BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

CALVIN HARLAND, Claimant, vs. N.J. MILLER, INC., Employer, and UNITED FIRE GROUP, Insurance Carrier, Defendants.	File No. 5052736 ARBITRATION DECISION Head Note Nos.: 1100; 1803

STATEMENT OF THE CASE

Calvin Harland, claimant, filed a petition in arbitration seeking workers' compensation benefits against N.J. Miller, Inc., employer, and United Fire Group, insurer, for an alleged work injury date of April 21, 2015.

This case was heard on July 13, 2016, in Davenport, Iowa. The case was considered fully submitted on August 15, 2016, upon the simultaneous filing of briefs.

The record consists of claimant's exhibits 1-19, defendants' exhibits A, B, D, E, G, I, K-P, R-W, Y-DD, claimant's testimony and Serle Brackey.

ISSUES

1. Whether the alleged injury is a cause of permanent disability and, if so;
2. The extent of claimant's industrial disability;
3. The appropriate assessment of costs.

STIPULATIONS

The parties agree that the claimant sustained a work injury on April 21, 2015. They further agree that the claimant is entitled to temporary benefits but disagree as to the period of entitlement.

If there is a permanent disability found, it is industrial in nature.

At the time of the injury, claimant's gross earnings were $569.33. He was single and entitled to one exemption. Based on those foregoing numbers, claimant's benefit rate is $355.59.

FINDINGS OF FACT

Claimant was a 35 year old person at the time. At all material times, he was single with a minor child. He has an associate's degree in criminal justice from Kaplan University.

His past work experience includes food service industry, sales, construction, security, and industrial warehousing. Most of his work has been primarily low skilled manual labor. Claimant has had personality conflicts with employers and co-workers and has been let go from more than one position.

On or about April 21, 2015, claimant was assisting with the laying of a storm drain. He was cutting a concrete pipe with a saw when the pipe bound and pinched the blade. The blade rebounded and struck claimant's face. 9-1-1 was called. Paramedics arrived at the scene, and claimant was transported to Genesis East Hospital and then transferred to University of Iowa Hospitals and Clinics (UIHC) where he was seen by David Runde, M.D. (Exhibit 8, page 1, Ex. K, p. 1) Dr. Runde confirmed the diagnosis of facial laceration. Claimant denied any loss of consciousness. (Ex. L, p. 1) His immediate complaints included pain, bleeding, difficulty swallowing and difficulty breathing. (Ex. 8, p. 1)

His face was cut open. He had two to three broken teeth and the tip of his tongue had been cut off. (Ex. 8, p. 3)

On April 21, 2015, Jerrod Keith, M.D., performed surgery of a fairly extensive nature to repair the claimant's complex lacerations in the chin and lower lip. (Ex. L, p. 10)

The operative report stated the following:

1. Complex laceration repair of the chin and lower lip involving through and through defect, muscle and subcutaneous tissue and skin 11 cm.

2. Complex laceration repair of the upper lip near the right philtral column involving the external tissue of skin, subcutaneous tissue, muscle, 3 cm in length.

3. Repair of intraoral gingiva and mucosa of the upper lip, 5 cm in length.

4. Repair of the lower lip oral mucosa and gingiva, 5 cm in length.

5. Repair of complex nasal laceration 3 cm in length, involving the nasal tip, columella, right ala and nasal floor.

(Ex. L, p. 10) Claimant was discharged from the hospital on April 23, 2015. On April 28, 2015, claimant was seen for a wound infection due to swelling, redness, and post procedure pain. (Ex. 8, p. 18) He was prescribed medication and discharged home. On May 5, 2015, he was seen by Jordan Tortorich, DDS, who recommended that the number 5 tooth be extracted after the facial lacerations that heal. (Ex. 8, p. 25) Dr. Tortorich also recommended that he follow up with general dentistry for a replacement for teeth number 7 and number 18. (Ex. 8, p. 25)

On May 14, 2015, Ryan Hill, DDS, filled three cavities and removed claimant's number 6 tooth. (Ex. 8, p. 26) He also recommended that teeth 5 and 7 should be removed. (Ex. 8, p 27) Tooth number 6 had been removed by Dr. Tortorich during the original surgery on April 21, 2015. (Ex. 8, p. 9-15)

On June 2, 2015, claimant returned to Dr. Tortorich with complaints of pain as well as pain in the upper left and lower right jaw region.

On June 3, 2015, claimant saw Eric Aschenbrenner, M.D., with complaints of TMJ, soreness in head and neck, pain in the face and jaw, difficulty sleeping, headaches, and impaired memory. (Ex. L, p. 10-15)

> Current symptoms: Mr. Harland brings a list with him today regarding symptoms and we additionally discuss symptoms. The list is scanned in (as was shared with Plastic surgery and dentistry yesterday). To summarize, it talks about stitches and concern of some drainage, ndicates [sic] that his jaw pops all the time, very sore in upper chest and neck region (not as sore now but still have pain), still have 'shooting pain' in face and jaw 'pain meds don't contain it half the time.' He also mentions a hard time with sleep, having headaches/migraines, have thoughts 'that scare me' and that he 'can be having a conversation, and be right in the middle of saying something and go blank, and can't remember what I was saying or what I was talking about.' His facial pain gets up to a '7' out of 10. He takes Percocet for the pain every four hours and indicates that does not take care of all the symptoms and refers to the patient controlled analgesia in the hospital that apparently did not even work. He indicates he remembers very little from the time of the incident until getting to UIHC other than holding his face. Reports his lips are numb on the right side and some decreased sensation by the areas of facial trauma.

