BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

DANIEL L. MILLS, Claimant, vs. HOUGHTON MIFFLIN HARCOURT, Employer, and NEW HAMPSHIRE INSURANCE COMPANY, Insurance Carrier, Defendants.	FILED MAR 09 2015 WORKERS COMPENSATION	File No. 5038673 ARBITRATION DECISION Head Note Nos.: 1100; 1402.40

STATEMENT OF THE CASE

Claimant, Daniel Mills, filed a petition in arbitration seeking workers' compensation benefits from Houghton Mifflin Harcourt, employer, and New Hampshire Insurance Company, insurance carrier, both as defendants, as a result of an alleged injury sustained on February 17, 2010. This matter came on for hearing before Deputy Workers' Compensation Commissioner, Erica J. Fitch, on March 4, 2014, in Cedar Rapids, Iowa. The record in this case consists of claimant's exhibits 1 through 14, defendants' exhibits A through BB, and the testimony of the claimant and Deborah Jessen. The parties submitted post-hearing briefs, the matter being fully submitted on April 4, 2014.

ISSUES

The parties submitted the following issues for determination:

1. Whether claimant sustained an injury on February 17, 2010 which arose out of and in the course of his employment; and if so,

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

3. Whether claimant is entitled to temporary disability benefits from February 23, 2012 through March 25, 2013;

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

5. The extent of claimant's industrial disability;

6. The proper commencement date for permanent disability benefits;

7. The rate of compensation;

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

9. Whether defendants are entitled to a credit pursuant to Iowa Code section 85.34(7); and

10. Whether claimant is entitled to penalty benefits under Iowa Code section 86.13 and, if so, how much.

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

At the conclusion of claimant's testimony at evidentiary hearing, claimant moved to amend his petition to assert a mental health claim for benefits. Defendants objected. The undersigned denied claimant's motion on the basis that granting such an amendment would be grossly prejudicial to defendants.

FINDINGS OF FACT

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

Claimant was 64 years of age on the date of hearing; claimant's 65th birthday was the following day. Claimant holds multiple advanced degrees, including an associate of arts degree in liberal arts, bachelor of arts degree in political science and communications, and master of arts degree in business communications. (Claimant's testimony; Exhibit A, page 2; Ex. C, p. 5) Claimant served in the United States Army from 1967 to 1971. During this period, claimant served two tours in Vietnam as a Morse code interceptor operator. (Claimant's testimony; Ex. A, p. 2; Ex. U, p. 85)

Claimant's work history includes positions in print, software and health care sales, public relations, marketing, financial account management, communications, client relations, workers' compensation case management, and as an unemployment insurance counselor. (Claimant's testimony; Ex. A, pp. 1-2) By claimant's answers to interrogatories, claimant outlined the reason for leaving each of his past employment positions. Generally speaking, claimant reported leaving for other employment opportunities or family reasons. Claimant also reported two layoffs. In 1982, claimant reported being fired from an employer due to personality conflicts with a company executive. (Ex. C, pp. 6-7)

Claimant worked for a company named River Deep, doing telephone sales for educational software. River Deep was purchased by defendant-employer in 2006. Claimant remained on staff and continued in his inside sales position. In 2009, claimant became an outside sales representative/regional account manager. Claimant's outside sales duties required him to travel between school districts, selling and implementing

software programs. His compensation package consisted of salary, quarterly commissions based on sales, and annual bonuses. (Claimant's testimony) At the time of the alleged work injury, claimant earned $2,884.62 biweekly. On November 14, 2009, claimant received a commission for third quarter sales in the amount of $11,842.87. (Ex. 8, p. 1; Ex. I, p. 25; Ex. K, pp. 29-30) Claimant testified commissions are paid based upon a formula promulgated by defendant-employer regarding sales goals. Claimant denied receiving a commission every quarter. (Claimant's testimony)

Claimant's medical history is significant for treatment of obsessive-compulsive disorder (OCD), dating to 1988 or 1989. Claimant also reported some anxiety in connection with his OCD. His anxiety was severe enough to warrant receipt of Social Security disability benefits from 1986 to 1988. (Claimant's testimony; Ex. M, pp. 40-42, 44, 46-47; Ex. S, p. 67; Ex. X, Deposition Transcript pp. 13-17) During the course of claimant's treatment for OCD, mention is also intermittently made to depression or depressive symptoms. (Ex. M, pp. 44; Ex. S, p. 67)

Claimant testified he lost many jobs as a result of interpersonal issues and OCD. Specifically, OCD caused tardiness and the need to leave work to check on things around his home. He also lashed out at coworkers and developed anxiety surrounding work scenarios. Claimant testified he had been fired for personality conflicts, lack of productivity, and lashing out at coworkers as a result of his mental health conditions. (Claimant's testimony) The evidentiary record, including claimant's mental health treatment records, support claimant's testimony. (Ex. M, pp. 40, 42)

Claimant's medical history is also significant for care of low back complaints. Medical records detail claimant seeking sporadic treatment of low back pain and spasms dating to 2001. (Ex. O, pp. 54-56) Beginning in 2003, claimant began seeking chiropractic services multiple times per year for complaints of low and mid back pain. These chiropractic visits continued from 2003 until 2009. (Ex. N, pp. 48-53) Claimant testified over a several year period, he felt general back discomfort in the L3-L4-L5 region, for which he treated occasionally with a chiropractor. In May 2009, due to an impending overseas vacation, claimant sought an adjustment. Claimant believes at this visit, the chiropractor herniated a disc in his low back. Thereafter, claimant suffered worsening back pain and eventually sought treatment with board-certified neurosurgeon, Darrin Smith, M.D. Claimant denied any radicular symptoms to his legs. (Claimant's testimony; Ex. 11, Depo. Tr. pp. 3-4; Ex. 11, Depo. Ex. 1; Ex. W, Depo. Tr. pp. 30-31, 33)

On June 11, 2009, claimant underwent an MRI of the lumbar spine. The radiologist noted the imaging was ordered in response to complaints of low back pain with left leg radiculopathy. The radiologist opined the results revealed a large nonenhancing soft tissue focus posterior to the disc space at L4-L5, causing moderate to severe spinal canal stenosis. The radiologist opined the results likely represented a disc fragment or disc extrusion. Other findings included mild spinal canal stenosis at L2-L3 and L3-L4, as well as multilevel degenerative disc and hypertrophic facet changes. (Ex. Q, pp. 58-59)

On June 17, 2009, claimant returned to Dr. Smith. Dr. Smith noted complaints of back pain radiating down the left leg of a six-week duration. Claimant also reported intermittent numbness and tingling in the same distribution. Claimant denied injury or similar episodes of pain in the past. (Ex. V, p. 138) Dr. Smith diagnosed a herniated disc at left L4-L5, causing spinal stenosis. Dr. Smith recommended a left L4-L5 microdiscectomy. (Ex. V, p. 140) On June 23, 2009, Dr. Smith performed a left L4-L5 laminotomy and microdiscectomy to treat a large left L4-L5 extrusion with severe stenosis and radiculopathy. (Ex. Q, p. 60) Following surgery, at claimant's one-week postoperative evaluation, claimant reported some left leg pain, but improved after surgery. Dr. Smith indicated claimant was doing well and should follow up in five weeks. (Ex. V, p. 141) On August 6, 2009, claimant telephoned Dr. Smith's office and informed staff he was "doing great," did not need to be evaluated, and desired to return to work on August 10, 2009. Claimant was provided with a release to return to work. (Ex. 1, p. 1) Claimant denied any ongoing back pain. (Claimant's testimony; Ex. W, Depo. Tr. p. 35)

