BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

CHERI JO DOWSON, Claimant, vs. STAPLES, INC., Employer, and INDEMNITY INSURANCE COMPANY OF NORTH AMERICA, Insurance Carrier, Defendants.	File No. 5042811 ARBITRATION DECISION Head Note Nos.: 1100; 1402.20; 1402.30

FILED
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WORKERS' COMPENSATION

STATEMENT OF THE CASE

Claimant, Cheri Jo Dowson, filed a petition in arbitration seeking workers' compensation benefits from Staples, Inc., employer, and Indemnity Insurance Company of North America, insurance carrier, both as defendants, as a result of an alleged injury sustained on April 5, 2012. This matter came on for hearing before Deputy Workers' Compensation Commissioner, Erica J. Fitch, on January 30, 2014, in Des Moines, Iowa. The record in this case consists of claimant's exhibits 1 through 8, defendants' exhibits A through O, and the testimony of the claimant. The parties submitted post-hearing briefs, the matter being fully submitted on March 14, 2014.

ISSUES

The parties submitted the following issues for determination:

1. Whether claimant sustained an injury on April 5, 2012, which arose out of and in the course of her employment;

2. Whether the alleged injury is a cause of temporary disability;

3. Whether claimant is entitled to temporary disability benefits from December 3, 2012 and continuing during the period claimant remains temporarily disabled;

4. Whether the alleged injury is a cause of permanent disability;

5. The extent of claimant's stipulated industrial disability;

6. The proper commencement date for permanent disability benefits;

7. Whether claimant is entitled to payment of various medical expenses;

8. Whether claimant is entitled to reimbursement of an independent medical evaluation pursuant to Iowa Code section 85.39; and

9. Whether claimant is entitled to alternate medical care pursuant to Iowa Code section 85.27.

At the time of evidentiary hearing, claimant moved to amend her petition to assert a claim for penalty benefits. Defendants objected. As defending a claim for penalty benefits requires presentation of specific facts and defendants were not provided the opportunity to gather such facts, defendants would be grossly prejudiced by granting the amendment. Therefore, claimant's motion to amend her petition to assert a claim for penalty benefits was denied.

The stipulations of the parties in the hearing report are incorporated by reference in this decision.

FINDINGS OF FACT

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

Claimant was 29 years of age at the time of hearing. She resides in Alton, Iowa with her husband and two minor children, ages 9 and 2. She graduated high school in 2002 and pursued one year of college, but has no postsecondary degrees or certifications. Claimant's work history consists of waitressing, fast food cashier and shift manager, and grocery store cashier, customer service, and clerk. Claimant denied any disciplinary issues at any of her former employers. In December 2006, claimant pled guilty to 5th degree theft; claimant indicated she was present with a friend when that friend stole lottery tickets. Claimant denied any bilateral shoulder problems prior to beginning work at defendant-employer. She is right hand dominant. (Claimant's testimony)

Claimant began work at defendant-employer in January 2012. Defendant-employer produces screen-printed and embroidered articles of clothing. Claimant was hired into the position of screen printer and earned $10.25 per hour. When claimant began her employment, she was placed in a position "ovening" products, which required her to remove shirts from a heated conveyor and inspect the quality of work. Claimant

testified this job required significant standing and twisting, handling up to 400 shirts per 90 minute period. While performing this duty, claimant testified she developed right shoulder difficulties which she attributed to repetitively loading and unloading shirts. Complaints included a tingling and burning sensation of the right shoulder. Claimant testified she reported her complaints and was sent for medical care and physical therapy. (Claimant's testimony; Exhibit L, Deposition Transcript pages 41-43)

On February 15, 2012, claimant presented to Orange City Area Health System (Orange City Health) and was evaluated by Douglas Grossmann, P.A. P.A. Grossmann noted a complaint of left shoulder pain which started around February 9, 2012; he noted claimant performed a lot of repetitive above-shoulder lifting at work. Following examination and x-ray, P.A. Grossmann assessed left shoulder tendonitis. He recommended a course of physical therapy and use of ibuprofen, as well as imposed work restrictions. (Ex. 2, pp. 63-64)

While P.A. Grossmann recorded he treated claimant for her left shoulder, claimant maintains she was seen for her right shoulder. For support, she indicates she underwent an x-ray of her right shoulder. (Claimant's testimony) Claimant denied any left shoulder symptoms at the time of evaluation by P.A. Grossmann. She expressed belief P.A. Grossmann made a mistake in his records. (Ex. L, Depo. Tr. pp. 44-46)

On February 24, 2012, claimant returned to Orange City Health and was evaluated by Harrison Hanson, M.D. Dr. Hanson recorded a history of claimant lifting repetitively over her head at work on February 9, 2012, with claimant suffering with persistent left shoulder pain since that date. Dr. Hanson noted claimant had been diagnosed with tendinitis and placed on ibuprofen and a course of physical therapy. Dr. Hanson indicated his examination revealed limited range of motion, some tenderness, and slight weakness of the rotator cuff muscles. He assessed impingement and tendinitis of the left shoulder and performed a corticosteroid injection of the left shoulder. He recommended claimant use Tylenol and continue physical therapy. Dr. Hanson imposed work restrictions of a maximum push-pull of 30 pounds occasionally and no above shoulder reaching. (Ex. 2, pp. 62-63)

Claimant returned to Dr. Hanson on March 2, 2012. Dr. Hanson noted claimant's "shoulder" pain seemed to have improved and moved into the trapezius muscles with spasm. Dr. Hanson indicated claimant denied pain in the shoulder. Following evaluation, Dr. Hanson assessed improved shoulder impingement but continued trapezius muscle spasm. He advised claimant on stretching and massage and recommended finishing the existing short course of physical therapy. Dr. Hanson released claimant to regular duty. (Ex. 2, pp. 61-62)

After a few weeks in the ovening job, claimant was moved to screen printing. Her duties required her to place a shirt on a board which then rotated under a screen filled with ink. Claimant testified her duties required working with her arms extended in front of her body, with 20 to 25 percent of the work above shoulder level. Claimant

testified she typically worked 40 to 50 hours per week, with her schedule including regular, mandatory overtime. (Claimant's testimony)

On April 5, 2012, claimant testified she lifted a tray of ink above her shoulders and felt a pop in her left shoulder. She then developed a burning pain through her shoulder, up into her neck and down into her left arm. Claimant testified she reported the event to her employer and was sent directly to physical therapy, as she was already treating with a provider for her right shoulder complaints. (Claimant's testimony; Ex. L, Depo. Tr. pp. 39-41, 43)

Claimant presented to physical therapy at Orange City Health on April 5, 2012. The physical therapy record refers to a list of physical problems, specifically including right shoulder pain, muscle weakness, and impaired posture. With regard to history of injury, the record indicates claimant reported suffering with right shoulder pain since March 29, 2012 "from having to perform lifting activities overhead at work repetitively." (Ex. 2, p. 1) The record continues:

> She states that with her left shoulder she was performing similar tasks within the last couple of months and was coming to Physical Therapy for that and then she was placed on the opposite side of the machine and now her right shoulder is hurting her.

