BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

ISAAC MILLANES ORTIZ,

Claimant,

vs.

LOYD ROLING CONSTRUCTION,

Employer,

and

GRINNELL MUTUAL REINSURANCE,

Insurance Carrier,
Defendants.

File No. 5041675
5048346

ARBITRATION

DECISION

Head Note Nos.: 1402.40; 1801; 1801.1; 1802; 4000

STATEMENT OF THE CASE

Claimant, Isaac Millanes Ortiz, filed petitions in arbitration seeking workers' compensation benefits from Loyd Roling Construction, employer, and Grinnell Mutual Reinsurance, insurance carrier, both as defendants, as a result of a stipulated injury sustained on September 28, 2012 and an alleged injury sustained on August 5, 2012. This matter came on for hearing before Deputy Workers' Compensation Commissioner, Erica J. Fitch, on November 21, 2014, in Des Moines, Iowa. The proceedings were translated by Evelyn Rudich. The record in this case consists of claimant's exhibits 1 through 20, defendants' exhibits A through L, and the testimony of the claimant and Loyd Roling. The parties submitted post-hearing briefs, the matter being fully submitted on March 4, 2015.

ISSUES

In File No. 5048346 (August 5, 2012 Date of Injury):

The parties submitted the following issues for determination:

1. Whether claimant sustained an injury to his left leg on or about August 5, 2012 which arose out of and in the course of employment; and
2. Whether claimant is entitled to payment of various medical expenses.

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

In File No. 5041675 (September 28, 2012 Date of Injury):

The parties submitted the following issues for determination:

1. Whether claimant is entitled to temporary disability benefits from January 20, 2014 through March 10, 2014 or is disqualified from receipt of such benefits pursuant to Iowa Code section 85.33(3) due to a failure to accept suitable work;
2. Whether the stipulated injury is a cause of permanent disability;
3. The extent of claimant's permanent disability, including whether the disability is unscheduled or to a scheduled member;
4. Whether claimant is entitled to payment of various medical expenses;
5. Whether claimant is entitled to alternate medical care pursuant to Iowa Code section 85.27;
6. Whether claimant is entitled to penalty benefits under Iowa Code section 86.13 and, if so, how much; and
7. Specific taxation of costs.

FINDINGS OF FACT

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

Claimant was 51 years of age at the time of hearing. He resides in Iowa City, Iowa, where he rents a room in a trailer from a family. (Claimant's testimony) Claimant obtained a high school degree in Mexico. (Exhibit 10, page 213) While in Mexico, claimant also took additional coursework in agronomy; he dropped out of school due to family problems. At the time of his withdrawal from school, claimant was two semesters shy of a degree in agricultural engineering. (Claimant's testimony; Ex. 16, Deposition Transcript p. 19) Claimant's primary language is Spanish. He testified he is able to speak, read and write a small amount in English. (Claimant's testimony)

While in Mexico, claimant worked as a ranch hand, security guard, or for Mexican Federal Security. In 2003, claimant moved to Texas and secured a job in the shipping department of a poultry processor. Claimant worked in this position until 2007. During this time, claimant earned $9.00 per hour and worked 40 to 50 hours per week. He estimated average earnings of $600.00 to $700.00 per week. In 2007, claimant moved to Mississippi, where he worked as a concrete laborer. Claimant estimated he earned $1,000.00 to $1,500.00 per week in this position. (Claimant's testimony; Ex. 10, p. 214; Ex. 16, Depo Tr. pp. 20-31)

Claimant began work at defendant-employer in October 2008 as a laborer and handyman. In this role, claimant performed a variety of tasks, including painting, roofing, driving, and feeding animals, essentially completing whatever task was assigned by owner, Loyd Roling. Claimant earned a minimum salary of $500.00 per week. Claimant testified he typically earned an additional $100.00 to $300.00. Claimant's pay was given to him in cash by Mr. Roling. Claimant was also provided housing. (Claimant's testimony; Mr. Roling's testimony; Ex. 10, p. 215; Ex. 16, Depo. Tr. pp. 34-35, 43) Mr. Roling testified claimant only received $500.00 per week in salary. (Ex. 18, Depo. Tr. p. 9)

Claimant testified he generally worked for defendant-employer from February through November of each year and then would be off work for about two months. Claimant testified he would often get another job during this period and then return to work for Mr. Roling in the spring. However, he indicated during these times, he would still present to Mr. Roling's residence to perform activities, when requested. (Claimant's testimony; Ex. 16, Depo. Tr. pp. 11-12, 38-40; Ex. 17, Depo. Tr. p 46) Mr. Roling described claimant as a "great employee" who was willing to do any task requested. (Ex. 18, Depo. Tr. p. 21)

Claimant claims on or about August 1, 2012, his left leg was cut by a nail while working. He did not seek immediate medical treatment, but eventually sought care at Mercy Medical Center in Iowa City and the University of Iowa Hospitals & Clinics in Iowa City. Claimant asserts Mr. Roling had actual notice of the injury. (Claimant's testimony; Ex. 10, p. 217; Ex. 17, Depo. Tr. pp. 8-9) Mr. Roling testified he did not know claimant's injury was work-related. He admitted upon seeing claimant's leg, he advised claimant to go to a doctor. (Mr. Roling's testimony)

On August 5, 2012, claimant presented to the emergency room of the University of Iowa Hospitals & Clinics (UIHC) and was evaluated by Jon Van Heukelom, M.D. Dr. Heukelom noted complaints of left lower extremity redness and swelling for approximately one week, as well as moderate to severe pain. Claimant informed Dr. Heukelom he sought medical care four days prior and was told he did not need treatment. (Ex. 3, p. 21) Examination revealed an area of fluctuance on claimant's left anterior shin with surrounding erythema. Dr. Heukelom assessed an abscess with surrounding cellulitis and performed an abscess incision and drainage. Claimant was also issued a prescription for Bactrim. (Ex. 3, pp. 20, 22)

Claimant returned to UIHC on August 7, 2012, with reports of increased pain, extension of erythema, and continued drainage. Claimant denied trauma to the location which became abscessed, but did report suffering with frequent nail penetrations in performance of construction work. Claimant stated he previously went to the emergency room of Mercy Hospital and was provided ibuprofen and subsequently presented to UIHC and underwent abscess incision and drainage. (Ex. 3, pp. 23, 28) Alexander Wittry, M.D., examined claimant and opined claimant failed outpatient

Bactrim therapy. He admitted claimant to the hospital overnight for IV antibiotic therapy. (Ex. 3, pp. 23-24, 30, 34, 38)

Claimant asserts Mr. Roling visited claimant while he was hospitalized and informed claimant all the medical bills would be paid. (Ex. 10, p. 217) Mr. Roling denied visiting claimant in the hospital, as he was unaware claimant was hospitalized. Mr. Roling testified claimant telephoned him and simply stated he had an infection. (Mr. Roling's testimony) Mr. Roling testified at that time, he was unaware claimant claimed he was injured in August 2012. (Ex. 18, Depo. Tr. pp. 19-20)

On August 8, 2012, claimant was discharged from UIHC with prescriptions for clindamycin and hydrocodone-acetaminophen. (Ex. 3, pp. 24, 26, 36, 38) Thereafter, claimant returned to work for Mr. Roling. (Claimant's testimony)

On September 28, 2012, claimant testified he was standing on a roof, painting, when he fell to the ground. Claimant testified he fell onto his left side and then ended up lying on his back. Claimant described suffering with a significant amount of pain. (Claimant's testimony; Ex. 16, Depo. Tr. p. 50) An ambulance arrived and transferred claimant to UIHC. (Ex. 8, pp. 189-190)

In the UIHC emergency department, claimant was evaluated by Dionne Skeete, M.D. Dr. Skeete noted complaints of chest pain and left arm pain. (Ex. 3, p. 43) Dr. Skeete also noted claimant's left arm was "grossly deformed." (Ex. 3, p. 44) Claimant underwent x-rays of the chest, pelvis, and left shoulder and left upper extremity, as well of CT scans of the chest and cervical spine. The CT of claimant's chest revealed left pneumothorax and rib fractures. X-rays revealed a mid-shaft fracture of the left humerus. Claimant was admitted to the trauma service for further care. (Ex. 3, p. 45) Dr. Skeete placed a chest tube as a result of the pneumothorax. (Ex. 3, p. 53)

Emilie Fowlkes, M.D., of the UIHC emergency department, assessed a closed, displaced, aped anterior lateral, mid diaphyseal fracture of the left humerus with a radial nerve palsy. Dr. Fowlkes performed a closed reduction with splinting of the humerus fracture. Dr. Fowlkes provided a cockup splint for the radial nerve palsy, as well as ordered a course of therapy for the right hand and radial nerve palsy. Dr. Fowlkes advised claimant the nerve injury required time to heal and it was not possible to predict what function claimant would regain. (Ex. A, p. 3)

While in the hospital, claimant testified he believed Mr. Roling visited him on one or two occasions. (Claimant's testimony) Mr. Roling testified he visited claimant five times, but acknowledged claimant was not notably conscious during some visits. (Mr. Roling's testimony)

Claimant was discharged from UIHC on October 3, 2012. (Ex. 3, pp. 54-55)

Claimant testified when he was discharged, he did not have a place to live, so a friend brought claimant to his residence. Claimant testified he did not recall if Mr. Roling offered him a place to live at that time. (Claimant's testimony)

Mr. Roling testified he went to the hospital one day to visit claimant, but claimant had been discharged. He indicated he did not know where claimant had gone. Mr. Roling testified claimant could have returned to his provided residence. Mr. Roling testified he intended for claimant to return and even joked with workers at the hospital about who would take care of claimant. (Mr. Roling's testimony)

Mr. Roling testified for a couple weeks after claimant was released from the hospital, Mr. Roling attempted to contact claimant on the telephone. He estimated making around a dozen phone calls to claimant's cell phone. Eventually, Mr. Roling testified he gave up, figuring claimant did not want to speak with him. (Ex. 18, Depo. Tr. pp. 39-40) At later dates, Mr. Roling indicated he went to the trailer where claimant had stayed with his girlfriend. Mr. Roling indicated he went to the trailer on 3 or 4 occasions in attempt to contact claimant, but no one answered the door. Each time, Mr. Roling indicated he would leave his business card with a note. (Ex. 18, Depo. Tr. p. 37, 42-44) Mr. Roling testified he also left notes on multiple trailers where he had heard claimant was staying. (Mr. Roling's testimony)

