). No loss of consciousness occurred, according to Dr. Curnes. (Def. Ex. A:4). Dr. Kitchell opined that the tests run by Dr. Fitzgerald were peculiar, and did not have any scientific basis or any indication of brain or ophthalmologic problems from a head injury. (Def. Ex. A:5). Dr. Kitchell noted, “I believe that the psychological problems are the cause of his psychogenic spells and his memory difficulty could be related to these psychosomatic problems and/or a sleep disturbance which it sounds as though he most likely has, as diagnosed by his sleep study.” (Def. Ex. A:5). Dr. Kitchell concluded, “I do not believe that Mr. Baker’s minor head injury on 04/14/17 caused any brain injury or any major subsequent symptoms. I believe that most, if not all, of Mr. Baker’s difficulties are related to some psychological disturbances that hopefully will respond to treatment.” (Def. Ex. A:5).

Randy Kardon, M.D., Ph.D., performed a record review, and issued opinions in a letter dated December 18, 2019. (Def. Ex. E17–E:21). Dr. Kardon is a tenured professor of ophthalmology in the neuro-ophthalmology division of the department of ophthalmology at the University of Iowa Carver College of Medicine. (Def. Ex. E:17). Dr. Kardon opined that, although Mr. Baker did not suffer a loss of consciousness or objective signs of neurologic dysfunction immediately following the incident, the presence of a headache met some experts’ broad definition of a mild traumatic brain injury. (Def. Ex. E:19). Dr. Kardon’s review of the records from Dr. Fitzgerald indicated that Mr. Baker does not suffer from any visual abnormalities due to the work incident. (Def. Ex. E:19). The results of vision testing on Mr. Baker did not specifically reveal cerebellar or parietal lobe dysfunction in the absence of neurological findings associated with dysfunction in locations of the brain. (Def. Ex. E:20). Dr. Kardon noted, “I do not agree with the diagnoses made by Dr. Fitzgerald regarding Mr. Baker’s vision symptoms and test results and my opinion is that no testing results consistently support

visual dysfunction due to the incident he experienced at work." (Def. Ex. E:20). Additionally, Dr. Kardon noted that the diagnoses made by Dr. Fitzgerald are such that they are not usually made by an optometrist. (Def. Ex. E:20). Dr. Kardon opined further that Dr. Fitzgerald's treatment and therapy do not have scientific rationale that is evidence-based, nor are they considered accepted treatment by the medical community. (Def. Ex. E:20). Dr. Kardon noted that Dr. Fitzgerald's treatments were not reasonable or necessary. (Def. Ex. E:20). Dr. Kardon further indicated that some of the subjective symptoms reported by Mr. Baker make it difficult to connect his headaches and visual symptoms to a brain injury. (Def. Ex. E:20-21). Dr. Kardon concluded his report by noting that Mr. Baker was not suffering from any vision problems related to his work injury, and that there was no reason that Mr. Baker should be unable to drive from a vision standpoint. (Def. Ex. E:21).

On December 19, 2019, Mr. Baker visited the emergency room at Mercy Des Moines. (JE 22:368-375). Mr. Baker reported feeling "out of it" and experiencing a four minute seizure during which he struck his head. (JE 22:368). He had not taken his prescribed medications for three days prior to the seizure. (JE 22:368). A CT scan of his head was completed, which showed no acute intracranial abnormalities. (JE 22:371). Neurology recommended that Mr. Baker be given valproic acid prior to discharge since he had a seizure and missed 3-days of medication. (JE 22:372).

Michael L. Cullen, M.D., a board certified neurologist with Neurology Associates in Moline, Illinois, issued a records review dated December 20, 2019. (Def. Ex. F:23-30). Dr. Cullen reviewed Mr. Baker's records from a number of providers, and recounted his lengthy medical history. Dr. Cullen concluded that there is no convincing evidence that Mr. Baker suffered a concussion or traumatic brain injury, but that he did have blunt trauma to the base of the skull. (Def. Ex. F:29). Mr. Baker's condition was noted to be a self-limited one. (Def. Ex. F:29). Dr. Cullen felt that treatment was based on the subjective reports of Mr. Baker without any objective clinical or diagnostic support. (Def. Ex. F:30).