(Ex. 2, p. 1)

Claimant reported her job duties involved lifting at elevated heights at a fast pace. Her duties did not allow her to rest her shoulders when they became painful, leading the pain to worsen. (Ex. 2, p. 1) The therapist assessed an overuse injury to claimant's right shoulder with impaired posture and identified the focus of therapy as postural education and strengthening, and right shoulder and neck flexibility and strengthening. (Ex. 2, p. 2)

Claimant expressed disagreement with the physical therapy record of April 5, 2012. Specifically, claimant testified she injured her left shoulder during an acute event that date and defendant-employer sent her straight to therapy. Claimant testified she informed the therapist of this history. She denied reporting sustaining an injury on March 29, 2012. (Claimant's testimony; Ex. L, Depo. Tr. pp. 48-52)

Claimant continued to attend physical therapy sessions at Orange City Health throughout April and May 2012. Treatment notes of April 10, April 12, April 18, and April 20, April 25, and April 27, 2012 all denote treatment for the right shoulder and cervical regions. (Ex. 2, pp. 4-5, 7-10, 13-15) Physical therapy notes of April 23, 2012 indicate claimant's right shoulder was slightly more sore than usual from pushing a stroller at the zoo the prior Saturday. (Ex. 2, p. 11) Treatment notes of April 30, 2012 indicate claimant expressed complaints in the "neck and shoulder region." (Ex. 2, p. 16) May 2, 2012 notes reflect pain of claimant's back behind the shoulder blades. (Ex. 2, p. 18) Treatment notes of May 4, 2012 reflect complaints of pain throughout the shoulders,

neck and back. (Ex. 2, p. 20) Shoulder and neck pain were highlighted on May 7, 2012. (Ex. 2, p. 22) On May 9, 2012, claimant complained of pain throughout the thoracic and lower cervical region, affecting her upper extremity motion. (Ex. 2, p. 23) Notes of May 11, 2012 reflect complaints of pain in the right shoulder and mid back regions. (Ex. 2, pp. 24-25)

Physical therapy notes of May 15, 2012 denote problem areas of right shoulder pain and a left shoulder strain. The record indicates claimant stated she had strained her left shoulder earlier that day while lifting a screen full of ink. (Ex. 2, pp. 26-27) Due to lack of improvement with physical therapy, claimant was referred to Douglas Martin, M.D., for evaluation. (Claimant's testimony)

On May 16, 2012, claimant presented to Dr. Martin for evaluation of bilateral shoulder pain. Dr. Martin's history indicates:

> [Claimant] reports that, back in January of 2012, she began to experience insidious onset of left shoulder pain. She went to see Dr. Hansen [sic] at the time, who, based upon the medical documentation that I have, gave her a subacromial bursal injection which she states did absolutely nothing. She subsequently has seen Physician's Assistant Grossmann, who also saw her for some right shoulder pain that had the onset of problems at the end of March. She then did something last week where she apparently had acute exacerbation of left shoulder pain above and beyond what she was dealing with prior.

(Ex. E, p. 29)

Following examination, Dr. Martin assessed bilateral trapezius/levator scapula/rhomboid myofascial pain syndrome and perhaps a mild degree of bilateral rotator cuff tendinitis. He expressed belief claimant's problem arose from the scapular musculature. Dr. Martin also explained to claimant that the subacromial injection performed by Dr. Hanson was done to treat impingement syndrome and a lack of benefit seemingly implied a broader myofascial problem. (Ex. E, p.30) Dr. Martin prescribed Vimovo and Skelaxin and recommended continued physical therapy. He also imposed work restrictions requiring claimant to keep her arms close to her body, only occasional outstretched arm postures, no reaching above shoulder level, and a maximum occasional 10-pound material handling limit. (Ex. E, pp. 31-32)

Claimant took issue with the history relayed by Dr. Martin. Claimant testified the cause of her symptoms was not insidious, but from a specific event. She also denied sustaining an exacerbation the week prior to evaluation. Claimant testified she did not see P.A. Grossmann for her left shoulder and furthermore, she did not know who the referenced Dr. Hanson was. (Claimant's testimony)

Following evaluation by Dr. Martin, claimant returned to physical therapy at Orange City Health. (Ex. 2, p. 28) During claimant's remaining May 2012 therapy

visits, claimant complained of bilateral upper extremity issues, left greater than right. (Ex. 2, pp. 29-30)

Claimant returned to Dr. Martin on May 30, 2012 and reported bilateral shoulder problems, left greater than right. Following examination, Dr. Martin assessed bilateral trapezius/levator scapular/rhomboid myofascial pain syndrome and bilateral rotator cuff tendinitis. He recommended continued physical therapy, prescribed Vimovo and Soma, and maintained claimant's work restrictions. (Ex. E, pp. 33-34) Claimant then returned to physical therapy at Orange City Health, with the majority of claimant's complaints arising from the left shoulder. (Ex. 2, pp. 32, 34-39)

On June 5, 2012, defendant-employer counseled claimant on excessive absenteeism. (Ex. C, pp. 21-22)

Claimant returned to Dr. Martin on June 13, 2012. Dr. Martin recommended continued physical therapy and work restrictions, and prescribed Vimovo and Amitriptyline. He indicated if claimant's discomfort did not resolve by the next appointment, he would likely pursue injection therapy. (Ex. E, pp. 35-36) Physical therapy throughout the remainder of June 2012 focused on the shoulders, neck, and upper trapezius. (Ex. 2, pp. 41-46)

On June 27, 2012, claimant returned to Dr. Martin. Claimant reported an asymptomatic right shoulder, but continued discomfort of the left shoulder. Dr. Martin revised his prior diagnoses to reflect an asymptomatic right shoulder and "only a scapular stabilizer myofascial discomfort" of the left shoulder. Dr. Martin proceeded with trigger point injections of the left trapezius, levator scapula, and rhomboid muscles. Dr. Martin recommended continued physical therapy, medications, and work restrictions. (Ex. E, p. 37) Claimant resumed her course of physical therapy and reported some relief with the injections performed by Dr. Martin. (Ex. 2, pp. 47-53)

At physical therapy on July 11, 2012, the therapist noted claimant demonstrated the best flexion since "May when she injured her arm." (Ex. 2, p. 54)

That same date, July 11, 2012, claimant returned to Dr. Martin. She continued to report a "well" right shoulder. Claimant reported minimal relief following the injection of June 27, 2012. Dr. Martin reviewed claimant's physical therapy records and opined the notes appeared to demonstrate claimant received a better response from injection "than what she is telling me today." Following examination, Dr. Martin assessed left parascapular myofascial pain syndrome. Absent more favorable subjective reports of relief, Dr. Martin discontinued injections. He recommended a continuation of conservative measures of physical therapy and medications, albeit he opined claimant was close to maximizing the benefit of physical therapy. Dr. Martin cautioned of a strong possibility claimant would have to learn to live with a certain degree of pain. (Ex. E, p. 39) Claimant resumed her physical therapy; the therapist noted progress in claimant's complaints. (Ex. 2, pp. 55-58)