On February 17, 2010, claimant attended defendant-employer's annual conference in Orlando, Florida. At evidentiary hearing, claimant provided an account of what occurred that date. Around 7:30 a.m., claimant testified he and some coworkers were congregating outside their hotel to load into rental vans to travel to the conference location. These rental vans were driven by employees of defendant-employer. Claimant was standing on the driver's side of one van with driver, Christopher Cook. Another van, driven by Deborah Jessen, attempted to pass by Mr. Cook's van. Claimant was unable to get out of the way and was struck in the stomach area by Ms. Jessen's van. As Ms. Jessen continued to drive by, claimant was "twisted" and "torqued" between the vehicles. Claimant testified he was afraid he would be "crushed" between the vans. (Claimant's testimony)

Following the incident, claimant testified he proceeded to get into Mr. Cook's van and travel to the conference. Ms. Jessen met claimant at the door and apologized for what had occurred. Claimant testified he acted as if he were fine because he did not want to ruin the last day of the conference and did not want Ms. Jessen to feel badly. One of claimant's supervisors, William Weiler, asked if claimant was okay, to which claimant replied affirmatively. (Claimant's testimony)

By his deposition testimony, claimant provided a similar account of the incident the morning of February 17, 2010. Claimant testified the two vans, transport vans designed to carry 15 to 17 people, were parked in a staggered fashion with Mr. Cook's van at the curb. Claimant testified he and Mr. Cook were standing on the driver's side of Mr. Cook's van. Ms. Jessen filled her van and proceeded to drive past Mr. Cook's van. As Ms. Jessen drove by, claimant was pinched and twisted between the two vans. (Ex. W, Depo. Tr. pp. 37-43) Claimant testified he believed he would be "crushed to death." (Ex. W, Depo. Tr. p. 42) Claimant testified he was later told by Ms. Jessen's passengers that they warned Ms. Jessen she was about to hit claimant and then after the incident, advised her she had hit claimant but Ms. Jessen continued on to the meeting location. (Ex. W, Depo. Tr. p. 42)

Christopher Cook provided deposition testimony in this matter. Mr. Cook admitted he acted as a driver of one of the vans involved in the incident of February 17, 2010. (Ex. 12, Depo. Tr. p. 4) Mr. Cook testified at the time of the incident, his van was parked outside the hotel and he was standing beside the driver's door. He believed claimant was standing beside him on the driver's side of the van. Mr. Cook described the incident with the two vans as follows:

> The second van started to pull out and was – basically had gotten too close to my van, the one that was waiting to pick up additional people and I guess for lack of better terms, pinched or rolled [claimant] from the driver's side to the front. And I had just gotten out of the way.

(Ex. 12, Depo. Tr. p. 7)

After the contact, Mr. Cook testified he observed a "fairly good-sized dent" on the front passenger side of Ms. Jessen's van. (Ex. 12, Depo. Tr. p. 8) Mr. Cook denied damage to the van he was driving. (Ex. 12, Depo. Tr. pp. 9-10) He also denied observing any type of physical injury to claimant, but believed claimant may have expressed being in some level of discomfort on the way to the conference after the incident. (Ex. 12, Depo. Tr. pp. 10-11)

Mr. Cook's testimony is consistent with that offered by claimant and to a lesser extent, Mr. Weiler, as to the occurrence of an incident on February 17, 2010. There is no objective support in the record for Mr. Cook's testimony he observed a dent in Ms. Jessen's van. However, the dent or lack thereof ultimately plays a small role in the merits of this case. The undersigned was presented with no other reason to doubt Mr. Cook's veracity. Therefore, Mr. Cook's testimony is found credible.

William Weiler, claimant's manager at the time of the alleged work injury, also provided deposition testimony. (Ex. 14, Depo. Tr. pp. 5-6; Ex. Y, Depo. Tr. pp. 5-6) Mr. Weiler testified he was present in the van driven by Ms. Jessen at the time of the alleged work injury. Mr. Weiler's account of the incident is as follows:

> As we were leaving, there was some commotion, confusion, a couple of people, you know, raising their voices, but apparently [claimant] was caught in between the two vans as we were about to leave, and I didn't witness it, but the incident probably took, you know, no more than five seconds . . . .

(Ex. 14, Depo. Tr. pp. 6-7; Ex. Y, Depo. Tr. pp. 6-7)

> Yeah. The woman that was at the back of the van, you know, like yelled, "Watch out, stop." I think stop. I can't recall exactly.
>
> But, you know, there were people from both sides that were seeing this, you know, the incident unfold, and [Ms. Jessen] stopped her vehicle,

> and [claimant] proceeded to get into [Mr. Cook's] van, and we made sure that he seemed okay.

(Ex. 14, Depo. Tr. p. 12; Ex. Y, Depo. Tr. p. 12)

Upon arriving at the conference, Mr. Weiler testified he spoke with claimant and claimant reported he was fine. He denied observing any visible sign of injury to claimant or physical damage to either of the vans involved. Mr. Weiler did not personally inspect the vans; however, had there been damage to either van, Mr. Weiler testified he would have been made aware, as he would have needed to take steps to have the damage processed through defendant-employer's corporate insurance. (Ex. 14, Depo. Tr. pp. 7-8, 13; Ex. Y, Depo. Tr. pp. 7-8, 13) Mr. Weiler indicated the incident was also reported to Roberta Beaulieu, human resources liaison, over the telephone. (Ex. 14, Depo. Tr. p. 7; Ex. Y, Depo. Tr. p. 7)

Mr. Weiler's testimony regarding the occurrence of an incident is consistent with the testimony of claimant and Mr. Cook. His testimony regarding conversations between himself, Ms. Jessen, and claimant following the incident is consistent with the testimony of Ms. Jessen and claimant. The only inconsistency of note is Mr. Weiler's assertion Ms. Jessen stopped at the scene of the accident, which is soundly refuted by the other testimony in the record. Given Mr. Weiler's testimony was provided during a telephone deposition and not in person at evidentiary hearing, the undersigned attributes this inconsistency not to an intentional untruth, but to a possible miscommunication between Mr. Weiler's intended testimony and what is taken down and read by the undersigned. The undersigned was presented with no other reason to doubt Mr. Weiler's veracity. Mr. Weiler's testimony is found credible.

Deborah Jessen testified at evidentiary hearing. Ms. Jessen testified she rented a minivan which seated approximately seven people. On the morning of February 17, 2010, she testified the two vans were parked outside of the hotel loading passengers. When her van became loaded, she began to drive away. As she pulled forward, she passed between a hotel pillar on the driver's side of her van and Mr. Cook's van on the passenger side of her van. Ms. Jessen testified she has no personal knowledge of seeing claimant or whether or not she struck claimant with the van. She did not observe claimant and she heard no noise of impact. In the event she had known she struck claimant, Ms. Jessen testified she would not have continued driving to the conference. (Ms. Jessen's testimony)

On the way to the conference, Ms. Jessen testified she heard passengers laughing, so upon arrival at the conference location, she asked what had prompted the laughter. Ms. Jessen testified she was then told claimant had been joking around and acting as if he were sucking in his stomach to allow her van to pass. When claimant arrived at the conference, Ms. Jessen approached claimant and asked what occurred. Claimant explained the van had brushed against his stomach, but he was unhurt. She apologized for the incident. Ms. Jessen testified she inspected her van and observed no damage. She also noted she was not charged for any damage to the van by the rental car company. (Ms. Jessen's testimony)

Ms. Jessen also provided deposition testimony in this matter. Ms. Jessen testified both she and Mr. Cook rented minivans seating approximately six people. (Ex. Z, Depo. Tr. pp. 19-20) At the time of the alleged work injury, Ms. Jessen testified employees were gathering at the entrance of the hotel to go to the conference location. Ms. Jessen testified she drove her van from the parking lot to the entrance of the hotel and put the vehicle in park. She did not recall if she got out of the van. Ms. Jessen testified she believed the vehicles were parked parallel, side by side, but staggered, with Mr. Cook's vehicle in front. She indicated Mr. Cook's vehicle was located to the right side of her van. (Ex. Z, Depo. Tr. pp. 24-28)

Ms. Jessen testified she loaded passengers and proceeded to leave the hotel entrance:

> A. When I started driving, I was watching the front of the van as I pulled out of the porte-cochère area because there was a pillar, and then the other van was to the right of me. So I was watching the front left and front right of the car as I pulled out slowly. And as I was pulling out, something was happening outside the van and the folks inside the van were laughing.
>
> Q. And what do you mean something was happening outside?
>
> A. The folks inside my van were very lighthearted, and they were laughing about something that was occurring outside there.