Mr. Baker visited Dr. Gallagher again on January 15, 2020. (JE 19:352-353). Mr. Baker was generally doing better, but he had a seizure-type episode which necessitated a trip to the emergency room. (JE 19:352). Mr. Baker noted that he was playing the guitar again to regain some muscle memory. (JE 19:352). Things were going well at home, as well. (JE 19:352). Dr. Gallagher followed-up this meeting with a January 20, 2020, letter claimant's attorneys. (JE 19:354-356). Dr. Gallagher opined that Mr. Baker suffered a head injury and brain injury, and that Mr. Baker was not malingering. (JE 19:356). Mr. Baker was noted to be working towards independence as much as possible. (JE 19:356).

On January 24, 2020, Dr. Manshadi issued a letter directed to attorneys for the claimant. (JE 6:113-114). Dr. Manshadi noted he reviewed additional medical reports or letters from Dr. Jones, Dr. Cullen, and Dr. Kitchell. (JE 6:113). Dr. Manshadi affirmed his previous opinions and diagnoses. (JE 6:113). Dr. Manshadi also recommended that Mr. Baker not drive and not return to work, while also making the recommendation that Mr. Baker have 24-hour supervision.

Joseph J. Chen, M.D., examined Mr. Baker on February 10, 2020, for the purposes of an independent medical examination (IME). (Def. Ex. O:66-O:83). Dr. Chen is the medical director of Mercy Rehabilitation hospital, and a diplomate with the American Board of Physical Medicine and Rehabilitation. (Def. Ex. O:84-85). Dr. Chen noted that he spent two hours examining Mr. Baker and discussing his recommendations for Mr. Baker's treatment. (Def. Ex. O:66). Dr. Chen also reviewed Mr. Baker's medical records. (Def. Ex. O:66-70). Dr. Chen examined Mr. Baker and noted his subjective complaints of confusion, dizziness and memory loss. (Def. Ex. O:71). Mr. Baker believed he was unsafe while driving or operating power equipment, as well as using a stove, as he had put towels and/or cardboard in the oven when he was "out of it." (Def. Ex. O:71). Mr. Baker reported that Dr. Fitzgerald's treatments were helpful to his peripheral vision, but that it is still poor. (Def. Ex. O:71). He also reported concern about his left arm shaking. (Def. Ex. O:71). Mr. Baker believed that he could not return to work due to his inability to show up on time, oversleep, or being too tired to work. (Def. Ex. O:71). He also reported poor concentration as a barrier to returning to work. (Def. Ex. O:71). His psychiatric mood and affect were normal upon examination. (Def. Ex. O:72). His overall behavior was normal, but there was an episode of left hand shaking that resolved after Dr. Chen told him there was no worrisome neurological findings on imaging studies or EEG. (Def. Ex. O:72). Mr. Baker completed a symptom diagram which Dr. Chen interpreted as follows, "Nonphysiologic partitioning of pain symptoms from head, shoulders, left-right hemi-body, torso demarcation separating upper and lower extremities. This pattern is not consistent with any peripheral nerve or muscle distribution." (Def. Ex. O:74).

Dr. Chen's diagnoses at the time of Mr. Baker's examination were: chronic myofascial head, beck and low back pain, severe anxiety and depression, high fear avoidance beliefs, and high pain catastrophization. (Def. Ex. O:74). Dr. Chen noted that the medical records show Mr. Baker was wearing a hard-hat when a large shelf fell on him, and over the next several months, he began to complain about a myriad of subjective symptoms with had no objective correlation on MRI or other testing. (Def. Ex. O:74). Dr. Chen felt that there was room for improvement with Mr. Baker's anxiety and depression. (Def. Ex. O:74-75). Dr. Chen noted that Mr. Baker has chronic daily headaches, and not migraine headaches, due to the medications failing to alleviate his symptoms. (Def. Ex. O:75). Dr. Chen could not connect the headaches to a post-concussive etiology, as those type of headaches would be expected to improve within six to twelve months post-injury. (Def. Ex. O:75). Dr. Chen also could not diagnose a traumatic brain injury because of the reports in the contemporaneous medical records indicating no suspicion for loss of consciousness, and the progression of subjective symptoms over the course of days, months, and years are inconsistent with a traumatic cause of brain injury. (Def. Ex. O:75). Due to the negative EEG's, Dr. Chen indicated that there was no presence of a seizure disorder. (Def. Ex. O:75). Mr. Baker's physical examination provided inconsistent results for a left hemiparesis. (Def. Ex. O:75). With regard to Mr. Baker's reported poor cognition and safety concerns, Dr. Chen's medical opinion was that Mr. Baker's severe anxiety and/or depression led to his complaints in stressful situations. (Def. Ex. O:75). Mr. Baker's chronic insomnia was also a potential source of cognition problems. (Def. Ex. O:76). Dr. Chen opined that the diagnoses of chronic headache, myofascial neck and back pain, and severe anxiety and depression are not casually connected to the work injury. (Def. Ex. O:76). Dr. Chen stated,