(Ex. L, p. 11) Claimant reported pain and memory loss which Dr. Aschenbrenner attributed to opiate use and recommended a neurocognitive evaluation for the pain. (Ex. L, p. 14)

Claimant had another consultation with Dr. Aschenbrenner on June 17, 2015 and then again on July 10, 2015. (Ex. 10, p. 1; Ex. L, p. 17) Claimant had once referred to Dr. Aschenbrenner as the quarterback of his medical care. Claimant reported constant headaches, difficulty with work, pain in the neck, jaw popping problems, and ability to eat due to pain, mental anguish including a lot of patients, short temper, and memory issues. (Ex. 10, p. 1, L. P. 18) Dr. Aschenbrenner recommended a number of treatment modalities including referrals to specialists. Claimant called in to the office on June 22, 2015, concerned about being back at work. (Ex. L, p. 21) He also was frustrated with the TMJ injury and worried that he had a bad disc that was causing pain and headaches. (Ex. L, p. 21) Dr. Aschenbrenner did not take claimant off work but recommended claimant seek local counseling for his nerves. (Ex. L, p. 21)

On July 10, 2015, claimant saw Dr. Aschenbrenner again and brought with him a list of complaints.

1) Constant headaches that never seem to go away. They are accompanied with neck pain and ringing in my ears. He expresses a difficult time at work due to these headaches. He indicates that tasks at work like shoveling dirt off the cement irritate his headaches and make them worse. He indicates that after work he has to sit in his car for a while before he feels comfortable enough to drive home. His headaches cause some nausea, dizziness, and vomiting. He expresses concern that perhaps something is going on with his neck.

2) Jaw still has 'problems.' He indicates that it "pops on both sides." He indicates that he 'barely' eats due to the pain. He indicates that he has upcoming appointments with the dentist to discuss future treatments.

3) Mr. Harland indicates that he has had appointments with Dr. Keith to inspect the incision. The incision still 'has to stay covered' and it 'still has had blood and pus come out of it.'

4) Regarding mental status, he feels 'this has not improved.' He feels his mental state has become worse and he still has 'thoughts that scare' and cause him to be 'more anxious and skittish' with 'nightmares of dying.' He is concerned with being 'not ready to return to full duty at work.' Further he feels he has 'less patience, a shorter temper, and my memory is not as well as it was.' He feels he should be seen sooner, if at all possible, by the neuropsychologist.

5) He discusses the medication regiment, what others have suggested, as he has ongoing pain.

6) Finally, also mentioned is that while at work he feels like he gets overheated.

(Ex. L, p. 22-23) To address the complaints, Dr. Aschenbrenner increased claimant's Lyrica prescription, recommended claimant keep the wound covered, but noted that the irritation was "superficial." Physical therapy was ordered for the facial and neck pain. Dr. Aschenbrenner noted that physical therapy recommended restrictions of no lifting more than 30 pounds and avoiding jobs that required being in the presence of excessive vibration. (Ex. L, p. 24) Claimant did not want Dr. Aschenbrenner to increase his work hours, but Dr. Aschenbrenner stated:

> He indicated he did not feel that was a good idea. As there is no medical contraindication and no specific hour limit listed by plastic surgery or dentistry for any reason. I discussed the need to move forward with increasing duration. I will also check back with him in about 2 weeks to see how things are going.

(Ex. L, p. 24-25)

Claimant returned to Dr. Aschenbrenner on August 25, 2015, with ongoing complaints of "facial pain with numbness/pin and needles sensation in face as well as aching in the head which gets up to 8-9 out of 10 intensity." (Ex. L, p. 26) Claimant did feel that physical therapy had helped with the neck pain. At this time, Dr. Aschenbrenner referred claimant to Valerie Keffala, Ph.D., for pain psychology evaluation. (Ex. L, p. 28) Again, claimant appeared somewhat resistant to any increased work hours.

> 7. Regarding work, I discussed with the patient increasing his work and potentially being able to do some therapy during work. However, as there is no contra-indication for therapy after work and that I cannot include child care coverage as a reason for getting him home sooner (apparently if no accident he would work from 7 am and up to 6:30 pm anyway). We discussed just going to 8 hour days but after visiting with him I will have him increase work to 7.5 hours x 1.5 weeks and then 8 hours per week thereafter (see specific work note for details). He must be allowed to have 15 minutes morning and afternoon break in addition to his 30 minute lunch break. Other restrictions remain.

(Ex. L, p 29)

Claimant's first visit to Dr. Keffala was on August 28, 2015. (Ex. L, p. 30) He reported that his primary concern was a headache and insomnia. (Ex. 9, p. 1) Test results showed that claimant had a tendency toward catastrophizing.