On October 10, 2012, claimant's attorney directed a letter to Mr. Roling, providing a copy of claimant's original notice and petition for benefits and a signed patient waiver. Counsel advised Mr. Roling to forward this information to his workers' compensation insurer or to his attorney. He also requested payment of workers' compensation benefits, specifically healing period benefits. (Ex. 15, pp. 243-244; Ex. J, pp. 3-4)

Claimant was assigned a nurse case manager, Jane Collins, RN, BSN. Ms. Collins' notes dated October 18, 2012 indicate claimant lived at a property owned by defendant-employer until the date of the fall, but after discharged from UIHC, claimant moved to an address on Laura Drive in Iowa City. (Ex. 10, p. 212) Claimant indicated he was staying with friends. Mr. Collins secured claimant's phone number and address. (Ex. 9, p. 194)

On October 23, 2012, claimant's counsel directed a letter to Debbie Miller of defendant-insurance carrier. By the letter, claimant requested initiation of healing period benefits and provided claimant's current address on Laura Drive in Iowa City. (Ex. 15, pp. 245-246; Ex. J, pp. 1-2)

Defendant-insurance carrier issued a check to claimant on October 25, 2012, in the amount of $1,292.48. (Ex. 15, p. 247)

On November 8, 2012, Ms. Collins authored an email to Ms. Miller. Ms. Collins indicated she had received a "hostile" telephone call from Mr. Roling and had advised him to contact Ms. Miller with respect to issuance of proper checks. Mr. Roling stated claimant "went into hiding" after the injury; Ms. Collins explained claimant needed

physical assistance, so he was staying with friends and receiving care from visiting nurses daily. Ms. Collins indicated Mr. Roling ultimately hung up the phone. (Ex. 9, p. 196)

On December 12, 2012, claimant presented to the UIHC orthopedics department and was evaluated by Mary Greve, PA-C. Claimant requested an opinion from John Marsh, M.D., on possible surgical intervention due to nonunion of the humeral fracture. (Ex. 3, pp. 59-60) Claimant also complained of left-sided chest, neck, and shoulder pain. PA Greve noted these symptoms began about one week prior, corresponding in time "with him trying to increase his exercise program." Claimant described carrying a heavy bag around his neck to rest his arm upon while walking. (Ex. 3, p. 60) PA Greve noted:

> It sounds like this corresponded almost exactly with the onset of his rib and shoulder and neck-type pain. The pain is alleviated when he stops using the bag.

(Ex. 3, p. 60)

X-rays showed nonunion of the humeral shaft, leading Dr. Marsh to recommend open reduction internal fixation. (Ex. 3, p. 60) Claimant was provided a shoulder immobilizer to use and was advised to no longer wear the bag around his neck. (Ex. 3, p. 61)

Claimant testified the bag in question was not heavy, it was a small bag akin to a purse, which he used to carry his phone. (Claimant's testimony)

On December 17, 2012, claimant returned to PA Greve with complaints of redness and swelling of the left lower extremity which began the prior night. (Ex. 3, p. 40) Examination revealed a small indurated, warm, slightly erythematous area over the left distal anterior tibia. PA Greve prescribed Keflex. (Ex. 3, p. 41)

On January 3, 2013, claimant's counsel authored a letter to defendants' former counsel. Claimant's counsel stated defendants had failed to pay healing period benefits for the weeks of December 1, 2012 through December 7, 2012 and December 15, 2012 through January 4, 2013. Counsel requested benefit checks be sent to claimant in care of his attorney's office. (Ex. 15, p. 248) Counsel issued a repeat request for payment on January 15, 2013. (Ex. 15, p. 250)

On January 22, 2013, defendants' former counsel authored a responsive letter to claimant's counsel. By this letter, defendants' counsel represented defendants had issued checks for the dates in question, with those checks mailed to claimant's residence. Defendants' counsel indicated it was his understanding that claimant no longer lived at that address. Accordingly, counsel indicated he had advised defendants to place a stop payment on the separate checks and reissue a check for these weeks of temporary benefits to claimant in care of his attorney. (Ex. I, p. 1)

Defendant-insurance carrier issued a check for $1,292.48 to claimant in care of his attorney's office on January 25, 2013. (Ex. 15, p. 252)

On January 28, 2013, Dr. Marsh performed an open reduction internal fixation of claimant's humeral nonunion. (Ex. 3, pp. 65, 79; Ex. A, pp. 8, 12-13) Claimant was discharged from UIHC on January 30, 2013. (Ex. 3, pp. 70-71; Ex. A, pp. 8-11) Dr. Marsh removed claimant from work at that time. (Ex. A, p. 11) Following surgery, claimant continued to follow up at UIHC and progress with physical therapy, medications, and activity restrictions. (Ex. 3, p. 78; Ex. A, pp. 17-22) On April 24, 2013, Dr. Marsh imposed a work restriction of 10 pounds of lifting with the left upper extremity. (Ex. 3, p. 78; Ex. A, p. 22)

On May 3, 2013, claimant served his answers to interrogatories, at which time he revealed residing at an address on Laura Drive in Iowa City, Iowa since September 28, 2012. (Ex. 10, p. 212)

Defendants served their responses to claimant's requests for admissions on May 10, 2013. Request No. 2 asked defendants to admit or deny whether claimant "suffered an injury to his left arm, left shoulder, back, neck, head, and chest in the course of his employment on September 28, 2012." Defendants denied the request, stating the medical records did not document treatment or injury to claimant's back, neck, and head. (Ex. 11, p. 218)

On July 6, 2013, an ambulance was called to transport claimant to UIHC for what were noted as primary symptoms of alcohol intoxication, as well as altered mental state, slurred speech, and anxiety. (Ex. 8, pp. 192-193) The emergency room notes from UIHC described claimant as intoxicated. The records note claimant reported suffering with left arm pain for the last 1 ½ years and he drank beer and tequila to "take the pain away." Records also note claimant stated he wanted "God to kill him" and asked the emergency room personnel to "give him a shot where he will go to sleep and never wake up." Claimant also expressed intention to kill the man "who killed his wife and child." (Ex. 3, p. 105; Ex. A, p. 26) Amy Maule, M.D., assessed alcohol intoxication, and passive suicidal and homicidal ideation. She recommended psychiatry consult after claimant had sobered up. (Ex. 3, p. 103)

Claimant slept in the emergency room and then underwent psychiatric evaluation. At the time of the psychiatric consult, claimant indicated he felt well and asked to go home. Claimant described pressures related to his work injury, difficulties with chronic pain, and trouble balancing pain medications with functionality. Claimant stated he went to a bar and began drinking tequila; he did not remember anything after that time. When confronted with his comments to the emergency room personnel, claimant laughed and indicated he should never drink tequila again. (Ex. 3, p. 105)

Adam Nardini, M.D., performed the consultation for the UIHC psychiatry department. Dr. Nardini opined claimant was not suicidal. He further opined claimant did not meet the criteria for psychiatric admission and recommended discharge to home

when claimant became medically stable. Claimant was encouraged to follow-up with the Community Mental Health Center. (Ex. 3, pp. 106-108; Ex. A, pp. 28-29)

Paul Tschetter, M.D., of the UIHC emergency department opined claimant was not actually suicidal and was simply intoxicated. Dr. Tschetter opined claimant was a low risk for suicide attempt and permitted claimant to be discharged. (Ex. 3, p. 104)

Claimant testified around Independence Day of 2013, he went to a bar to watch celebrations. He began drinking tequila and does not recall any other details until he awoke in the hospital the next morning. (Ex. 16, Depo. Tr. p. 79)

Records of the UIHC social worker indicate a call was placed to claimant on July 11, 2013. The social worker assisted in facilitation of counseling sessions at Seashore Psychology Clinic at the University of Iowa, which were attributed to claimant's "pain and pain related depression." (Ex. 3, p. 81)

At Dr. Marsh's referral, on July 17, 2013, claimant presented to the UIHC Pain Clinic and was evaluated by Rapipen Siriwetchadarak, M.D. At that time, Dr. Siriwetchadarak noted complaints of diffuse pain over the left upper portion of claimant's body, primarily localized in the left arm and forearm. Claimant also reported paraspinal cervical muscle tenderness and cramping, upper thoracic tenderness and cramping, left axillary pain, and numbness and tingling of the left upper extremity. Claimant related his symptoms to the fall in September 2012. (Ex. 3, pp. 80, 82) Dr. Siriwetchadarak assessed diffuse pain of the left upper extremity, left radial nerve palsy, and associated musculoskeletal pain of the upper thoracic/lower cervical region, left axilla, and left sternum/chest wall. (Ex. 3, p. 85) Dr. Siriwetchadarak recommended a TENS unit, medications, and physical therapy. He also referred claimant to the health psychology department, as he believed claimant would benefit from pain psychology for coping skills. (Ex. 3, p. 85)

Claimant began counseling sessions at Seashore Psychology Clinic on August 2, 2013. Claimant complained of pain of the left shoulder and arm and feeling distressed, frustrated with struggling, knocked down, sad, hopeless, and tense, with difficulty sleeping. (Ex. 7, pp. 172-174) Thereafter, claimant participated in continuous counseling sessions with Edmarie Guzman-Velez, a bilingual clinical psychology graduate student, under the supervision of James Marchman, Ph.D. (Ex. 7, pp. 175-188)

On August 21, 2013, claimant returned to Dr. Marsh. Dr. Marsh opined x-rays revealed a healed humeral shaft fracture with good fixation. However, claimant continued to complain of pain in the elbow, mid-humerus, and proximally in the shoulder. Dr. Marsh opined claimant's radial nerve palsy was resolving, with return of motor function but some potentially associated paresthesias. Dr. Marsh recommended continued therapy and adherence to the Pain Clinic treatment regimen. (Ex. 3, pp. 87-88)

On September 16, 2013, claimant's attorney authored a letter to defendants' attorney, requesting to see a psychologist or psychiatrist per the recommendation of Dr. Siriwetchadarak. (Ex. 12, p. 222) Claimant's attorney made a repeat request on October 3, 2013. (Ex. 12, p. 223)

