BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

RAYMOND GRIFFIN, Claimant, vs. DOUBLE S TRUCK LINE, INC., Employer, and DAKOTA TRUCK UNDERWRITERS, Insurance Carrier, Defendants.	:	File No. 5044225 A P P E A L D E C I S I O N Head Note Nos.: 1402.40, 1703, 1803

Defendants Double S Truck Line, Inc., employer, and its insurer, Dakota Truck Underwriters, appeal from an arbitration decision filed on November 13, 2014. The case was heard on September 9, 2014, and it was considered fully submitted on September 29, 2014, in front of the deputy workers' compensation commissioner

The deputy commissioner found that claimant's January 21, 2010, work injury is the cause of 25 percent industrial disability.

Defendants assert on appeal that the deputy commissioner erred in awarding industrial disability benefits. Claimant asserts that the deputy commissioner's award should be affirmed.

Having performed a de novo review of the evidentiary record and the detailed arguments of the parties, pursuant to Iowa Code sections 86.24 and 17A.15, I reverse the deputy commissioner's award of 25 percent industrial disability.

RELEVANT STIPULATION AT HEARING

The parties agreed that on January 21, 2010, claimant sustained an injury to his head which arose out of and in the course of his employment with defendant-employer when claimant slipped and fell on an icy parking lot.

ISSUES ON APPEAL

1. Whether the work injury of January 21, 2010, was a cause of a loss of vision acuity.

2. If so, the extent of claimant's entitlement to permanent disability as a result of his vision loss.

In the arbitration decision, the presiding deputy did not find a causal relationship between the work injury of January 21, 2010, and claimant's other physical complaints asserted in this proceeding as work-related, namely, chronic headaches, chronic neck pain and back pain, loss of depth perception and loss of vision acuity beyond 20/60. Claimant did not cross-appeal the presiding deputy's denial of benefits for these other conditions.

FINDINGS OF FACT

Most of the following findings were contained in the arbitration decision and are adopted in this appeal decision. Where I disagree with the arbitration decision is clearly set forth below.

Claimant is a 60-year-old man, who lives in Council Bluffs, Iowa. (Tr. p. 18) He has only a ninth grade education but has obtained a GED. (Ex. C, p. 3; Tr. p. 9) Claimant has been employed as an over-the-road commercial truck driver since the age of 18. (Tr. p. 19) He started driving a semi for defendant-employer in approximately 1999. (Ex. C, p. 6; Tr., p. 18)

On January 21, 2010, claimant was making a delivery in Chariton, Iowa. He exited his truck, slipped and fell on ice. He struck the back of his head on the ground and sustained a significant laceration on the back of his head. (Ex. 1) At his initial emergency room visit, claimant denied any loss of consciousness or associated symptoms and reported no neck or back pain and no vision problems. (Ex. 1) After receiving staples to close his head laceration at a local hospital, claimant returned to work the same day. He then was dispatched to Marshalltown to pick up a load and he subsequently delivered that load to defendant-employer's terminal in Avoca, Iowa. (Tr. p. 23) He then delivered a load to Omaha and returned to Iowa. (Id)

After a couple of scheduled days off, claimant was dispatched to take a load from Iowa to North Carolina and deliver the load in Omaha. (Id.) Claimant states at this time, he informed the dispatcher that he was not feeling good, but thought things would clear up so he accepted the dispatch. (Tr. p. 23-24) Claimant left for North Carolina on January 24, 2010. (Tr., pp. 24, 61)

Claimant testified that he began developing vision difficulties during the return trip from North Carolina, but he was able to deliver the load to Omaha before returning his truck to Avoca, a few days later on January 28, 2010. Claimant testified his blurriness "was worse than it already was" and received complaints over his CB that he was

cutting off other trucks while passing them. (Tr. p. 24) Claimant asserts he has not driven a truck or any other vehicle since January 28, 2010, due to vision problems. (Tr. p. 26) Also, January 28, 2010, was the last time claimant has been employed and he testified he has not sought any type of employment since leaving defendant-employer. (Tr, pp. 28-29) At hearing, claimant was seeking benefits for permanent total disability allegedly caused by the slip and fall injury on January 21, 2010.