> MBMD result:
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> Mr. Harland's profile on the MBMD indicated significant elevations when compared to both general medical norms and chronic pain patient norms. His percentile scores based on chronic pain patient norms

> indicate over one-third of the scales above the 95 percentile, and all but 3 scales at or above the 80th percentile, with these 3 scales at or below the 30th percentile. Prevalence scores based on general medical norms indicate significant elevations on 12 of 27 clinical scales. Seven of the clinical scales have a prevalence score at or above 85.
>
> Mr. Harland's MBMD profile indicates significantly high levels of depression and anxiety. Patients with similar profiles have marked pain sensitivity and catastrophizing, in addition to significant concerns about ability to function. The profile indicates that he may have difficulty changing his behavior and may have difficulty achieving and maintaining gains. The profile indicates that he may feel overwhelmed and may lack a sense of good self-efficacy. He may be moody, irritable, and fearful. His level of anxiety and depression may result in a more complicated recovery process. It is suggested that he may have 'an exaggerated negative reaction to stressful or invasive medical procedures' and a potentially poor response to traditional medical procedures. This profile suggests that Mr. Harland would likely have difficulty benefitting from a multidisciplinary pain program.
>
> Mr. Harland's MBMD profile indicates significantly elevated distress regarding cognitive difficulties and memory loss.
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> The interpretation of this profile suggests that he may respond well to 'firm, clear instructions that include an emphasis on the value of self-care.' Conservative pharmacological interventions and psychological interventions are suggested as a means to improve pain coping and diminish distress.

(Ex. L, p. 32) She concluded after the first session that he was experiencing significant anxiety about his ability to function and a significantly depressed mood. (Ex. 9, p. 4)

On September 1, 2015, claimant was see by Rahul Rastogi, M.D., for head and neck pain. (Ex. 13) MRI of the c-spine showed no abnormalities. (Ex. 13, p 4) On examination he showed normal range of motion in the cervical spine and upper extremities. (Ex. 13, p. 3) Dr. Rastogi recommended behavioral therapy and coping strategies. (Ex. 13, p. 4)

Claimant continued to complain of TMJ pain to his dentist Dr. Hill. (Ex. 12, p. 1)

> 34 y.o. male with previous trauma incident presents to Hospital Dentistry for NPE. Recommend that patient have all disease control completed prior to any rehabilitation phases (RPD or implant prosthesis). Recommend operative treatment, RCT on teeth #10 and 13, and prophy. Following disease control phase pt was given 2 options to replace missing teeth (RPD and implant supported FPD). It was explained to patient that

> they [sic] only dental related treatment that is related to his trauma incident would be his missing teeth in the UR quadrant and his fractured tooth #17. Other treatment for caries and periapical pathosis is due to chronic dental caries. Pt understands this.

(Ex. 12, p. 3)

On October 7, 2015, claimant underwent botox injections to alleviate the TMJ popping and pain. (Ex. 12, p. 8) These injections had little positive affect. (Ex. 12, p. 11)

On October 2, 2015, he was evaluated by Daniel T. Tranel, Ph.D. (Ex. L, p. 38) Claimant described himself as having some short term memory loss and despite several records indicating that claimant reported no loss of consciousness, to Dr. Tranel, claimant "stated that his coworkers informed him that he did not lose consciousness" and "he reported 'no memory' for events" until he woke up in the hospital. (Ex. L. p. 39) This account is different from the history told to Dr. Aschenbrenner or Dr. Keffala. To Dr. Aschenbrenner, claimant described himself as having short term memory loss post the incident, but not off the incident itself. (Ex. L, p. 11) Claimant was able to account for the injury, how it happened and that he was taken first to Genesis and then transferred to UIHC. (Ex. L, p. 10) Dr. Keffala noted that claimant had "significantly elevated distress regarding cognitive difficulties and memory loss." (Ex. L, p. 32)

Dr. Tranel observed as follows:

> Behavioral Observations
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> Speech and comprehension were normal. Thought processes were slowed and distractible. He interrupted the examiner at times. The patient was guarded on interview and he became somewhat agitated when the interviewer requested further details (e.g., the presence/period of post-traumatic amnesia, handedness). Mood was depressed and anxious with restricted affect. He often expressed frustration with his medical providers (e.g., 'my whole medical team is retarded') and this testing (e.g., 'what does this testing have to do with my brain, anxiety, and suicide thoughts?'). Effort was poor during the exam, as he required frequent prompting, completed tasks exceedingly slowly, and gave up easily (at times when he was close to completing an item correctly).

(Ex. L, p. 39) Because of poor performance, claimant's "performance validity testing was below expectations" and "speeded manual dexterity was bilaterally impaired." Memory was borderline, ranging "from severely impaired to average." (Ex. L, p. 39)

> Symptom validity testing showed an unusually high endorsement of difficulties overall, particularly for neurological impairment, affective disorders, low intelligence, and amnesia disorders. On brief self-report

> questionnaires, Mr. Harland endorsed symptoms consistent with severe depression and anxiety. On a measure of personality and emotional functioning (MMPI-2), his profile was invalid and not interpretable due to an unusually high endorsement of physical and emotional symptoms.

