BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

MARY DELEHANTY,	:	
Claimant,	:	File Nos. 5063812 and 5063813
vs.	:	ARBITRATION
FINLEY HOSPITAL,	:	DECISION
Employer, Self-Insured, Defendant.	:	Head Note Nos: 1800, 1803 2500, 2502, 2701

STATEMENT OF THE CASE

Claimant, Mary Delehanty, has filed a petition for arbitration seeking WC benefits against Finley Hospital, a self-insured employer, as defendant.

In accordance with agency scheduling procedures and pursuant to the Order of the Commissioner in the matter of the Coronavirus/COVID-19 Impact on Hearings, the hearing was held on Thursday, October 10, 2020, via CourtCall. The record was kept open until October 19, 2020, and the case was considered fully submitted on November 16, 2020, upon the simultaneous filing of briefs.

The record consists of Joint Exhibits 1-14, Claimant's Exhibits 1-8, Defendants Exhibits A-I, and the testimony of claimant and Christopher Mueller.

ISSUES

Whether claimant sustained a permanent disability arising out of the work injury, and, if so, the extent of such disability;

Whether claimant is entitled to reimbursement of medical expenses itemized in Exhibit 5;

Whether claimant is entitled to reimbursement of an independent medical examination pursuant to Iowa Code section 85.39;

Whether claimant is entitled to alternate care under Iowa Code section 85.27;

Whether claimant is entitled to mileage reimbursement itemized in Claimant's Exhibit 6; and

Claimant's request for assessment of costs.

STIPULATIONS

The parties filed a hearing report at the commencement of the arbitration hearing. On the hearing report, the parties entered into various stipulations. All of those stipulations were accepted and are hereby incorporated into this arbitration decision and no factual or legal issues relative to the parties' stipulations will be raised or discussed in this decision. The parties are now bound by their stipulations.

The parties stipulate claimant sustained an injury arising out of and in the course of her employment on December 18, 2017. While they dispute claimant's entitlement to permanent partial disability benefits, they agree if the stipulated injury is found to be a cause of permanent disability, the disability is industrial in nature and the commencement date for permanent partial disability benefits, if any are awarded, is December 19, 2017.

At the time of the December 18, 2017, injury, the claimant's gross earnings were $749.71 per week. The claimant was married and entitled to two exemptions. Based on the foregoing, the weekly benefit rate is $491.96, for the December 18, 2017, injury. At the time of the June 22, 2016, injury, the claimant's gross earnings were $646.96 per week. The claimant was married and entitled to two exemption. The weekly benefit rate for the June 22, 2016, injury is $431.50.

The defendants waive all affirmative defenses.

Claimant seeks reimbursement of medical expenses itemized in Claimant's Exhibit 5. The defendants do not agree that the requested expenses were authorized or that the treatment was reasonable and necessary or causally related to the work injury, however, the parties do agree that the fees and prices charged by the providers are fair and reasonable. The medical providers would testify as to the reasonableness of their fees and contrary evidence was not offered. Further, although the causal connection of the expenses to a work injury cannot be stipulated, the parties agree that the listed expenses are at least causally connected to the medical condition upon which the claim of injury is based.

Claimant seeks reimbursement of an independent medical examination itemized in Claimant's Exhibit 3. Pursuant to the hearing report, the defendants have agreed to pay this expense.

Defendants are entitled to no credits.

FINDINGS OF FACT

Claimant, Mary Delehanty, was a 63-year-old person at the time of the hearing. She graduated from high school in 1974 and went on to obtain a two-year college degree in therapy. She also has been certified as an activity director and a nurse's assistant.

Her past relevant work history has been at nursing homes or similar facilities working as an activity director or certified nursing assistant. On April 7, 2014, claimant began working for the defendant employer as a Mental Health Tech. (Ex E:1) On April 25, 2016, claimant moved to the Resource Tech position wherein she received a raise to $15.39 per hour. (Ex E:4)

In the remote past, claimant had diagnosis and treatment for fibromyalgia, depression, and anxiety. (See e. g. Exhibit 14) She had suffered from migraines. (JE 14-428) Claimant also treated consistently with Terrance Norton, M.D. or a partner in his practice from 2014 through 2020 for anxiety and depression. (See e.g. JE 14:429)

In August 2015, claimant injured her right upper arm and low back when a patient grabbed claimant's hand and twisted her around. (JE 14:463) She received some physical therapy and was given instructions to stretch and exercise. (JE 14: 464-467) In October 2015, she was discharged. (JE 14:467)

On June 22, 2016, claimant was working in the psychiatric unit of the defendant employer. An aggressive patient asked for assistance in showering. During the shower, the patient became agitated and attempted to rise. While claimant was handling the patient, she felt a severe back pain which shot down into her left buttock. She completed her shift and went home. That night and the next day claimant treated her back pain with heat and naproxen. When the pain did not alleviate, claimant sought medical care with the defendant employer. On her visit with Kimberly Deppe, ARNP, on June 24, 2016, she rated her current level of discomfort as six on a ten scale. (JE 2:9) She had pain in the sciatic distribution area with palpation over the left buttock. Id. Ms. Deppe diagnosed claimant with exacerbation of low back pain that started in October, 2015, with instructions for claimant to continue with the naproxen, ice or heat for comfort, and stretching exercises. Claimant was eventually referred for physical therapy. (JE 2:12) There was no mention of neck pain at this appointment.

This back injury was accepted by the defendant employer, however, they dispute that the injury migrated into the neck or that it resulted in any permanent injury or disability.