During his return trip to Iowa after leaving North Carolina, claimant retained legal counsel, who sent him for evaluation by a neurosurgeon, Charles Taylon, M.D., on January 29, 2010. Claimant at this time did not report his problems to defendant-employer. Dr. Taylon recorded complaints of visual problems, including difficulties with visual acuity, depth perception, headaches, and neck pain. (Ex. 2, p. 2) Dr. Taylon ordered a brain MRI and a CT of claimant's neck, both of which were negative. (Ex. 2, p. 3) Dr. Taylon ordered a follow-up MRI of claimant's neck, which was also negative. (Ex. 2, p. 5)

Upon referral by Dr. Taylon, claimant obtained an evaluation by a neurologist, Joel T. Cotton, M.D., on March 15, 2010. Dr. Cotton's neurologic evaluation was normal and he noted "significant variabilities and inconsistencies on his physical examination." (Ex. L, p. 3) Dr. Cotton "was unable to explain his multiple symptoms or why he would be developing additional symptoms following his injury." (Ex. L, p. 3) Dr. Cotton specifically opined, "his complaints of low back and numbness and tingling in both of his legs do not appear to be a work type injury." (Ex. L, p. 3) Dr. Cotton recommended no further neurologic testing or work-up and imposed no work restrictions upon claimant. (Ex. L, p. 3) Dr. Taylon concurred that claimant's low back symptoms are not related to his work injury. (Ex. 2, p. 3)

On April 5, 2010, on referral by Dr. Taylon, Christopher W. Anderson, D.O., a specialist in physical medicine and rehabilitation, evaluated claimant. Claimant reported to Dr. Anderson that he did not lose consciousness when he fell. Dr. Anderson concurred with Dr. Taylon that claimant's low back symptoms were not related to the fall at work. (Ex. 3, pp. 2-4) Dr. Anderson provided the impression that claimant had cervicalgia with posttraumatic headaches. He recommended a neuro-ophthalmology consultation and he also recommended a formal driver's evaluation to determine claimant's ability to drive. (Ex. 3, pp. 3-4)

Upon referral from Dr. Taylon, claimant attended physical therapy for a number of sessions from March 2010 through April 2010. (Ex. H) Physical therapist, Angela Davis, recorded some significant concerns and inconsistencies in her therapy notes. Specifically, on April 12, 2010, Ms. Davis noted:

> Again, I am concerned with Ray's inconsistent pain behaviors. While ambulating through the gym he turns over his right shoulder to look in the parking lot and demonstrates full rotation ROM. In addition, there are many instances where he has been able to see the T.V. or see an object

> that is 20-30 feet away. This is inconsistent with his reports that anything over 15 feet is blurry.

(Ex. H. p. 12)

Ms. Davis reiterated those concerns and inconsistencies during trial testimony. Ms. Davis' notes reflect and she testified that claimant made comments about driving a Camaro. Claimant denied operating any vehicles since January 2010. Yet, I have no reason to believe that Ms. Davis provided inaccurate medical notes or testimony. As will be detailed throughout, claimant lacks credibility. Whether claimant actually drove a Camaro during his treatment with Ms. Davis, I believe he told Ms. Davis he drove a Camaro at a car show. The deputy commissioner viewed the testimony of both claimant and Ms. Davis, and having compared their testimony to other available evidence in the record, the deputy commissioner found Ms. Davis' testimony to be credible and her therapy notes to be accurate as to her observations. There is nothing in the record of this case which causes me to reach a different conclusion.