(Ex. L, p. 39-40)

Dr. Tranel concluded:

> Impression
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> Mr. Harland did not cooperate with our neuropsychological examination with adequate or credible effort. Additionally, he described emotional symptoms of an implausible severity on psychological assessment. Therefore, we cannot arrive at valid determinations regarding possible cognitive or psychological impairments. Given what we know about the facts of his accident, we would consider it very unlikely that he has any permanent brain damage. He could have a psychological condition caused by the accident, however.

(Ex. L, p. 40)

Meanwhile, claimant continued to treat with Dr. Keffala in September through January. (Ex. 9, p. 6) He reportedly continued headaches along with anxiety and depression. (Ex. 9, p. 7) Because of his ongoing depressive symptoms, Dr. Keffala recommended an antidepressant medication. (Ex. 9, p. 9) He did not return to see Dr. Keffala until January 2016. He expressed anxiety over the scar revision surgery and she encouraged him to exercise breathing and relaxation techniques. (Ex. 9, p. 11) Claimant was also seen by Dr. Rastogi whose conclusion regarding claimant's neck pain was unchanged. (Ex. 13, p. 21) He made no changes to claimant's work status or treatment regime. (Ex. 13, p. 24)

Dr. Aschenbrenner saw claimant on November 13, 2015, who noted that claimant had a botox treatment by Dr. Kendrick on October 7, 2015, but that it only provided minimal benefit. (Ex. L, p. 42) Dr. Aschenbrenner recommended claimant return to physical therapy and continue treatment with Dr. Keffala and Dr. Rastogi. (Ex. L, p. 44)

The work restrictions were as follows:

Calvin A. Harland may work with the following restrictions:

- He may work 7.5 hours per day from 8/19/15 through 8/30/15
- He may work 8.0 hours per day starting 8/31/15

- Must be allowed to take a 15 minute break in the morning and afternoon in addition to his regular lunch break
- No lifting over 30 pounds.
- No vibratory tools.
- Avoid jobs in the presence of excessive vibration and ear protection should be provided.

(Ex. L, p. 45)

The scar revision surgery took place on January 7, 2016, primarily due to a cystic scar around the chin that needed to be drained occasionally. (Ex. 11, p. 4)

On April 4, 2016 claimant underwent oral surgery to address the bilateral TMJ athroscentesis after the failed botox injections. (Ex. 12, p. 4, p. 16)

On April 5, 2016, claimant saw Dr. Rastogi for the unabated facial pain and headaches. (Ex. 13, p. 6) Dr. Rastogi again recommended conservative treatment and noted that claimant's acupuncture sessions had helped to alleviate headache pain. (Ex. 13, p. 6) There was also a notation that the Cymbalta appeared to be working since the claimant was not as depressed as he was prior. (Ex. 13, p. 6)

In the intervening time, claimant was seen by Dr. Aschenbrenner on April 13 2016.

> Mr. Calvin A. Harland returns regarding his head and neck region symptoms. I last saw the patient on 2/5/16 and recommended follow up with Dr. Kendrick, Pain Clinic, and Dr. Keffala. We also spoke on possible acupuncture. he [sic] did see Dr. Kendrick and opted for bilateral temporomandibular joint arthrocentesis which was done on 4/5/16. Thus far there has been no significant improvement in symptoms. Mr. Harland also followed up with Dr. Rastogi from Pain clinic who opted to increase Baclofen to 10 mg three times daily to see if it helps. As Trileptal did not appear to be providing benefit it was discontinued. Cymbalta was to continue. Dr. Rastogi did not plan additional follow up. Mr. Harland did have acupuncture, apparently six visits and it provided some temporary benefit. During his work with Dr. Keffala he indicates it was suggested that he participate in more exercise so he has been walking a couple of miles for the last few weeks. He does use his albuterol inhaler before his walks or he gets a little winded. Mr. Harland has also given up smoking. Finally, final dental work is still pending.

> Current symptoms: The patient currently has ongoing pain in the face and head, predominantly right sided. This pain currently rated 5-6/10. At night the pain can be more noticeable. He indicates he has been doing some research and questions whether Zomig and/or Indomnethacin may be effective. He notes that he was taking Ibuprofen 800 mg dosage after his intervention as well as had Hydrocodone on hand. Mr. Harland notes that the Hydrocodone helped with his pain but understands that it has been indicated that opiates would not be used for management of this chronic pain.

(Ex. 10, p. 8) Dr. Aschenbrenner recommended the following treatment plan.

> Plan:
>
> 1. Regarding medication, propranolol was a consideration for prophylaxis but given his asthma this is not indicated. I concur with not using opiates for chronic benign musculoskeletal pain. Zomig is not recommended for his headache given that his headache is daily and not necessarily migrainous. He appears to have myofascial discomfort likely contributing to his headache. Indomethacin could be tried but I indicated to use on days when the headache is particularly bothersome. Cymbalta may also be continued as well as Baclofen.
>
> 2. I suggest ongoing psychology treatment for pain. I anticipate treatmetn [sic] with Dr. Keffala would be done by mid-May 2016 but if Dr. Keffala would like me to review additional recommendations for the treatment I would be open to that.
>
> 3. Regarding acupuncture, it appears that it has provided some benefit. I'd like the patient to attend a total of 10 sessions (based on the information provided to me, four additional sessions will be prescribed).
>
> 4. Continue with exercise.
>
> 5. After aforementioned and dental work completed, the patient would tentatively be considered to be at maximum medical improvement, anticipate 1-2 months.
>
> 6. There are no work restrictions.