By August, 2016, claimant's back condition had largely resolved. Her gait was normal. She had good range of motion with some tenderness over the low back area primarily on the left. (JE 2:17) Ms. Deppe observed that claimant could cross and uncross her legs, heel walk, toe walk, and climb on and off the examination table without difficulty. (JE 2:21) Physical therapy was discontinued, and she was instructed to continue to take meloxicam, exercise, use heat on the area of pain, and attend ART therapy. (JE 2:17) Throughout this time, claimant was working without restrictions.

Claimant continued to receive conservative treatment in the form of ART stretching, chiropractic care, and meloxicam. (JE 2:23) On October 3, 2016, she received treatment with Jeffrey F. Dye, D.C., for chronic back pain, specifically acute sharp and frequent low back pain. (JE 3:89) She also reported acute frequent aching in the neck on both sides. (JE 3:89) Motion palpation indicated vertebral level C5 subluxation on the left with acute restriction of the joint. (JE 3:89) In November, 2016, the prescription for meloxicam was reduced to an as-needed basis.

On December 8, 2016, claimant was seen by George Isaac, M.D., who had been treating claimant for her fibromyalgia. (JE 4:94) In the medical records it was noted that she had a diagnosis of fibromyalgia and low back pain as well as carpal tunnel syndrome. (JE 4:94) Dr. Isaac shared with claimant that fibromyalgia flared with changes in the weather and that no change in the prescription was necessary at this time. (JE 4:94) Claimant was to return if she did not improve. There was no mention of the cervical complaints. (JE 4:94)

On the same date, claimant consulted with Gretchen Hong, ARNP, for low back pain as a new patient to manage the fibromyalgia, for which she was seeing Dr. Isaac, along with bilateral thumb pain. (JE 5:98) Claimant's history of ailments included carpal tunnel syndrome, fibromyalgia, major depressive disorder with a recurrent episode, and hypothyroidism. (JE 5:98) Ms. Hong preferred for claimant to stay with a specialist, but if that was not an option for claimant, Ms. Hong would help to manage the care. (JE 5:99)

Claimant was sent for an x-ray of her lumbar spine on December 8, 2016. (JE 6:110). The x-ray showed lumbar spine degeneration. (JE 6:110)

She returned on December 16, 2016, to discuss the x-ray. Peggy Barton, ARNP, diagnosed claimant with degenerative disc disease resulting in chronic back pain. Claimant had mildly reduced range of motion with forward flexion somewhat limited to about 60 degrees, however, she was able to walk on her heels and toes and had good range of motion in all other areas. (JE 2:28) Claimant was found to be at MMI and discharged with instruction to return as needed.

Claimant returned to ARNP Hong on March 31, 2017, presenting with an array of problems. (JE 5:101) The primary complaints were toenail infection and left shoulder complaints.

> Left shoulder pain
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> Mary complains of left shoulder bothering her mostly at night, but also 2-3 times throughout the day. She states that when she sleeps like usual with her arm over her head, she is now noting that it is painful to bring her arm down. This has been ongoing for 6 months and worsening. No prior injury to this shoulder. She reports weakening of that arm, "no strength." She works as a nursing aide and needs to help adjust patients in bed, but that her coworkers ask for additional help when she is there because Mary is not strong enough to help much due to this shoulder injury. Mary has been taking Aleve for a few months for thumb arthritis with some improvement, but not noting that it helps much for her shoulder.

(JE 5:101)

On examination, she had point tenderness in the anterior left shoulder, but full range of motion bilaterally in both the shoulders and back. (JE 5:103) There was no mention of cervical pain. Ms. Hong provided a list of exercises and suggested a course of physical therapy, but claimant wanted to see if that was covered under her insurance before agreeing to treatment. (JE 5:103)

Over a year later, on June 2, 2017, claimant was seen by Dr. Isaac for her long-standing diagnosis of fibromyalgia. (JE 4:96) Dr. Isaac noted claimant had a "history of fibromyalgia, low back pain, and osteoarthritis of the thumbs bilaterally." (JE 4:96) However, claimant stated "she was doing fine," but had "a lot more pain in the legs and her hands related to rainy, cold weather." (JE 4:96) She had joint tenderness involving the first CMC joints and generalized tenderness involving her proximal and distal muscles in the lumbar spine along with discomfort on range of motion. (JE 4:96) Again, there was no mention of the cervical issues. Dr. Isaac was concerned about her pain management, particularly with use of the fentanyl patch. He planned to refer her to a pain clinic. (JE 4:97) Claimant said that she was under the care of Dr. Miller and that Dr. Miller was sending her to a pain clinic in Des Moines, which Dr. Isaac believed was related to detoxification. (JE 4:97)

On June 27, 2017, she was seen by Tanya Bronson, N.P., at Advanced Pain Management at the recommendation of Dr. Isaac. (JE 8:185) Claimant reported multiple complaints of pain in her neck, bilateral shoulders, low back radiating to her left buttock into her leg, bilateral knee pain while walking and using the stairs. On examination she

was tender over the cervical spine in the C6–7 segment and over the lumbar spine in the L4–L5, L5–S1 segment. (JE 8:187) An MRI was recommended for the lumbar and cervical spine.