> It is my medical opinion that a more probable explanation for the temporal association and escalation of his subjective symptoms following his work incident was the disruption in his personal lifestyle with the entry of a newborn infant. Whether this event led to increased personal stressors, disturbed sleep, financial distress, is certainly possible as nearly all new parents would experience.

(Def. Ex. O:76). Dr. Chen believed that Mr. Baker could be gainfully employed again. (Def. Ex. O:76). Dr. Chen's opinion was that the crucial factor in Mr. Baker's inability to return to work was a very poor sense of confidence in his own skills. (Def. Ex. O:76). Mr. Baker expressed concern that if he were allowed to work in his shop or drive his car, he would injure himself or others. (Def. Ex. O:76). Dr. Chen encouraged Mr. Baker to believe in himself, and that in treating previous patients with brain injuries, cerebral strokes, and advanced dementia, many patients do not have the insight to be able to report what Mr. Baker reported. (Def. Ex. O:76). Mr. Baker's expressed inability to wake on time, remain awake, follow directions, or remember how to perform tasks are attributed to a low interest in returning to gainful employment. (Def. Ex. O:76). Dr. Chen did not believe Mr. Baker to require 24-hour supervision due to the work incident. (Def. Ex. O:77). Mr. Baker's excessive dependence on another individual's constant attention could be taken as a sign of a "specific dependent personality disorder." (Def. Ex. O:77).

With regards to future medical treatment, Dr. Chen opined that treatment with Dr. Manshadi was no longer necessary, especially since Dr. Manshadi placed him at MMI. (Def. Ex. O:77). Dr. Chen agreed with Dr. Kardon that treatment with Dr. Fitzgerald was no longer reasonable or medically necessary, and that there was no medical reason from a vision standpoint that Mr. Baker could not drive. (Def. Ex. O:77). Dr. Chen noted that neuropsychometric testing from the reports of Drs. Campbell and Jones showed severe psychological distress, while contemporaneous medical records did not indicate early post-traumatic confusion or neurological symptoms. (Def. Ex. O:77). Additionally, imaging studies were normal, and Drs. Stephens, Hines, and Cullen could not find objective abnormalities consistent with a traumatic brain injury. (Def. Ex. O:77). Dr. Chen noted that his medical opinion was that Mr. Baker did not require any additional supervised medical treatment as a result of the work injury. (Def. Ex. O:78). Dr. Chen noted that Dr. Gallagher's advice and treatment were appropriate in attempts to return Mr. Baker to an independent life. (Def. Ex. O:78). Dr. Chen notes that Mr. Baker will not require lifelong counseling as a result of the work injury; however, Mr. Baker may benefit from a time-limited period of additional monthly professional counseling. (Def. Ex. O:78).

On February 13, 2020, Dr. Fitzgerald issued a letter regarding Mr. Baker's continued issues. (JE 8:137-143). The bulk of this is to justify Dr. Fitzgerald's treatment and the efficacy thereof. Dr. Fitzgerald opined that Mr. Baker is suffering from a brain problem starting with the work injury. (JE 8:143).

Mr. Baker followed-up with Dr. Gallagher on February 19, 2020, for a psychiatric appointment. (JE 19:357.1-357.2). Mr. Baker's mood was good, but he lacked energy. (JE 19:357.1). The previous weekend, there were issues with getting his medication on

time. (JE 19:357.1). Due to going into discontinuation syndrome from a lack of Cymbalta, the claimant ended up in the emergency room. (JE 19:357.1). The only trigger seen by Dr. Gallagher for Mr. Baker's anxiety and depression was the injury that occurred at work. (JE 19:357.1). Despite newer reports, Dr. Gallagher did not change his opinion regarding causation. (JE 19:357.2). Treatment was to continue for depression and anxiety. (JE 19:357.2). Dr. Gallagher noted that Mr. Baker continued demonstrating inattentiveness and forgetfulness around the house, including a time where he became distracted and allowed the kitchen sink to overflow. (JE 19:357.2).