On July 25, 2012, claimant returned to Dr. Martin and reported no change in her symptoms. Following examination, Dr. Martin assessed left parascapular myofascial pain syndrome. He indicated he had exhausted his treatment options and therefore, recommended evaluation by orthopedic specialist, Wade Jensen, M.D. Pending consultation, Dr. Martin imposed work restrictions of a 10-pound maximum material handling and limited reaching above shoulder level and with outstretched arm postures. (Ex. E, pp. 41-42)

On August 13, 2012, claimant presented to the Orange City Health Emergency Department and was evaluated by Jonathan Grossmann, M.D. Claimant relayed she had woken up that morning with a very tight upper and lower back, shoulders, and neck, as well as bilateral arm and leg tingling. Dr. Grossmann noted tightness across claimant's shoulders and upper back, tenderness down the entire spine, and tingling in the upper and lower extremities with light pressure on the spine. Dr. Grossmann assessed tingling of the extremities, with the physician uncertain "what to make of this symptom," and tight muscles of the shoulders and upper back, likely aggravating her lower back. (Ex. 2, p. 60) He prescribed Flexeril and physical therapy, and removed claimant from work pending a scheduled appointment with Dr. Jensen. (Ex. 2, pp. 60-61)

On August 15, 2012, claimant presented to board certified orthopedic spinal surgeon, Dr. Jensen. (Ex. O, p. 124) In connection with the appointment, claimant completed a patient history form. She reported an onset of symptoms on April 2, 2012 when she felt a pop in her left shoulder at work. (Ex. G, p. 47) At evidentiary hearing, claimant testified she wrote the incorrect date on this form. Rather than an event occurring on April 2, claimant indicated the event occurred on April 5, 2012. Claimant indicated she had previously informed her providers of a specific work injury, but this was the first opportunity she had to complete medical forms regarding the cause of her left shoulder complaints. (Claimant's testimony)

Dr. Jensen noted a history of left shoulder pain with an onset following an incident at work on April 2, 2012. Claimant also complained of radiating neck and back pain. Claimant reported an onset with lifting a tray of ink overhead and suffering a pop in her shoulder. (Ex. G, p. 53) Dr. Jensen ordered and reviewed x-rays of claimant's cervical spine and left shoulder. He opined the cervical spine x-rays showed a relatively straight cervical spine without other evidence of cervical degenerative disc disease, spondylolisthesis and spondylolysis. Left shoulder x-rays were read as normal, without evidence of fracture, but minimal AC joint degeneration and a weak type 2 acromion. (Ex. G, p. 52) Dr. Jensen assessed symptomatic left shoulder subacromial bursitis, possible biceps symptoms of the left shoulder, and mild AC joint arthrosis of the left shoulder. He ordered an MRI of the left shoulder. (Ex. G, pp. 54-55) Dr. Jensen also imposed work restrictions against use of the left shoulder. (Ex. H, p. 77)

Claimant underwent an MRI of her left shoulder on August 23, 2012. The radiologist opined the results revealed supraspinatus tendinosis with a partial bursal surface tear; infraspinatus tendinosis, without a demonstrated tear; mild subacromial

bursitis; and a small volume joint effusion of the glenohumeral articulation. (Ex. D, p. 24)

Claimant returned to Dr. Jensen on August 29, 2012. Dr. Jensen opined claimant's left shoulder MRI revealed evidence of subacromial bursitis and a slight, partial thickness bursal-sided supraspinatus tear. He also noted a type 1 acromion and a small glenohumeral joint effusion. Dr. Jensen assessed symptomatic subacromial bursitis and symptomatic biceps tendinitis. He performed two injections, one of the subacromial space and one of the anterior shoulder. Dr. Jensen recommended continued physical therapy. (Ex. G, p. 57)

On October 11, 2012, defendant-employer counseled claimant regarding work absences. (Ex. C, pp. 18-20)

Claimant returned to Dr. Jensen on October 18, 2012. Following examination, Dr. Jensen indicated he did not believe claimant's neck pathology contributed to her overall symptomatology. With regard to the left shoulder, Dr. Jensen recommended proceeding with an arthroscopic subacromial decompression and evaluation for involvement of the biceps tendon. He also indicated an intention to perform some bone spur removal off the anterior acromion. (Ex. G, p. 63) Pending surgery, Dr. Jensen imposed work restrictions of a maximum lift of 34 pounds occasionally and 19 pounds frequently and only occasional reaching above the shoulder. (Ex. H, p. 78)

On October 26, 2012, claimant presented to chiropractor, Daron De Jong, D.C. Dr. De Jong noted the following history:

> [Claimant] presents to the office today following an [sic] work related accident on April 5, 2012 for a totally new condition. She was lifting a screen of ink over her head and felt and heard an audible pop in her neck and left shoulder. She states that there was immediate pain.

(Ex. 3, p. 1)

Claimant expressed complaints of neck, mid back and low back pain and stiffness. (Ex. 3, p. 1) Dr. De Jong opined claimant's complaints represented a new symptom complex, unrelated to prior complaints. Dr. De Jong diagnosed pain of the cervical and thoracic spine, segmental dysfunction of the cervical spine, and muscle spasm; he performed chiropractic manipulation of the spine. (Ex. 3, pp. 1-2)

On November 7, 2012, defendant-employer counseled claimant on tardiness; specifically, for use of the company "grace period" four times between October 29 and November 2, 2012. (Ex. C, pp. 15-17)

During the time claimant remained under physician-imposed work restrictions, defendant-employer provided claimant light-duty work. Pending left shoulder surgery, claimant continued to receive physical therapy treatment; if those sessions were

scheduled during work hours, claimant was paid her full wages during the appointment. (Claimant's testimony)

On November 30, 2012, claimant testified she presented to physical therapy for a 1:30 p.m. appointment. She testified she was forced to wait, as her physical therapist was running late. When her session began, claimant testified her therapist performed massage for about 15 minutes, followed by 20 to 25 minutes of exercises, an additional 30 minutes on the TENS unit, and 10 minutes waiting for someone to remove the unit thereafter. Claimant testified by the time she completed her session, dressed, and scheduled her next appointment, it was after 3:00 p.m. Claimant did not return to work after her medical appointment. She was paid until 3:15 p.m. Claimant testified if she had completed her session before 3:00 p.m., she would have returned to work like she had on each past occasion. Claimant further testified she attended physical therapy appointments two to three times per week and those appointments typically lasted 1 to 1 ½ hours. (Claimant's testimony)

On November 30, 2012, defendant-employer's human resources coordinator, Melony Jackson, authored an email to Sue Wallin and Cindy Sketch, which stated:

> I noticed on [claimant's] time card she did not clock back in today after her physical therapy appointment. I have the confirmed time she left from the therapist. I would like to ask her on Monday as to what time she got done, because she was instructed to return to work if she was done by 3:15, correct? If she does not provide factual information, I will have to reach out to Cindy Sketch because this would be considered time card fraud and that is grounds for termination.