On July 25, 2017, she underwent the lumbar MRI which showed multilevel disc bulging, spinal stenosis, and foraminal narrowing through the lumbar region with some distortion of the thecal sac and partial sacralization of L5 with pseudoarticulation bilaterally. (JE 6:111)

On August 9, 2017, claimant reviewed the MRI with Ms. Bonson. (JE 8:189) The cervical MRI showed moderate disc bulge at C6–7 and multilevel foraminal narrowing, worse on the right than the left. (JE 8:191) Claimant was most concerned about her neck pain, and it was decided that given that she had failed extensive conservative care, an epidural should be administered. (JE 8:192) Another round of injections was given on September 21, 2017, however, they appeared to have no lasting effect. (JE 8:193-200) By November 28, 2017, claimant had returned to Ms. Bonson with repeated complaints of bilateral neck pain and low back pain. (JE 8:200) Ms. Bonson was concerned about claimant's reliance on narcotics and recommended weaning her off them, which claimant agreed to upon her return from a cruise. (JE 8:200)

Claimant testified she was also receiving treatment from a chiropractor during this period of time, but that the treatment did not help. Claimant also testified that she reported pain between her shoulder blades, but the complaint was never addressed. This is not recorded in the medical records of Dr. Isaac, NP Hong, NP Barton, or NP Deppe. However, the chiropractic records did make note of the cervical spine issues, and Dr. Dye wrote in his treatment records of his belief that there was a subluxation in the cervical spine. (JE 3) The first complaints of the neck pain outside of the chiropractor appeared in June, 2017, although there was a mention of shoulder pain in March, 2017, to NP Hong.

Robin Sassman, M.D. performed an IME on February 20, 2020. (CE 2) In the report, Dr. Sassman opined claimant sustained a neck injury arising from the June 22, 2016, work incident. Claimant relayed to Dr. Sassman that the fibromyalgia symptoms were "more of a stiff feeling, while the symptoms she noted after the incident were specifically in the trapezius and cervical paraspinous musculature and in the lumbar paraspinous musculature area." (CE 2: 20). The pain was different in terms of severity and localization. (CE 2:17)

At the February 20, 2020, examination, claimant reported pain in the left side of her neck radiating down her arms and into her hands at times. (CE 2:17) She maintained that the symptoms were different from her fibromyalgia in terms of intensity on the left side of her neck, and the symptoms since the injury were piercing in nature.

(CE 2:17) During the examination, she exhibited tenderness to palpation over the cervical spine and the trapezius musculature bilaterally but was nontender to palpation of the bilateral shoulders with normal strength bilaterally. (CE 2:18) There was some reduced range of motion at the cervical spine but normal range of motion in both upper extremities. (CE 2:18) She was also tender to palpation over the lumbar spinous processes and the lumbar paraspinous musculature with reduced range in flexion, extension, and lateral motion. All other testing was normal. (CE 2:19)

Dr. Sassman diagnosed claimant with cervicalgia and low back pain with radiculopathy. (CE 2:19) In Dr. Sassman's opinion, claimant's 2015 back pain had resolved with conservative treatment, and despite the long-standing history of fibromyalgia which manifested in similar locations as claimant's post-work injury complaints, there was a distinct difference articulated by the claimant between the fibromyalgia symptoms and the work-related injury symptoms. (CE 2:20) Therefore, Dr. Sassman concluded that claimant had sustained an aggravation of her underlying degenerative condition on June 22, 2016. (CE 2:19) Dr. Sassman assessed a 16% impairment rating based on the loss of function and the radicular complaints and recommended restrictions of no lifting, pushing, pulling or carrying above 20 pounds occasionally from floor to waist, no more than 30 pounds at waist level occasionally, no more than 20 pounds above shoulder height on an occasional basis. (CE 2:21) Further, despite no signs of carpal tunnel syndrome and no shoulder issues, Dr. Sassman recommended limiting the use of vibratory or power tools on a rare basis. (Cl 2:21)

Dr. Sassman found claimant to be tender to palpation over the cervical spine and the trapezius musculature bilaterally. (CE 2:18) Using the two-inclinometer method to measure range of motion, claimant exhibited 20 degrees of flexion, 30 degrees of extension, 40 degrees of right rotation, and 40 degrees of left rotation in the cervical spine. (CE 2:18)

Dr. Sassman concluded that claimant's underlying degenerative changes in the lumbar and cervical spine were aggravated by the June 22, 2016, work incident given that she had no cervical or lumbar symptoms prior to the injury and the mechanism was consistent with the injury.

The mechanism of injury was a patient grabbing claimant's hand and causing claimant to twist at the waist. This is consistent with the claimant's complaints of pain in the low back rather than an upper vertebral body cervical injury.

The problem with Dr. Sassman's opinions is not in the careful measurements taken or the detailed clinical review of the medical records, but that Dr. Sassman ignores or disregards the impact of contemporaneous complaints in order to arrive at the causation conclusions that benefit the claimant. Dr. Sassman's conclusions rely on

proximity between the pain complaints after the work injury and the lack of pain complaints before the injury. However, claimant saw four medical professionals from June 2016 through December 2016, in addition to the radiologist and the physical therapist. None of those medical professionals except the chiropractor documented cervical complaints. Dr. Sassman gives no explanation for this other than the one entry on CE 2:10 wherein Dr. Sassman asked claimant if claimant mentioned the neck pain at that visit. (CE 2:10) Claimant maintained that she recalls sharing her upper back and neck pain symptoms, but that it was not treated [1]. (CE 2:10) Given the lack of contemporaneous medical evidence and the injury described by claimant, Dr. Sassman's opinion is given low weight as it relates to causation and extent arising out of the June 2016 work injury.