Claimant presented to Douglas Sedlacek, M.D., of the Mercy Pain Clinic on October 23, 2013. Dr. Sedlacek assessed: status post mid shaft humeral fracture with radial palsy, partially rehabilitated; status post open reduction internal fixation with good healing; deconditioning and shoulder pain, suspected to be secondary to the length of time the arm was immobilized and in the attempts to gain movement of the shoulder, claimant had developed myofascial pain of the shoulder girdle muscles; and some neuropathic pain in the left upper extremity likely secondary to claimant's radial palsy. (Ex. 4, p. 122) Dr. Sedlacek performed a left stellate ganglion block and left trapezius trigger point injections. (Ex. 4, pp. 120, 123) Claimant reported little benefit on October 30, 2013; Dr. Sedlacek advised claimant to allow additional time for relief. (Ex. 4, p. 123)

On November 20, 2013, claimant presented to Dr. Marsh. Claimant's nurse case manager was also present for the evaluation. Dr. Marsh noted claimant had begun treating with a new physical therapy provider about three weeks prior, with dramatic improvement since the change. Claimant also reported tremendous relief of symptoms with the injections of October 23, 2013. Claimant's case manager requested an additional six weeks of therapy, with evaluation at that time to determine maximum medical improvement (MMI). She also requested an advance to a 20-pound weight restriction so as to allow claimant to "start to look for work." (Ex. 3, p. 90) Dr. Marsh agreed with the case manager's request, ordered 6 additional weeks of therapy, and increased claimant's weight limitation to 20 pounds. (Ex. 3, p. 92)

At defendants' request, on December 3, 2013, claimant presented to licensed psychologist, Philip Ascheman, Ph.D., for psychological evaluation. During interview of claimant, Dr. Ascheman noted reference to two suicide attempts: (1) January 2013 when he took too many medications and a friend drove him to the emergency room in Iowa City; and (2) July 2013 when he drank too much tequila and woke up in the emergency room at the University of Iowa. Claimant indicated he was depressed and described an inability to do prior tasks, a loss of strength, and pain. Claimant also reported forgetting and misplacing items, and then becoming violent. He stated he "really" wanted to shoot himself. Dr. Ascheman asked claimant if he believed he would improve physically. Claimant replied he was told he could lift 20 pounds, but he believed he could only lift 1 pound. (Ex. B, p. 3)

Claimant reported listening to English lessons, as he desired to learn English in order to perform lighter work. Claimant expressed interest in becoming a welder or a cook. Mental status testing was performed which Dr. Ascheman opined revealed no identifiable cognitive deficits. (Ex. B, p. 4)

Following records review and interview, Dr. Ascheman opined claimant presented with some depressive symptoms "that do not rise to the level of a mental health disorder." He indicated claimant's symptoms were transient and expectable reactions to psychosocial stressors. (Ex. B, p. 4) Dr. Ascheman noted:

> The patient's counselor also indicated that there are "many contributing factors" to his emotional presentation. Therapy notes appear to indicate that the most significant and consistent issues are related to his relationship with his father, which is a long-standing issue, and the death of cousin. He believes that he will not be able to work jobs requiring heavy lifting again, and he is frustrated in facing that issue. It was interesting to note that he described his fear that he will not be able to work, although he is actively planning to receive training and jobs that he will be able to do in the future. The most recent notes by his counselor suggests that he has been able to turn around his thinking on many issues, including developing positive expectations about working.

(Ex. B, p. 4)

. . . .

> Overall, it is my opinion that this individual does not have any limitations due to a mental health issue.

(Ex. B, p. 5)

On January 17, 2014, defendants' counsel authored an email to claimant's attorney. Defendants' counsel represented that Mr. Roling had informed counsel he had attempted to contact claimant regarding returning to work, but claimant had refused to speak with Mr. Roling or had made himself otherwise unavailable. Counsel indicated Mr. Roling had confirmed the availability of light duty work "no matter what the restriction." Accordingly, counsel extended an offer of light duty to claimant, beginning on Monday, January 20, 2014. Mr. Roling offered to transport claimant, if necessary. (Ex. H, p. 1)

Defendants' counsel authored a follow-up email to claimant's attorney on Monday, January 20, 2014. Counsel represented that Mr. Roling had advised claimant did not appear or contact Mr. Roling that day regarding the light duty offer. Counsel asked for an explanation for claimant's failure to appear. Counsel also represented claimant's weekly temporary disability benefits would be suspended pursuant to Iowa Code section 85.33 during the period of claimant's refusal of work. (Ex. H, p. 1)

Claimant's counsel issued a responsive letter to defendants' attorney on January 22, 2014. Counsel indicated he had been out of the office and did not receive the email messages of defendants' counsel until January 21, 2014. Counsel indicated when he learned Mr. Roling was offering suitable work, he contacted claimant. Claimant

confirmed he would be agreeable to performing suitable, light duty work, provided defendant-employer respected his temporary work restrictions and be provided transportation. Counsel requested confirmation Mr. Roling was willing to pick-up and drop-off claimant. Counsel also requested continuation of claimant's healing period benefits as claimant's attorney was only provided two days' notice of the offer of work and one of those days was a federal holiday. (Ex. 15, pp. 253-254)

On January 22, 2014, the paralegal to claimant's counsel authored an email to defendants' attorney. By her email, the paralegal provided claimants' physical address on Laura Drive in Iowa City and asked for confirmation Mr. Roling would pick up claimant for work the following day. The paralegal also stated claimant's belief his restrictions were no lifting greater than 10 pounds with that arm. (Ex. H, p. 2)

Defendants' counsel issued an email response on January 23, 2014. Counsel stated defendant-employer had light duty available that week and claimant did not show, thus his benefits had ceased. Counsel indicated defendant-employer was willing to accommodate claimant and was agreeable to picking up claimant on the following Monday. In regards to claimant's work restrictions, counsel indicated defendant-employer would be following the restrictions of Dr. Marsh, specifically a 20-pound lift. (Ex. H, p. 2)

On January 24, 2014, defendants' attorney authored an email to claimant's attorney. Counsel indicated he was now aware claimant had physical therapy Monday, Wednesday and Friday at 10:30 a.m. Accordingly, counsel indicated Mr. Roling would pick up claimant at his residence on Monday, January 27, 2014 at 1:00 p.m., for light duty. (Ex. H, p. 3)

Claimant's attorney authored an email to defendants' attorney on January 27, 2014. By his message, counsel indicated claimant had telephoned him and reported Mr. Roling stated he had no work for claimant. Claimant reportedly informed Mr. Roling he was willing to work whenever Mr. Roling needed him; Mr. Roling reportedly informed claimant he would contact claimant the following day, but did not guarantee work would be given. On this basis, claimant's counsel requested payment of healing period benefits. (Ex. H, p. 4)

That same date, January 27, 2014, defendants' counsel authored an email response to claimant's counsel. According to counsel, claimant informed Mr. Roling he had a 2-pound lifting restriction. Mr. Roling thus indicated he did not have work within such a restriction. Counsel stated claimant was actively attempting to avoid work and as a result, his benefits remained suspended. Counsel indicated Mr. Roling would telephone claimant the next morning regarding pick up. (Ex. H, p. 4)

On January 28, 2014, claimant's counsel emailed defendants' counsel. Counsel represented claimant had telephoned that morning and indicated Mr. Roling stated he had no work available due to severe weather. Claimant reportedly informed Mr. Roling he was willing to work within Dr. Marsh's restrictions. Counsel confirmed claimant's

willingness to work within Dr. Marsh's restrictions. Counsel also argued defendants' refusal to offer suitable work and simultaneous denial of weekly benefits was unreasonable and the basis for a claim for penalty benefits. (Ex. 20, p. 267)

On January 29, 2014, claimant's counsel authored an email to defendants' counsel. Counsel indicated claimant had telephoned and stated Mr. Roling had no work available. Counsel requested recommencement of temporary disability benefits. (Ex. H, p. 5) Later that date, defendants' counsel issued an email response to claimant's attorney. He stated Mr. Roling had advised counsel he did offer work, but claimant refused to do construction-type or cleaning work. According to counsel, claimant maintained he had a 2-pound lifting restriction. (Ex. 20, p. 268)

On January 30, 2014, claimant's counsel authored an email to defendants' counsel purporting to summarize the content of a voicemail message he previously left for defendants' counsel. Claimant's counsel proposed a four-way telephone call between both attorneys, Mr. Roling, and claimant, with respect to the offer of work scenario. (Ex. 20, p. 268)

Claimant admitted in approximately January 2014, Mr. Roling contacted claimant with respect to returning to work. Claimant testified at that time, he was still participating in physical therapy multiple times per week and he did not have a car. At evidentiary hearing, claimant testified Mr. Roling never provided work for him in the winter months, as defendant-employer's work is generally performed outdoors. (Claimant's testimony)

Despite claimant's assertion he did not typically work in winter months, claimant admitted Mr. Roling telephoned him and indicated he had light duty work available for claimant. Claimant testified he was told he should call Mr. Roling each day for details. Claimant testified he would telephone Mr. Roling and indicate he was ready for work, but Mr. Roling would not pick him up or would claim the weather was too cold to work. Claimant testified this occurred on multiple occasions. Claimant testified he eventually asked Mr. Roling for his paycheck, as he considered the days Mr. Roling did not follow through with an offer of work to be work days. Claimant testified Mr. Roling then became upset. Claimant denied ever telling Mr. Roling he had a 2-pound lifting restriction. (Ex. 17, Depo. Tr. pp. 50-52)

In January or February 2014, Mr. Roling testified he began to attempt to contact claimant with respect to light duty work, but was unable to recall the specific dates of contact. He testified the dates he provided during his testimony were estimates. (Ex. 18, Depo. Tr. pp. 93-94) Mr. Roling testified he never offered claimant light duty work prior to this time period because he did not have a telephone number for claimant until January 2014. (Ex. 18, Depo. Tr. pp. 59, 72-73)

Mr. Roling testified he believed he telephoned claimant on Friday, January 17, 2014 and spoke to claimant later that day when claimant returned his call. During the conversation, Mr. Roling testified he asked claimant to perform some light duty work

around his home. Mr. Roling identified odd jobs, including drywall, installing insulation, cleaning, or work in the barn. (Ex. 18, Depo. Tr. pp. 58-61, 68) Mr. Roling testified at that time, claimant advised him he had a 2 or 3 pound lifting restriction. (Ex. 18, Depo. Tr. p. 62) Mr. Roling indicated he thought claimant's restriction was 20 or 30 pounds, thus allowing claimant to assist with hanging drywall. During the telephone call, Mr. Roling testified he informed claimant they would "work with" whatever claimant was able to lift. (Ex. 18, Depo. Tr. p. 62)