(Ex. M, p. 112)

Ms. Sketch, human resources manager for defendant-employer, authored an email response to Ms. Jackson on December 3, 2012. Ms. Sketch inquired what time claimant left physical therapy and indicated if claimant did not return to work, claimant should be counseled, but the missed punch would not "necessarily be [a] time card issue." (Ex. M, p. 111)

Ms. Jackson replied to Ms. Sketch by email on December 3, 2010. She indicated claimant left at 1:17 p.m. for her 1:30 p.m. therapy session. She also indicated claimant informed Ms. Jackson and Ms. Wallin that her appointment lasted until 3:00 p.m. Ms. Jackson wrote she had contacted the therapist's office and was advised claimant left at 2:18 p.m. Ms. Jackson confirmed claimant did not return to work following the therapy appointment. (Ex. M, p. 110)

Ms. Wallin, decoration manager for defendant-employer, emailed in response, stating she had spoken with claimant prior to the appointment about defendant-employer's expectation she return to work if therapy was over before 3:15 p.m. Ms. Wallin indicated claimant had stated she was aware of the policy. Ms. Wallin also

indicated Ms. Jackson approached claimant that morning, December 3, 2012, about the appointment:

> This morning [Ms. Jackson] asked her what time she got done, that was her chance to admit she got done at 2:18. If she would have told us the truth this morning, we could have worked with her, but instead she was dishonest and said 3:00.

(Ex. M, p. 109)

Defendant-employer terminated claimant effective December 3, 2012. Her termination was based upon a violation of company policy, specifically insubordination and timecard falsification. Claimant's termination letter states claimant had been instructed to return to work following physical therapy should she finish before 3:15 p.m., and while claimant informed defendant-employer the appointment ended at 3:00 p.m., clinic documentation indicated claimant left the clinic at 2:18 p.m. (Ex. 7, p. 1; Ex. C, pp. 14, 23)

Following her termination, claimant testified she approached her therapist. Her therapist indicated she was unaware what time claimant left therapy. The therapist subsequently informed claimant she contacted Ms. Jackson in an attempt to clear up the question of the duration of the appointment, but Ms. Jackson informed the therapist it was too late. Claimant further indicated while there was no sign in/sign out sheet at the physical therapy office as of November 30, 2011, shortly thereafter, such a sheet was instituted by the clinic. (Claimant's testimony)

On December 5, 2012, Dr. Jensen performed left shoulder arthroscopy with limited shoulder debridement and subacromial decompression. He opined a postoperative diagnosis of symptomatic subacromial bursitis. (Ex. 1, pp. 1-2) Following surgery, claimant continued to follow-up with Dr. Jensen. Immediately following surgery, Dr. Jensen ordered use of a sling immobilizer. (Ex. G, p. 65) At follow up two weeks post-surgery, December 17, 2012, Dr. Jensen noted claimant was doing well, tolerated physical therapy, and did not complain of pain except achiness. (Ex. G, p. 66) He recommended following claimant conservatively, in order to see how she progressed with time. (Ex. G, p. 67)

Claimant returned to Dr. Jensen on January 16, 2013. At that time, she complained of neck pain and tightness, and interscapular pain with headaches. Claimant also complained of upper arm swelling and some pain, but Dr. Jensen noted he observed no swelling as compared to the right side. On examination, Dr. Jensen noted near full cervical range of motion and full left shoulder range of motion. Dr. Jensen noted positive impingement signs, reproducing interscapular pain. X-rays revealed a relatively normal appearing cervical spine. Due to the change in claimant's symptoms from the shoulder to the neck, Dr. Jensen recommended a cervical spine MRI. (Ex. G, pp. 69-70)

On January 21, 2013, claimant presented to Mark Turek, D.O., for a physical. With the exception of difficultly losing weight following her pregnancies, Dr. Turek noted no other significant medical problems. (Ex. I, p. 81) Claimant testified she did not mention her work-related complaints to Dr. Turek because she had not been approved to see Dr. Turek for these issues. (Claimant's testimony)

Claimant underwent cervical spine MRI on January 23, 2013. The radiologist opined it revealed a mild disc bulge at C5-C6 and C7-T1 without focal disc herniation. (Ex. D, p. 26)

On January 28, 2013, claimant returned to Dr. Jensen. Claimant continued to report tightness of the trapezius muscles, neck pain, and headaches. Dr. Jensen opined claimant's cervical spine MRI revealed minimal disc bulging at C5-C6 and C7-T1 which he opined were not causing claimant's symptoms. Following examination, Dr. Jensen opined claimant's symptoms were myofascial in nature and prescribed a TENS unit. (Ex. G, pp. 72-73) Dr. Jensen imposed work restrictions of a maximum lift of 19 pounds occasionally and 10 pounds frequently, and only occasional reaching above shoulder level. (Ex. H, p. 79)

Following Dr. Jensen's restricted work release on January 28, 2013, defendants did not pay temporary disability benefits on the basis defendant-employer would have had light-duty work available had claimant not been terminated for cause. However, defendants did volunteer 25 weeks of permanent partial disability benefits. (Ex. 7, p. 2; Ex. J, p. 85) Claimant's attorney vehemently objected to defendants' termination of claimant's temporary disability benefits. (Ex. 7, pp. 4-5)

On April 29, 2013, claimant returned to Dr. Jensen with reports of persistent left shoulder pain, interscapular pain, and some radiating left upper arm pain. On examination, Dr. Jensen found mild impingement signs of the left shoulder and some interscapular pain associated with shoulder motion, but no severe radicular complaints. Dr. Jensen assessed status post left shoulder arthroscopy and subacromial decompression "with partial bursal-sided surface tear possibly contributing to further symptoms" and a cervical disc bulge at C5-C6, possibly contributing to symptoms. Dr. Jensen recommended a left shoulder MRI and an epidural steroid injection. Dr. Jensen recommended claimant return after undergoing both procedures; he indicated no restrictions were necessary pending follow up. He further indicated he anticipated placing claimant at maximum medical improvement (MMI) for the left shoulder within six weeks, assuming the MRI revealed no changes. (Ex. D, p. 28; Ex. G, p. 74; Ex. H, p. 80) As justification for the MRI, Dr. Jensen indicated:

> [Claimant] has areas [of the left shoulder] that cause her pain and because of this small delamination tear in her rotator cuff, she wants to know if this has actually gotten worse. I think that is going to take some more imaging studies, such as an MRI postoperatively to determine that.

(Ex. G, p. 74)

On June 7, 2013, claimant filed an alternate medical care petition, seeking the care recommended by Dr. Jensen. The action was dismissed by a distinct deputy workers' compensation commissioner after defendants filed an answer disputing liability for claimant's neck complaints, while admitting liability for the left shoulder. Defendants' counsel did not present for hearing to elaborate on the specific details of the denial, leading the deputy to interpret the denial of liability as a general one thus warranting dismissal of the action.