(Ex. Z, Depo. Tr. pp. 29-30)

Ms. Jessen indicated at the time, she was not aware what her passengers were laughing about. (Ex. Z, Depo. Tr. p. 31) Ms. Jessen testified she did not stop the van and no one inside the van told her to stop. (Ex. Z, Depo. Tr. pp. 35-36) She subsequently learned the cause of the laughter from passenger, Craig Pritchard, who stated:

> He said that – once we were driving out of the parking lot that [claimant] and [Mr. Cook] were in between the van, and [claimant] was being silly and leaned up against the van and pretended to suck it in – his stomach in as we passed through, and [Mr. Cook] jumped into his van's side door.

(Ex. Z, Depo. Tr. p. 31)

When she learned of Mr. Pritchard's account, Ms. Jessen testified she sought out Mr. Weiler and indicated they needed to see if claimant was okay. (Ex. Z, Depo. Tr. p. 32) When claimant entered the room at the conference location, Ms. Jessen testified he was joking and pretending to drag his leg. She and Mr. Weiler questioned claimant as to what occurred. Ms. Jessen testified as follows regarding that interaction:

A. And Dan had said to us that when my van pulled out that he was in between the vans, he thought he could suck it in, but his stomach got out -- in the way and that his button got caught inside the van -- or on something on the van and that when it got caught, it spun him as I -- as I drove away slowly, he spun slowly with the van.

Q. What button, do you know?

A. On his blazer --

Q. What did it get --

A. -- which he proceeded to show me.

. . . .

A. I don't recall if the button had fallen off or if it was just on -- hanging on by a thread.

(Ex. Z, Depo. Tr. p. 34)

Ms. Jessen testified she apologized to claimant and asked if he was hurt. Claimant indicated he was not. Ms. Jessen testified she sat near claimant throughout the day's meetings to allow her to check on claimant and make sure he was feeling fine. (Ex. Z, Depo. Tr. p. 35) Ms. Jessen testified she later inspected her van and noted no damage. She did not inspect Mr. Cook's van. (Ex. Z, Depo. Tr. p. 36) Ms. Jessen's rental car return receipt does not identify any charge for damage to Ms. Jessen's van. (Ex. G, p. 19)

Ms. Jessen's testimony with regard to the details of the accident is not inconsistent with other testimony in the record, as it simply lacks the detail associated with personal observation. Her testimony with regard to the mood of her passengers is inconsistent with Mr. Weiler's, although Mr. Weiler's testimony was not certain on details. Ms. Jessen's testimony regarding verbal contact with claimant at the conference location is consistent with the testimony of claimant and Mr. Weiler, as well as the written evidentiary record. Her testimony as to lack of damage to the rental van she drove is consistent with the rental car receipt detailing no charges for damage. The undersigned had the opportunity to observe Ms. Jessen at evidentiary hearing. At that time, she provided testimony entirely consistent with her deposition testimony and her demeanor provided the undersigned no reason to doubt her veracity. Ms. Jessen is found credible.

Over the course of the morning of February 17, 2010, claimant testified his pain and bruises worsened. The conference concluded midday and claimant flew to Cedar Rapids, Iowa. Upon arriving home, claimant took ibuprofen. The following day, claimant telephoned his personal physician, Todd Butler, M.D., who advised claimant to present to the emergency room. (Claimant's testimony)

Claimant presented to the emergency room at St. Luke's Hospital on February 18, 2010 and was evaluated by Anthony Carter, D.O. Claimant reported being "pinched between two vans," with the second van squeezing by and rolling him up against another van. Claimant reported being spun 180 degrees. Claimant denied significant initial discomfort, but reported he had begun to develop discomfort in his left ankle, left knee, and back. Claimant denied numbness, tingling, or weakness. (Ex. 5, p. 1) Examination revealed good range of motion of the back with minimal midline tenderness at approximately the L2-L3 level. (Ex. 5, p. 1) X-rays of the low back revealed lumbar spondyloarthropathy without evidence of fracture. Dr. Carter diagnosed multiple contusions, ankle strain, and back contusions. He recommended use of ice, Motrin and Robaxin. (Ex. 5, pp. 1-2)

After a three day period off work, claimant returned to work out of his home office. Claimant testified he felt generally sore, but eventually started to improve. Claimant testified he continued to have back pain, but he was able to manage his own work schedule to reflect his pain levels. (Claimant's testimony)

Following the alleged work injury, Ms. Jessen indicated she contacted claimant about the incident on several occasions. The first time was the week after the incident, after claimant saw a doctor. She testified claimant advised her the doctor provided him pain pills and recommended he take it easy for a few days. Ms. Jessen testified claimant assured her he was fine. (Ex. Z, Depo. Tr. pp. 39-40)

On March 5, 2010, Ms. Jessen sent an email to claimant. Ms. Jessen indicated she was "checking in" on claimant and asked how he was feeling. Claimant authored a response to Ms. Jessen's email that same date, stating "I am feeling fine! No ill effects..." (Ex. E, p. 10)

On March 22, 2010, claimant presented to Dr. Butler in follow up of his hypertension. In the portion of Dr. Butler's medical note referencing discussion of active problems, there is no reference to back pain. During examination, Dr. Butler noted claimant appeared to sit comfortably. Dr. Butler's assessment and plan of care also do not include any reference to back complaints. (Ex. S, pp. 69-70)

On March 23, 2010, Ms. Jessen authored an email to claimant inquiring, "[h]ow are ya [*sic*] Dan?" Claimant responded the following day, stating "I'm doing fine! Thanks for thinking of me." (Ex. E, p. 11)

Ms. Jessen emailed claimant again on May 7, 2010, asking how he was feeling. Three days later, claimant responded and wrote, "I am feeling great... and thanks for asking!" (Ex. E, p. 12)

Despite his responses to Ms. Jessen's emails, claimant testified he was not feeling well and continued to have back pain. As his symptoms were not severe, claimant testified he chose to keep his complaints private. (Claimant's testimony)

On September 28, 2010, claimant returned to Dr. Butler for a physical. Claimant reported occasional problems with indigestion, but he otherwise felt "well" and denied other symptoms. Examination of the back did not demonstrate costovertebral angle (CVA) or spinal tenderness. (Ex. S, p. 72) Dr. Butler did not assess or mention back pain. (Ex. S, p. 74) Despite lack of mention by Dr. Butler, claimant testified he informed Dr. Butler of back complaints during this visit. (Claimant's testimony)

At some point in 2010, claimant presented to the Veterans Health Administration (VA) hospital for certification to receive a handicapped parking placard. (Claimant's testimony)

Claimant testified he continued to alter his work schedule throughout 2010. In the summer of 2010, claimant testified he began having episodes of back pain which rendered him barely able to get out of bed. He began to use ibuprofen, heat/ice, and left over hydrocodone and muscle relaxers. Claimant then began to perform more of his work duties over the telephone than in person. Claimant testified he did not file a workers' compensation claim because he believed doing so could result in him losing his job, as many layoffs were occurring. Additionally, claimant indicated he did not wish to cause conflict with his new supervisor, Ms. Jessen. (Claimant's testimony)