On May 13, 2010, Dr. Taylon released claimant from his care. He concluded that claimant had no neurologic abnormalities per his examination and permitted a return to work from a neurologic standpoint on June 1, 2010. However, Dr. Taylon recommended evaluation by a neuro-ophthalmologist given claimant's complaints of vision change. (Ex. 2, p. 3) Dr. Taylon's final diagnosis of claimant's condition was cervical contusion for which he offered a five percent permanent impairment rating but imposed no permanent work restrictions. (Ex. 2, p. 9)

Upon referral from Dr. Taylon, claimant was evaluated by Richard H. Legge, M.D., a neuro-ophthalmologist on May 19, 2010. Dr. Legge recorded complaints which included blurred vision, a headache and an eye ache. Dr. Legge recorded that claimant reported a possible loss of consciousness when the accident occurred. (Ex. 4, p. 2)

Dr. Legge's testing demonstrated a subjective 20/400 visual acuity which would render claimant legally blind. (Ex. D, p. 2). Dr. Legge noted that vision testing at the Nebraska Medical Center on March 8, 2010, indicated a visual acuity of 20/50 in the right eye and 20/60 in the left eye. (Ex. D, p. 9) However, Dr. Legge noted that this visual acuity score represented "functional embellishment, either conscious or unconscious." (Ex. 4, p. 2) There are no records of this vision testing in evidence.

Dr. Legge opines that brain injury vision loss does not deteriorate further after a few days following a traumatic injury and concluded that the March 8, 2010, testing indicated claimant's actual vision loss. (Ex. D, p. 11; Trans. pp. 40-43) Therefore, Dr. Legge attributed only the vision loss of 20/60 to a traumatic brain injury on January 21, 2010, and this organic vision loss was not correctable. (Ex. D, p. 38) Dr. Legge considered any greater loss exhibited in his vision testing and subsequent testing was non-organic or functional, possibly due to a psychological conversion disorder, conscious or unconscious. The doctor initially did not believe this was malingering. The doctor recommended psychological evaluation to refine is assessment. (Ex. 4, pp. 3-5)

Also, Dr. Legge diagnosed claimant with a measureable loss of depth perception, which he believed was also consistent with a traumatic brain injury. (Ex. 4, p. 2)

While still being treated by Dr. Legge, claimant sought an independent medical evaluation, performed by Jeffrey A. Passer, M.D., on May 21, 2010. Dr. Passer appears to be a board-certified internal medicine physician with additional credentials in nephrology and holistic medicine. Dr. Passer opined that claimant's blurred vision, depth perception complaints, neck pain, right arm, low back pain, and pain in both of claimant's legs were all causally related to the fall on January 21, 2010. Dr. Passer's diagnosis included a concussion with severe headaches, visual impairment, and a cervical injury. Dr. Passer opined that claimant sustained permanent impairment totaling 44 percent of the whole person as a result of his headaches, visual impairment and cervical injury. (Ex. 5)

Dr. Anderson ordered a driver rehabilitation evaluation, which occurred on August 27, 2010. The occupational therapist performing that testing recommended against claimant being able to perform any driving. However, the therapist noted, "The results of the visual skills analysis on this date are very inconclusive as Ray's presentation varied from question to question." (Ex. 3, p. 15) The therapist noted significant inconsistencies between claimant's claim of depth perception difficulties and later observations of his abilities during different skills testing. (Ex. 3, p. 15)

During the driver rehabilitation evaluation, claimant demonstrated visual acuity of 20/100, which the therapist noted was inconsistent with either the March 8, 2010, testing from the University of Nebraska Medical Center (20/50 and 20/60) or Dr. Legge (20/400). Claimant told the therapist he could not make out shapes and numbers, but during later testing was able to read scores off a screen to the therapist. The occupational therapist noted that claimant's ability to observe and read items during non-acuity testing was not consistent with the results of the visual acuity testing. (Ex. 3, p. 15)

Another troubling finding by the occupational therapist during the driving rehabilitation test was described by the therapist as follows:

> Ray was told that the evaluator would be keeping track of the time it took for him to process each question as well as the answers. On the first 13 questions where he was instructed on this it took him an average of 9.6 seconds to process each answer. After 13, Ray was told that the evaluator would no longer be keeping track of time, and the average for those remaining questions were 4.4 seconds, which falls very close to what is considered normal for his age group. It should also be noted that although Ray stated his vision was so significantly impaired; however, he was able to read the small print labeling A, B, C, and D that were below each of the questions without any difficulty. . . After having completed the test, it was identified that the evaluator had actually been keeping track of all of the time for the entire test, and the discrepancy between the 2 times

> was brought up to Ray. He did not seem to have an explanation for the significant difference in completion times when he thought processing time was being recorded and not being recorded.