Mr. Roling testified he then telephoned claimant on January 20, 2014, but claimant did not answer. (Ex. 18, Depo. Tr. p. 58) Mr. Roling testified he next spoke with claimant via telephone on January 21, 2014. Mr. Roling testified he wanted to clarify claimant's restrictions with him and in the event claimant was able to lift 20 or 30 pounds, Mr. Roling would likely pick up claimant for work. (Ex. 18, Depo. Tr. pp. 74, 86) Mr. Roling testified he did not have work available within a 2 to 3 pound restriction. (Ex. 18, Depo. Tr. p. 74) Mr. Roling testified claimant again stated he had a 2 to 3 pound restriction. (Ex. 18, Depo. Tr. p. 75) Mr. Roling testified claimant repeatedly informed him of a 2 to 3 pound restriction over subsequent conversations, despite Mr. Roling's possession of medical records denoting a 20-pound restriction. (Ex. 18, Depo. Tr. p. 85)

Mr. Roling testified if claimant was physically able to work, he had work available to claimant for the entire week of January 20 through January 24, 2014. (Ex. 18, Depo. Tr. p. 77) With respect to all of the odd jobs at his home, Mr. Roling estimated the tasks would take two to three months to complete. (Ex. 18, Depo. Tr. p. 78) With respect to his offer of light duty work to claimant, Mr. Roling testified:

> I had some odd jobs that I thought I could keep [claimant] doing a little bit here and there out at my house if he needed some work and some money.

(Ex. 18, Depo. Tr. p. 53)

Mr. Roling admitted as of January 2014, defendant-employer had zero employees. (Ex. 18, Depo. Tr. p. 51) He further admitted the only employee of defendant-employer that he contacted with respect to work was claimant. Mr. Roling testified defendant-employer began its first formal job of the year on March 13, 2014. (Ex. 18, Depo. Tr. pp. 51-53)

Had claimant participated in light duty, Mr. Roling testified the amount he would have paid claimant for the light duty work varied. He explained he likely would have paid claimant in the range of $10.00 or $12.00 per hour. If claimant was capable of returning to more full-time work, Mr. Roling indicated he likely would have returned to the pay arrangement the men had prior to claimant's injury. (Ex. 18, Depo. Tr. pp. 77-78)

Claimant completed physical therapy in January 2014. He testified to receiving relief with therapy and was advised in performance of a home exercise program. (Claimant's testimony)

On February 3, 2014, claimant presented to UIHC for evaluation with Joseph Chen, M.D. Dr. Marsh referred claimant to Dr. Chen for a physical medicine and rehabilitation consultation, as well as an impairment rating. Claimant indicated he felt unable to lift 20 pounds as stated in his work restriction from Dr. Marsh. Claimant also reported atrophy in his left arm muscles, intense pain with lifting or physical activities of the left arm, "stabbing" pains with lifting or movement of the left arm, pain along the left shoulder blade and chest, and some pain and tingling of the left arm. Dr. Chen noted improvement in radial nerve palsy. Dr. Chen also noted he reviewed a note indicating claimant demonstrated 120 pounds of grip strength on the right and only 30 pounds on the left. (Ex. 3, p. 93)

Following interview, records review and examination, Dr. Chen opined claimant presented with a left radial nerve injury which was improved and chronic myofascial left arm pain. Claimant expressed fear of returning to physical activities. Dr. Chen assured claimant he would not damage his hardware through activities. Dr. Chen also explained claimant's pain was likely myofascial and claimant should not limit his usual work and recreational activities. (Ex. 3, p. 96)

Dr. Chen recommended a functional capacity evaluation (FCE) to determine claimant's restrictions. He advised claimant to return following FCE, at which time Dr. Chen would issue permanent work restrictions and an impairment rating for the radial nerve injury. In the interim, Dr. Chen imposed work restrictions of lifting no more than 20 pounds and no ladder climbing. (Ex. 3, pp. 96-98)

On February 26, 2014, claimant underwent a functional capacity evaluation with John Kruzich, MS, OTR/L. Mr. Kruzich opined claimant failed to give maximum voluntary effort during the FCE and failed in the following validity criteria: (1) claimant demonstrated cog wheeling during manual muscle testing; (2) claimant's pain questionnaire answers indicated symptom magnification; (3) claimant failed 3 of 7 validity criteria in hand strength assessment; (4) there was an absence of correlation between lifts of unmarked steel bars and the corresponding lifts on the XRTS Lever Arm; and (5) claimant described high pain reports during and/or after the examination which were inconsistent with minimal or no demonstrated pain behavior. (Ex. C, pp. 1-2, 10) Due to the invalid effort, Mr. Kruzich opined he was unable to determine claimant's functional capabilities. (Ex. C, p. 2)

Following FCE, claimant returned to Dr. Chen on March 10, 2014. Dr. Chen noted:

> Because of numerous inconsistencies on my examination of [claimant] last month, I wanted him to obtain a Functional Capacity Evaluation to

> determine his material handling capabilities. This was done last month. He returns to discuss the test.

(Ex. 3, p. 99)

Dr. Chen indicated he reviewed claimant's FCE, "which showed grossly inconsistent effort on a variety of scales." At the time of evaluation, Dr. Chen opined claimant was "very dramatic in his description of his pain" and despite claimant's indication he was trying to "work through his pain," claimant stated he was unable to lift more than 20 pounds. (Ex. 3, p. 99)

Following examination, Dr. Chen opined claimant's left radial nerve injury was improving, with no further evidence of a radial neuropathy based on motor examination. Dr. Chen assessed chronic myofascial left arm pain which he attributed to "increased central nervous system hyperexcitability." Dr. Chen informed claimant chronic pain may hurt, but is not harmful. Accordingly, he indicated claimant needed to learn to manage the pain and should not limit his usual work or recreational activities. (Ex. 3, p. 101)

Dr. Chen placed claimant at maximum medical improvement (MMI) and released claimant to work without restrictions. Claimant indicated he had been searching for work options; Dr. Chen encouraged claimant to do so. (Ex. 3, pp. 101-102; Ex. A, p. 23) Due to full range of motion and strength of the shoulder, elbow and wrist, Dr. Chen opined claimant demonstrated no ratable impairment per the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition. (Ex. 3, pp. 101-102; Ex. A, p. 23)

Claimant testified Dr. Chen informed claimant he was capable of lifting 200 pounds. Claimant testified he disagreed and could not lift even 4 pounds at the time of evaluation. (Claimant's testimony)

As claimant's temporary benefits were suspended, claimant testified he was forced to seek employment. In March 2014, claimant began employment at a hotel in Iowa City. His position required claimant to ensure rooms and facilities were stocked. He worked 40 hours per week and earned $8.75 per hour. (Ex. 17, Depo. Tr. pp. 39-41) Payroll records denoting claimant's earnings reveal claimant last worked at the hospital during the pay period ending June 22, 2014. (Ex. L, p. 15)

At the arranging of claimant's counsel, on June 18, 2014, claimant presented for independent medical evaluation (IME) with board certified occupational and environmental medicine physician, Mark Taylor, M.D. Dr. Taylor issued a report of his findings and opinions dated July 14, 2014. Dr. Taylor's report indicates he spent 1 hour and 55 minutes with claimant obtaining a history and performing an examination. (Ex. 1, p. 1) During interview, claimant noted two alleged work injuries, one on or about August 1, 2012, when he was struck by a shingle and suffered a small cut on his left leg. Claimant reported receiving evaluation at Mercy Hospital and then subsequently at the University of Iowa on August 5, 2012. (Ex. 1, p. 2) Claimant also reported an injury on September 28, 2012, when he fell from a roof. (Ex. 1, p. 3)

Claimant complained of anterior chest wall pain with movement of the left arm, constant pain of the left humerus near the surgery and hardware site, pain in the armpit, pain beginning in the neck and stretching out over the shoulder and into the left arm, periodic swelling of the left arm, ongoing numbness of the left forearm down to the back of the hand, and a burning and pins-and-needles sensation when he lies upon his left side. Claimant reported an average pain level of 7 to 8 on a 10-point scale. Claimant indicated pain levels could increase to level 9 or 10 with activity or decrease to a level 4 or 5 with inactivity. (Ex. 1, pp. 7-8) Dr. Taylor noted claimant made daily use of prescription tizanidine and nabumetone. (Ex. 1, p. 9) Dr. Taylor summarized claimant's treatment to date and performed a physical examination, the findings of which are detailed in Dr. Taylor's report. (Ex. 1, pp. 2-7, 9-10)

Following interview, records review, and examination, Dr. Taylor opined the following diagnoses:

1. Left mid tibial abscess/cellulitis infection, August 2012.
2. Left distal tibia abscess/cellulitis, December 2012.
3. Right tibial cellulitis in March/April 2013.
4. Multiple left rib fractures due to September 2012 injury.
5. Left humeral fracture and subsequent open reduction and internal fixation in January 2013.
6. Left lung pneumothorax due to injuries sustained related to the fall.
7. Left upper extremity fungal infection likely related to use of the splint and moisture.
8. Left chest and shoulder/trapezius pain.
9. Left arm radial nerve palsy with evidence of reasonable recovery.

(Ex. 1, pp. 10-11)

Dr. Taylor authored opinions on the issue of causation between claimant's conditions and the alleged work injuries. With respect to the left lower extremity abscess and hospitalization in August 2012, Dr. Taylor opined he was unable to state, within a reasonable degree of medical certainty, that the condition and care was related to claimant's work activities. Dr. Taylor highlighted the lack of report of a traumatic event in the medical records and claimant's subsequent development of an infection in a different location on the left leg and development of cellulitis of the right leg. As a result, Dr. Taylor indicated he could only opine it was "possible" claimant sustained an injury at work which led to the development of an infection. (Ex. 1, p. 11)

With respect to the September 2012 fall, Dr. Taylor opined claimant sustained injuries consistent with a fall of a distance of 12 feet or more, including multiple rib fractures, a left humeral head fracture, a pneumothorax, and a radial nerve palsy. Dr. Taylor opined claimant also developed a fungal infection likely related to use of a brace and accordingly, should be considered a sequela of the fall injury. (Ex. 1, p. 11) Accordingly, Dr. Taylor opined the left rib fractures, pneumothorax, left humeral fracture,

and left arm radial nerve palsy were directly and causally related to the fall. (Ex. 1, p. 12)

Dr. Taylor noted claimant reported suffering with left anterior chest pain which radiated toward the shoulder blade and over the shoulder. According to Dr. Taylor, claimant initially assumed many of his symptoms would resolve when the arm and rib fractures began to heal. (Ex. 1, p. 12) Dr. Taylor opined:

> In my opinion, the persistent left shoulder and anterior chest wall pain, and trapezius/parascapular pain is also the result of the fall. This may not have initially been mentioned but he had mentioned this on at least a couple of occasions to his medical providers. Not surprisingly, the primary focus and primary pain was initially over his multiple broken ribs and significant left humeral fracture. It would have been difficult to note significant pain in the shoulder since his upper extremity was immobilized and he did not undergo surgery until January and was then further immobilized. All treatment was related to the work injury and his current residual symptoms are also related to the original injury.