Ms. Jessen testified she was employed by defendant-employer as a district manager February 2010, but she did not supervise claimant. Ms. Jessen began to supervise claimant in December 2010 after becoming a regional manager. After becoming regional manager, Ms. Jessen travelled with claimant and the rest of the team members for sales meetings. (Ex. Z, Depo. Tr. pp. 9-14)

One such trip occurred in February 2011, when the team travelled in Minnesota by car. Ms. Jessen indicated claimant drove himself from his home to the meeting and seemed fine, without complaints. Ms. Jessen indicated she was aware claimant was using a handicapped placard to park and further indicated the two had a discussion about claimant's need for a handicapped placard. (Ms. Jessen's testimony; Ex. Z, Depo. Tr. pp. 14-15) Ms. Jessen testified claimant mentioned a prior back surgery and an incident when "a chiropractor had herniated his disk." (Ex. Z, Depo. Tr. pp. 14-15) Ms. Jessen testified the team had another sales trip to Wisconsin in March 2011. She travelled with claimant by car; claimant again drove. (Ex. Z, Depo. Tr. p. 15) Ms. Jessen noted claimant offered to carry her bag and the bag of a pregnant coworker. The women declined due to knowledge of claimant's handicap placard. (Ms. Jessen's testimony)

On April 26, 2011, claimant authored an email to Ms. Jessen, stating in relevant part:

> My luggage arrived this morning... whew! I am having back issue today, though... the bed? Sleepless in New Orleans? Where's Meg Ryan when I need her?

(Ex. E, p. 13)

On May 6, 2011, claimant presented to Dr. Butler with complaints of back pain, with an onset one month prior, and numbness of the buttocks radiating down the left leg. Examination revealed no CVA or spinal tenderness, but a questionable straight leg raise on the left and decreased strength with plantar flexion. Dr. Butler assessed back pain with a history of lumbar disc degeneration and evidence of radiculopathy. He recommended an MRI of claimant's lumbosacral spine. (Ex. S, pp. 75-76) Dr. Butler also imposed restrictions against repetitive bending, stooping or lifting more than 20 pounds and against prolonged standing or sitting. (Ex. BB)

Claimant testified he presented to Dr. Butler at this time as his complaints were no longer limited to back pain and spasms. Claimant testified he had recently developed numbness and tingling throughout his left lower extremity and this concerned claimant. Claimant denied any injuries between the February 17, 2010 van incident and development of radiating symptoms. Claimant subsequently telephoned Dr. Butler for a referral to Dr. Smith, but was busy at work and did not follow through with the referral. (Claimant's testimony)

Claimant testified in July 2011 the radiating symptoms began to extend into his groin. He attempted to self-treat with ice, ibuprofen, and rest. However, his symptoms continued to worsen and claimant scheduled an appointment with Dr. Smith. (Claimant's testimony)

On August 17, 2011, claimant presented to Dr. Smith. Dr. Smith noted claimant was seen at the referral of Dr. Butler for complaints of back pain with bilateral leg and buttock numbness. Dr. Smith assessed a herniated lumbar disc, lumbar spinal stenosis, and low back pain. He ordered a lumbar MRI and prescribed Robaxin. (Ex. V, pp. 142-143)

Claimant's employment with defendant-employer was terminated effective August 18, 2011 due to downsizing. Eighteen positions in total were eliminated, including those of claimant and Ms. Jessen. Ms. Jessen was then hired into a different region of defendant-employer. (Claimant's testimony; Ms. Jessen's testimony; Ex. 14, Depo. Tr. pp. 9-10; Ex. B, p. 3)

Ms. Jessen testified she last spoke to claimant shortly after the layoffs. Ms. Jessen informed him she had no advance notice of his layoff, but would be willing to serve as a reference for claimant on a job application. Claimant reportedly informed Ms. Jessen he might not be returning to work, as he had sufficient money to retire. (Ex. Z, Depo. Tr. p. 51)

On August 30, 2011, claimant returned to Dr. Butler for a physical. At the time of evaluation, claimant reported he had been experiencing back pain and some numbness in the buttocks and down the left leg. Claimant reported receiving care for these complaints through Dr. Smith. (Ex. S, pp. 77-78)

Claimant then proceeded to seek authorization for medical care through defendant-insurance carrier. He was originally referred to a provider who removed

claimant from work. Claimant eventually received authorization to continue treatment with Dr. Smith. (Claimant's testimony)

On September 1, 2011, claimant underwent an MRI of the lumbar spine. The radiologist read the results as revealing:

1. Post left hemilaminectomy changes at L4-L5.

2. Narrow AP diameter of the spinal canal from L2-L3 through L4-L5.

3. Degenerative changes throughout the lumbar facets.

4. Soft tissue posterior to the L4-L5 disc slightly more prominent towards the right. Most of this soft tissue enhances suggesting scar tissue. There may be minimal right-sided disc bulge. The combination of these findings produces moderate spinal canal narrowing with possible compression on the right L5 nerve root.

5. Mild diffuse disc bulge at L3-L4 more prominent towards the right. There is moderate to severe spinal canal narrowing slightly greater on the right. There could be compression on the right L4 nerve root superior to the lateral recess. This appearance is similar to 06/11/2009.

6. Combination of bulging disc and facet arthropathy with narrow AP diameter of the spinal canal produces moderate to spinal canal narrowing which appears slightly progressed compared to 06/11/2009.

7. Mild to moderate foraminal narrowing is present at L5-S1 due to facet arthropathy, greater on the right.

(Ex. R, p. 62)

Claimant returned to Dr. Smith on September 7, 2011. At that time, claimant reported he developed back and leg pain "after being squeezed between cars at work." (Ex. 1, p. 2) Dr. Smith reviewed claimant's September 1, 2011 MRI and assessed severe lumbar stenosis at L3-L4 and L4-L5. Accordingly, Dr. Smith recommended L3 and L4 laminectomies. Dr. Smith also assessed severe left L4 foraminal stenosis, for which claimant required a foraminotomy. Based upon claimant's description of the injury and "the probable L4-5 disc extrusion," Dr. Smith opined it likely claimant's current complaints and need for surgery were causally related to the alleged work injury. (Ex. 1, p. 4) Dr. Smith removed claimant from work pending surgery. (Ex. 1, p. 5)

On September 16, 2011, claimant returned to Dr. Smith. He complained of continued low back pain and numbness of the bilateral buttocks with radiation to the left thigh, a burning sensation in the soles of his feet, and numbness of the right thigh with standing. (Ex. 1, p. 6) Following examination, Dr. Smith renewed his recommendation for surgery. (Ex. 1, p. 8)

On October 14, 2011, claimant returned Dr. Smith to discuss treatment options after denial of the recommended surgery under claimant's workers' compensation claim. At the time of examination, claimant reported increasing numbness with standing and numbness of the thighs, with radiation to the bottoms of his feet. Claimant also reported difficulty walking and worsening tripping. (Ex. 1, p. 9) Dr. Smith assessed lumbar stenosis with obvious nerve obstruction. Dr. Smith noted his prior recommendation for lumbar decompression had been denied twice. He elaborated:

> Their objections are difficult to understand as they seem to think bilateral weakness is less significant than unilateral weakness and epidural steroid injections should be tried for weakness despite acknowledging on the phone that it would be futile. I strongly recommend surgical decompression as soon as possible with or without insurance approval and do not believe his insurance is acting in patient's best interest.