(Ex. 3, p. 15)

Following the testing, the therapist noted:

> . . . the results were inconsistent throughout. It is believed that Ray does have the ability to perform better than what was presented at his evaluation as sometimes his eyes were extremely bad yet he was able to read small print and numbers that were inconsistent with how he scored on the actual visual testing. It is also of interest that his processing speed changed dramatically on the MVPT between the times he believed the processing speed was being tested and when it was no longer being recorded. It is believed that Ray did not provide an accurate depiction of his overall functional status. It is agreed that Ray is probably experiencing some difficulties resulting from his injury; however, it is difficult to determine and recommend what type of assistance can be provided when the information being received from the evaluation does not seem to accurately depict his current deficits.

(Ex. 3, p. 16)

A second neuro-ophthalmology consultation was performed at defendants' request by Yanjun Chen, M.D. at the University of Iowa Hospitals and Clinics on September 9, 2010. At this evaluation, claimant reported some amnesia occurred after the fall on January 21, 2010. (Ex. K, p. 1) No such reports had previously been recorded by any medical provider. Claimant told Dr. Chen he was unsure if he lost consciousness while lying on the ground after his fall. (Ex. K, p. 1) Claimant reported to Dr. Chen that he developed blurry vision within one hour after the fall. (Ex. K, p. 1) Following his physical examination, Dr. Chen noted:

> The etiology of decreased vision is unclear at this time. There was significant fluctuation of the visual testing during today's encounter, with VA varied from level of 20/100 to 20/60. There was also inconsistency between confrontation visual field and GVF, and during the color vision testing. With this much fluctuation, it is hard to estimate visual function reliably. There was no ocular pathology identified from today's exam that can explain fluctuation of the exam. However, his VA was measured better than what was documented in previous exam (20/400).

(Ex. K, p. 5)

Dr. Chen stated that the cause of claimant's vision loss was unclear. He explained that fluctuations in vision sometimes can be caused by neuro-degenerative

diseases or cognitive decline from traumatic injury. The doctor recommended a neuropsychological evaluation to assess claimant's cortical function. (Id.)

On May 19-20, 2011, claimant submitted to a neuropsychological evaluation performed by Marjorie A. Padula, Ph.D. The doctor did not assess claimant's cortical function or any cognitive loss as a result of a claimed traumatic brain injury. Dr. Padula only provided a psychological evaluation . At that evaluation, claimant told Dr. Padula he had flashbacks for about one to two years after he returned from Vietnam as a member of the United States Marine Corp. (Ex. F, p. 3) Claimant was in the Marine Corps, but never served overseas. He now denies reporting service in Vietnam to Dr. Padula. His attempt to deny that he provided this history to Dr. Padula is not convincing. Given another comment that will be discussed below, I find claimant provided inaccurate information to Dr. Padula regarding his military service. I find Dr. Padula's recording is accurate and claimant's denial that he provided this history is unconvincing.

Dr. Padula issued a report, opining as follows:

> Results of the Personality Assessment are consistent with an individual experiencing significant depression who is converting unrecognized psychological stress into physical symptoms, particularly Claimant's report of visual difficulty that is inconsistent with objective medical findings. Although his performance is inconsistent at times, and secondary gain for emotional financial reasons is a likely factor, Claimant does not appear to be consciously malingering. It is likely he is unconsciously biasing information to support his adoption of the sick rule.

(Ex. F, p. 9)

Dr. Padula recommended therapy with a psychologist. (Ex. F, p. 9)

Claimant submitted to psychological counseling between July 2011 and September 12, 2011, with T. J. Haley, Ph.D. Ultimately, claimant was resistant to the psychological counseling and became "belligerent" anytime the psychologist approached issues that dealt with symptom magnification. (Ex. O, p. 2) Dr. Haley released claimant from his care on September 12, 2011.