(Ex. 10, p. 10)

His mental state appeared to be unchanged during his subsequent visit to Dr. Keffala until the May 31, 2016, visit. (Ex. 9, p. 23) During that visit, he had noted that he had gotten a new apartment, obtained a new job, and had achieved some pain

alleviation with a headaches. (Ex. 9, p. 23) Dr. Keffala noted that, "he appears to be doing remarkably well." (Ex. L, p. 62) She further documented:

> He noted that he feels he has moved forward with his life, indicating that, 'For the most part I'm not thinking about' his pain and his injury. He stated, 'I just want to get the dental part done, and be done with it. I want the whole thing behind me.' He noted that the headache medication (indomethacin) Dr. Aschenbrenner is 'really helping with the headaches. It hasn't taken them completely away. It's annoying, but I'm not miserable.' He also noted that he believes the Cymbalta has also 'helped with my mood.' He reported the belief that, 'the job has been the primary thing' that has helped him feel better.
>
> Since he is doing so well, I determined that today would be our last session. We discussed the work we have completed together. Mr. Harland began working with me in [sic] on 8/28/2015. He initially presented as guarded and angry. Over time he became receptive and engaged in our work, completing all of the tasks outside of session that he was asked to complete. His motivation to find a job, and his eventual job offer appeared significant in this process. He noted that he feels he benefited from working with me over, and expressed feeling more aware of his responses and choices regarding his thoughts, feelings, and behaviors. He indicated feeling better able to be with what is uncomfortable, and to proactively change what he is able to change. He notes that he feels he is better at 'letting things go.'

(Ex. 9, pp. 23 – 24)

On March 1, 2016, claimant returned to UIHC to see Gillian J. Fox who was attempting to assist claimant in his return to work activities. Claimant was somewhat resistant to this. (Ex. P, p. 1) He also saw Dr. Keffala and reported increase pain and headaches. (Ex. P, p. 1) They meditated together and discussed having a more positive attitude. (Ex. P, p. 1)

On March 8, 2016, he met with Gillian Fox again for another contentious meeting regarding claimant's potential to return to work. (Ex. P., p. 2)

> Mr. Harland brought two references which we added to his resume. He did not have email addresses for them as they do not have work email. I suggested he use their personal e-mail if it was available. We completed his resume today, obtaining the employment information from Team Staffing. We updated his resume on Indeed.com. We began applying for positions and started our search in the DeWitt area. Mr. Harland demonstrated a high level of resistance to applying in the DeWitt area. He stated that he couldn't afford to move to DeWitt because he was $75,000 in debt and was waiting for his worker's compensation case settlement. I

> then confronted him and reminded him that he was the one who requested Return to Work assistance and the purpose of the resume development was to utilize it to apply for employment. After my confrontation regarding his resistance we began to look for positions in the Muscatine area. At this point, I confronted him again, suggesting that any positions I found for him to apply for he would find something wrong with. Mr. Harland then cooperatively applied for three positions with Blaine's Farm and Fleet in Muscatine.

(Ex. P, p. 2) Claimant continued to show "resistance" working with Ms. Fox. (Ex. P, p. 3)

During an April 29, 2016, visit with Dr. Keffala she documented that claimant continued "significant pain catastrophizing." (Ex. P, p. 4)

Claimant was seen on June 10, 2016, by Robin Sassman M.D., for an independent medical examination. (Ex. 3) During the examination, claimant reported constant headaches, a popping sensation from the TMJ, neck pain, anxiety, and depression. (Ex. 3, p. 10) He reported only being able to eat soft foods such as yogurt, blended food, pasta, and bread. (Ex. 3, p. 11) He also complained of inability to concentrate and bad dreams. (Ex. 3, p. 11)

Dr. Sassman diagnosed the following, all associated with the work injury:

1. Facial laceration with loss of sensation and facial disfigurement and right-sided nasal air passage defect.

2. Tooth fractures (#5, #6, #7, #18) and subsequent extraction of teeth #6, #5, #7

3. Temporomandibular joint pain from trauma.

4. Cervicalgia from whiplash relative to the injury

5. Chronic headaches.

(Ex. 3, p. 13) Dr. Sassman assessed a 26 percent impairment for the above mentioned diagnosis and recommended the following work restrictions:

> I would recommend that Mr. Harland limit lifting, pushing, pulling and carrying to 20 pounds rarely from floor to waist. He should not use vibratory or power tools. He should not work with or near a saw of any type. He should not be exposed to loud noises as these will exacerbate his headaches.