(Ex. 1, p. 11)

On November 3, 2011, defendant's counsel authored an email to claimant's counsel indicating defendants were in the process of scheduling an independent medical evaluation (IME) of claimant with board-certified neurosurgeon, Chad Abernathey, M.D., and requested a completed patient waiver. (Ex. F, p. 14; Ex. AA) On November 9, 2011, defendants' counsel advised claimant's counsel the IME with Dr. Abernathey had been scheduled for November 30, 3011 at 1:00 p.m. Defendants requested dismissal of a pending alternate medical care petition pending the outcome of the IME. (Ex. F, p. 15) That same date, claimant's counsel authored a response indicating claimant desired to go forward with the alternate care hearing given prior delays and increasing complaints. (Ex. F, p. 15) Defendants' counsel authored a response dated November 15, 2011, asking claimant to reconsider his position on the alternate care hearing given the presence of a causation issue which defendants' sought to have considered by Dr. Abernathey. (Ex. F, p. 15)

On November 18, 2011, defendants' counsel authored a letter to Dr. Abernathey, providing Dr. Abernathey with the medical records then in counsel's possession. Notably missing from the list of medical records is claimant's emergency room record of February 18, 2010. Counsel requested Dr. Abernathey's opinions on diagnosis, causation, the pending surgical recommendation, and assignment of permanent impairment or permanent restrictions. (Ex. T, pp. 80-81) That same date, November 18, 2011, claimant's counsel authored an email to defendants' counsel indicating claimant would be unable to attend the appointment scheduled with Dr. Abernathey on November 30, 2011, as claimant was scheduled to undergo surgery on November 29, 2011. (Ex. F, p. 17)

On November 29, 2011, Dr. Smith performed L3-L4 laminectomies with medial facetectomies and foraminotomies to treat a diagnosis of severe lumbar stenosis at L3-L4 with persistent radiculopathies. (Ex. R, p. 64) Post-surgery, claimant continued to follow up with Dr. Smith. On January 11, 2012, Dr. Smith recommended a course of physical therapy. (Ex. 1, pp. 12-14) Claimant began physical therapy on January 20,

2012. The listed history denotes claimant sustained a work injury on February 17, 2010 when a "[c]o-worker scrunched him between 2 rental vans." Claimant reported the injury "torqued" him and caused recurrent back problems which initially felt like a muscle spasm; the following February, claimant developed numbness and loss of feeling in the legs which prompted him to seek treatment. (Ex. 2, p. 1)

As claimant did not attend the scheduled IME with Dr. Abernathey, defendants requested Dr. Abernathey perform a records review. (Ex. T, p. 82) Dr. Abernathey did so and issued a report of his opinions dated December 5, 2011. Dr. Abernathey assessed left L5 radiculopathy secondary to a left L4-L5 recurrent disc extrusion with stenosis at L3-L4-L5. Dr. Abernathey indicated he did not believe claimant's symptoms were causally related to the alleged February 17, 2010 incident, but the surgery performed by Dr. Smith would be reasonable treatment of claimant's condition. Based upon the MRI and examination findings, Dr. Abernathey opined claimant had not sustained permanent impairment nor required restrictions related to the February 17, 2010 incident. (Ex. T, p. 83)

Based upon Dr. Abernathey's report, on January 24, 2012, defendants notified claimant no additional treatment would be authorized and weekly benefits would cease as of February 22, 2012. (Ex. F, p. 18)

On February 8, 2012, claimant returned to Dr. Smith and reported resolution of right leg and groin numbness, but some continued intermittent numbness of the left leg. Dr. Smith described claimant as significantly improved following surgery, but with some residual symptoms. (Ex. V, pp. 144-145)

On April 30, 2012, claimant completed an application for Social Security retirement benefits. Claimant requested benefits effective February 2012. (Ex. H, pp. 20-21) That same date, claimant also applied for Social Security disability benefits on the basis of a lumbar injury and numbness of the left leg. Claimant indicated his medical conditions caused him to make changes in his work activities as of January 30, 2011 and he ceased working on August 24, 2011 due to his medical conditions. (Ex. L, p. 37-38)

On May 5, 2012, the Social Security Administration approved claimant's application for retirement benefits, effective February 2012. Claimant's monthly benefit amount totaled $1,535.00. (Ex. H, p. 22)

On May 17, 2012, claimant completed a function report for the Social Security Administration. In the form, claimant narratively described how his medical condition limited his ability to work. (Ex. L, p. 33) Claimant also denied losing a job due to interpersonal conflicts. (Ex. L, p. 34)

At hearing, claimant testified the statement to the Social Security Administration about not losing a job due to interpersonal conflicts was untrue. He also testified that although he ceased working in August 2011 due to a layoff, he believed he was unable to work after that layoff. (Claimant's testimony)

On June 6, 2012, claimant presented to personal physician, Carol Tan, M.D., to establish a course of care. Claimant identified ailments which included chronic back pain, reportedly related to being pinned between two vehicles at work; left lower extremity paresthesias persisting after surgery; and lower extremity weakness, especially on the left, which resulted in a slightly unsteady gait. (Ex. 13, p. 1) Amongst other diagnoses, Dr. Tan assessed "back injury with chronic back pain." (Ex. 13, p. 2)

Claimant returned to Dr. Smith on June 8, 2012 with complaints of worsening low back pain and intermittent left leg pain and numbness. Dr. Smith ordered a repeat lumbar MRI due to complaints of worsening low back pain, left thigh numbness, and difficulty walking due to weakness. (Ex. 1, p. 15; Ex. V, p. 146) Claimant underwent the recommended MRI on June 14, 2012. (Ex. 1, pp. 15-16) The following day, claimant returned to Dr. Smith, who opined the MRI revealed left L4-L5 and to a lesser extent, left L3-L4 foraminal stenosis, and disc degeneration at L4-L5 with tilting of the disc, which contributed to the left foraminal stenosis. Dr. Smith ordered bilateral lower extremity EMG/NCV testing. He also recommended a left L4-L5 epidural steroid injection, which claimant indicated he would consider. (Ex. 1, pp. 16, 18)

Robert Schultes, M.D., performed a disability evaluation in connection with claimant's application for Social Security disability benefits. Dr. Schultes authored a report of his findings dated June 29, 2012. Following history, records review and examination, Dr. Schultes issued diagnoses of chronic low back pain with neuropathy and decreased strength, decreased ambulation, and decreased range of motion. (Ex. 3, p. 3)

On July 11, 2012, claimant underwent EMG/NCV testing performed by Erich Streib, M.D. Dr. Streib opined results revealed electrodiagnostic abnormalities consistent with the presence of chronic or subacute L5 radiculopathy. (Ex. R, p. 65)

Claimant returned to Dr. Smith on July 13, 2012, following EMG/NCV testing. At the time of evaluation, claimant used a cane to assist with ambulation. Following examination, Dr. Smith assessed left lateral recess and foraminal stenosis at L4-L5. Dr. Smith ordered an x-ray series and opined it likely an L4-L5 fusion would be required given the EMG finding of left L5 radiculopathy. (Ex. 1, p. 19)

After a dynamic x-ray series, claimant returned to Dr. Smith on July 20, 2012. Dr. Smith noted the decompression had helped with most of claimant's symptoms, but claimant continued to present with severe left L4 foraminal stenosis which could not be relieved without fusion or removal of the facet. Accordingly, Dr. Smith recommended a right L4-L5 direct lateral interbody fusion (DLIF). (Ex. 1, pp. 19, 22) Dr. Smith opined claimant's condition represented an "extension of his previous injury at work." (Ex. 1, p. 22)

On August 7, 2012, a determination was made regarding claimant's application for Social Security disability benefits. Claimant filed for benefits on the bases of a lumbar injury and numbness of the left leg. Claimant alleged an inability to function and/or work as of August 18, 2011. (Ex. 4, pp. 1, 7) The examiner outlined exertional

limit levels of lifting or carrying occasionally of 10 pounds and less than 10 pounds frequently; a 3-hour maximum sit; and the need to alternate between sitting and standing periodically. (Ex. 4, pp. 5-6) It was determined claimant lacked the residual functional capacity to perform his past relevant work because he was placed under functional limitations for less than a full range of sedentary work. Claimant was determined disabled with an onset date of August 18, 2011. (Ex. 4, pp. 8-10) Claimant testified he receives approximately $330.00 more per month in Social Security disability benefits than he did on Social Security retirement. (Claimant's testimony)