Throughout the period of October 30, 2012 through June 7, 2013, claimant continued to receive intermittent continued chiropractic care of neck, back, and left shoulder pain. (Ex. 3, pp. 2-8)

Defendants' counsel authored a letter to Dr. Jensen dated July 15, 2013, inquiring as to his opinions on claimant's neck and left shoulder complaints. (Ex. A, pp. 2-3) Dr. Jensen authored a response dated July 18, 2013. Dr. Jensen indicated he reviewed his records and found no significant findings regarding claimant's cervical spine. He further indicated any cervical symptoms which claimant may be complaining of were not related to the alleged April 5, 2012 work injury or her work activities. In regard to claimant's left shoulder injury history, Dr. Jensen indicated Dr. Martin would be in the best position to address potential inconsistencies between claimant's history and reported injury. (Ex. A, p. 1)

At defendants' direction, claimant presented to Dean Wampler, M.D., on July 23, 2013 for independent medical evaluation (IME). Claimant reported experiencing right shoulder symptoms prior to the alleged work injury of April 5, 2012, for which she remained under treatment at the time of the alleged left shoulder injury. Claimant related her right shoulder pain to her work duties loading shirts into a screen printing machine. In regard to her left shoulder symptoms, claimant related a very specific injurious event occurred on April 5, 2012. Claimant reported lifting a large ink tray overhead when she felt a pop in her shoulder and developed burning pain throughout the shoulder to the neck and upper arm. Claimant indicated she reported these symptoms to defendant-employer and was sent straight to physical therapy, as she was already under a physical therapist's care for her right shoulder. After claimant failed to improve with physical therapy, claimant was sent to Dr. Martin. Claimant was subsequently referred to Dr. Jensen. (Ex. B, p. 7)

Dr. Wampler indicated during shoulder arthroscopy, Dr. Jensen found subacromial bursitis, resected inflamed tissue, and debrided a small tear, but all other aspects of shoulder anatomy were found to be normal. Claimant denied relief in her symptoms following arthroscopy. (Ex. B, p. 7) Claimant reported continuing to suffer with burning pain in the left upper humerus which migrated through the trapezius into the base of her head, resulting in daily migraines. She reported similar, but less intense, symptoms on the right side. (Ex. B, p. 8)

On examination, Dr. Wampler observed no asymmetry between the shoulders or outward sign of atrophy in the left. Left shoulder examination revealed tenderness of the AC joint and upper humerus, with pain referring into the base of the neck with palpation. Cervical mobility was normal, although claimant demonstrated reluctance out of fear of discomfort. Passive manipulation of the left shoulder revealed modest subacromial crepitus and abduction with external rotation produced increased pain. Dr. Wampler noted claimant demonstrated preserved strength in the rotator cuff group when tested. (Ex. B, p. 8)

Following interview, records review and examination, Dr. Wampler opined claimant demonstrated findings of persistent myofascial pain. Dr. Wampler opined the bursitis and small rotator cuff tear repaired by Dr. Jensen were not a significant cause of symptoms. He also did not believe claimant's minor cervical degenerative disease played any role in claimant's past or present symptoms. Dr. Wampler indicated claimant's pattern of symptoms and lack of response to treatment might suggest suprascapular or other nerve injury or entrapment. Dr. Wampler expressed belief claimant's treatment to date had been reasonable and appropriate for claimant's "mysterious diagnosis." He opined claimant had relayed the same symptom complaints and displayed consistent physical examination findings to her medical providers. Dr. Wampler therefore reasoned claimant presented with a shoulder pathology which had not been identified. (Ex. B, p. 9)

On the question of causation, Dr. Wampler noted claimant reported a specific incident with regard to her left shoulder complaints. He indicated the actions claimant was performing at the time of the alleged injury usually produced a soft tissue injury around the shoulder structures, but could also cause a nerve stretch injury or impingement within the shoulder girdle muscles, resulting in longstanding complaints. For these reasons, Dr. Wampler opined it more likely claimant's condition was caused by work than any other source. (Ex. B, p. 9)

Prior to opining on MMI, Dr. Wampler recommended an EMG and nerve conduction studies of the left upper extremity to investigate the possibility of nerve involvement or myopathy. (Ex. B, p. 9) Due to his recommendation for further evaluation, Dr. Wampler declined to opine as to the extent of claimant's permanent disability. In the event such testing was normal, Dr. Wampler opined claimant may benefit from a course of treatment with gabapentin or Lyrica, as her pain findings were suggestive of peripheral nerve issues. Pending additional evaluation, Dr. Wampler imposed temporary work restrictions of lifting up to 20 pounds to chest height, no lifting over chest height, and all lifting must occur within 18 inches of the body. (Ex. B, p. 10)

Dr. Wampler was subsequently provided a copy of Dr. Jensen's letter dated July 18, 2013. Following review, he issued a responsive letter dated August 1, 2013. Dr. Wampler indicated he too did not believe claimant sustained a cervical injury or neck pathology as a result of the alleged injury on April 5, 2012. He maintained his opinion

claimant sustained an acute left shoulder injury on April 5, 2012, as detailed in his IME report. (Ex. B, p. 11)

By correspondence dated August 27, 2013, defendants' counsel indicated authorization was given for claimant to return to Dr. Jensen in follow up of her shoulder complaints, but not for any neck complaints. Counsel indicated claimant should schedule the follow up appointment. (Ex. 7, p. 15) Claimant telephoned and scheduled an appointment with Dr. Jensen, but subsequently received a return call from his office indicating his office was cancelling the appointment because defendants would not authorize the care. (Ex. 7, p. 16) When this was conveyed to defendants' counsel, counsel indicated claimant should hold off on scheduling follow up with Dr. Jensen until the EMG recommended by Dr. Wampler had been undergone. (Ex. 7, pp. 17, 21)

Claimant underwent EMG and nerve conduction testing. Dr. Wampler reviewed the results and issued a supplemental IME report on October 10, 2013. Dr. Wampler opined the EMG and needle study did not reveal any peripheral neuropathy, radiculopathy, brachioplexopathy or myopathy. As the results failed to identify any potential treatment modalities, Dr. Wampler opined claimant achieved MMI at the time of the study, October 8, 2013. Dr. Wampler opined claimant demonstrated a chronic pain syndrome which affected her physical abilities and accordingly, recommended a functional capacity evaluation (FCE). In regard to permanent functional impairment, Dr. Wampler indicated the AMA Guides to the Evaluation of Permanent Impairment, does not address chronic localized myofascial pain syndrome. He therefore opined claimant warranted a 5 percent left upper extremity impairment due to the shoulder dysfunction caused by claimant's objective muscle abnormality. (Ex. B, pp. 12-13)

At the advice of her counsel, claimant did not agree to attend the FCE recommended by Dr. Wampler. (Claimant's testimony)

On December 13, 2013, claimant presented for her IME with board certified occupational health physician, Sunil Bansal, M.D. In regard to history of her complaints, claimant reported on April 5, 2012, she was lifting an ink tray when she felt a pop in her left shoulder. She immediately developed burning pain in the shoulder, with pain and numbness radiating to her neck and down her arm. (Ex. 4, p. 7) Dr. Bansal noted claimant experienced prior left shoulder discomfort beginning in February 2012 which she attributed to her work duties; she was released from care in March 2012. (Ex. 4, p. 7) Dr. Bansal described claimant's work duties for defendant-employer in great detail. (Ex. 4, pp. 8-9) Later in his report, Dr. Bansal indicates claimant's February 2012 complaints were to the right shoulder. (Ex. 4, p. 8) Claimant reported also developing neck pain as a result of the April 2012 incident, but doctors had focused on her shoulder and disregarded her neck complaints. (Ex. 4, p. 8)

In regard to her ongoing complaints, claimant reported a constant ache with occasional sharp shooting pains of the left shoulder, with an increase of pain in the right shoulder due to compensating for the left. Claimant also reported a shooting pain from the base of her skull, down her neck and into the area between the shoulder blades.