Mr. Baker reported hospitalization in 2010 due to depression and anxiety. During that time, he complained of nightly headaches, memory loss, dropping things, a history of stuttering and blurred vision; however, he denied memory of that during his deposition. Mr. Baker plead guilty in 2015 to fifth degree theft. (Def. Ex. J:45). He scanned items into the cash register, but then pocketing them and/or not depositing the proper amount of payment in the cash register. During his interviews with the Grundy Center Police, Mr. Baker's story shifted and changed over time. (Def. Ex. J:47).

Mr. Baker was engaged to Kristin Hestness at the time of the incident. (Def. Ex. T:131). Ms. Hestness quit her job at Record Automation in order to be a 24-hour caregiver for Mr. Baker. (Def. Ex. T; Testimony). Ms. Hestness has one daughter, who is approximately 21-years old, and an infant born three weeks after the work incident. (Def. Ex. T). While Ms. Hestness was caring for a newborn infant through toddler-aged child, she was also caring for Mr. Baker on a full-time basis. She claimed that this was easy thanks to her motherly instincts. (Def. Ex. T). Mr. Baker helped care for his youngest son by changing his diaper, getting him dressed, playing with him, and taking him for walks in his wagon. (Def. Ex. T, V). Ms. Hestness did not always accompany Mr. Baker and their young son on these walks. (Def. Ex. T). She also noted that when she needed help, Mr. Baker would help care for their young son. (Def. Ex. T:138). However, Mr. Baker noted in his deposition that he could not be left alone with his young son. (Def. Ex. V).

Ms. Hestness describes the kind of help that Mr. Baker needs around the house in her deposition as follows,

> …it's mainly to watch him to make sure that he does not, kind of overstimulate himself or try to do too much. And to watch his signals and keep tabs on him – you know, when he gets a bad headache. It's – I just pretty much – just kind of – I mean, doing all the physical – the physical, like, kind of labor work – you know, keep him in line.

(Def. Ex. T:132). Interestingly, despite Ms. Hestness supervising Mr. Baker, she does not have a background in nursing or healthcare. (Def. Ex. T:132). Ms. Hestness testified at her deposition that she would mow the yard and shovel snow while leaving Mr. Baker inside, unattended, with a baby monitor that connects to her phone. (Def. Ex. T). In her subsequent deposition, Ms. Hestness notes that she ceased utilizing the monitor, but that he continues to take walks around the block, sometimes alone. (Def. Ex. V). Ms. Hestness also reported going to the store when both Mr. Baker and her son are asleep. (Def. Ex. T). She reported that the store is four to five blocks from their home. (Def. Ex. T). Ms. Hestness reported an incident where Mr. Baker cut his hair in

the middle of the night. (Testimony). Mr. Baker reported no memory of this the next day. (Testimony).

Mr. Baker testified that Ms. Hestness does "[a]ll of the driving," takes care of his medications, takes him to his appointments, schedules his appointments, helps redirect his depression and anxiety, and keeps him grounded within his family. (Testimony). He described her as his "rock." (Testimony). During at least one appointment, one of Mr. Baker's sons transported him to a medical appointment rather than Ms. Hestness. (Testimony). Mr. Baker noted burning a fish while being unsupervised. (Testimony). He also noted caring for a dog, but testified that it was with the help of Ms. Hestness. (Testimony). Mr. Baker fell in the shower while under the care of Ms. Hestness. (Testimony). Mr. Baker was able to clean and organize around the house. (Testimony). Mr. Baker also testified that he washed dishes, swept the floor, helped with the laundry, and cared for his and Ms. Hestness's son. (Testimony). Mr. Baker and Ms. Hestness never placed their son in daycare, and he stayed home while Ms. Hestness is supervising Mr. Baker. (Testimony). There was also a time when Ms. Hestness was not transporting Mr. Baker to appointments. (Testimony). Mr. Baker no longer carries a driver's license, but instead has a brain injury identification card that he claims was suggested by one of his doctors. (Testimony). Ms. Hestness acknowledged that Mr. Baker has twice fallen while under her care. (Testimony). One fall occurred while Mr. Baker was in the shower in their home. (Testimony). The next fall occurred while Mr. Baker had his youngest son with him in the bathroom during a doctor's appointment (as noted further below). (Testimony). Ms. Hestness could not account for why Mr. Baker was unsupervised during these times. As noted elsewhere in the opinion, Mr. Baker and Ms. Hestness moved to the Des Moines, Iowa, area. During her testimony, Ms. Hestness admitted that she did not supervise Mr. Baker while the move was occurring, rather, her 21-year old daughter did. (Testimony).