On September 13, 2012, Dr. Smith performed a right L4-L5 direct lateral lumbar interbody fusion to treat a preoperative diagnosis of severe left L4-L5 foraminal stenosis with spondylosis and radiculopathy. (Ex. R, p. 66) Post surgery, claimant continued to follow up with Dr. Smith. Treatment included use of a brace and physical therapy. (Ex. 1, pp. 23-26)

Claimant testified following surgery, his mental condition deteriorated and he believed his life "started to go to hell in a hand basket." In addition to pain complaints, claimant suffered with fear his condition would not heal, and he was unable to perform recreational or activities of daily living. Claimant testified he was angry and lashing out, as well as dealing with anxiety and depressive symptoms. He also began abusing alcohol during this time. He presented to the VA hospital for evaluation in what he believed was a pain management clinic. He ended up joining a support group to assist veterans in dealing with chronic pain. (Claimant's testimony; Ex. U, p. 105)

On January 23, 2013, claimant underwent psychiatric evaluation at the VA. Records note a chief complaint of PTSD, with past treatment for depression, anxiety, and OCD. (Ex. U, p. 84) Claimant described OCD rituals lasting about 90 minutes each morning, which claimant reported caused him to be frequently late for work. (Ex. U, p. 85) As a result of the PTSD, claimant reported suffering with nightmares and flashbacks, feeling constantly restless and fidgety, and easily losing his temper, often yelling profanities at himself and yelling at others. Claimant reported getting into trouble at past jobs as a result of losing his temper. He also reported an inability to tolerate group settings due to hyper-vigilance. (Ex. U, p. 85) Claimant reported having a "really bad work record" due to conflict, including cursing at or threatening coworkers. Claimant also reported "lashing out" at family members and occasionally slapping or punching himself in the face. (Ex. U, p. 86)

On February 1, 2013, claimant underwent a PTSD disability benefits evaluation at the VA with Jeanette Oleskowicz, M.D. Following the evaluation, claimant was diagnosed with chronic PTSD, OCD, and alcohol abuse. (Ex. U, pp. 88-89, 101) Claimant reported being terminated from multiple employers due to personality conflicts or lack of productivity. (Ex U, p. 93) Dr. Oleskowicz found claimant demonstrated occupational and social impairment with reduced reliability and productivity. (Ex. U, p. 91)

During the spring of 2013, claimant began to undergo therapy sessions with a psychologist at the VA to address coping with symptoms of depression and chronic

pain. (Ex. U, pp. 102-103, 105, 112, 114) Claimant also began a course of psychiatric care at the VA with a goal maximizing psychosocial functioning. (Ex. U, p. 110) Psychiatric records note treatment was provided for OCD, PTSD, depression, and borderline personality disorder. (Ex. U, p. 113)

On March 25, 2013, claimant returned to Dr. Smith for an impairment evaluation. Dr. Smith authored a letter of his opinions dated March 25, 2013. He noted a history of claimant developing low back and leg pain "after being squeezed between cars at work." (Ex. 1, p. 28) Dr. Smith noted claimant continued to complain of numbness of the left leg and weakness of the left foot which caused him to stumble; pain in the left hip and leg; low back pain which limited sitting and driving; interrupted sleep due to numbness and pain; and pain with lifting over 10 pounds. Dr. Smith opined claimant fell within DRE Lumbar Category V based upon the lumbar fusion with loss of motion segment and persistent radiculopathy with numbness and weakness of the left leg. Such a placement warranted a permanent impairment rating of 25 percent whole person. (Ex. 1, pp. 28-29) Dr. Smith opined claimant's condition resulted from a work injury on February 17, 2010. (Ex. 1, p. 27)

Claimant testified Dr. Smith also advised him not to lift more than 35 pounds and to bend and twist as limited by his mobility. Dr. Smith also advised claimant to continue to perform stretching exercises. (Claimant's testimony)

The Department of Veterans Affairs completed claimant's mental disorders disability evaluation on July 21, 2013. Claimant reported strained familial relationships. Claimant also reported being fired from "every job he has ever had" as a result of psychological issues, including tardiness as a result of OCD and authority issues. (Ex. 6, p. 4; Ex. U, p. 119) Claimant was noted as taking psychotropic medications, buspirone and paroxetine. (Ex. 6, p. 5) Claimant was diagnosed with PTSD, obsessive-compulsive disorder, recurrent and moderate major depressive disorder, and anxiety disorder. (Ex. 6, p. 2; Ex. U, pp. 116-117) It was determined claimant demonstrated a total occupational and social impairment as a result of these mental diagnoses. (Ex. 6, p. 3; Ex. U, p. 118) Claimant was opined to be currently unemployable. (Ex. U, p. 125)

Claimant continued to undergo psychiatric care at the VA throughout the summer and fall of 2013. During sessions, claimant reported slapping himself in the face multiple times per week out of frustration. He also reported feeling very irritable, with one of his major problems being lashing out verbally at others. Claimant reported being fired from every job he had held due to OCD and interpersonal issues. (Ex. U, pp. 127-128, 134, 137) During this time, claimant also continued with psychotherapy care at the VA. Claimant admitted his OCD caused problems in his working career, but attributed the majority of his job failures to depression and anger. (Ex. U, pp. 130-132)

On September 24, 2013, the Department of Veterans Affairs issued a decision increasing claimant's disability for PTSD with alcohol abuse, obsessive-compulsive disorder, major depressive disorder, and anxiety disorder, from 30 percent to

100 percent effective September 14, 2012. (Ex. 9, pp. 1, 3) Claimant receives disability benefits in the amount of $2,816.00 per month. (Ex. 9, p. 2)

On November 8, 2013, claimant returned to Dr. Smith with a report of development of immediate pain two weeks prior while bending over. Pain was slow to improve, but claimant indicated he nearly cancelled his appointment due to improvement. Claimant reported the belief his injuries took longer to heal than they had previously. (Ex. 1, pp. 30-31)

Dr. Smith provided deposition testimony on February 26, 2014. Dr. Smith indicated he began treating claimant in 2009 for back and left leg pain. An MRI at that time revealed a herniation at L4-L5 on the left, for which Dr. Smith performed surgery on June 23, 2009. Post-operatively, claimant attended a one-week follow-up, at which time his symptoms had improved. (Ex. 11, Depo. Tr. pp. 4-5) Claimant did not present for a six-week follow-up, leading Dr. Smith to "assume he was much better." (Ex. 11, Depo. Tr. p. 5)

Dr. Smith again began treating claimant in August 2011 for complaints of back pain and bilateral leg and buttock numbness. Dr. Smith indicated the lower extremity numbness was a new complaint, different from claimant's 2009 symptoms. (Ex. 11, Depo. Tr. pp. 5-6) In September 2011, claimant reported developing symptoms after being "squeezed between cars at work." (Ex. 11, Depo. Tr. pp. 5, 6, 24-35) Dr. Smith did not possess the date of the reported accident and did not recall seeing the contemporaneous emergency room record. (Ex. 11, Depo. Tr. pp. 5-6) When provided a copy of the emergency room record, Dr. Smith opined the recorded mechanism of injury was consistent with claimant's history as reported to Dr. Smith and with the condition for which he provided treatment. (Ex. 11, Depo. Tr. pp. 39-40) Dr. Smith testified upon resumption of care, he ordered a new lumbar spine MRI, which revealed evidence of the prior surgery left at L4-L5 and worsening of stenosis at L3-L4. He opined the severity of stenosis represented a significant change from the 2009 MRI. (Ex. 11, Depo. Tr. p. 7)

Dr. Smith addressed the issue of causation of claimant's complaints at the time of his deposition. Claimant's counsel posed the following questions, to which Dr. Smith opined:

> Q. So based on your treatment of him over these several years we've talked about and your evaluation of him on March 25th, 2013, is it your opinion that the February 17, 2010, incident in which Mr. Mills was pinched and rolled or twisted between two vans was a cause of the treatment you provided, including the two surgeries?
>
> A. Yes.
>
> Q. And is that opinion to a reasonable degree of medical certainty?
>
> A. Yes.