She also complained of bilateral arm numbness and tingling. With the left arm, claimant reported the ability to lift only 8 to 10 pounds occasionally. (Ex. 4, pp. 7-8) Claimant denied any complaints with her bilateral shoulders or neck prior to beginning work at defendant-employer. (Ex. 4, p. 9) On examination, Dr. Bansal noted palpable tenderness over the lower cervical paraspinals into the left periscapular region, tenderness to palpation of the left shoulder at the acromioclavicular joint into the subacromial bursa, and decreased range of motion and strength of the left shoulder. (Ex. 4, pp. 10-11)

Dr. Bansal opined the mechanism of injury reportedly sustained by claimant on April 5, 2012 when coupled with an immediate clinical presentation, was consistent with claimant's need for left shoulder arthroscopy. (Ex. 4, p. 12) He opined claimant also sustained a periscapular strain from the April 5, 2012 injury, which to certain patients, felt like a neck problem. (Ex. 4, p. 13) He opined no further treatment was warranted with regard to claimant's neck complaints. (Ex. 4, p. 14) Due to claimant's continued reports of pain and the decreased range of motion, Dr. Bansal recommended a repeat left shoulder MRI. (Ex. 4, p. 12) Specifically, Dr. Bansal opined claimant fit the criteria of a failed decompression, thus warranting the MRI. (Ex. 4, p. 13)

While issuing an opinion suggesting a repeat MRI, Dr. Bansal also offered opinions on the extent of claimant's permanent disability and need for work restrictions. Based upon deficits in range of motion, Dr. Bansal opined claimant sustained a permanent impairment of 10 percent left upper extremity or 6 percent whole person. (Ex. 4, p. 12) Dr. Bansal recommended permanent restrictions of a maximum lift of 10 pounds and no lifting greater than 5 pounds occasionally with the left arm; no frequent overhead lifting with the left arm; no pushing or pulling greater than 10 pounds with the left arm; and no frequent pushing or pulling with the left arm. (Ex. 4, p. 13)

On December 20, 2013, defendants' counsel authored a letter to Dr. Jensen purporting to set forth opinions expressed by Dr. Jensen in a prior conversation. On January 11, 2014, Dr. Jensen signed the letter, indicating his agreement with the contents of the letter. Dr. Jensen thereby opined claimant did not present with a repairable tear of the rotator cuff and displayed largely normal range of motion. He opined claimant sustained a 5 percent permanent impairment for chronic pain, but did not require permanent work restrictions or future medical care. (Ex. A, pp. 4-5)

Dr. Jensen provided deposition testimony on January 27, 2014. By his testimony, Dr. Jensen sought to clarify two items. First, Dr. Jensen clarified his reference to the right shoulder in the August 15, 2012 record was a typo and actually should reflect complaints of the left shoulder. (Ex. O, p. 125) Dr. Jensen also clarified that during surgery, the posterior labrum was debrided and not the rotator cuff. He therefore took issue with Dr. Wampler's IME report which referenced a repair had been made to the rotator cuff during arthroscopy. (Ex. O, p. 134) Despite this clarification, Dr. Jensen agreed with Dr. Wampler's opinion of a 5 percent permanent functional disability. (Ex. O, p. 133) Dr. Jensen also opined no permanent restrictions were

warranted for the left shoulder, as of the time of his final evaluation of claimant. (Ex. O, pp. 132, 134)

Dr. Jensen also reviewed Dr. Bansal's IME report. After doing so, he opined Dr. Bansal's examination findings could signify re-accumulation of bursitis or development of scar tissue. He further indicated the range of motion findings documented by Dr. Bansal were slightly decreased from the time of Dr. Jensen's last evaluation. (Ex. O, pp. 132-133) Dr. Jensen opined if claimant continued to struggle with left shoulder complaints and demonstrated limited shoulder motion, a minimum level of care should be provided, including an MRI. (Ex. O, p. 135)

Defendants provided Dr. Martin with records to review, including Dr. Jensen's medical notes, correspondence, and deposition transcript, and the IME reports of Dr. Bansal and Dr. Wampler. In addition to review of these documents, Dr. Martin reviewed his office notes from May 16, 2012 to July 25, 2012, claimant's physical therapy notes, and medical notes from P.A. Grossmann and Dr. Hanson. Following such review, Dr. Martin issued his responses to various questions by a report dated February 24, 2014. Dr. Martin expressed agreement that "there seems to be some inconsistency with respect to the recorded date of injury." (Ex. N, p. 113) Defendants' counsel posed the following question, with Dr. Martin penning his response:

> "In your opinion, did [claimant] suffer a traumatic work injury to her left shoulder on April 5, 2012?"
>
> *Answer*: I have no record of this occurring. The first encounter date note from May 16, 2012 indicates that she reported initial left shoulder pain in January of 2012 with a worsening that occurred several weeks prior to my evaluation of May 16, 2012. The physical therapy documentation that I have, interestingly, includes the first day of physical therapy evaluation being the same date that is being asked here of April 5, 2012 does not reveal any report of an acute traumatic incident.

(Ex. N, p. 114)

Dr. Martin also opined the MRI results were "gray" with respect to elucidating claimant's pain generators. Given that claimant experienced little relief following arthroscopy, Dr. Martin opined perhaps the findings present on claimant's MRI were not claimant's pain generators. (Ex. N, p. 115) Dr. Martin opined a repeat left shoulder MRI would not necessarily "shed any additional light" on claimant's condition:

> Given her situation, it appears as though that, with the MRI scan of the cervical spine being essentially unremarkable and her having consistent symptoms with myofascial discomfort, an MRI scan is probably not going to shed any additional light onto her situation. [Defendants' counsel's] point is a good one, in that if she has not returned to work since December of 2012, one of the things that one has to look at, with respect to ongoing

> symptomatology, is probably a disuse type of situation, rather than any type of 'injury.'