(Ex. 3, p. 15) It is presumed, although Dr. Sassman does not state this explicitly, that the exertion restrictions arise out of the purported whiplash injury to claimant's neck

despite Dr. Sassman recording normal range of motion in both the neck and shoulders and showing only tenderness to palpation over the trapezius. In the current symptom section, Dr. Sassman recorded the claimant as having "some issues with his neck in terms of pain at times." (Ex. 3, p. 13) It is challenging to see how Dr. Sassman would impose 20 pound weight restrictions for such modest pain complaints with no corresponding objective signs of injury. Dr. Sassman assigned 5 percent impairment for the neck due to guarding noted on examination although there was no guarding noted in the current symptom section or the examination portion of the report. (Ex. 3, p. 10-13)

Dr. Sassman also assigned a 5 percent impairment for facial scarring and a 10 percent impairment for the inability to chew. These do not appear to limit claimant's ability to work.

Defendants retained John Brook, Ph.D., a clinical psychologist, who was deposed on June 27, 2016. (Ex. 18) Claimant reported fears of saws and noises that reminded him of saws prevented him from pursuing employment with at least one employer. (Ex. E, p. 3) He further expressed problems with nightmares. (Ex. E, p. 3) Physically, claimant listed headaches, numbness and tingling or loss of muscle tone, TMJ pain, and pain in the neck that radiates down the sides of his neck into his upper back. (Ex. E, p. 4)

Dr. Brook diagnosed claimant as suffering mild Somatic Symptom Disorder and insomnia, but not any mental disorder from his injury such as PTSD, depression, anxiety or MBI. (Ex. E, p. 5) Dr. Brook characterized claimant as exaggerating his complaints. (Ex. E, p. 5) In his deposition, Dr. Brook explained that claimant's tendency to focus on his pain allowed the pain to become more important to him than to another person. (Ex. G, p. 39-40) Additionally, claimant scored a 50 out of 63 on the BDI test which Dr. Brook interpreted as "the person is exaggerating their situation." (Ex. E, p. 59)

Defendants also had the claimant undergo an examination with Jeffrey Westpheling, M.D. Dr. Westpheling concluded the claimant had sustained three missing teeth, a facial injury, decreased sensation over the right to area, hypersensitivity to the right of the nose, and neck tenderness. (Ex. 19, p. 6) Dr. Westpheling did not believe claimant required any work restrictions due to his injuries of April 21, 2015. (Ex. B, p. 4) Dr. Westpheling is not an expert in orthodontistry or in the treatment of TMJ. (Ex. C, p. 26-29)

Dr. Westpheling did make clear in his deposition that the complaints of the claimant regarding his neck or back were not present at the time of his initial injury.

> Q. Is that report by the claimant to Dr. Runde and then incorporated in Dr. Sassman's report, does that lead you to render any opinions as to whether claimant sustained any permanent neck injury or any permanent back injury as a result of the event of April 21st?

A. Yes, I would conclude that he did not sustained [sic] a – sustain a significant neck or back injury as a result of the April 21st, 2015, work incident.

Q. The fact that when he was immediately provided care, the claimant denied any headache, would that – and also denied any visual changes, would that lead you to opinions as to whether there currently is any work-related headache or head injury that was related to the August – or to the April 21st, 2015 episode?

A. Yes, that would similarly lead me to conclude that he did not sustain a significant head injury as a result of the original work accident

(Ex. C, p. 34-37) However, when pressed on cross examination, Dr. Westpheling acknowledged that claimant later brought up the issue of headaches with Dr. Aschenbrenner, Dr. Keffala, and Dr. Tranel.

When speaking with Dr. Westpheling, claimant did not express any challenges with his work due to his facial injuries. (Ex. C, p. 34-37)

At some point in the future, claimant may have teeth implants. There is no guarantee that the implants would improve claimant's TMJ although Dr. Westpheling felt that the restorative dental work would allow claimant to resume a normal diet. (Ex. C, p. 38-41)

Claimant was terminated by Erin Holst in August when there was no work available within claimant's restrictions. (Ex. 4, p. 4) Due to the work restrictions, claimant could only do busy work in the shop. The defendant employer is a small corporation with 17 employees and four crews.

Claimant is currently working full time at an air freshener manufacturing plant. He has no work restrictions. His work requires him to pick items and place them on a pallet and then use a forklift to the pallet into the warehouse. He is currently earning $10.50 per hour. When he was working for the defendant he earned $14 per hour. His position with the defendant employer was seasonal and subject to weather changes. He was laid off in the winter.

His current supervisor, Serle Brakey at Car Freshener, testified that the claimant's work involved moving product under 20 pounds. The work environment is more quiet than in production but the forklifts are constantly emitting an audible backup alarm. Claimant has been able to perform all the duties of his position without accommodations or specific restrictions.

CONCLUSIONS OF LAW

The party who would suffer loss if an issue were not established has the burden of proving that issue by a preponderance of the evidence. Iowa R. App. P. 6.14(6).