Q. Is the mechanics of his description of the events, being pinched and rolled or turned between these two vans, consistent with the type of injury or condition you were treating him for?

A. I believe so. He had stenosis, and he had a previous disk injury. So his back was not normal before the accident. So from his description of it, having his symptoms start after this accident, he had this preexisting condition, and then this accident is what then caused it to become symptomatic. So given the degree of preexisting disease in there and his description of the onset of symptoms, it would make sense that this is the cause of his symptoms.

(Ex. 11, Depo. Tr. pp. 15-16)

Q. With the understanding that it does not have to be the sole cause or a major cause, is it your opinion to a reasonable degree of medical certainty that the incident on February 17, 2010, that Mr. Mills described to you was the cause for the – was a cause for the back problems for which you saw and treated him after that date?

A. Yes.

Q. If he had a preexisting back condition as you referred to, is it your opinion to a reasonable degree of medical certainty that the February 2010 incident that Mr. Mills described to you caused a permanent worsening or exacerbation of that back condition?

A. Yes.

Q. Was that exacerbation a cause of the condition for which you treated him?

A. Yes.

Q. Does the fact that he may have attempted to self-treat or treat through his general care providers for over a year before he ended up back in your office change your opinion about whether or not the February 2010 incident that he described was the cause of his back problems?

A. No.

(Ex. 11, Depo. Tr. pp. 18-19)

Defendants' counsel inquired as to when claimant reported developing back pain. Dr. Smith indicated he was unable to identify a specific date, whether it be at the time of the accident or within hours or days thereafter. Rather, claimant informed Dr. Smith his symptoms began after the work incident. (Ex. 11, Depo. Tr. pp. 31-32) Had those symptoms not begun until more than a year after the accident, Dr. Smith indicated it

would "absolutely" be more difficult for him to causally relate claimant's symptomatology to the alleged work incident. (Ex. 11, Depo. Tr. pp. 32) Defendant's counsel then provided Dr. Smith with a copy of Dr. Butler's medical note of May 6, 2011, which Dr. Smith indicated he did not recall seeing prior. The following interaction then transpired:

> Q. And it's two pages. On the first page, you can see what I have highlighted there where it says, "Patient here today with back pain, onset one month?"
>
> A. Um-hm.
>
> Q. Then I flip over to the second page. Under "OAP note," it says, "He's a 62-year-old male. He comes in today because of back pain going on for about a month."
>
> That would be inconsistent with the history that he reported to you, wouldn't it?
>
> A. If he didn't have back pain before that and his onset was a month before a visit in May 2011, yes, that would be different, inconsistent.
>
> Q. And when we – and he saw – He saw Dr. Butler on September 28th, 2010, for a physical. Let me show you the second page of that note. It talks about him coming in for a physical. Talks about pain in his stomach for indigestion, a few other things. And there's no mention of any back pain and the exam says, "no tenderness." Do you see that?
>
> A. Yes.
>
> . . . .
>
> Q. So according to this record, there's no indication of any ongoing back pain or any back complaints. Would that be inconsistent with the history that Mr. Mills provided to you when you saw him in August 2011?
>
> A. Consistent with? No, that would seem inconsistent.

(Ex. 11, Depo. Tr. pp. 32-33)

Dr. Smith then clarified that his previously provided causation opinions were premised upon the history provided to him by claimant; specifically, that the back pain started after the work incident and was continuous up until the time claimant presented to Dr. Smith in August 2011. Given this history, Dr. Smith opined the work incident would be a cause of a lighting up of claimant's previously asymptomatic condition. (Ex. 11, Depo. Tr. pp. 34, 41-42)

Claimant testified he continues to suffer with back pain on an occasional basis; although the episodes of pain are debilitating when they do occur. He also complained of continued significant numbness of the left leg. Claimant testified he would be unable to return to his prior job at defendant-employer. Back pain prevents prolonged car travel. He is unable to lift greater than 10 pounds, having thrown out his back lifting a mattress corner to attach a fitted sheet. Claimant testified he is also unable to stand longer than 5 minutes before developing left leg numbness. Claimant testified he is unable to clean his home or move snow. He no longer goes dancing or belongs to a health club. Claimant testified he is also unable to exercise at home, as he is unable to do crunches, pushups, or use his elliptical machine. Claimant estimated he gained 20 to 30 pounds following the alleged injury and the most significant activity he engages in is going out drinking with his son. Claimant has not worked or applied for work since his layoff by defendant-employer. (Claimant's testimony)

CONCLUSIONS OF LAW

The first issue for determination is whether claimant sustained an injury on February 17, 2010, which arose out of and in the course of his 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 Elec. 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.

Claimant testified at hearing and deposition that he was struck by Ms. Jessen's van and twisted, pinched, or torqued between the two vehicles. Claimant's testimony is consistent with that of Mr. Cook, who testified claimant was pinched and rolled between the two vans as Ms. Jessen drove past. Although Mr. Weiler did not view the incident, he was informed by a passenger that claimant had been caught between the vans. Ms. Jessen herself testified she did not observe claimant at all during this period and therefore, could not speak as to the specifics of claimant's report. While claimant did not seek immediate medical attention, emergency room records of the following day report the same mechanism of injury as testified to by claimant and denotes injuries claimant sustained as a result of the incident. Quite simply, there are no records which

sufficiently contradict the occurrence of an injury on February 17, 2010. The incident occurred, resulted in an injury to claimant, and arose out of and in the course of claimant's employment.

The next issue for determination is whether the injury of February 17, 2010 is a cause of temporary disability. The next issue is whether claimant is entitled to temporary disability benefits from February 23, 2012 through March 25, 2013. 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).

While a claimant is not entitled to compensation for the results of a preexisting injury or disease, its mere existence at the time of a subsequent injury is not a defense. Rose v. John Deere Ottumwa Works, 247 Iowa 900, 76 N.W.2d 756 (1956). If the claimant had a preexisting condition or disability that is materially aggravated, accelerated, worsened or lighted up so that it results in disability, claimant is entitled to recover. Nicks v. Davenport Produce Co., 254 Iowa 130, 115 N.W.2d 812 (1962); Yeager v. Firestone Tire & Rubber Co., 253 Iowa 369, 112 N.W.2d 299 (1961).

While claimant sustained a work related injury on February 17, 2010 and missed a brief period of work shortly thereafter, claimant has not claimed entitlement to temporary benefits during this period. Rather, claimant seeks temporary disability benefits from February 23, 2012 through March 25, 2013. This time represents the period after which defendants terminated claimant's temporary disability benefits up until Dr. Smith placed claimant at MMI.

Therefore, the relevant causation inquiry with regard to temporary disability benefits, as well as claimant's overall claim for benefits in this hearing, is whether claimant's subsequent symptoms are properly attributable to the work related injury. Therefore, the undersigned must consider whether claimant has proven the subsequent symptoms are causally related to the work injury or whether claimant's initial symptoms resolved, thus rendering claimant's subsequent symptoms non-work related.

In reviewing the record as a whole, it is determined claimant has failed to meet his burden of proving by a preponderance of the evidence that his symptoms from 2011 forward are causally related to the work injury of February 17, 2010. While claimant testified he had symptoms from the date of injury onward, there is no corroborating evidence in the evidentiary record.