(Ex. N, p. 117)

Dr. Martin reiterated a diagnosis of left parascapular myofascial pain syndrome, as of his last evaluation of claimant. Dr. Martin further opined claimant had achieved MMI as of the date of his last evaluation, July 25, 2012, as claimant had plateaued in respect to the care he could offer. (Ex. N, p. 115) Dr. Martin opined claimant likely had a very minimal degree of permanent impairment of the left shoulder and such an impairment should be based upon range of motion measurements; however, he did not defer to Dr. Bansal's measurements due to concerns with regard to Dr. Bansal's methodology. He therefore declined to opine on permanent impairment without personally examining claimant. (Ex. N, pp. 116-117)

Claimant admits there are inconsistencies in the medical records, but maintained she never provided an inconsistent history to her providers. Claimant denied any shoulder or shoulder blade difficulties prior to her work at defendant-employer. She testified her left shoulder now feels the same as it did prior to surgery. She has altered the manner in which she performs household tasks and foregoes recreational sports. Claimant testified she feels the restrictions imposed by Dr. Bansal are consistent with her own experiences in attempting to use her left arm. (Claimant's testimony)

Claimant incurred medical expense in seeking chiropractic care. She argues defendants should be held responsible for these expenses because defendants refused to return her for treatment with Dr. Jensen. Claimant testified the chiropractic treatment provided relief for a few days at a time, but her symptoms would always return. Claimant continues to desire medical treatment and wants to receive such care in the Sioux City area. Specifically, claimant seeks a repeat MRI as recommended by Dr. Jensen, as she hopes doing so will identify the problem in her shoulder and allow the condition to be fixed. (Claimant's testimony)

Claimant testified she has not worked since her termination by defendant-employer. Claimant believes she is capable of working; however, as her youngest child was two years old at the time of hearing, he would require care should claimant become employed. Claimant testified a minimum wage job would not allow her to earn enough to counter this daycare expense. Therefore, her family elected to have claimant stay home with her child. Claimant testified in her job search, the jobs in her geographic area which paid more than minimum wage were production/warehouse work. She indicated she applied for some production positions, but did not believe those positions fell within her permanent restrictions due to lifting requirements. Due to a desire to return to the labor market, claimant testified she investigated returning to college. Specifically, claimant testified she scheduled an appointment to complete financial aid paperwork at Northwest Community College for shortly after evidentiary hearing. Claimant testified she intends to pursue a pharmacy technician certification. She has no plans to seek work until she completes her program of study. (Claimant's testimony)

CONCLUSIONS OF LAW

The first issue for determination is whether claimant sustained an injury on April 5, 2012 which arose out of and in the course of her employment.

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.

Claimant alleges she suffered a traumatic injury at work on April 5, 2012. Specifically, claimant alleges she suffered an injury to her neck and left shoulder when she felt a pop and suffered an immediate onset of pain while lifting a tray of ink overhead. Defendants deny the occurrence of a traumatic injury on April 5, 2012.

Although not at issue in this claim, claimant also represents she sustained an injury to her right shoulder as a result of repetitive work duties. Claimant testified these right shoulder difficulties began soon after she began work at defendant-employer in January 2012. Claimant further indicated she informed defendant-employer of right shoulder problems and was sent for medical care. While claimant alleges the complaints were with her right shoulder, contemporaneous medical records are not consistent with her account, thus making the questions surrounding these prior complaints relevant to issues of causation and claimant's credibility in the instant file.

A medical record authored by P.A. Grossmann on February 15, 2012 denotes a complaint of left shoulder pain with an onset of approximately February 9, 2012 and resulting from repetitive work duties. Following x-ray and examination, P.A. Grossmann assessed left shoulder tendinitis. Claimant disputes P.A. Grossmann's record, indicating she complained of right shoulder pain and received a right shoulder x-ray. The radiographic report itself is not in evidence to confirm which shoulder was in fact, x-rayed on February 15, 2012.

On February 24, 2012, a medical record authored by Dr. Hanson denotes a history of performing repetitive overhead work on February 9, 2012, with claimant suffering with left shoulder pain since that date. Following examination, Dr. Hanson assessed impingement and tendinitis of the left shoulder and performed a corticosteroid injection of the left shoulder. Claimant followed up with Dr. Hanson on March 2, 2012, at which time Dr. Hanson released claimant, but suggested completion of an existing course of physical therapy. Claimant disputes Dr. Hanson's records, as she claims she did not see Dr. Hanson.

Claimant's self-serving testimony stating she suffered with right, not left, shoulder complaints prior to the alleged April 5, 2012 date of injury is contrary to the contemporaneous medical notes of P.A. Grossmann and Dr. Hanson. The record does not contain any physical therapy records dated prior to April 5, 2012 which could corroborate claimant's claim. Therefore, the undersigned is left to weigh claimant's testimony against contemporaneous medical records.

Claimant testified she suffered an injury on April 5, 2012 while lifting a tray of ink over her shoulders. Claimant testified she felt a pop and immediately developed symptoms in the left shoulder and stretching into the neck and left arm. Claimant testified she informed defendant-employer and was directed to present to physical therapy, as she was already seeing a therapist for right shoulder complaints.

Interestingly, the evidentiary record contains a physical therapy note dated April 5, 2012. The record denotes a history of right shoulder pain since March 29, 2012 due to repetitive work activities. It also indicates claimant had suffered with prior left shoulder difficulties and participated in physical therapy for these complaints, but claimant was moved to the opposite side of a machine at work and the symptoms then began in her right shoulder. The evaluating therapist assessed an overuse injury to the right shoulder. The physical therapy record of April 5, 2012 is void of any reference to a specific injurious event, let alone an injury which purportedly occurred early that day and prompted the visit to therapy. Furthermore, the record only mentions claimant's left shoulder in passing, not as the focus of the visit as one would assume would occur if claimant reported suffering an injury to the left shoulder on that date.

Physical therapy records from the remainder of the month of April 2012 denote a focus on claimant's right shoulder and cervical regions. It is not until May 15, 2012 that physical therapy records reflect claimant sustained a traumatic left shoulder injury. The record of May 15, 2012 does not, however, reference an April 5, 2012 date of injury. The therapist on May 15, 2012 recorded a history of claimant sustaining a left shoulder strain while lifting a tray of ink earlier in the day. Therefore, the first medical record denoting claimant's reported mechanism of injury did not occur on April 5, 2012, as would be expected, but over one month later on May 15, 2012.

Following the May 15, 2012 physical therapy report, claimant presented to Dr. Martin on May 16, 2015. Dr. Martin's history reflects an insidious onset of left shoulder pain in January 2012, development of right shoulder pain in the end of March 2012, and an exacerbation of left shoulder pain the prior week. There is no reference to sustaining an injury on April 5, 2012 and no mention of the specific injurious event reported to physical therapy the day prior.

It is not until evaluation by Dr. Jensen on August 15, 2012 that medical records begin to consistently reflect the occurrence of a specific injurious event at work which caused a pop of claimant's left shoulder. However, even the records of Dr. Jensen dated August 15, 2012, including a patient history form completed by claimant, state a date of injury of April 2, 2012.