Rather, it is found that the contemporaneous medical records in 2016 that depict claimant as having suffered a mild low back problem that resulted in mild forward flexion range of motion loss and ongoing pain which required treatment are accurate and adopted as the basis for determining causation and extent.

On or about December 18, 2017, claimant was putting on her shoes, and when she stood up she bumped her head against the corner of a cabinet. She did not lose consciousness, but the wound did bleed. After striking her head, she began noticing headaches, fogginess, problems with losing things and difficulty with balance. Claimant was seen on February 13, 2018[2] by Jill Hunt, M.D., for those symptoms. (JE 2:30) Dr. Hunt diagnosed claimant with a concussion without a loss of consciousness and referred her for an MRI. (JE 2:30) In a follow-up visit on February 27, 2018, Dr. Hunt discussed the MRI results and the ongoing symptoms. (JE 2:35) The MRI showed a flare thought to be an artifact or minimal small vessel ischemic disease in the right frontal white matter and small air-fluid levels in her right maxillary sinus. (JE 2:35) Claimant described neck pain in addition to fogginess and off vision. She did not have slurred speech or difficulty speaking. (JE 2:35)

She was taking Vyvanse for ADD and Ativan for high depression and anxiety, which she stated was more difficult in the winter. (JE 2:35) Dr. Hunt recommended claimant obtain a neurologic consult for the working diagnosis of closed head injury with persistent post-concussive symptoms and new neck pain which was likely a re-aggravation of a chronic condition. (JE 2:36)

Prior to this, claimant was treating at Southwest Behavioral OP Services by Terrence J. Norton, M.D. (JE 7:121) The purpose of the January 9, 2017, visit was

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[1] Relying on claimant's memory is somewhat problematic given that part of the claimant's claim for benefits arises out of an alleged traumatic brain injury which affects her memory.

[2] This was claimant's first visit for her head injury issues.

medication management. Id. Claimant was currently taking Vyvanse one a day every morning for major depressive disorder. (JE 7:121) It was noted claimant's brother had passed away the previous month, but she had been managing well. (JE 7:121) Her concentration was good and she was generally calm. (JE 7:122) Dr. Norton noted that he spent 30 minutes in total with the claimant, of which 20 minutes were spent counseling claimant on stress. (JE 7:123)

On May 23, 2017, claimant returned to Dr. Norton for medication management. (JE 7:124) .She was having increased sleep disturbances, experiencing increased nervousness throughout the day, but had good appetite and normal concentration. (JE 7:124) Her short-term memory was intact and her medication was unchanged. (JE 7:126) Dr. Norton continued to counsel claimant on stress. (JE 7:128)

On October 11, 2017, claimant was seen by Maher Fattouh, M.D. for back and bilateral neck pain. (JE 9:265) She exhibited tenderness in the bilateral C5-C7 segments, mildly reduced range of motion in the neck, pain with left lateral flexion and right lateral flexion. (JE 9:268) She had an antalgic gait, tenderness in the bilateral L3-S1 segments of the lumbar region and tenderness in the hips bilaterally. (JE 9:268) Dr. Fattouh administered CESI injections for the cervical pain. (JE 8:270)

She returned to Dr. Norton on December 5, 2017. (JE 7:130) She complained of decreased energy, impaired concentration and lower moods. Id. She was in a pain clinic for her chronic pain and was looking forward to the holidays. (JE 7:130) Dr. Norton continued to diagnose claimant with major depressive disorder with recurring episodes, moderate in nature. Id.

After the December 18, 2017, injury, claimant had a medical visit with Dr. Norton's office on January 29, 2018. (JE 7:133) There was no mention of the head injury. She mentioned being off work for carpal tunnel surgery, spending time with her grandkids, and enjoying the holidays. She had enjoyed her time off work. (JE 7:133) Dr. Norton provided claimant with a brief education on the psychophysiological effects of stress and continued claimant's current medication regimen. (JE 7:134)

On January 15, 2018, claimant treated with NP Bonson. (JE 8:202) During this visit, claimant reported bilateral neck pain, but no mention of the head injury, concussion complaints, loss of memory, or balance issues. (JE 8:202) During this visit, it was documented claimant received greater than 70% relief from her cervical pain after the injection. (JE 8:204) She continued to complain of all over pain, and Ms. Bonson noted that claimant had radicular axial pain for years in addition to bilateral arm and hand pain despite a carpal tunnel release. (JE 8:204) Ms. Bonson was pleased that claimant was able to reduce hydrocodone down to BID and 25 mg of fentanyl. (JE 8:205).

On February 19, 2018, claimant first reported the head injury to Ms. Bonson in addition to neck pain radiating to her bilateral shoulders, arms and hands, headaches, fogginess, and low back pain. (JE 8:206) Ms. Bonson documented that claimant did not share the head injury with Bonson as claimant was dealing with it through employee health at work. (JE 8:209) No medical visits were made to employee health prior to this, however. Ms. Bonson did note that claimant was "not herself" even though she exhibited no deficiencies during a complete neurological exam. (JE 8:209)

At the order of Dr. Hunt, an MRI of the brain was conducted on February 22, 2018. (JE 6:113) The impression was a normal-appearing MRI of brain without contrast aside from small air-fluid level right maxillary sinus in single focus of FLAIR high signal right frontal region. (JE 6:114)