(Ex. 1, p. 12)

As claimant had not undergone evaluation of the left shoulder, Dr. Taylor recommended evaluation by a shoulder specialist in order to determine if any treatment would be beneficial. (Ex. 1, p. 12) Claimant also described suffering with left anterior chest wall pain with movement of the left arm. Dr. Taylor opined this symptom could represent musculoskeletal-type pain or may have a cervical spine or intrathoracic source. Therefore, he recommended further evaluation of claimant's chest pain by a primary care provider. Due to claimant's ongoing use of prescription medications, Dr. Taylor opined claimant would likely require continuing pain management. He therefore recommended evaluation by a pain management specialist for determination of treatment recommendations and medication management. Dr. Taylor selected a maximum medical improvement date of March 10, 2014. He, however, cautioned this date may need to be adjusted should claimant receive further treatment of his left shoulder and trapezius/parascapular pain. (Ex. 1, p. 13)

Dr. Taylor issued the following impairment ratings: 3 percent left upper extremity for loss of elbow motion; 6 percent left upper extremity for decrements in left shoulder range of motion; 3 percent left upper extremity for sensory deficits from the radial nerve palsy; and 4 percent left upper extremity for motor deficits from the radial nerve palsy. Dr. Taylor opined a combined impairment of 16 percent left upper extremity or 10 percent whole person. (Ex. 1, p. 14)

Dr. Taylor noted claimant had undergone an FCE, during which the therapist found claimant failed to give a maximum effort and accordingly, the results should not form the basis of restrictions. (Ex. 1, p. 7) However, Dr. Taylor noted claimant reported providing his best effort during examination and suffering with "fairly significant pain."

(Ex. 1, p. 14). Given claimant's residual symptoms, Dr. Taylor recommended work restrictions. (Ex. 1, p. 15) Dr. Taylor recommended restrictions of a 40-pound lift rarely, 30-pound lift occasionally, 20-pound maximum lift above shoulder level, and a 10-pound maximum lift with the left arm on a rare to occasional basis. He also recommended occasional stooping, bending, kneeling, or work on uneven surfaces; rare crawling; avoidance of vertical ladders and repetitive use of the left upper extremity; no forceful gripping or grasping with the left upper extremity; and occasional use of vibratory or power tools with the right upper extremity, but not with the left. In the event claimant utilized tizanidine, which can cause drowsiness, during daytime hours, Dr. Taylor recommended avoidance of driving or work tasks where sedation could compromise safety. (Ex. 1, p. 15)

Claimant testified his evaluation with Dr. Taylor lasted approximately one hour. He did not recall the physical examination and stated he remembered Dr. Taylor asked numerous questions. (Claimant's testimony)

On August 6, 2014, claimant's counsel authored a letter to defendants' counsel requesting the medical care recommended by Dr. Taylor. (Ex. 12, p. 224) A repeat request was made September 2, 2014, specifically with respect to left shoulder evaluation. (Ex. 12, p. 225) Defendants' denied claimant's request for left shoulder evaluation in writing on September 22, 2014 based upon a purported lack of left shoulder complaints in the medical records and claimant's deposition testimony relating left shoulder complaints to overuse of the left arm in his current employment. (Ex. 12, p. 226) Claimant filed an alternate care petition seeking care for claimant's left shoulder, but defendants' disputed liability for the left shoulder condition. Accordingly, the alternate care petition was dismissed without prejudice by this agency on September 25, 2014. (Ex. 12, pp. 227-231)

In response to a request for further explanation of his FCE findings, Mr. Kruzich authored a letter to defendants' attorney dated September 24, 2014. Mr. Kruzich indicated he had reviewed Dr. Taylor's IME report and noted both claimant and Dr. Taylor attributed the invalid FCE result to claimant's perceived pain levels. Mr. Kruzich opined claimant's inconsistencies on FCE were not related to pain, "but rather only explainable through abnormal test behavior." (Ex. C, p. 13)

Mr. Kruzich then explained the testing performed which had bearing on his opinion of the validity of claimant's FCE. With respect to the XRTS Hand Strength Assessment, Mr. Kruzich noted published research found the test was able, with 99.5 percent accuracy, to distinguish between patients giving maximum effort and those feigning hand weakness. Mr. Kruzich opined claimant failed 3 of 7 validity criteria during this test. According to Mr. Kruzich, the combined odds of a compliant subject producing this result is less than 1 in 250,000. On this basis, Mr. Kruzich opined claimant failed the validity criteria due to abnormal test behavior and not due to pain. (Ex. C, pp. 13-14)

With respect to the XRTS Lever Arm Assessment test, Mr. Kruzich explained an individual's lifting capacity evaluation is performed with unmarked steel weights and then tested on the XRTS Lever Arm apparatus. Mr. Kruzich indicated claimant failed the validity criteria for this test due to: (1) an average variability on all lifts of greater than 25 percent; (2) at least one set of lifts had a variability greater than 40 percent; (3) at least half of the lifts had variability greater than 25 percent; and (4) two or more sets of lifts had variability of greater than 30 percent. (Ex. C, p. 15) Mr. Kruzich opined it was illogical to assume the presence of pain resulted in failure of validity criteria, as claimant lifted an average of twice the amount of weight at the conclusion of testing than he did at the beginning of testing. He explained if claimant were in pain, he would anticipate claimant to lift the same or less weight as the pain levels increased. Mr. Kruzich opined the only explanation for the "significant" variation in claimant's lifting abilities was abnormal test behavior. (Ex. C, p. 16)

Mr. Kruzich also identified additional failed validity criteria, including providing responses indicative of symptom magnification on questionnaires, feigned weakness throughout the entire left upper extremity during musculoskeletal examination, and claimant's high pain reports during and/or after the FCE which Mr. Kruzich opined were inconsistent with claimant's minimal or complete lack of demonstrable pain behavior. Mr. Kruzich confirmed the presence of a language interpreter at the FCE and described excellent communication throughout the FCE. (Ex. C, p. 16)

Mr. Kruzich opined claimant demonstrated "highly inconsistent effort during objective testing which invalidated" the FCE. He further opined while claimant sustained a work injury, there was a lack of objective evidence to verify the existence of functional deficits. Accordingly, Mr. Kruzich opined he was unable to make recommendations for appropriate work restrictions, as the recommendations would be based almost entirely on claimant's subjective reports of pain and dysfunction. (Ex. C, p. 16)

On October 27, 2014, claimant presented to the Mercy Hospital Emergency Department and was seen by Eric Stenberg, D.O. Claimant complained of left-sided chest pain with pain radiating down the left arm. Dr. Stenberg described an exacerbation of claimant's chronic and recurrent chest pain. (Ex. 6, pp. 167-168) Dr. Stenberg diagnosed anterior chest wall pain consistent with a chest wall strain. (Ex. 6, p. 169)

Claimant testified he sought care on this date after suffering with increased pain at work. Through a newspaper advertisement, claimant had located a job packaging cosmetics. Claimant testified he worked five to seven hours per day, six days per week. He earned $8.50 or $8.75 per hour. Claimant indicated during his packaging duties, he was generally able to use his right arm more than his left. For two days, he was assigned to a task working with boxes and he suffered with increased pain. Claimant testified he became afraid he was suffering with a heart condition due to his pain and shortness of breath. Claimant testified he presented to the emergency room due to worsening shoulder and chest pain, as well as concerns over a difficulty breathing.

Claimant testified the doctor recommended he avoid lifting for six weeks, stating the pain would decrease. As a result, claimant testified he did not return to work and his pain lessened somewhat. (Claimant's testimony)

Claimant testified he worked in this placement for approximately two months prior to this event, but did not return to work after discharged. Claimant testified he was told not to work for six weeks due to pain, but admitted he did not tell his then-employer of his restrictions. At the time of evidentiary hearing, he had not returned to employment in any form. (Claimant's testimony)

Dr. Marsh authored a letter to defendants' attorney dated November 20, 2014. By the letter, Dr. Marsh opined claimant had reached MMI with respect to the humerus fracture. Dr. Marsh also opined:

> [Claimant] also had a radial nerve injury at the time of his injury, which has improved by objective measures and clinical presentation; however, I understand he continues to have some complaints of pain which might be consistent with ongoing nerve dysfunction, although are not necessarily attributable to a radial nerve injury.

