BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

BAJRO RIZVIC, Claimant, vs. TITAN TIRE CORPORATION, Employer, ZURICH AMERICAN INS. CO., Insurance Carrier, Defendants.	File No. 5058293 APPEAL DECISION Head Notes: 1108.50; 1402.40; 1804; 2501; 2701; 2907;

Defendants Titan Tire Corporation, employer, and its insurer, Zurich American Insurance Company, appeal from an arbitration decision filed on May 31, 2019. Claimant Bajro Rizvic responds to the appeal. The case was heard on April 12, 2018, and it was considered fully submitted in front of the deputy workers' compensation commissioner on June 4, 2018.

In the arbitration decision, the deputy commissioner found claimant developed a permanent pain syndrome as a result of his stipulated work-related electrocution which occurred on August 24, 2016. The deputy commissioner found claimant is permanently and totally disabled as a result of the work injury. The deputy commissioner awarded alternate medical care in the form of treatment with Majed Baranzanji, M.D., along with claimant's requested past medical expenses itemized in Claimant's Exhibit 7. In making these findings, the deputy commissioner found claimant's testimony was "generally credible." The deputy commissioner also ordered defendants to pay claimant's costs of the arbitration proceeding.

On appeal, defendants assert the deputy commissioner erred in finding claimant developed a permanent pain syndrome as a result of the work injury. Defendants specifically assert the deputy commissioner erred by finding claimant to be credible. Defendants alternatively argue the deputy commissioner erred in finding claimant is permanently and totally disabled or entitled to alternate medical care or past medical expenses.

Those portions of the proposed agency decision pertaining to issues not raised on appeal are adopted as a part of this appeal decision.

I performed a de novo review of the evidentiary record and the detailed arguments of the parties. Pursuant to Iowa Code sections 86.24 and 17A.15, the arbitration decision filed on May 31, 2019, is respectfully reversed. I provide the following findings, conclusions, and analysis for my decision:

The deputy commissioner found claimant "most likely developed a pain syndrome as a result of the electrocution," and in doing so the deputy commissioner relied upon the medical opinion of Irving Wolfe, D.O., the testimony of claimant and his wife, and claimant's functional capacity evaluation (FCE). (Arbitration Decision, pp. 8-9)

I turn first to Dr. Wolfe's opinion. Dr. Wolfe assigned claimant's permanent impairment based on Chapter 18 of the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, which considers pain. Dr. Wolfe explained his rationale for his reliance on this chapter as follows:

> It is my opinion that upon a review of medical literature that chronic persistent symptoms occurred in individuals who has [sic] suffered a low-voltage (less than 1,000-volt current) injury are credible and as such, Chapter 18 can be utilized to rate persistent symptoms as a result of low-voltage electrical injury.

(Claimant's Exhibit 6, p. 21)

Dr. Wolfe, however, never addressed the credibility of claimant's complaints specifically. This is problematic given the numerous notations in the record of symptom magnification or embellishment by claimant. As noted in section 18.3b of the Guides, "Since the assessment of pain-related impairment depends heavily on the verbal reports of individuals, examiners must be careful to provide ratings only for those who provide information that appears to be reasonable and accurate." Guides, p. 571.

Claimant's electrocution occurred on August 24, 2016. By January 11, 2017, the authorized treating physician, Kurt Smith, D.O., indicated claimant was showing "signs consistent with symptom magnification." (Joint Ex. 5, p. 68) As of that appointment, claimant had been evaluated in occupational health and wellness with "[n]o serious abnormalities noted on physical exam," and several months of conservative treatment, including an epidural steroid injection, had failed to improve his symptoms. (See JE 3, p. 21) By February, Dr. Smith became aware that claimant's physical therapist was also "noting inconsistencies with full participation; self-limits." (JE 5, p. 72)