On March 29, 2018, claimant established care with Jill Miller, ARNP-DNP, for evaluation of continued symptoms following a concussion when she hit her head on the corner of a cabinet in December 2017. (JE 10:272) The week following she noticed troubles with headaches, dizziness, fogginess and balance issues. (JE 10:272) Her symptoms improved, but continued until February when she was informed by her boss she needed to be evaluated by Employee Health. (JE 10:272) She complained of pain on the top/side of the head and into her neck. She had light and sound sensitivity, some nausea, but no vomiting. She was experiencing headaches twice a week and some foggy vision. (JE 10:272) Stress exacerbated her dizziness and headaches whereas rest alleviated her symptoms. (JE 10:272)

Neurologically, Ms. Miller observed short-term memory issues, however, her other neurological testing was normal including no disorientation for location, time, date, calculation ability. Her speech was normal and showed no difficulty in repeating sentence or following a three-stage verbal command. (JE 10:275). Her muscle tone and strength were normal. (JE 10:275) Her tandem gait showed no abnormalities. (JE 10:275) Ms. Miller diagnosed claimant with concussion and occipital neuralgia. (JE 10:275) She had significant tenderness over the left occipital groove, and Ms. Miller found claimant to be a good candidate for an occipital block. (JE 10: 275)

Claimant returned to Ms. Bonson on April 2, 2018 with continued complaints of bilateral neck pain and constant and stable headaches. (JE 8:210) Claimant shared that she was taking hydroxyzine 25 mg up to 4 a day, which Ms. Bonson had been previously unaware. Ms. Bonson advised claimant to follow up with her neurologist and to reduce her fentanyl intake. (JE 8:23)

Claimant was seen again by Dr. Hunt on April 3, 2018, with ongoing complaints of balance, falling, headaches, back pain, and neck pain. (JE 2:39) Dr. Hunt maintained the diagnosis of concussion and added occipital neuritis, which she contemplated was

caused by cervical spine problems. (JE 2:40) Dr. Hunt felt that the occipital neuralgia was not work related. (JE 2:40) Claimant admitted that she fabricated a motor vehicle collision because she was late for an appointment. She testified that Dr. Hunt intimidated her. This story about the MVA was repeated to other medical providers in the following months.

On that same day, claimant was seen by Dr. Norton for medication management. (JE 7:138) It is unclear whether Dr. Norton knew of claimant's treatment with Dr. Hunt as there is no mention of the head injury or related medical treatment. (JE 7:138) Instead, Dr. Norton notes that "she has been feeling ok overall. She has been more tense and edgy. Has episodes of being unable to breathe, with shortness of breath and tightness. Does have some tearful episodes, but they are decreased. She sleeps fair. Good appetite." (JE 7:138) It was noted that her concentration was okay and her short-term memory was intact. (JE 7:139) Dr. Norton stopped claimant's Xanax and started Klonopin. (JE 7:139)

On April 12, 2018, claimant reported concentration and lack of focus issues. (JE 2:43) A co-worker had noticed claimant was falling asleep intermittently at work in the afternoon and seemed slightly confused at times. Claimant was working without restrictions. (JE 2:43)

On April 19, 2018, claimant underwent occipital nerve blocks with NP Miller. (JE 10:280) She returned for a follow-up appointment on May 31, 2018. (JE 10:281) Claimant related that her headaches had improved, but that she was experiencing balance issues and slow and slurred speech. (JE 10:281) In the examination section, back pain was documented, but neck pain was not. (JE 10:282-83) Ms. Miller documented slow improvement in claimant's symptoms, but a worsening of anxiety and depression. (JE 10:284) She was given work restrictions of no floor CNA work. Claimant could do 1 to 1 sitting or tele-sitting. (JE 10:285)

On May 7, 2018, claimant returned to NP Bonson for complaints of the back pain. (JE 8:215) She reported she had fallen three times since the last time that Ms. Bonson had treated her. Her balance continued to be a problem, and she continued to have headaches, although the occipital nerve block did provide some relief. (JE 8:217) Claimant was not ready to discontinue fentanyl. Additionally, she was taking Norco for breakthrough pain. (JE 8:217) Ms. Bonson cautioned claimant on the potential interactions with the benzodiazepine medications she was taking. (JE 8:217) Claimant continued to exhibit difficulty with word finding that Ms. Bonson attributed to her post-concussion syndrome. (JE 8:217)

On May 17, 2018, she was seen by Dr. Hunt for continued issues regarding balance, focus, and concentration. (JE 2:47) She reported 4-5 headaches that kept her

up at night. She would occasionally fall asleep at work, fall against the walls, stumble rising out of her chair. (JE 2:47) During the examination, she had difficulty with dates and answering direct questions. Her physical presentation was mostly normal. (JE 2:48)

On June 18, 2018, claimant returned to NP Bonson for follow-up for her back pain which was radiating into her legs and up into the neck. (JE 8:220) On the positive side, she had no falls since the last visit and her headaches were less intense. (JE 8:220) Her balance was still poor, but the occipital nerve injections appeared to be helping reduce her headaches. (JE 8:223)

She returned to Dr. Hunt's office on June 29, 2018, and because Dr. Hunt had left Finley Occupational Health, claimant's care was taken over by Amanda Addison, APNP. (JE 2:62) New glasses were helping with her vision and she was not falling asleep like she used to. However, based on her presentation, work restrictions of no ambulating outside of the work area except to go to the cafeteria were imposed and referrals were set up for a neuropsychiatry consult. (JE 2:62)