(Ex. K, p. 1)

Dr. Marsh indicated he had reviewed Dr. Taylor's IME, the FCE report, and Dr. Chen's notes. He expressed agreement with Dr. Chen's assessment with respect to the lack of need for restrictions. Dr. Marsh based his opinion on the behaviors cited by Dr. Chen, including "overt and magnified pain behaviors as well as the failed validity criteria on the FCE report." (Ex. K, p. 1)

With respect to claimant's need for further care, Dr. Marsh opined given claimant's good recovery of function and the passage of time, it was unlikely any treatment would change claimant's complaints of "possibly neuropathic pain" associated with the radial nerve palsy. Dr. Marsh also indicated he did not recommend further work up of the neck complaints, as he had seen no documentation indicating the cervical spine was the source of claimant's pain complaints. (Ex. K, p. 2) On the other hand, Dr. Marsh opined it was possible claimant sustained a shoulder injury or aggravation resulting from the work injury or sequela of treatment. He further indicated it was possible claimant sustained some permanent impairment due to shoulder dysfunction. Dr. Marsh indicated claimant might benefit from evaluation by a shoulder specialist and further stated he would defer to that physician on causation issues. (Ex. K, pp. 1-2)

Dr. Marsh opined claimant's continued use of medications was reasonable for a patient with this type of injury. He recommended these medications be managed by a primary care physician. Given claimant stated the treatments received at the pain clinic did not provide relief and claimant's function had returned to a reasonable level, Dr. Marsh opined claimant did not require additional care from a pain service. (Ex. K, p. 2)

Dr. Marchman authored a letter to defendants' attorney dated December 12, 2014. In his letter, Dr. Marchman described claimant as fully cooperative and engaged in therapy, having attended every appointment and completed assignments between sessions. Dr. Marchman indicated claimant had been depressed about his physical condition, the pain especially, and his inability to work. Dr. Marchman opined claimant probably met the criteria for a Major Depressive episode before therapy began, but their working diagnosis was Adjustment Disorder with Depressed Mood. He further opined claimant's emotional problems are a response to pain, disability, and the "financial and social consequences." (Ex. 7, p. 184)

Despite suffering with what Dr. Marchman described as significant depressive problems, Dr. Marchman opined the problems are not "disabling in and of themselves." Dr. Marchman expressed belief claimant had a strong work ethic and intended to receive training to qualify for a job within his physical limitations. He further described claimant as a "conscientious man who is strongly motivated to get back to work." Dr. Marchman indicated he therefore expected claimant to recover from his depression with improvement in his physical condition and a return to work or the ability to engage in further training. Dr. Marchman opined claimant's condition did not represent a "chronic psychiatric disorder." (Ex. 7, p. 184)

At evidentiary hearing, claimant introduced evidence of medical expenses incurred which he causally relates to the alleged work injuries. Claimant submitted expenses related to treatment of his left leg on August 5, 2012, August 7, 2012 and December 17, 2012, which he relates to the claimed date of injury of August 5, 2012. (Ex. 13, p. 232) Claimant also submitted medical expenses incurred for the care he received on July 6, 2013 and October 27, 2014, as well as for the counseling sessions he participated in from August 14, 2013 through October 15, 2014. (Ex. 13, pp. 233-237, 239-240)

Mr. Roling's testimony was clear and consistent with his deposition testimony. His presentation at the time of hearing gave the undersigned no reason to doubt his veracity. Mr. Roling is found credible.

Claimant's primary language is Spanish, not English, thus necessitating the use of interpreters throughout the pendency of claimant's claims. As a result of utilizing a third person, the words attributed to claimant may vary somewhat through no fault of claimant. Such variations are not properly used to impeach claimant's credibility. However, upon review of the entirety of the evidentiary record, the undersigned finds claimant was not a credible witness.

Claimant's testimony regarding the timing of his work for defendant-employer varied: from never working during winter months and seeking alternate employment, to presenting to defendant-employer as needed during the winter months.

Claimant's testimony regarding his decision not to return to the residence provided by Mr. Roling lacked clarity: claimant claimed he had no place to live after his work injury of September 28, 2012 and resulting hospitalization, yet Mr. Roling testified claimant could have returned to the residence. Following claimant's release from the hospital, he did not respond to Mr. Roling's telephone calls and denied receipt of notes from Mr. Roling, despite Mr. Roling's credible testimony regarding attempted contact.

Mr. Roling opined claimant purported to have a 2 to 3 pound lifting restriction during the unsuccessful return to work in January 2014. Claimant denied ever making such a statement, however, medical records reveal claimant made similar statements to providers immediately before and after the attempt to return to work. On December 3, 2013, claimant informed Dr. Ascheman he was unable to lift even one pound, despite a 20-pound lift restriction imposed by Dr. Marsh. Claimant expressed an inability to lift 20 pounds and a fear of returning to physical activities to Dr. Chen on February 3, 2014. On March 10, 2014, Dr. Chen released claimant without a permanent weight restriction and claimant testified Dr. Chen told him claimant was capable of lifting 200 pounds. At hearing, claimant testified at the time Dr. Chen made this statement, claimant believed he was unable to lift even 4 pounds.

Additionally, Mr. Kruzich opined claimant's FCE results were invalid. Although Dr. Taylor disregarded this opinion, Mr. Kruzich provided a detailed explanation of his opinion. This explanation establishes an objective basis to support a determination claimant engaged in abnormal test behavior, highly inconsistent effort, and symptom magnification, as opposed to having the results of the examination marred by claimant's pain complaints.

Accordingly, the undersigned finds claimant was not a credible witness. Any of claimant's testimony not corroborated by the remainder of the evidentiary record is entitled to little weight.

CONCLUSIONS OF LAW

In File No. 5048346 (August 5, 2012 Date of Injury):

The first issue for determination is whether claimant sustained an injury to his left leg on or about August 5, 2012 which arose out of and in the course of 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).

Claimant argues he sustained an injury to his left leg in late July or early August 2012, when struck and cut by a shingle nail. There are no witness reports corroborating claimant's testimony. The undersigned found *supra*, that claimant's uncorroborated testimony is entitled to little weight. Notably, claimant's contemporaneous reports to medical providers deny a specific injurious event and only one record contains any reference to nail penetrations, although this record speaks only generally to sustaining this type of injury.

Additionally, no medical provider causally related claimant's left leg condition to his work for defendant-employer, let alone a specific injury as testified to by claimant. Claimant's own IME physician, Dr. Taylor, was only able to opine it "possible" claimant's need for medical treatment resulted from an injury as described by claimant. Dr. Taylor specifically opined he was unable to state within a reasonable degree of medical certainty that claimant's condition was work-related. In so opining, he highlighted the lack of report of a traumatic injury in the medical records, as well as claimant's

subsequent development of another infection in a different location of the left leg and cellulitis of the right leg.

Claimant carries the burden of establishing by a preponderance of the evidence that his claimed injury occurred and is work-related. Claimant failed to carry his burden on either allegation. Claimant's testimony was not credible and he provided no corroborating evidence in the form of witness statements or medical opinions. It is therefore determined claimant failed to prove he sustained an injury on or about August 5, 2012 arising out of and in the course of his employment. As claimant failed to carry his burden on this issue, he is not entitled to payment of medical expenses incurred in treatment of the left leg condition, specifically the claimed treatment on August 5, 2012, August 7, 2012 and December 17, 2012. (See Ex. 13, p. 232)

In File No. 5041675 (September 28, 2012 Date of Injury):

The first issue for determination is whether claimant is entitled to temporary disability benefits from January 20, 2014 through March 10, 2014 or is disqualified from receipt of such benefits pursuant to Iowa Code section 85.33(3) due to a failure to accept suitable work.

When an injured worker has been unable to work during a period of recuperation from an injury that did not produce permanent disability, the worker is entitled to temporary total disability benefits during the time the worker is disabled by the injury. Those benefits are payable until the employee has returned to work, or is medically capable of returning to work substantially similar to the work performed at the time of injury. Section 85.33(1).

Healing period compensation describes temporary workers' compensation weekly benefits that precede an allowance of permanent partial disability benefits. Ellingson v. Fleetguard, Inc., 599 N.W.2d 440 (Iowa 1999). Section 85.34(1) provides that healing period benefits are payable to an injured worker who has suffered permanent partial disability until the first to occur of three events. These are: (1) the worker has returned to work; (2) the worker medically is capable of returning to substantially similar employment; or (3) the worker has achieved maximum medical recovery. Maximum medical recovery is achieved when healing is complete and the extent of permanent disability can be determined. Armstrong Tire & Rubber Co. v. Kubli, Iowa App., 312 N.W.2d 60 (Iowa 1981). Neither maintenance medical care nor an employee's continuing to have pain or other symptoms necessarily prolongs the healing period.

In order to avoid payment of such compensation, defendants must show that the employee refused to perform work that was both offered and suitable:

Iowa Code section 85.33(3) states, in relevant part:

> If an employee is temporarily, partially disabled and the employer for whom the employee was working at the time of injury offers to the employee suitable work consistent with the employee's disability the employee shall accept the suitable work, and be compensated with temporary partial benefits. If the employee refuses to accept the suitable work with the same employer, the employee shall not be compensated with temporary partial, temporary total, or healing period benefits during the period of the refusal.

The Iowa Supreme Court has endorsed consideration of factors personal to an employee in determination of whether an employer has offered suitable employment. See Neal v. Annett Holdings, Inc., 814 N.W.2d 512 (Iowa 2012).

Claimant's refusal must be an intentional act to cause denial of benefits. See Harrison v. KONE, Inc., File Nos. 5024317, 5024318 (App. August 21, 2009); Woods v. Siemens-Furnas Controls, File Nos. 1273249, 1303082 (App. July 22, 2003).

In order for defendants to properly suspend claimant's temporary total disability/healing period benefits, defendants must first establish an offer of work was made. Defendants have established such an offer for work was made, with work to commence on January 20, 2014. This offer of work was confirmed through oral testimony and the email correspondence between the counsel of record. While claimant asserts Mr. Roling made only a tentative offer of work and then failed to follow through with actual work, the undersigned found claimant was not a credible witness. Accordingly, it is determined defendants have proven an offer of work was made effective January 20, 2014.

Having established an offer of work was made, defendants must also prove the work offered was suitable. Mr. Roling testified beginning in January 2014, he had odd jobs for which he was willing to pay claimant. Such tasks are not inconsistent with the past work scenario between Mr. Roling and claimant. While claimant did not typically perform construction work for defendant-employer during winter months, he admitted he performed odd jobs for Mr. Roling as needed, for which he was paid by defendant-employer. Additionally, Mr. Roling testified some of the tasks he sought to complete were begun by he and claimant prior to claimant's September 2012 injury. There is no evidence the tasks proposed by Mr. Roling exceeded claimant's work restrictions imposed by Dr. Marsh, namely a 20-pound maximum lift. Claimant argues the offer of work was unreasonable, as claimant had been off work for an extended period prior to the offer of light duty work and little notice was provided. However, at the time of the offer, claimant did not object to returning to work on that basis. There is also some question as to the amount of money claimant would have been paid had he returned to work on light duty; however, this dispute does not render defendant-employer's offer of work unsuitable. Rather, this is the precise situation temporary partial disability benefits are designed to compensate. Defendants have provided sufficient evidence to establish suitable work was offered.

Defendant-employer offered claimant work beginning January 20, 2014. As determined, *supra*, the work offered was suitable and consistent with claimant's work restrictions. Claimant failed to make himself available for such work from January 20 through January 23, 2014. Claimant, therefore, is not entitled to temporary disability benefits for this period.