Claimant then underwent an EMG/NCV at Dr. Smith's direction, but this EMG did "not correlate with MRI of the cervical spine, carpal tunnel syndrome on the left." (JE 5, p. 78) As a result, Dr. Smith again indicated "[t]here continues to be inconsistences in examination." (JE 5, p. 78)

These inconsistencies were also noted by Trevor Schmitz, M.D., a spine surgeon, who evaluated claimant at the request of Dr. Smith. Dr. Schmitz explained:

> I certainly do not see anything on his EMG or magnetic resonance imaging that could explain diffuse LEFT arm numbness and tingling. He has several findings on examination consistent with a nonanatomic source for his pain. He also has some evidence of symptom magnification. I discussed with him that I certainly have nothing to offer him from a surgical standpoint. I do think Dr. Smith's nonoperative treatment up to this point has been more than appropriate. From my perspective he can follow back up with Dr. Smith, as once again, there is nothing surgically I see that could reliably improve his symptoms.

(JE 5, p. 82)

Dr. Schmitz then confirmed, in a letter drafted by defendants' counsel, that during his examination of claimant "there was a 'significant amount of give way' pain," which occurs when a patient is attempting to "demonstrate pain or weakness that is not present." (JE 5, p. 84) Dr. Schmitz also noted claimant's "positive axial compression test was indicative of pain magnification" and that claimant's EMG testing did not fit claimant's symptoms. (JE 5, p. 84) Thus, based on these objective tests, it was Dr. Schmitz's opinion that claimant's "pain complaints were not credible." (JE 5, p. 84)

When claimant returned to Dr. Smith, Dr. Smith noted claimant continued to complain of "nonspecific pain and weakness" with "inconsistencies in examination where subjective symptoms are not supported by objective findings." (JE 5, p. 86) Because claimant's treatment elicited no improvement, Dr. Smith placed claimant at maximum medical improvement and referred him for an FCE. (JE 5, p. 87) Though that FCE was deemed valid, Dr. Smith opined claimant could do more from a physical standpoint given the "numerous inconsistencies in examination and symptom magnification." (JE 5, p. 91)

The opinions of Dr. Schmitz and Dr. Smith were also consistent with Amber Buyck, PA-C, who evaluated claimant at DMOS at the request of claimant's primary care provider, Dr. Barazanji. Ms. Buyck noted claimant's symptoms did not match his radiographic findings and Ms. Buyck noted she could not attribute all of claimant's findings to the cervical spine. (JE 11, p. 130) Steven Adelman, D.O., a neurologist, likewise did "not have a good explanation" for claimant's sensory loss, which he described as "nonanatomic," or claimant's description of weakness. (JE 13, p. 139)

In sum, Dr. Wolfe's report fails to adequately address these numerous reports of inconsistences and symptom magnification. Dr. Wolfe instead simply lumped claimant in with individuals contained in his review of the medical literature and he assumed claimant's symptoms were credible. This is especially troublesome given the warning in the Guides regarding credibility when assigning ratings for pain under Chapter 18. For these reason, I am not persuaded by Dr. Wolfe's opinions.

In addition to Dr. Wolfe's opinions, the deputy commissioner also relied heavily on claimant's valid FCE. While I acknowledge the FCE was deemed valid, it - much like

Dr. Wolfe's report - is the outlier when compared against the bulk of the evidence in the record. As noted above, claimant's symptoms were unexplained by several objective tests, including an MRI and an EMG, and other objective testing performed by Dr. Schmitz actually revealed pain magnification and claimant's efforts to demonstrate pain and weakness that were not present. For these reasons, I adopt the opinion of Dr. Smith that despite the valid FCE, claimant "is able to do more from a physical standpoint than is documented." (JE 5, p. 91)

With respect to claimant's credibility, I generally give considerable deference to the findings, expressly or impliedly made, by the deputy commissioner who presided at the arbitration hearing. In this case, the deputy commissioner found claimant to be "generally credible." However, the deputy commissioner also noted claimant's mannerisms at hearing were "fairly dramatic," and he acknowledged there were a "multitude of medical reports from various providers asserting that claimant's complaints were inconsistent, magnified or otherwise not credible." It is precisely this multitude of reports that causes me to reverse the deputy commissioner's credibility findings. Because I am not persuaded by Dr. Wolfe's opinion or claimant's FCE, I simply cannot ignore the numerous assertions of symptom magnification in the record.