In her deposition, Ms. Hestness described the alleged seizures suffered by Mr. Baker by indicating that his eyes start to droop, his pupils dilate, and it appears as though he is looking right through her. (Def. Ex. T:133). She also noted that his hands tremble and his gait changes. (Def. Ex. T:133). She noted that to get him coherent, she will need to shake Mr. Baker, and then it takes him some time to recover. (Def. Ex. T). However, during his deposition, the claimant noted that his balance was improving, his memory was improving, and his pain was not spiking as much. (Def. Ex. V). Mr. Baker reports no longer being able to use a computer due to it being "too much" for his processing. (Def. Ex. V). He noted that he had restrictions on using a smartphone, but that they were removed. (Def. Ex. V). He continued to have issues with short term memory. (Def. Ex. V). Ms. Hestness noted that Mr. Baker discussed wanting to go back to work, especially as a public speaker or at Vision in Motion to help patients with similar conditions. (Def. Ex. V).

Ms. Hestness was terminated from her employment with United Services in 2015 due to embezzlement of funds. (Def. Ex. M:59). This lead to Ms. Hestness being charged and pleading guilty to several counts of felony second degree theft, and forgery in 2016. (Def. Ex. K:52). She was ordered to pay $6,237.00 in restitution to United Services. (Def. Ex. M:61). During her deposition and at hearing, when she was asked why she was terminated from United Services, Ms. Hestness claimed that she was fired

due to a pending lawsuit that her parents had against United Services, and then proceeded to claim that she was fired because she was not a good fit for the position. (Def. Ex. T:135; Testimony). It was not until later in the deposition and the hearing that she revealed the criminal charges stemming from her time at United Services. (Def. Ex. T:136; Testimony). Ms. Hestness was also charged with identity theft stemming from her time with a previous employer. (Testimony).

CONCLUSIONS OF LAW

Causation and Permanent Disability

The claimant has the burden of proving by a preponderance of the evidence that the injury is a proximate cause of the disability on which the claim is based. A cause is proximate if it is a substantial factor in bringing about the result; it need not be the only cause. A preponderance of the evidence exists when the causal connection is probable, rather than merely possible. George A. Hormel & Co. v. Jordan, 569 N.W.2d 148 (Iowa 1997); Frye v. Smith-Doyle Contractors, 569 N.W.2d 154 (Iowa App. 1997); Sanchez v. Blue Bird Midwest, 554 N.W.2d 283 (Iowa App. 1996).

The question of medical causation is “essentially within the domain of expert testimony.” Cedar Rapids Community School Dist. v. Pease, 807 N.W.2d 839, 844-45 (Iowa 2011). The commissioner, as the trier of fact, must “weigh the evidence and measure the credibility of witnesses.” Id. The trier of fact may accept or reject expert testimony, even if uncontroverted, in whole or in part. Frye, 569 N.W.2d at 156. When considering the weight of an expert opinion, the fact-finder may consider whether the examination occurred shortly after the claimant was injured, the compensation arrangement, the nature and extent of the examination, the expert’s education, experience, training, and practice, and “all other factors which bear upon the weight and value” of the opinion. Rockwell Graphic Systems, Inc. v. Prince, 366 N.W.2d 187, 192 (Iowa 1985). Unrebutted expert medical testimony cannot be summarily rejected. Poula v. Siouxland Wall & Ceiling, Inc., 516 N.W.2d 910 (Iowa App. 1994). Supportive lay testimony may be used to buttress expert testimony, and therefore is also relevant and material to the causation question.

Mr. Baker alleges he is permanently and totally disabled under the statute and common law odd-lot doctrine. Defendants reject this assertion, and assert that the claimant has suffered no permanent disability.