On July 29, 2018, she presented to the emergency room with complaints of a persistent headache. (JE 6:115) It was noted that she was negative for chest, abdominal, flank or back pain. (JE 6:116) Her neck exam showed normal range of motion. (JE 6:116) She exhibited normal speech and cognition. She was discharged on the same day with instructions to see her family medicine doctor. (JE 6:119)

On August 3, 2018, she expressed frustration to Ms. Addison over work issues and the scheduled appointment with Dr. Tranel who she said had a 1.4 star rating out of 5 online. (JE 2:68)

Claimant consulted with Dr. Norton on August 28, 2018, for medication management. (JE 7:141) Again, there was no mention of claimant's head trauma and no mention of her other medical care. Dr. Norton writes, "She has been feeling ok overall. She still gets tense at times. Concentration improving. Occasional headaches still. Does have some tearful episodes, but they are decreased. She sleeps fair. Good appetite. Back to working as a CNA but is struggling with this." (JE 7:141) No changes in treatment were made.

On August 6, 2018, claimant treated with Ms. Bonson for "all over pain." (JE 8:225) Claimant presented with low back pain radiating intermittently into her left leg, pain behind knees, weakness in the bilateral legs and back, neck pain radiating into bilateral shoulders and into her hands, and extreme fatigue. (JE 8:225) She attributed the increased pain all over to her fibromyalgia. (JE 8:225) Ms. Bonson recommended discontinuation of fentanyl, increasing Norco, follow-up with neuro for nerve blocks to

alleviate headaches and hydrocodone. (JE 8:227-28) Claimant was not working as a CNA, but doing tele-sitting only. (JE 8:225)

On August 13, 2018, claimant returned to NP Addison following two occipital injections administered with NP Miller on August 9. (JE 2:71) She reported a massive headache over the weekend and fogginess on Sunday. (JE 2:71) She also expressed concern about continuing to work with patients as a CNA as she did not feel she could physically perform her duties. (JE 2:71)

On August 9, 2018, claimant returned to NP Miller for follow-up. (JE 10:286) She continued to have a lot of pain and horrible headaches, but her balance had improved. (JE 10:286) She was not sleeping, her speech was slow and slurred while tired, and she had an increase in the "foggy" feeling. (JE 10:286) In the examination portion, no back pain was noted but neck pain was documented. (JE 10:287-288) Because of the headaches, occipital injections were administered and she was given a prescription for nortriptyline. (JE 10:289)

On August 28, 2018, claimant returned to Ms. Bonson for back and neck pain. (JE 8:229) The back pain was radiating into the left lower leg and the neck pain was radiating into the bilateral shoulder region and down into her hands. (JE 8:229) It was unclear whether claimant informed Ms. Bonson of the August 13, 2018, occipital nerve injections because it was not noted in the records. (JE 8:229, 231) Instead, Ms. Bonson noted that claimant had a neuro appointment coming up for the repeat nerve block. (JE 8:230) Ms. Bonson was concerned about claimant's medication regimen.

> She is now off Fentanyl altogether. She tries to bring up some symptoms since being off this, but I do not believe any of this is related to her not being on the small dose of Fentanyl she was on for months before stopping. Overall, I believe polypharmacy was her biggest issues. I have asked to stop some of her psychotropic/benzos she is not as obtunded today as she has been in the past, again long discussion of risks of opioids and benzodiazepines, the side effects which she clearly demonstrates yet denies.
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> She is needing to work with her psych provider to find alternatives as well.

(JE 8:231)

Claimant had another occipital injection on September 17, 2018. (JE 10:290) During the examination, she was oriented to person, place and time. Her memory was intact. Her speech and language examination was normal. Her cranial nerves were normal. Her station and gait were normal. (JE 10:292)

Claimant returned to NP Bonson on September 18, 2018. (JE 8:233) Claimant was confrontative with the staff over her medication, and Ms. Bonson had to give claimant a "stern warning." (JE 8:235) Claimant was re-prescribed fentanyl, claiming that it gave her 100% relief. (JE 8:235) Ms. Bonson instructed claimant to take Diclofenac BID, fentanyl 12 mcg, no increases, and Norco for severe breakthrough pain. (JE 8:235)

On November 18, 2018, claimant was seen by Virginia Wilson, MD, in rheumatology. In the notes, it mentioned that claimant had chronic pain worsened by a work injury suffered a few years prior. Dr. Wilson prescribed claimant meloxicam for this pain.

On December 11, 2018, claimant returned to Dr. Norton who noted that claimant had been diagnosed with CDiff in October. (JE 7:144) There was no mention of the head trauma. He noted that work had been stressful. She had been off two weeks for the CDiff illness, and when she returned to work, she fatigued easier. (JE 7:144) Her concentration was fair with occasional headaches and fair sleep patterns. (JE 7:144) No changes in medication were made. (JE 7:145)

On December 12, 2018, claimant returned to Ms. Bonson. (JE 8:237) Claimant related that when she was off work due to CDiff that she felt much relief from her intense pain. (JE 8:237) It should be noted that claimant had to cease all other medications during the time she was treated and recovering from CDiff. Claimant was not doing CNA work but telesite viewing. There was discussion claimant could benefit from trigger point injections for her disabling myofascial pain in the left greater than right cervical paraspinals and upper trapezius with headaches. (JE 8:239) She informed Ms. Bonson that neuro treatment was discontinued due to a denial of work comp. (JE 8:239)

On January 7, 2019, NP Miller signed a letter authored by defendants' counsel agreeing with the opinions of Dr. Tranel and NP Addison that claimant no longer suffered from post-concussion syndrome, reached MMI and had no permanent impairment. (JE 10:295) Ms. Miller opined that claimant could return to full duty work without restrictions, but extra hours over her scheduled hours would cause a worsening of headaches. (JE 10:295)

On February 12, 2019, claimant went back to Dr. Norton. (JE 7:147) The medical records note that the last visit was on January, 2019, but there was not a record of this in evidence. The February 12, 2019, visit is the first where Dr. Norton mentions a concussion. (JE 7:147) He writes, "She is still recovering from her concussion. Work has been stressful." (JE 7:147) No medication changes were made.