Claimant's testimony at evidentiary hearing was not entirely consistent with his deposition testimony and portions of the evidentiary record. When claimant described the February 17, 2010 alleged work injury, claimant described the mechanism of injury consistently throughout the records. Claimant was very well-spoken and clearly intelligent. During the course of evidentiary hearing, his physical presentation was consistent with complaints of ongoing back and leg symptoms. Specifically, claimant stood multiple times for short periods; when he stood, he often placed his hands on the table or his low back; he shifted in his chair in an effort to reach a comfortable position; and often sat with his hands at the base of his back. Claimant's physical presentation is consistent with his ongoing complaints, complaints which are undisputed in the medical records. However, the physical presentation alone does not automatically support a determination that his complaints are work related.

The evidentiary records contain inconsistencies regarding claimant's statements. Claimant denied suffering with radicular symptoms in 2009. His contemporaneous medical records consistently detail radicular complaints. Claimant reported back and leg symptoms ongoing from the date of the alleged work injury, reports that are not supported in the remainder of the evidentiary record, as set forth in detail *infra*. Claimant's Social Security disability benefits application denied losing work for interpersonal reasons, a statement claimant himself and the evidentiary record refute. The Social Security disability application also states claimant was unable to work as a result of his back and leg complaints as of August 2011, when the reason claimant's employment ended at that time was due to a layoff and presumably claimant would have continued to work through that period had the layoff not occurred. Claimant is a clearly intelligent and educated man, one with more than cursory knowledge of the workers' compensation system via his prior employment in a workers' compensation case management firm. Given these reasons, it is determined claimant's testimony, standing alone without substantiation, is not credible.

Ms. Jessen followed up with claimant on multiple occasions, including three emails. To each email, claimant responded he was fine and without ill effects. While claimant indicated he did not relay his complaints due to fear of layoff and subsequently, to avoid conflict with Ms. Jessen once she became his supervisor, the evidentiary record suggests to the contrary. Claimant did complain to Ms. Jessen by email of back

complaints on April 26, 2011, at a time Ms. Jessen served as his supervisor. He attributed his symptoms possibly to use of a bed while on a work trip, a scenario which theoretically could have given rise to a workers' compensation claim. Claimant demonstrated willingness to pass this back complaint along to Ms. Jessen; it therefore makes little sense for claimant to argue he did not report his prior complaints arising out of the work injury for fear of retaliation.

It was not until after this email to Ms. Jessen in April 2011 that claimant's medical records support the existence of back complaints. Claimant presented to his personal physician, Dr. Butler on March 22, 2010 and September 28, 2010. Dr. Butler noted no complaints from claimant regarding his back, nor identified any examination findings which indicated an ongoing back problem. When claimant returned to Dr. Butler in May 2011, claimant complained of back problems with radicular symptoms of a one month duration, a time period which corresponded closely to when claimant expressed complaints to Ms. Jessen.

The record is void of any medical notes referencing back pain between February 18, 2010 and May 6, 2011. Claimant testifies he did complain to Dr. Butler of back pain at the two visits, but Dr. Butler failed to note such complaints. Claimant testified he sought additional care when the symptoms began radiating and he developed lower extremity numbness. Dr. Butler's record reveals he offered care when claimant expressed such complaints. Given Dr. Butler's knowledge of claimant's past back treatment, the undersigned finds it unlikely Dr. Butler would fail to note back complaints should claimant have made them and then change course and provide care in May 2011, simply due to the new symptom of numbness.

When claimant presented to Dr. Butler in May 2011, Dr. Butler made no reference to claimant's work injury in February 2010. There is also no reference to the February 2010 work injury in Dr. Smith's medical record of August 17, 2011. It was not until after claimant's layoff by defendant-employer that any medical record notes claimant related his back and leg pain to the February 2010 work injury. From this time forward, claimant's medical records consistently reference a reported history of the symptoms relating to the February 17, 2010 work injury.

Even aside from the issue of history of expression of symptoms, the undersigned finds Dr. Smith's opinion on causation entitled to little weight. Claimant relies upon Dr. Smith's opinion that claimant had a preexisting back condition which was exacerbated, worsened, or lighted up by the February 17, 2010 work injury. There are weaknesses in Dr. Smith's opinion, specifically that Dr. Smith based his opinion on an inaccurate and incomplete history. Dr. Smith testified he based his causation opinion upon the history claimant expressed directly to him, that claimant consistently suffered with back symptoms following the work injury. Claimant's counsel even inquired whether claimant's attempts to self-treat or treat through personal providers for over one year prior to seeing Dr. Smith changed his opinion.

The only evidence claimant's symptoms persisted following the work injury is claimant's own testimony regarding these symptoms and his need to self-treat. There is

simply no evidence to substantiate claimant's testimony. The record clearly demonstrates claimant sought no medical treatment of back complaints for over one year. Claimant did not mention any residual back complaints at routine medical appointments or to defendant-employer. He did report back symptoms to his supervisor in April 2011, following which he sought medical treatment and those medical records support the existence of such a complaint. However, these records do not reference back to the February 2010 incident, but rather reference a more recent onset of symptoms.

Dr. Smith opined if symptoms did not present for over one year, it would "absolutely" be more difficult for him to relate such complaints to the February 2010 work injury. He also testified claimant's lack of complaints at medical appointments was inconsistent with claimant's report to him of ongoing symptoms dating to February 2010. Dr. Smith based his causation opinion entirely upon claimant's reports of ongoing symptoms. Due to the reasons set forth *supra*, claimant's report is simply not credible. As Dr. Smith's causation opinion is based upon claimant's inaccurate history, Dr. Smith's opinion is entitled to little weight.

Defendants offered the opinion of Dr. Abernathey, who did not believe claimant's symptoms related to the work injury on February 17, 2010. Dr. Abernathey's opinion is not without flaws. Most significantly, Dr. Abernathey's opinion is based entirely upon a records review, as claimant refused to attend the scheduled IME. However, in completing said review, it appears Dr. Abernathey did not have claimant's emergency room record to review and consider. While possession of this record may not have ultimately changed Dr. Abernathey's opinion, it is a crucial piece of evidence which should have been considered, as it makes it clear claimant did complain of back symptoms contemporaneous to the work injury. Lack of this record leads the reader to believe claimant sought no medical care at all for over one year following the work injury. Due to this incomplete medical history, Dr. Abernathey's opinion is also entitled to little weight.

The undersigned has discounted the opinions of both medical experts, Drs. Smith and Abernathey. It is ultimately claimant who bears the burden of proving by a preponderance of the evidence that a causal relationship exists between the work injury of February 17, 2010 and his symptoms from spring 2011 onward. The evidentiary record contains too many inconsistencies and the claimant's testimony lacks sufficient credibility to allow claimant to meet his burden outside of supportive medical evidence. Dr. Smith's opinion fails to assist claimant in meeting his burden for the reasons set forth *supra*.

While claimant proved a work injury occurred on February 17, 2010, claimant has failed to prove a causal connection between his complaints documented in 2011, 2012, and 2013 and the work injury of February 17, 2010. As claimant has failed to meet his burden of proving a causal connection between the work injury of February 17, 2010 and the medical condition which forms the basis of his claim for disability, consideration of the other issues presented for determination is unnecessary, as moot.

ORDER

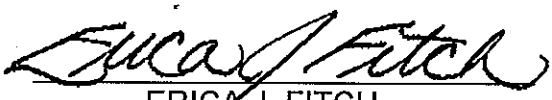
THEREFORE, IT IS ORDERED:

Claimant shall take nothing from these proceedings.

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

Costs are taxed to claimant pursuant to 876 IAC 4.33.

Signed and filed this 9th day of March, 2015.



ERICA J. FITCH
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

Copies To:

Theresa C. Davis
Attorney at Law
PO Box 2107
Cedar Rapids, IA 52406-2107
tcd@shuttleworthlaw.com

Aaron T. Oliver
Attorney at Law
5th Fl. U.S. Bank Bldg.
520 Walnut St.
Des Moines, IA 50309-4119
aoliver@hmrlawfirm.com

EJF/srs

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.