In Iowa, a claimant may establish permanent total disability under the statute, or through the common law odd-lot doctrine. Michael Eberhart Constr. v. Curtin, 674 N.W.2d 123, 126 (Iowa 2004)(discussing both theories of permanent total disability under Idaho law and concluding the deputy’s ruling was not based on both theories rather, it was only based on the odd-lot doctrine). Under the statute, the claimant may establish that they are totally and permanently disabled if the claimant’s medical impairment, taken together with nonmedical factors totals 100-percent. Id. The odd-lot doctrine applies when the claimant has established the claimant has sustained something less than 100-percent disability, but is so injured that the claimant is “unable to perform services other than ‘those which are so limited in quality, dependability or

quantity that a reasonably stable market for them does not exist.'" Id. (quoting Boley v. Indus. Special Indem. Fund, 130 Idaho 278, 281, 939 P.2d 854, 857 (1997)).

"Total disability does not mean a state of absolute helplessness." Walmart Stores, Inc. v. Caselman, 657 N.W.2d 493, 501 (Iowa 2003)(quoting IBP, Inc. v. Al-Gharib, 604 N.W.2d 621, 633 (Iowa 2000)). Total disability occurs when the injury wholly disables the employee from performing work that the employee's experience, training, intelligence, and physical capacities would otherwise permit the employee to perform." IBP, Inc., 604 N.W.2d at 633. However, finding that the claimant could perform some work despite claimant's physical and educational limitations does not foreclose a finding of permanent total disability. See Chamberlin v. Ralston Purina, File No. 661698 (App. October 1987); Eastman v. Westway Trading Corp., II Iowa Industrial Commissioner Report 134 (App. May 1982).

In Guyton v. Irving Jensen, Co., the Iowa Supreme Court formally adopted the "odd-lot doctrine." 373 N.W.2d 101 (Iowa 1985). Under that doctrine, a worker becomes an odd-lot employee when an injury makes the worker incapable of obtaining employment in any well-known branch of the labor market. An odd-lot worker is thus totally disabled if the only services the worker can perform are "so limited in quality, dependability, or quantity that a reasonably stable market for them does not exist." Id., at 105.

Under the odd-lot doctrine, the burden of persuasion on the issue of industrial disability always remains with the worker. Nevertheless, when a worker makes a prima facie case of total disability by producing substantial evidence that the worker is not employable in the competitive labor market, the burden to provide evidence showing availability of suitable employment shifts to the employer. If the employer fails to produce such evidence and the trier of fact finds the worker does fall in the odd-lot category, then the worker is entitled to a finding of total disability. Guyton, 373 N.W.2d at 106. Factors to be considered in determining whether a worker is an odd-lot employee include: the worker's reasonable but unsuccessful effort to find steady employment, vocational or other expert evidence demonstrating suitable work is not available for the worker, the extent of the worker's physical impairment, intelligence, education, age, training, and potential for retraining. No factor is necessarily dispositive on the issue. Second Injury Fund of Iowa v. Nelson, 544 N.W.2d 258 (Iowa 1995). Even under the odd-lot doctrine, the trier of fact is free to determine the weight and credibility of evidence in determining whether the worker's burden of persuasion has been carried, and only in an exceptional case would evidence be sufficiently strong as to compel a finding of total disability as a matter of law. Guyton, 373 N.W.2d at 106.

In this case, there is a conflict between the opinions of the various medical providers and examiners. On one side, there are the opinions of Drs. Manshadi, Fitzgerald, and Gallagher. These treating medical providers opine that Mr. Baker is: 1. incapable of returning to employment; 2. unable to drive; and, 3. requires around the clock supervision and care.

On the other side are the opinions from Drs. Kitchell, Kardon, Cullen, Jones, and Chen. Dr. Kitchell, Dr. Kardon, and Dr. Cullen all performed record reviews of the extensive medical records of Mr. Baker. Dr. Kitchell opines that his review of the

records showed that Mr. Baker's symptoms were consistent with a psychogenic cause. Additionally, Mr. Baker's left-sided sensory and motor deficits were never correlated with any objective findings. Dr. Kardon, a tenured professor at the University of Iowa Carver College of Medicine also performed a records review. Dr. Kardon also opines that Mr. Baker lacked objective signs of neurologic dysfunction. Dr. Kardon reviewed the records of Dr. Fitzgerald and found no evidence of any visual dysfunction or abnormality. Dr. Kardon's opinion is clear that the methodologies and tests utilized by Dr. Fitzgerald are not those commonly accepted or proven in the medical community. Dr. Kardon states that the claimant's visual symptoms were the result of a non-organic, psychogenic problem. Finally, Dr. Cullen, a board-certified neurologist, performed a record review. Dr. Cullen agreed that objective evidence and certain subjective symptoms do not show an organic basis for Mr. Baker's symptomatology.