On March 13, 2019, claimant returned to Ms. Bonson for neck and low back complaints as well as ongoing headaches. (JE 8:241) The history portion noted that the symptoms of claimant's multi-sited pain began eight years ago. (JE 8:241) She also reported multiple falls since the last visit along with the lumbar, cervical spine pain with radiation, bilateral shoulder pain, weakness in the arms, and increased pain in the bilateral hands, rights and thumbs. (JE 8:241) Claimant was working twelve hour shifts, but suffered from frequent falls and memory loss. (JE 8:243)

During the March 18, 2019, visit with Dr. Norton, claimant mentioned that she had been managing better at work. (JE 7:150) Dr. Norton noted that claimant had fair concentration, occasional headaches and stress related to her husband. (JE 7:150) He recorded that she felt she was managing as well as she could. (JE 7:150)

On April 8, 2019, claimant underwent another occipital injection with NP Miller. (JE 10:299) She presented with a normal examination, but had complaints of dizziness, fogginess, and balance. (JE 10:300-301)

On June 12, 2019, claimant returned to NP Bonson with symptoms unchanged from the March 13, 2019, visit. (JE 8:245) Her headaches had improved through treatment with neurology. (JE 8:247) She had lost her job and was seeking new employment. (JE 8:247) Claimant was organized and able to have a sensible conversation. She was using her medications with good relief. (JE 8:247) Trigger point injections were again recommended.

On June 19, 2019, claimant was seen by Dr. Norton for medication management. (JE 7:156) She was unemployed at this time and felt her stress levels were lower since she stopped working. However, she did have tremors and felt edgy. Id. Dr. Norton described her concentration as fair with occasional headaches. (JE 7:156)

She returned to NP Bonson on July 10, 2019. (JE 8:252). Her symptoms were unchanged from the previous appointments with Ms. Bonson. (JE 8:252) Prescription history was reviewed, and the results were as expected. (JE 8:254) Trigger points were injected to treat the myofascial pain. (JE 8:254) Claimant reported fewer headaches since being off of work for two months. (JE 8:254) It was noted that she was starting a new position as a CNA the following day. (JE 2:55)

During a July 12, 2019, visit with NP Miller, the records note that claimant was "about 95% back to her baseline. She continues to have some issues with memory. Headaches have not been an issue. Speech is back to normal. Balance is back to baseline and not having falls or close falls." (JE 10:303)

On July 3, 2019, claimant underwent a physical for employment by Emily Armstrong, PA-C. (JE 11:307) In the history section, the following was recorded:

> Employment physical. Pt. will be working as a CNA for St. Dominic Villa Trinity. She has extensive CNA work history. She states she just quit a job at Finley where she was working as a CNA. She states she quit because it was very high paced.
>
> PMHX: She has a history of chronic low back pain. She states she has constant 4 out of 10 pain, but is very physically active despite it. She denies radicular symptoms in her lower extremities. She states that occasionally CNA work will worsen her back pain. States she is able to manage quite well. She states she walks for exercise daily. She states she regularly babysits her 3 grandchildren, age 4 months, 2 years and 6 years.

(JE 10:307)

The physical requirements of the job included frequent kneeling, crouching, reaching, lifting, sitting, walking and lifting, along with the ability to push, pull move or lift. (JE 11:310) Claimant maintained she could easily lift, push, pull 25 pounds. (JE 11:310) During the examination, she had mild low back pain, but changed position with ease during the examination. (JE 11:310) Ms. Armstrong had no reservations employing claimant and wrote that the claimant did not require any accommodations. (JE 11:310) There was no mention of any brain trauma. (JE 11:310)

On September 11, 2019, claimant returned to NP Bonson with largely unchanged symptomatology. (JE 8:256) Claimant did not want to repeat injections. (JE 8:258) She had started work again as a CNA and experienced an exacerbation of pain, but not as severe because she was not doing any lifting. (JE 8:258) Ms. Bonson re-prescribed the 25 mcg fentanyl patch. (JE 8:258)

On October 22, 2019, she reported to Dr. Norton that she had found a new CNA job and that she had been in a recent MVA but suffered no injuries. (JE 7:159) Claimant testified at hearing that the MVA had been fabricated. She was tearful and expressed lower motivation. (JE 7:159) She had been isolating more at home. (JE 7:159) Dr. Norton documented her concentration as fair with occasional headaches. (JE 7:159)

On November 18, 2019, claimant was seen by Virginia K. Wilson, M.D. for a rheumatologic evaluation. (JE 12:338) Claimant's history was a long history of chronic pain worsened by a work injury at which time she suffered a concussion followed by headaches. (JE 12:338) Dr. Wilson suggested meloxicam to treat the widespread chronic pain which Dr. Wilson attributed primarily to OA and fibromyalgia. (JE 13:340) There was no mention of slurred speech, balance issues or other signs of brain trauma in this medical record. (JE 13:340)