Claimant is entitled to temporary total disability benefits for January 24, 2014. While Mr. Roling testified he had work available for claimant that entire week, including Friday January 24, 2014, an offer of work was not made for January 24, 2014. On January 23, 2014, defendants' counsel indicated work had been available, but defendant-employer was willing to attempt to accommodate claimant again the following week, beginning January 27, 2014. Therefore, no offer of work was technically made for January 24, 2014. Claimant, accordingly, is entitled to temporary total disability benefits for this date.

The following week, beginning January 27, 2014, defendant-employer again offered claimant suitable, light duty work. Claimant argues Mr. Roling rescinded this offer on January 27, 2014; however, Mr. Roling only did so after claimant maintained he had a 2-pound work restriction. Mr. Roling, correctly, made an offer of work within Dr. Marsh's restrictions. By stating his work restrictions were far more stringent than they actually were, claimant constructively refused a suitable offer of light duty work. This type of behavior persisted from January 27, 2014 through January 29, 2014. Accordingly, claimant is not entitled to temporary disability benefits during this period.

The evidence in the record establishes defendant-employer last offered claimant work on January 29, 2014. The record lacks any evidence defendants made an offer of light duty work after that date. Mr. Roling credibly testified the light duty projects he had available to claimant would have lasted two to three months in duration; however, there is no evidence additional offers of work were made to claimant after January 29, 2014. Defendants' frustration with claimant's constructive refusal of suitable work is understandable and may have justified a failure to continually offer work under certain facts. However, the undersigned does not believe claimant's actions in this matter rose to such a level as to warrant termination of benefits throughout the remainder of claimant's recuperation period. The issue of light duty had been posed less than two weeks prior and importantly, on January 30, 2014, claimant's counsel proposed a four-way telephone conference call in an attempt to resolve the light duty issue. There is no evidence defendants attempted to cooperate with claimant beyond January 29, 2014. Defendants bear the burden of proving an offer of suitable light duty work was made and have failed to so prove after January 29, 2014 upon the facts of this case.

It is therefore determined claimant is entitled to temporary total disability/healing period benefits on January 24, 2014 and from January 30, 2014 through March 10, 2014.

The next issue for determination is whether the stipulated injury is a cause of permanent disability. The next issue for determination is the extent of claimant's permanent disability, including whether the disability is unscheduled or to a scheduled member. These issues will be considered together.

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).

Claimant argues he sustained a physical-mental claim, with permanent injuries to his left arm, left shoulder, neck, head and chest, as well as his mental health. Defendants argue claimant sustained no permanent disability as a result of the stipulated fall on September 28, 2012.

As a result of the stipulated fall, claimant suffered a mid-shaft fracture of his left humerus and a radial nerve palsy. Claimant suffered additional, immediately apparent injuries in the form of rib fractures and a pneumothorax.

The fracture ultimately required an open reduction internal fixation procedure. Claimant's surgeon, Dr. Marsh, eventually referred claimant to Dr. Chen for an impairment opinion. On February 3, 2014, Dr. Chen recommended an FCE to determine claimant's abilities; he directed claimant to return after FCE for imposition of permanent work restrictions and an impairment rating for the radial nerve injury. Claimant subsequently underwent FCE, with Mr. Kruzich opining the results were invalid. Claimant then returned to Dr. Chen, who reviewed the FCE. He opined claimant's left radial nerve injury was improving, with no further evidence of a radial neuropathy on motor examination. Dr. Chen assessed chronic myofascial left arm pain

which he attributed to increased central nervous system hyperexcitability. He opined claimant had achieved MMI and recommended claimant learn to deal with his pain. Due to full range of motion and strength of the shoulder, elbow and wrist, Dr. Chen opined claimant sustained no ratable impairment by the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition.

Claimant then underwent an IME with Dr. Taylor, who opined claimant's injuries of left rib fractures, pneumothorax, left humeral fracture, and left arm radial nerve palsy were all directly and causally related to the fall. Dr. Taylor also related claimant's residual left shoulder and anterior chest wall pain, and trapezius/parascapular pain to the fall. Dr. Taylor opined claimant sustained the following permanent impairments: 3 percent left upper extremity for loss of elbow motion; 6 percent left upper extremity for decrements in left shoulder range of motion; 3 percent left upper extremity for sensory deficits from the radial nerve palsy; and 4 percent left upper extremity for motor deficits from the radial nerve palsy. Despite the invalid FCE, Dr. Taylor opined claimant's residual symptoms warranted permanent restrictions of a 40-pound lift rarely, 30-pound lift occasionally, 20-pound maximum lift above shoulder level, and a 10-pound maximum lift with the left arm on a rare to occasional basis. He also recommended occasional stooping, bending, kneeling, or work on uneven surfaces; rare crawling; avoidance of vertical ladders and repetitive use of the left upper extremity; no forceful gripping or grasping with the left upper extremity; and occasional use of vibratory or power tools with the right upper extremity, but not with the left.

Claimant's treating surgeon, Dr. Marsh opined claimant had achieved MMI from the left humerus fracture. He also opined claimant suffered a radial nerve injury, which had improved by objective measures and clinical presentation. Despite objective improvement, Dr. Marsh noted claimant continued to express complaints of pain which were potentially consistent with ongoing nerve dysfunction. He also cautioned claimant's complaints may not necessarily be attributable to a radial nerve injury. Following review of Dr. Chen's notes, the FCE report, and Dr. Taylor's IME, Dr. Marsh expressed agreement with Dr. Chen's decision not to impose permanent work restrictions. Dr. Marsh based his opinion upon the behaviors cited by Dr. Chen, including overt and magnified pain behaviors and the failed validity criteria on the FCE. Dr. Marsh opined he saw no evidence indicating the cervical spine was the source of any ongoing complaints. He opined it possible claimant sustained a shoulder injury as a result of the work injury and indicated claimant might benefit from evaluation by a shoulder specialist.

With respect to claimant's mental health claim, Dr. Ascheman opined claimant suffered with no limitations attributable to a mental health issue. Dr. Marchman assessed a working diagnosis of adjustment disorder with depressed mood and opined the mental condition was a response to pain, disability, and the financial and social consequences of both. However, Dr. Marchman opined the mental health problems were not disabling in and of themselves.

Claimant bears the burden of proving he sustained permanent disability and the situs of the disability. Claimant has claimed permanent disability to his left arm, left shoulder, neck, head and chest, as well as his mental health. Claimant certainly suffered with a fracture of the left humerus, requiring placement of hardware, and a radial nerve palsy injury. However, Dr. Chen opined claimant sustained no ratable impairment as a result of these conditions. Dr. Taylor opined claimant sustained ratable impairment, but did so in spite of FCE findings which rendered examination results questionable. The undersigned is bothered by Dr. Taylor's disregard for the FCE results and the determination of Mr. Kruzich that claimant's FCE results could only be described as demonstrating abnormal testing behavior, with signs of symptom magnification. Mr. Kruzich convincingly rejected Dr. Taylor's assertion claimant's poor FCE performance could be attributable to increased pain complaints. As Dr. Taylor bases his permanent impairment ratings upon measures subject to manipulation and fails to adequately explain claimant's poor performance at FCE, the undersigned determines the opinions of Dr. Taylor are entitled to little weight. Having provided greater weight to the opinion of Dr. Chen, in conjunction with the invalid FCE findings of Mr. Kruzich, it is determined claimant has failed to prove he sustained permanent disability to his left arm.

The only physician to definitively causally relate claimant's left shoulder, chest wall pain, and trapezius/parascapular pain to the work injury is Dr. Taylor. For the reasons outlined *supra*, Dr. Taylor's opinions regarding claimant's subjective reports are entitled to little weight. While claimant testified he related his ongoing symptoms in these regions to the work injury, the undersigned found claimant was not a credible witness. Claimant also has claimed disability to his head, but the undersigned is unable to determine a specific, anatomical injury to claimant's head. It is therefore determined claimant has failed to prove he sustained permanent disability to his left shoulder, chest, neck, or head.

Finally, claimant argues he sustained permanent disability in the form of his mental health conditions. Drs. Ascheman and Marchman each opined claimant's mental health conditions were not limiting and disabling of their own accord. There is no contrary opinion in evidence. It is therefore determined claimant has failed to prove he sustained permanent disability in the form of a mental health condition.

The next issue for determination is whether claimant is entitled to payment of various medical expenses.

The employer shall furnish reasonable surgical, medical, dental, osteopathic, chiropractic, podiatric, physical rehabilitation, nursing, ambulance, and hospital services and supplies for all conditions compensable under the workers' compensation law. The employer shall also allow reasonable and necessary transportation expenses incurred for those services. The employer has the right to choose the provider of care, except where the employer has denied liability for the injury. Section 85.27. Holbert v. Townsend Engineering Co., Thirty-second Biennial Report of the Industrial Commissioner 78 (Review-Reopening October 1975).

As detailed in Exhibit 13, claimant has requested defendants be found responsible for various medical expenses he relates to the work injury of September 28, 2012. The first such request pertains to the medical treatment claimant received on July 6, 2013. (Ex. 13, pp. 233-237, 239-240) On this occasion, claimant was transported to the hospital and received care as a result of intoxication. Claimant indicated he drank to take away the pain in his left arm; however, the medical treatment necessitated by claimant's drinking is not defendants' responsibility. Claimant has failed to prove a causal connection between the care sought on July 6, 2013 and his stipulated work injury of September 28, 2012.

Claimant also requests defendants' be found responsible for medical expenses incurred for the care he received on October 27, 2014. (Ex. 13, pp. 233-237, 239-240) On this occasion, claimant presented for care of left-sided chest pain with pain radiating down the left arm. The provider assessed pain consistent with a chest wall strain. Claimant, himself, testified symptoms began after a period of utilizing both arms in his employment role for a new employer. Claimant also testified he became fearful he suffered with a heart condition due to the pain and shortness of breath he suffered. On these facts, claimant has failed to prove a causal connection between the care sought on October 27, 2014 and his stipulated injury of September 28, 2012.