Dr. Jones, who performed a neuropsychological evaluation on the claimant, indicated that Mr. Baker had severe psychological distress unrelated to the work incident. The salient medical records did not convince Dr. Jones of any impairment on the part of Mr. Baker. Mr. Baker claims that Dr. Jones only examined him for a short period of time; however, Dr. Jones' report is voluminous and contains a number of opinions. Dr. Chen also examined Mr. Baker. Dr. Chen is board certified in physical medicine and rehabilitation. Dr. Chen notes the lack of objective findings and that the gradual increase in symptoms complained of by Mr. Baker may reflect an idiopathic or unknown etiology. Dr. Chen also noted inconsistent symptomatology to correlate a traumatic brain injury.

Beyond the doctor's findings noted above, diagnostic testing has shown no objective findings. Mr. Baker had a CT and an MRI which were normal. He also had two EEG studies, one of which was a 69-hour EEG. These both were normal with no signs of true seizures.

While Mr. Baker's treating physicians believe that he is permanently and totally disabled, I find the reasoning presented by Drs. Kardon, Jones, Chen, Kitchell, and Cullen to be more persuasive. Therefore, I find that, while Mr. Baker sustained an injury in the April 14, 2017, incident, it did not result in a permanent disability. I also find that the evidence presented by the claimant failed to meet the burden to prove that Mr. Baker is permanently and totally disabled, or that he meets the burden of proof for an odd-lot disability.

85.27 Alternate Care

Iowa Code 85.27(4) provides, in relevant part:

> For purposes of this section, the employer is obliged to furnish reasonable services and supplies to treat an injured employee, and has the right to choose the care…. The treatment must be offered promptly and be reasonably suited to treat the injury without undue inconvenience to the employee. If the employee has reason to be dissatisfied with the care offered, the employee should communicate the basis of such dissatisfaction to the employer, in writing if requested, following which the employer and the employee may agree to alternate care reasonably suited to treat the

> injury. If the employer and employee cannot agree on such alternate care, the commissioner may, upon application and reasonable proofs of the necessity therefor, allow and order other care.

Iowa Code 85.27(4).

An employer's right to select the provider of medical treatment to an injured worker does not include the right to determine how an injured worker should be diagnosed, evaluated, treated, or other matters of professional medical judgment. Assmann v. Blue Star Foods, File No. 866389 (Declaratory Ruling, May 19, 1988). Reasonable care includes care necessary to diagnose the condition and defendants are not entitled to interfere with the medical judgment of its own treating physician. Pote v. Mickow Corp., File No. 694639 (Review-Reopening, June 17, 1986).

By challenging the employer's choice of treatment - and seeking alternate care – claimant assumes the burden of proving the authorized care is unreasonable. See e.g. Iowa R. App. P. 14(f)(5); Bell Bros. Heating and Air Conditioning v. Gwinn, 779 N.W.2d 193, 209 (Iowa 2010); Long v. Roberts Dairy Co., 528 N.W.2d 122 (Iowa 1995). Determining what care is reasonable under the statute is a question of fact. Long v. Roberts Dairy Co., 528 N.W.2d 122 (Iowa 1995).

An application for alternate medical care is not automatically sustained because claimant is dissatisfied with the care he has been receiving. Mere dissatisfaction with the medical care is not ample grounds for granting an application for alternate medical care. Rather, the claimant must show that the care was not offered promptly, was not reasonably suited to treat the injury, or that care was unduly inconvenient for the claimant. Id. Because "the employer's obligation under the statute turns on the question of reasonable necessity, not desirability," and injured employee's dissatisfaction with employer-provided care, standing alone, is not enough to find such care unreasonable. Id. Reasonable care includes care necessary to diagnose the condition, and defendants are not entitled to interfere with the medical judgement of its own treating physician. Pote v. Mickow Corp., File No. 694639 (Review-Reopening, June 17, 1986).