The claimant has the burden of proving by a preponderance of the evidence that the alleged injury actually occurred and that it both arose out of and in the course of the employment. Quaker Oats Co. v. Ciha, 552 N.W.2d 143 (Iowa 1996); Miedema v. Dial Corp., 551 N.W.2d 309 (Iowa 1996). The words "arising out of" referred to the cause or source of the injury. The words "in the course of" refer to the time, place, and circumstances of the injury. 2800 Corp. v. Fernandez, 528 N.W.2d 124 (Iowa 1995). An injury arises out of the employment when a causal relationship exists between the injury and the employment. Miedema, 551 N.W.2d 309. The injury must be a rational consequence of a hazard connected with the employment and not merely incidental to the employment. Koehler Electric v. Wills, 608 N.W.2d 1 (Iowa 2000); Miedema, 551 N.W.2d 309. An injury occurs "in the course of" employment when it happens within a period of employment at a place where the employee reasonably may be when performing employment duties and while the employee is fulfilling those duties or doing an activity incidental to them. Ciha, 552 N.W.2d 143.

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).

A personal injury contemplated by the workers' compensation law means an injury, the impairment of health or a disease resulting from an injury which comes about, not through the natural building up and tearing down of the human body, but because of trauma. The injury must be something that acts extraneously to the natural processes of nature and thereby impairs the health, interrupts or otherwise destroys or damages a part or all of the body. Although many injuries have a traumatic onset, there is no requirement for a special incident or an unusual occurrence. Injuries which result from cumulative trauma are compensable. Increased disability from a prior injury, even if brought about by further work, does not constitute a new injury, however. St. Luke's

Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); Ellingson v. Fleetguard, Inc., 599 N.W.2d 440 (Iowa 1999); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995); McKeever Custom Cabinets v. Smith, 379 N.W.2d 368 (Iowa 1985). An occupational disease covered by chapter 85A is specifically excluded from the definition of personal injury. Iowa Code section 85.61(4) (b); Iowa Code section 85A.8; Iowa Code section 85A.14.

Nontraumatically caused mental injuries are compensable under Iowa Code section 85.3(1). Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995).

Under Dunlavey, mental injuries caused by work-related stress are compensable if, after demonstrating medical causation, the employee shows that the mental injury was caused by work place stress of greater magnitude than the day to day mental stresses experienced by other workers employed in the same or similar jobs, regardless of their employer. Id. at 857.

Both medical and legal causation must be resolved in claimant's favor before an injury arising out of and in the course of the employment can be established. To establish medical causation, the employee must show that the stresses and tensions arising from the work environment are a proximate cause of the employee's mental difficulties. If the medical causation issue is resolved in favor of the employee, legal causation is examined. Legal causation involves a determination of whether the work stresses and tensions the employee experienced, when viewed objectively and not as the employee perceived them, were of greater magnitude than the day to day mental stresses workers employed in the same or similar jobs experience routinely regardless of their employer.

The employee has the burden to establish the requisite legal causation. Evidence of stresses experienced by workers with similar jobs employed by a different employer is relevant; evidence of the stresses of other workers employed by the same employer in the same or similar jobs will usually be most persuasive and determinative on the issue. Id. at 858.

The primary issue is the nature and extent of claimant's admitted work-related injury of April 21, 2015. Claimant asserts he has ongoing headaches, neck pain, shoulder pain, anxiety, depression, and TMJ issues.

Claimant received treatment for his anxiety and depression by Dr. Keffala. Based on the medical records, the treatment was helpful as Dr. Keffala helped claimant cope with his pain, anxiety and injury giving rise to those symptoms. Dr. Aschenbrenner initially believed that the feelings of anxiousness and the episodes of nightmares were not related to the work injury.

Dr. Tranel did not make a specific causation finding but he did not believe claimant suffered from PTSD. Dr. Tranel felt claimant did not put forth an adequate or credible effort during testing.

An expert retained by the defendant, Dr. Brook, diagnosed claimant as suffering from mild Somatic Symptom Disorder and insomnia and suggested the extent of the mental damage was not as extensive or debilitating as claimant may be alleging.

The two mental health experts both concluded that claimant suffered from some mental distress arising out of the work injury. It is found that claimant sustained a mental injury arising out of the work injury of April 21, 2015.

Since May 2016, however, claimant has exhibited a marked improvement in his medical condition. The primary work restriction related to claimant's mental injury is to avoid work with or near a saw.

As it relates to the neck, shoulder and headaches, Dr. Sassman concluded claimant had sustained a whiplash injury and headaches from the April 21, 2015. Dr. Aschenbrenner felt that the myofascial pain was contributing to claimant's headaches, neck and shoulder pain (to the extent that there was such pain). Claimant did have history of headaches and reporting the same to doctors as recently as January 2, 2015. While claimant did not initially report headaches and neck pain, he did mentioned them to Dr. Tranel, Dr. Keffala and Dr. Aschenbrenner. While claimant's tests were negative for any damage to the neck, it is undisputed that claimant sustained a serious facial injury. The injury was the cause of pain in the neck and head, although there is scant evidence of an insult to the neck or shoulders.

While Dr. Sassman opined that the claimant sustained a whiplash injury, Dr. Sassman's opinion appears to be based solely on claimant's historical complaints of neck pain as Dr. Sassman recorded normal range of motion in both the neck and shoulders and only tenderness to palpation over the trapezius. Dr. Rastogi found claimant showed normal range of motion in the cervical spine and upper extremities. Dr. Aschenbrenner, who claimant referred to as the quarterback of his medical care, determined that claimant suffered pain and discomfort throughout his head and neck as a result of the facial injury.