Finally, claimant requests defendants be found responsible for the costs of counseling sessions from August 14, 2013 through October 15, 2014. (Ex. 13, pp. 233-237, 239-240) Claimant began his counseling sessions at Seashore Psychology Clinic in August 2013, following a referral from a social worker at the UIHC in connection with claimant's hospitalization for intoxication and suicidal/homicidal ideation in July 2013. However, authorized pain management provider Dr. Siriwetchadarak recommended claimant be referred to the health psychology department for development of coping skills. It is claimant who carries the burden of proving the care was causally related to the work injury. Given the care was initiated in response to a non-work related event of intoxication with suicidal and homicidal ideation, the undersigned finds claimant has failed to provide sufficient evidence to prove the care provided was in treatment of a work-related condition. Defendants are therefore, not responsible for the cost of claimant's claimed counseling sessions from August 14, 2013 through October 15, 2014.

The next issue for determination is whether claimant is entitled to alternate medical care pursuant to Iowa Code section 85.27. Claimant sought designation of Dr. Nepola and Seashore Psychology Clinic as authorized providers. However, the undersigned has found claimant failed to prove a causal relationship between the ongoing complaints and his work injury at defendant-employer. Therefore, claimant is not entitled to an award of alternate care.

The next issue for determination is whether claimant is entitled to penalty benefits under Iowa Code section 86.13 and, if so, how much.

If weekly compensation benefits are not fully paid when due, section 86.13 requires that additional benefits be awarded unless the employer shows reasonable cause or excuse for the delay or denial. Robbennolt v. Snap-on Tools Corp., 555 N.W.2d 229 (Iowa 1996).

Delay attributable to the time required to perform a reasonable investigation is not unreasonable. Kiesecker v. Webster City Meats, Inc., 528 N.W.2d 109 (Iowa 1995).

It also is not unreasonable to deny a claim when a good faith issue of law or fact makes the employer's liability fairly debatable. An issue of law is fairly debatable if viable arguments exist in favor of each party. Covia v. Robinson, 507 N.W.2d 411 (Iowa 1993). An issue of fact is fairly debatable if substantial evidence exists which would support a finding favorable to the employer. Gilbert v. USF Holland, Inc., 637 N.W.2d 194 (Iowa 2001).

An employer's bare assertion that a claim is fairly debatable is insufficient to avoid imposition of a penalty. The employer must assert facts upon which the commissioner could reasonably find that the claim was "fairly debatable." Meyers v. Holiday Express Corp., 557 N.W.2d 502 (Iowa 1996).

If the employer fails to show reasonable cause or excuse for the delay or denial, the commissioner shall impose a penalty in an amount up to 50 percent of the amount unreasonably delayed or denied. Christensen v. Snap-on Tools Corp., 554 N.W.2d 254 (Iowa 1996). The factors to be considered in determining the amount of the penalty include the length of the delay, the number of delays, the information available to the employer and the employer's past record of penalties. Robbennolt, 555 N.W.2d at 238.

Iowa Code 86.13, as amended effective July 1, 2009, states:

> 4. a. If a denial, a delay in payment, or a termination of benefits occurs without reasonable or probable cause or excuse known to the employer or insurance carrier at the time of the denial, delay in payment, or termination of benefits, the workers' compensation commissioner shall award benefits in addition to those benefits payable under this chapter, or chapter 85, 85A, or 85B, up to fifty percent of the amount of benefits that were denied, delayed, or terminated without reasonable or probable cause or excuse.
>
> b. The workers' compensation commissioner shall award benefits under this subsection if the commissioner finds both of the following facts:
>
> (1) The employee has demonstrated a denial, delay in payment, or termination of benefits.
>
> (2) The employer has failed to prove a reasonable or probable cause or excuse for the denial, delay in payment, or termination of benefits.

c. In order to be considered a reasonable or probable cause or excuse under paragraph *"b"*, an excuse shall satisfy all of the following criteria:

(1) The excuse was preceded by a reasonable investigation and evaluation by the employer or insurance carrier into whether benefits were owed to the employee.

(2) The results of the reasonable investigation and evaluation were the actual basis upon which the employer or insurance carrier contemporaneously relied to deny, delay payment of, or terminate benefits.

(3) The employer or insurance carrier contemporaneously conveyed the basis for the denial, delay in payment, or termination of benefits to the employee at the time of the denial, delay, or termination of benefits.

Claimant argues he is entitled to penalty benefits for defendants' delay or denial of indemnity benefits in four instances: (1) delay in payment of temporary total disability/healing period benefits from September 29, 2012 through October 26, 2012; (2) delay in payment of temporary total disability/healing period benefits from December 1 through December 7, 2012 and December 15, 2012 through January 4, 2013; (3) denial of temporary total disability/healing period benefits from January 20, 2014 through March 10, 2014; and (4) non-payment of permanent partial disability benefits.

Following claimant's work injury of September 28, 2012, the parties do not dispute claimant was entitled to temporary total disability/healing period benefits. Such benefits were not delivered to claimant from September 29, 2012 until October 25, 2012. Claimant has therefore, demonstrated a delay in payment of benefits owed. The burden then shifts to defendants to prove a reasonable or probable cause or excuse for the delay. Section 86.13(4)(c) sets forth specific requirements for defendants to fulfill in order to establish a reasonable or probable cause or excuse. Defendants admit benefits were owing and represent defendant-insurance carrier was unable to forward claimant's benefits due to lack of knowledge of his address. While this may be accurate, defendants failed to provide evidence such checks were issued and delivery to claimant attempted. Furthermore, defendant-employer had knowledge of claimant's representation by counsel on October 10, 2012 and still, no benefits were paid for over two weeks. Defendants provided counsel no contemporaneous written explanation for the failure to pay benefits owed, as is required by section 86.13(4)(c)(3). Accordingly, claimant is entitled to penalty benefits for the period of delayed temporary total disability/healing period benefits.

Claimant's entitlement to temporary disability benefits from September 29, 2012 through October 25, 2015, when defendant-employer issued a check for indemnity benefits owed, totals 3.857 weeks. The parties stipulated at the time

of the stipulated work-related injury, claimant's gross average weekly wage was $500.00 and claimant was single and entitled to 1 exemption. The proper rate of compensation is therefore, $323.12. Claimant's temporary total disability benefits owed from September 29, 2012 through October 25, 2015, therefore totals $1,246.27. Claimant's failure to return to his pre-injury address or formally update his address with defendants serves to mitigate the penalty benefit award. It is determined a penalty of $500.00 is warranted for defendants' failure to timely pay indemnity benefits from September 29, 2012 through October 25, 2015.

Claimant also claims entitlement to penalty benefits for defendants' delay in payment of temporary total disability/healing period benefits from December 1 through December 7, 2012 and December 15, 2012 through January 4, 2013. Defendants admit benefits were owing during this period and introduced evidence representing indemnity checks were issued for these dates to claimant's address on-file. When notified these checks were issued to an incorrect address, defendants reissued the benefits to claimant in care of his attorney's office. After this date, there are no other periods of delayed indemnity benefits. It is determined defendants demonstrated a reasonable or probable cause or excuse for the delay in benefits from December 1 through December 7, 2012 and December 15, 2012 through January 4, 2013.

Next, claimant claims entitlement to penalty benefits for defendants' failure to pay temporary total disability/healing period benefits from January 20, 2014 through March 10, 2014. No such benefits were paid during this period due to the dispute regarding claimant's alleged refusal of suitable work. While the undersigned found claimant entitled to benefits for a portion of the claimed period, claimant's entitlement to such benefits was fairly debatable. Defendants conveyed the basis of the refusal to pay benefits contemporaneously with the denial. On these facts, no award of penalty benefits is warranted.

Finally, claimant claims entitlement to penalty benefits for defendants' failure to pay permanent partial disability benefits. By this decision, the undersigned found claimant failed to prove the work injury resulted in permanent disability and accordingly, no benefits were owed. As no indemnity benefits were owed, none were improperly denied, and there is no basis for an award of penalty benefits.

The final issue for determination is a specific taxation of costs pursuant to Iowa Code section 86.40 and rule 876 IAC 4.33. Claimant requests taxation of the costs of: $100.00 filing fee; $12.92 service fees of original notice and petitions; $6.46 service fees of alternate care petition; $502.15 deposition transcript of Mr. Roling; $90.00 cost of subpoena to Dayspring Medical Case Management; $176.50 deposition transcript of claimant, part one; and $99.50 deposition transcript of claimant, part two. (Ex. 19, p. 262-266)

The costs of $100.00 filing fee, $12.92 service fees of the original notice and petition, $502.15 deposition transcript of Mr. Roling, and $276.00 deposition transcripts of claimant are taxable costs and are taxed to defendants. Claimant also requests taxation of the costs of $6.46 in service of claimant's alternate care petition. An alternate care proceeding is separate from an arbitration proceeding and furthermore, claimant failed to prove the subject of the alternate care proceeding was causally related to the stipulated work injury. Therefore, this cost is not taxed to defendants. Claimant also requests taxation of fees charged in connection with copying of medical records. Review of the invoice reveals a $70.00 charge for the act of copying and a $20.00 charge marked as a "late fee," presumably due to counsel's failure to timely pay the bill. While the copying costs may be taxed to defendants, the undersigned refuses to tax defendants with the late fee associated with delayed payment to the provider. Defendants are therefore taxed with total costs of $961.07.

ORDER

THEREFORE, IT IS ORDERED:

In File No. 5048346 (August 5, 2012 Date of Injury):

Claimant shall take nothing from these proceedings.

In File No. 5041675 (September 28, 2012 Date of Injury):

Defendants shall pay unto claimant temporary total disability benefits at the weekly rate of three hundred twenty-three and 12/100 dollars ($323.12) for the date of January 24, 2014 and from January 30, 2014 through March 10, 2014.

Defendants shall pay penalty benefits in the amount of five hundred and no/100 dollars ($500.00).

Defendants shall pay interest on the penalty benefits from the date of this decision. See Schadendorf v. Snap On Tools, 757 N.W.2d 330, 339 (Iowa 2008).

Defendants shall pay accrued weekly benefits in a lump sum.

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

Defendants shall receive credit for benefits paid.

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 as set forth in the decision.

Signed and filed this 13th day of January, 2016.

ERICA J. FITCH
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

Copies to:

Stephen W. Spencer
Attorney at Law
6800 Lake Drive, Suite 125
West Des Moines, IA 50266
steve.spencer@peddicord-law.com

William J. Bribriesco
Attorney at Law
2407 – 18th St., Ste. 200
Bettendorf, IA 52722
bill@bribriescolawfirm.com

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.