The claimant is requesting 24/7 care or services pursuant to the recommendations of Dr. Manshadi, and his other treating physicians. Mr. Baker is also requesting payment for 24/7 care provided by Ms. Hestness since the time of the work incident and ongoing to the present. Finally, the claimant is requesting continued medical care with his treating physicians.

Dr. Manshadi opines that Mr. Baker needs 24/7 supervision, and that it has been needed since the April 14, 2017, work injury. Dr. Fitzgerald, in a "check box" type of letter concurs with Dr. Manshadi's opinion and in a handwritten note indicates that Mr. Baker should not be left alone, nor be allowed to care for others. Dr. Gallagher agrees with Drs. Manshadi and Fitzgerald that Mr. Baker requires 24/7 supervision. Dr. Gallagher noted that Mr. Baker was simply comfortable with Ms. Hestness being his 24-hour caretaker, and that another person relieving her could produce a regression.

Mr. Baker and Ms. Hestness describe incidents wherein Mr. Baker has forgotten to remove a burnt fish, forgotten about a piece of fruit that rotted, and forgotten to provide a meal for their young son. They also describe incidences where Mr. Baker “zones out” and has a seizure-like occurrence. This has not been corroborated by objective evidence.

While several of Mr. Baker’s medical providers have either indicated in their records, or provided “check box” responses with the opinion that Mr. Baker needs 24/7 supervision, and further that the supervision should be done by Ms. Hestness, the conduct and supervision provided by Ms. Hestness has left much to be desired. Ms. Hestness has no medical or nursing background, outside of Dr. Manshadi training her to kick or hit Mr. Baker in order to attempt to wake him up from his seizure-like episodes. Ms. Hestness also did not attend or transport Mr. Baker to all of his medical appointments. There also were times where Ms. Hestness was not supervising Mr. Baker, including two specific incidences in which Mr. Baker fell. Ms. Hestness also admitted to leaving Mr. Baker and their young son alone while she went to the store or gas station. I found Mr. Baker to be a mostly credible witness, but was concerned by some of the inconsistencies in his testimony. I also found inconsistencies in Ms. Hestness’s testimony, which were concerning.

Mr. Baker indicates that he is able to care for his own personal hygiene. He can perform tasks around the house like cleaning, and doing laundry. He also spends time providing care for his and Ms. Hestness’ young son.

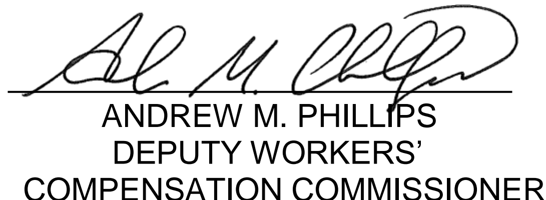
Since I found that Mr. Baker has suffered no permanent impairment based on the opinions of medical expert evidence, and I have adopted the opinions of Drs. Kitchell, Kardon, Cullen, Jones, and Chen as most persuasive, I find that Mr. Baker is not entitled to 24/7 care and supervision. I also find that this care would not be reasonable based on the foregoing evidence. Finally, I find that the defendants do not owe for past 24/7 nursing care services, or ongoing medical care.

ORDER

IT IS THEREFORE ORDERED:

The claimant is shall take nothing further from these proceedings.

Signed and filed this __31st_____ day of July, 2020.



ANDREW M. PHILLIPS
DEPUTY WORKERS’
COMPENSATION COMMISSIONER

The parties have been served, as follows:

Randall Schueller (via WCES)

Jean Dickson (via WCES)

Right to Appeal: This decision shall become final unless you or another interested party appeals within 20 days from the date above, pursuant to rule 876-4.27 (17A, 86) of the Iowa Administrative Code. The notice of appeal must be filed via Workers' Compensation Electronic System (WCES) unless the filing party has been granted permission by the Division of Workers' Compensation to file documents in paper form. If such permission has been granted, the notice of appeal must be filed at the following address: Workers' Compensation Commissioner, Iowa Division of Workers' Compensation, 150 Des Moines Street, Des Moines, Iowa 50309-1836. The notice of appeal must be received by the Division of Workers' Compensation within 20 days from the date of the decision. The appeal period will be extended to the next business day if the last day to appeal falls on a weekend or legal holiday.