Therefore, it is determined claimant suffered no injury to his neck, shoulder or upper back, but instead the pain and discomfort in those regions stem from his facial injury.

There does not appear to be a dispute that claimant's TMJ is related to the work injury.

In summary, the evidence supports a finding that claimant's facial injury of April 21, 2015, resulted in TMJ, face pain, headaches, neck pain, shoulder pain, and Somatic Symptom Disorder.

As a result of the physical injury, claimant has few work restrictions. Dr. Sassman imposed work restrictions for lifting, pushing, pulling and carrying but those weight restrictions do not match claimant's actual post injury work capabilities and are not

consistent with the finding of normal ranges of motion in neck and shoulders with only tenderness to palpation over the trapezius. Dr. Sassman also recorded complaints of "some issues...at times."

While claimant may have sustained a mental injury arising out of the work injury, there is insufficient evidence to support a finding that this mental injury is limiting claimant's ability to find work other than with saws. Dr. Keffala released claimant on May 31, 2016, and did not indicate that he had any restrictions related to his mental injury. Dr. Sassman did not include any restrictions for claimant's mental state either.

Defendants included a statement from the claimant's former partner who testified that claimant had some interpersonal problems and that claimant was participating as a father in the same manner post-injury as he was pre-injury. This statement was given only low weight as claimant was not able to cross examine the witness and the contents of the statement only tangentially related to any issue of industrial disability. Whether claimant gets along with his family has little bearing as to whether his access to the labor market is reduced because of his injury.

During claimant's last visit with Dr. Aschenbrenner, Dr. Aschenbrenner wrote that there were no restrictions he would impose on claimant's work abilities. Dr. Westpheling, the defendants' retained examiner, also recommended no work restrictions. Claimant currently works full-time as a forklift operator and picker for an air freshener manufacturing plant. He has asked for no accommodations nor has indicated he has any work restrictions.

Claimant suffered a serious injury to his face. He is prevented from eating solid foods. Claimant testified credibly that he has a significant scar which bothers him, ongoing pain in his face which at times extends to his neck and into his head. He has a credible aversion to saws.

While claimant initially seemed hesitant to return to work, he has found full-time employment in a year-around position as opposed to the seasonal work he did for the defendants.

He is a fairly young worker with a two year associates degree.

Since claimant has an impairment to the body as a whole, an industrial disability has been sustained. Industrial disability was defined in Diederich v. Tri-City R. Co., 219 Iowa 587, 258 N.W. 899 (1935) as follows: "It is therefore plain that the legislature intended the term 'disability' to mean 'industrial disability' or loss of earning capacity and not a mere 'functional disability' to be computed in the terms of percentages of the total physical and mental ability of a normal man."

Functional impairment is an element to be considered in determining industrial disability which is the reduction of earning capacity, but consideration must also be given to the injured employee's age, education, qualifications, experience, motivation,

loss of earnings, severity and situs of the injury, work restrictions, inability to engage in employment for which the employee is fitted and the employer's offer of work or failure to so offer. McSpadden v. Big Ben Coal Co., 288 N.W.2d 181 (Iowa 1980); Olson v. Goodyear Service Stores, 255 Iowa 1112, 125 N.W.2d 251 (1963); Barton v. Nevada Poultry Co., 253 Iowa 285, 110 N.W.2d 660 (1961).

Compensation for permanent partial disability shall begin at the termination of the healing period. Compensation shall be paid in relation to 500 weeks as the disability bears to the body as a whole. Section 85.34.

Based on the foregoing, it is determined claimant has sustained a 12 percent impairment of the whole person based on the serious facial injury which causes ongoing pain and discomfort.

Claimant seeks an assessment of costs including the $1,200 fee for the deposition of Dr. Westpheling. According to Young, rule 876 IAC 4.33 allows for "the reasonable costs of obtaining no more than two doctors' or practitioners' reports" to be assessed. Des Moines Area Reg'l Transit Auth. v. Young, 867 N.W.2d 839 (Iowa 2015). Dr. Westpheling's deposition falls within that rubric.

Claimant's costs are assessed against the defendants.

ORDER

THEREFORE, it is ordered:

That defendants are to pay unto claimant sixty (60) weeks of permanent partial disability benefits at the rate of three hundred fifty-five and 59/100 dollars ($355.59) per week from October 16, 2015.

That defendants shall pay accrued weekly benefits in a lump sum.

That defendants shall pay interest on unpaid weekly benefits awarded herein as set forth in Iowa Code section 85.30.

That defendants shall pay the costs of this matter pursuant to rule 876 IAC 4.33. Including the deposition of Dr. Westpheling.

Signed and filed this 14th day of October, 2016.

JENNIFER S. GERRISH-LAMPE
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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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 in writing and received by the commissioner's office 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 a legal holiday. The notice of appeal must be filed at the following address: Workers' Compensation Commissioner, Iowa Division of Workers' Compensation, 1000 E. Grand Avenue, Des Moines, Iowa 50319-0209.