For these reasons, I reverse the deputy commissioner's finding that claimant developed a serious pain syndrome from his work-related electrocution. I find there is insufficient evidence to support claimant's allegation that he suffers from a pain disorder related to his electrocution at work.

Instead, I adopt the opinion of Dr. Smith that the objective findings do not support claimant's subjective symptoms and, as a result, I find claimant sustained no permanent impairment as a result of his work-related electrocution. (JE 5, p. 94)

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 causal connection is essentially within the domain of expert testimony. The expert medical evidence must be considered with all other evidence introduced bearing on the causal connection between the injury and the disability. Supportive lay testimony may be used to buttress the expert testimony and, therefore, is also relevant and material to the causation question. The weight to be given to an expert opinion is determined by the finder of fact and may be affected by the accuracy of the facts the expert relied upon as well as other surrounding circumstances. The expert opinion may be accepted or rejected, in whole or in part. St. Luke's Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); IBP, Inc. v. Harpole, 621 N.W.2d 410 (Iowa 2001); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995). Miller v.

Lauridsen Foods, Inc., 525 N.W.2d 417 (Iowa 1994). Unrebutted expert medical testimony cannot be summarily rejected. Poula v. Siouxland Wall & Ceiling, Inc., 516 N.W.2d 910 (Iowa App. 1994).

I reject the opinions of claimant's expert, Dr. Wolfe, I am not persuaded by claimant's FCE, and I reverse the deputy commissioner's finding that claimant was "generally credible." Instead, I adopt the expert opinion of Dr. Smith, who opined that claimant did not sustain any permanent impairment as a result of his work-related electrocution. For these reasons, I find claimant failed to carry his burden of proof to establish he sustained any permanent disability as a result of the work injury. The deputy commissioner's finding that claimant is permanently and totally disabled as a result of the work injury is therefore respectfully reversed.

Having determined claimant failed to satisfy his burden of proof to establish he sustained any permanent disability, the issue of alternate medical care for claimant's alleged ongoing complaints is moot.

The final issue to be addressed is claimant's medical expenses as set forth in Claimant's Exhibit 7. As noted by defendants, the charges at issue occurred on February 3, 2017, February 9, 2017, and September 21, 2017, and there are no medical records in evidence relating to these dates of service. While claimant testified these bills were related to his work-related condition, he did not specify what treatment he received on those dates. Therefore, I find insufficient evidence to causally relate those charges to claimant's work injury. As such, I conclude claimant failed to carry his burden of proof to establish entitlement to reimbursement for those charges. The deputy commissioner's finding regarding claimant's medical expenses is therefore respectfully reversed.

Pursuant to rule 876 IAC 4.33, because claimant has not prevailed on appeal, I respectfully reverse the deputy commissioner's order that defendants pay claimant's costs of the arbitration proceeding.

ORDER

IT IS THEREFORE ORDERED that the arbitration decision, filed on May 31, 2019, is reversed.

Claimant shall take nothing from these proceedings.

Pursuant to rule 876 IAC 4.33, the parties shall pay their own costs of the arbitration proceeding, and claimant shall pay the costs of the appeal, including the cost of the hearing transcript.

Pursuant to rule 876 IAC 3.1(2), defendants shall file subsequent reports of injury as required by this agency.

Signed and filed on this 14th day of April, 2020.

Joseph S. Cortese II

JOSEPH S. CORTESE II
WORKERS' COMPENSATION
COMMISSIONER

The parties have been served as follows:

Nicholas L. Shaull	Via WCES
Gene R. La Suer	Via WCES
Luke Draisey	Via WCES
Joni L. Ploeger	Via WCES