Dr. Padula re-evaluated Claimant after the psychological counseling failed. She performed repeat neuropsychological testing on claimant on February 2-3, 2012, and authored a supplemental report dated February 14, 2012. Ultimately, Dr. Padula concluded, claimant's "assessment results continue to support a psychological basis for his reported physical/visual problems. Secondary gain for emotional and financial reasons is also likely helping to maintain his symptoms." (Ex. F, p. 13) Dr. Padula concluded, "Resolution of his worker's compensation claims is likely to result in improvement in his reported symptoms." (Ex. F, p. 14)

Claimant returned to Dr. Legge on April 11, 2012. At that time, claimant reported ongoing difficulties with depth perception, blurred vision, headaches, and for the first time I identified, he contended he was experiencing light sensitivity and required the use of very dark sunglasses when outdoors. (Ex. 4, p. 6) Surveillance conducted by defendants in May 2011 demonstrated claimant outside on more than one occasion without sunglasses. In fact, the surveillance depicted claimant mowing his lawn on a bright day without any glasses. (Ex. S) The activities depicted on Exhibit S certainly contradict the reported photo sensitivity reported by claimant to Dr. Legge in April 2012.

After reviewing the neuropsychological evaluation reports from Dr. Padula, Dr. Legge concluded that claimant has:

> Traumatic brain injury with combination of organic vision loss due to his accident of January 21, 2010, in combination with functional or nonorganic vision loss. I can certify his organic vision loss of 20/60 bilaterally as this acuity was measured at the Nebraska Medical Center following his accident. However, I do think the additional vision loss to the 20/200 level to be nonorganic and probably embellishment.

(Ex. 4, p. 6)

In his deposition testimony, Dr. Legge stated that the psychological evaluations ruled out conversion disorder and agreed that the non-organic vision loss in excess of 20/60 was malingering. (Ex. D, p. 8; Tr. p. 31) Dr. Legge declared maximum medical improvement as of his April 11, 2012, evaluation. He opined that claimant cannot drive, operate power equipment or work at heights. However, Dr. Legge also indicated, "I do think the patient has adequate vision to perform work that does not require reading, such as janitorial work." (Ex. 4, p. 7) Dr. Legge testified that claimant's 20/60 visual acuity disqualifies him from commercial driving, but is able to drive a vehicle for personal use. (Ex. D, p. 10; Tr. p. 38)

Ultimately, Dr. Legge offered a 33 percent permanent visual impairment rating under the AMA Guides, Fifth Edition. (Ex. 4, p. 8) Dr. Legge's rating includes a three percent impairment for photosensitivity. Given claimant's ability to be outside for extended periods of time in 2011, as depicted on the surveillance video, I do not accept the photosensitivity diagnosis or impairment rating as accurate.

In response to claimant's independent medical evaluation and the treatment that had occurred to date, defendants sought a records review by an occupational medicine physician, Charles Mooney, M.D. Dr. Mooney authored a report dated August 13, 2012, stating as follows:

> It is my opinion upon review of the medical records that there are marked inconsistencies of the visual skill performance provided by Mr. Griffin. There is significant variation in his visual acuities and symptoms. Several medical providers including Dr. Legge, Dr. Chen, and Dr. Cotton agree

> that objective findings and visual acuities are not reproducible. Numerous providers have suggested that Claimant is intentionally falsifying his perceived abilities and statements provided by the occupational therapist also reveal that there are inconsistencies in performance and stated activity level. This supported by the [sic] Dr. Haley's intervention and resistance to discussion regarding issues of symptom magnification and psychological overlay.....Overall, it is my opinion that none of the providers are willing to diagnose malingering or intentional secondary gain manipulation due to potential litigation related to Mr. Griffin's injury which would create a further dependency on the provider to provide testimony.