The chiropractic note authored by Dr. De Jong on October 18, 2012 is the first record which reflects the same mechanism and date of injury as testified to by claimant. Dr. De Jong's record reflects a work injury occurred on April 5, 2012, when claimant felt a pop in her left shoulder/neck while lifting a screen of ink. The IMEs performed by Drs. Wampler and Bansal each reflect this reported mechanism of injury.

Prior to October 18, 2012, there is no mention in the medical records of a specific injurious event occurring on April 5, 2012. If one were to give claimant the benefit of the doubt, the first medical reference to a mechanism of injury consistent with that which she testified to at evidentiary hearing was to Dr. Jensen on August 15, 2012, albeit, claimant herself reported the injury occurred on April 2, 2012. However, physical therapy records indicate this mechanism of injury occurred on May 15, 2012.

It is acknowledged by the undersigned that typographical errors can and do occur. However, it is claimant who carries the burden of proof in regard to establishment of her workers' compensation injury. Therefore, it is claimant who ultimately bears the burden of correcting purportedly erroneous records. Claimant has simply failed to do so based upon the facts of this case. Claimant could have sought correction of the medical records purportedly in error or provided other testimony which supported her account of events or assertions of errors. She did not do so, leaving the undersigned to weigh only claimant's self-serving testimony against the weight of these records.

As claimant's testimony is of vital importance to the success of her claim, careful attention must be paid to claimant's credibility. Claimant's hearing testimony was consistent with that offered at her deposition. At evidentiary hearing, claimant testified for herself rather than in response to leading questions. Her testimony was delivered in a clear fashion, her physical presentation was consistent with that of a person claiming ongoing neck and shoulder difficulties, and her demeanor gave the undersigned no independent reason to doubt claimant's veracity. However, the written evidentiary record deviates from claimant's testimony repeatedly, as identified *supra*. Of additional note is claimant's conviction for theft, which bears upon claimant's credibility, and claimant's termination by defendant-employer on the basis of what amounts to dishonesty. While claimant disputes her termination, she provided no evidence supporting her version of events. The sheer multitude of inconsistency in the medical record when coupled with questions surrounding claimant's honesty, lead the undersigned to find claimant's testimony, absent corroboration, is not credible.

Given this credibility finding, claimant requires independent evidence if she is to meet her burden of establishing she sustained a work related injury on April 5, 2012. In regard to a claim for a neck injury, claimant has failed to meet her burden. Dr. Jensen opined claimant's objective neck pathology did not contribute to her complaints and any cervical symptoms claimant reported were not causally related to the alleged April 5, 2012 work injury or claimant's work activities. Dr. Wampler opined claimant's neck pathology did not play a role in claimant's symptoms, past or present, and claimant did not suffer any neck pathology as a result of the alleged April 5, 2012 injury. Dr. Bansal

opined claimant sustained a periscapular strain on April 5, 2012, which could feel like a neck injury to a patient. Simply, there is no medical evidence which supports the existence of a work related neck injury.

On the issue of a causal relationship between claimant's left shoulder complaints and the alleged April 5, 2012 injury, three physicians offered opinions. In addition, Dr. Jensen deferred to Dr. Martin to address the potential inconsistencies in claimant's histories. Dr. Martin agreed some inconsistency was present in the records with respect to the mechanism and date of injury. For his part, Dr. Martin indicated his records lacked any reference to claimant sustaining a traumatic work injury on April 5, 2012. He also drew attention to the lack of reference to a traumatic work injury in the physical therapy record of April 5, 2012. Dr. Wampler opined causation existed between claimant's complaints and the specific mechanism of injury reported to him by claimant. Similarly, Dr. Bansal opined the mechanism of injury reported to him, coupled with an immediate clinical presentation, was consistent with claimant's need for arthroscopy.

Although Dr. Wampler and Dr. Bansal both opine a causal link exists, the opinions are premised upon the occurrence of a specific event on April 5, 2012, as reported by claimant. As the undersigned found claimant's unsubstantiated reports lacked credibility, the opinions of Drs. Wampler and Bansal must be discounted as based upon an inaccurate history. Furthermore, Dr. Bansal's opinion is premised upon an immediate clinical presentation which cannot be verified by the contemporaneous medical records.

Given the above, it is determined claimant has failed to meet her burden of proving by a preponderance of the evidence that she sustained an injury on April 5, 2012 arising out of and in the course of her employment with defendant-employer. As claimant failed to meet this burden, consideration of the issues of causation of temporary disability, entitlement to temporary disability benefits, causation of permanent disability, extent of industrial disability, commencement date for permanent partial disability benefits, entitlement to payment of medical expenses and medical mileage, and entitlement to alternate care is unnecessary, as moot.

The final issue for determination is whether claimant is entitled to reimbursement of an independent medical evaluation pursuant to Iowa Code section 85.39.

Section 85.39 permits an employee to be reimbursed for subsequent examination by a physician of the employee's choice where an employer-retained physician has previously evaluated "permanent disability" and the employee believes that the initial evaluation is too low. The section also permits reimbursement for reasonably necessary transportation expenses incurred and for any wage loss occasioned by the employee attending the subsequent examination.

Defendants are responsible only for reasonable fees associated with claimant's independent medical examination. Claimant has the burden of proving the reasonableness of the expenses incurred for the examination. See Schintgen v.

Economy Fire & Casualty Co., File No. 855298 (App. April 26, 1991). Claimant need not ultimately prove the injury arose out of and in the course of employment to qualify for reimbursement under section 85.39. See Dodd v. Fleetguard, Inc., 759 N.W.2d 133, 140 (Iowa App. 2008).

Claimant seeks reimbursement for Dr. Bansal's IME of December 13, 2013 in the amount of $2,495.00. (Ex. 5, p. 1) Although claimant ultimately failed to prove her injury arose out of and in the course of her employment with defendant-employer, this is not fatal to her claim for reimbursement of an IME. Employer-retained physician, Dr. Wampler issued an opinion on the extent of claimant's permanent impairment on October 10, 2013. This opinion triggered claimant's right to a section 85.39 IME, which she subsequently procured from Dr. Bansal on December 13, 2013. There is no evidence the fee charged by Dr. Bansal was unreasonable. Therefore, defendants are responsible for Dr. Bansal's IME fee and shall reimburse claimant in the amount of $2,495.00.

ORDER

THEREFORE, IT IS ORDERED:

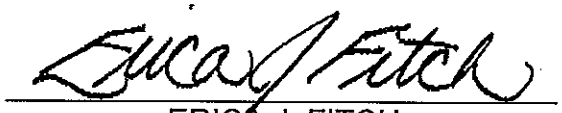
Claimant shall take nothing from these proceedings by way of indemnity benefits.

Defendants shall reimburse claimant for Dr. Bansal's independent medical evaluation in the amount of two thousand four hundred ninety-five and no/100 dollars ($2,495.00).

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

Costs are taxed to defendants pursuant to 876 IAC 4.33.

Signed and filed this 24th day of March, 2015.



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EJF/kjw

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.