(Ex. E, p. 4)

Dr. Mooney opined that there is no objectively identifiable criterion upon which a permanent impairment rating can or should be awarded to claimant under the AMA Guides, Fifth Edition. Dr. Mooney opined that claimant achieved maximum medical improvement. (Ex. E, p. 4)

Defendants retained a second neuropsychologist, Robert Jones, Ph.D., to evaluate claimant. Dr. Jones performed neuropsychological testing of claimant's cognitive functioning for seven to eight hours on December 13, 2012. (Ex. G) Dr. Jones noted claimant was unsure if he lost consciousness, but that there was no retrograde amnesia. This directly contradicts claimant's reporting to Dr. Chen in September 2010 and is a good example of the variability and inconsistency of the information claimant provided to his medical providers. (Ex. G, p. 3; Ex. K, p. 1) Given the report to the initial emergency room physician and the report to a physician chosen by claimant's attorney, Dr. Taylon, I find the history relayed by Dr. Jones is the accurate medical history, i.e., claimant did not suffer amnesia after the fall in January 2010.

Claimant told Dr. Jones that "he had been arrested twice as a younger person, but was never charged with a crime." (Ex. G, p. 3) Yet, claimant has provided various versions of his criminal history and is clearly not consistent or credible when discussing his criminal history. He has reported felony charges and convictions in Texas, only to recant later. He reported charges in California, only to deny those later in this case.

Claimant clearly has provided multiple versions of events, his criminal history, and is not credible. Ultimately, my findings of fact and conclusions are not based in any significant degree upon the testimony of claimant because I find claimant's testimony is not credible.

Following his battery of tests and psychological interview of claimant, Dr. Jones stated, "Testing of effort reflected findings that suggested that he may not have been putting forth full effort during the examination." (Ex. G, p. 5) The doctor opined as follows:

> We would not diagnose a traumatic brain injury or postconcussive syndrome in this case. Mr. Griffin reportedly suffered a concussion at the time he fell on ice in January 2010. However, the results of the current examination are largely within expectations, with very little evidence of cognitive impairments secondary to concussion. This is consistent with the available information about the event itself and in particular the fact that neuropsychological deficits would not be expected given the limited immediate consequences of the fall (including little or no loss of consciousness, no retrograde amnesia, and 2-3 minutes of post traumatic amnesia at most).

(Id.)

Dr. Jones further commented that the few cognitive weaknesses that may appear to be present in the current examination are unreliable because the data from the current assessment cannot be taken at face value, since claimant may well have "underperformed" by not providing valid effort during the examination. (Id.)

After considering all of the relevant medical opinions in this case, I accept the opinions of Dr. Taylon, Dr. Cotton and Dr. Anderson that the alleged low back conditions are not causally related to the work injury. Claimant produced a competing causation opinion from Dr. Passer. However, I find that Drs. Taylon, Cotton and Anderson have superior credentials to Dr. Passer, who is an internal medicine physician, on issues pertaining to causation of a low back condition. I also note Dr. Taylon was specifically selected by claimant's attorney for the initial evaluation. Dr. Taylon's opinion that the low back was not initially mentioned and is not causally related carries significant weight, particularly when supported by a rehabilitation physician (Dr. Anderson) and a neurologist (Dr. Cotton). I find claimant's low back complaints are not related to the January 21, 2010, work injury.

With respect to the issues of claimant's headaches, I accept the opinions of Dr. Cotton and Dr. Mooney. I find claimant has clearly offered exaggeration and symptom magnification throughout the course of this claim and throughout his medical care. Dr. Cotton opined there was no objective neurologic evidence to support claimant's claims. Therefore, I find claimant has failed to prove permanent disability related to his alleged headaches.

Claimant concedes his neck symptoms and condition resolved after being provided physical therapy. He has not proven any permanent disability related to his neck, despite the opinions of permanent impairment offered by Dr. Taylon and Dr. Passer.

I find claimant has not sufficiently proven a permanent change in his depth perception. Once again, claimant's testing demonstrated inconsistencies and likely symptom magnification on this issue. Claimant did not carry his burden to establish a permanent loss of depth perception by a preponderance of the evidence. Instead, I find

the inconsistencies documented on the driving test in August 2010 demonstrate he does not have an actual permanent change in his depth perception.

With respect to claimant's visual acuity, I find claimant clearly exaggerated his symptoms and he provided false bad scores to medical providers, including his physical therapist, to Dr. Legge, to Dr. Chen, and during his driving test. Certainly, the findings of Dr. Legge of 20/400 acuity are not objectively verifiable or proven accurate by claimant.

This is where I depart from the deputy commissioner's findings. The deputy ultimately found convincing Dr. Legge' views that claimant suffered at least a loss of visual acuity of 20/60 from a traumatic brain injury on January 21, 2010. I do not agree. As aptly pointed out by defendants in their appeal brief, there is no evidence concerning vision testing at or before his fall on January 21, 2010, showing he had better vision than 20/60. There is no dispute claimant was wearing bifocal corrective lenses at the time he fell and he admits he has not changed his corrective lens prescription since the work injury. (Ex. A, p. 16; Tr. pp. 58-59) Claimant did have a commercial driving license at the time of this fall. One must have at least 20/40 vision with or without corrective lenses to be an interstate commercial driver. (49 CFR 391.41(b)(10)) Claimant testified at hearing that his commercial drivers' license expired on September 2, but he did not provide the year. (Tr. p. 26) Presumably, he meant 2010. If so, he had to have demonstrated 20/40 vision at his last medical DOT evaluation in either August or September 2008 as medical certificates for commercial drivers last only two years. (49 CFR 391.43) It is possible claimant's vision could have deteriorated over 15-16 months prior to the injury. If the CDL expired in later years, then he would have had no vision loss after the injury. His claim that his vision deteriorated only after the January 21, 2010, injury is based solely on claimant's statements to his doctors and his testimony, which has been shown to be unreliable.

Also, I find problems with Dr. Legge's views. He rejects the vision loss claim over 20/60 based on malingering, but somehow accepts that claimant was not malingering or gave honest responses during the March 8, 2010, testing at the Nebraska Medical Center. I don't understand how Dr. Legge can view one test as malingering and an earlier test as valid. The doctor admitted that the only objective testing available with current technology was the "visual evoked potential test" which in claimant's case only indicated he had better vision than 20/100. (Ex. D, p. 4; Tr. p. 13) The doctor also admitted there is no objective testing procedure to determine claimant's actual vision loss and testing to differentiate between 20/30 versus 20/100 and must rely upon a person's self-reporting of the loss. (Ex. D, p. 9; Tr. p. 34) Therefore, to conclude that the fall injury caused vision loss, we again must rely upon claimant's ability to honestly self-report in March 2010. Such ability has not been shown in this case, even in Dr. Legge's reports.

Finally, there is no way I can reconcile the view of Dr. Legge that claimant suffered a traumatic brain injury and the view of Dr. Jones that he did not suffer such an injury. Dr. Legge, as a neuro-ophthalmologist, certainly is qualified to diagnoses such

an injury. However, Dr. Chen felt it necessary to obtain cognitive testing by a neuropsychologist to complete his assessment and Dr. Legge does not explain why he did not believe it was necessary to do so. Dr. Jones, who rejects such an injury, is a board certified neuropsychologist and clinical professor at the University of Iowa School of Medicine. The primary function of a clinical neuropsychologist is to diagnose and rehabilitate persons with brain injuries and cognitive loss.

Therefore, I am unable to find that the work injury of January 21, 2010, is a cause of any vision loss.

CONCLUSIONS OF LAW

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 treating physician's opinions are not to be given more weight than a physician who examines the claimant in anticipation of litigation as a matter of law. Gilleland v. Armstrong Rubber Co., 524 N.W.2d 404, 408 (Iowa 1994); Rockwell Graphic Systems, Inc. v. Prince, 366 N.W.2d 187, 192 (Iowa 1985).

In this case, claimant failed to carry his burden of proof to show by convincing credible evidence that he suffered a vision disability from the January 21, 2010, work accident. I find claimant is not entitled to further benefits for that injury.

ORDER

IT IS THEREFORE ORDERED the award of benefits in the arbitration decision filed on November 13, 2014, is reversed.

1. Claimant shall take nothing from these proceedings.

2. Claimant shall pay the costs of the arbitration action and the costs of the appeal pursuant to administrative rule 876 IAC 4.33.

Signed and filed this 5th day of February, 2016.

Joseph S. Cortese II

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WORKERS' COMPENSATION
COMMISSIONER

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