On November 27, 2019, she returned to Dr. Norton with a condition largely unchanged from the previous visit. (JE 7:162) Dr. Norton decreased her NTP to 50 mg/day, increased Vyvanse to 70mg/day and Klonopin to 1.5mg BID. (JE 7:163)

On January 8, 2020, claimant returned to NP Bonson. (JE 8:261) Her presentation was largely the same with chronic low back pain radiating intermittently into her left leg, pain behind the knees, weakness in the bilateral legs and back, night pain with intermittent tingling/numbness in bilateral legs. (JE 8:261) She also complained of neck pain radiating into her bilateral shoulders, down her arms and into her hands with weakness in the hands and pain in the bilateral hands, thumbs and wrists. (JE 8:261) She refused injections. (JE 8:263) Claimant was continuing to work. Her care was transferred to Dr. White. (JE 8:263) There was another mention of the car accident. (JE 8:263)

Jeffrey White, D.O. cared for claimant during 2020, managing her medications (see e.g. JE 12). There were times claimant had difficulty following the orders of Dr. White such as when he recommended tapering off the hydrocodone. (JE 12:327) She was taking hydrocodone 3-4 tablets a day, using a fentanyl 25 mcg patch and Bengay, but despite all of this, her pain was uncontrolled. (JE 12:331) Dr. White increased the fentanyl dosage. (JE 12:331)

On July 1, 2020, Dr. White signed a letter authored by the claimant's attorney agreeing with Dr. Patra's diagnosis with regard to the head injury and mental health injuries including the causal connection Dr. Patra drew between the December 18, 2017, injury to the symptoms. (JE 12:336) Dr. White based his opinions on his own treatment as well as the extensive history written by Dr. Patra. Dr. White did not believe that claimant was employable due to her balance problems, concentration problems, memory issues, word findings issues, fluency, slurred speech, problem solving difficulties, and getting lost in familiar places. (JE 12:336) He found that her cognitive abilities decreased significantly between April 2014 when he stopped treating claimant and November 2019 when her treatment with him resumed. (JE 12:336)

On February 12, 2020, claimant returned again to Dr. Norton. In the history, claimant mentioned she was taking personal time off of work due to stress, poor energy and low motivation. (JE 7:168) She had decreased concentration, and due to increased medications, she was having them bubble packed to avoid mixing them up. She was nervous much of the time and was experiencing ongoing memory issues. (JE 7:168) The time off seemed to help as when she presented to Dr. Norton on March 4, 2020, her moods were better, she was sleeping ok with good appetite. (JE 7:171)

On March 31, 2020, claimant's moods were worse. (JE 7:174) The family trip to Arizona was a struggle. She was tearful much of the time and had ongoing stress with her husband. (JE 7:174)

Due to COVID-19, claimant's care with Dr. Norton transitioned to Telehealth. (JE 7:177) She had moved into a new home. Her moods had improved, but she was struggling with not seeing her children or grandchildren. (JE 7:177) She and her husband were getting along better though. She had planned to return to work in early June. (JE 7:178)

On September 24, 2020, in response to an inquiry from claimant's counsel, Dr. Norton wrote the following:

> Mary Delehanty has been a patient of mine in the SBS outpatient clinic for over 5 years. She has been diagnosed with a Major Depressive Disorder, recurrent, currently moderate. She has also suffered significant anxiety as well as ongoing cognitive symptoms. Her depression has dramatically worsened since her injury at Finley on December 18, 2017. Prior to the injury she has help [*sic*] several full time positions in the past, including as an activity director at several different facilities as well as a CNA. She had been performing well in her profession but has struggled considerably since this time. Her depression has been intensified since this injury. She has developed severe and at times disabling anxiety, as well as chronic problems with concentration and attention span since the injury. We have made multiple changes to her medications since that time. She has had ongoing difficulties and at this time is unable to work a full time job due to her ongoing struggles. It is likely that her symptoms will continue over an extended period of time given how severe and difficult to treat they have become. With any questions or concerns, I can be reached at (608) 342-3019.

(JE 7:184)

Claimant was seen by Dr. Daniel Tranel, Ph.D. on September 26, 2018, for a neuropsychological evaluation of her December 18, 2017, work injury where she struck her head on the corner of a cabinet while standing up at work. (Ex A:4) He recorded a history consistent with that which claimant related to Dr. Hunt on February 13, 2018, specifically that she did not lose consciousness, but that in the following days and weeks she experienced headaches, mental fogginess, balance problems and neck pain. In the testing, claimant exhibited normal intact cognitive functioning with low average to average intellectual abilities. Her cognitive abilities were commiserate with her intellectual abilities. "Specifically, her memory, speech and language, perception,

construction, attention, orientation, concentration, judgment, planning, decision-making, and concept formation are normal," Dr. Tranel concluded. (Ex A:11) He pointed out that these findings were consistent with a minor head injury, no signs of significant traumatic brain injury, and the normal brain MRI conducted on February 22, 2018. (Ex A:11) Given the normal function of her brain, Dr. Tranel opined that claimant did not have any lingering signs or symptoms of post-concussion syndrome. (Ex A:11)

As for her mild depression and anxiety, Dr. Tranel believed that these were unrelated to the work injury, predated the work injury, and that the accident caused neither a temporary or permanent aggravation of pre-existing conditions. (Ex A:11) ,

Claimant was sent to Kunal Patra, M.D. on May 10, 2019, for an independent evaluation of her neurological deficits, if any. (CE 3:30) The two discussed claimant's work issues, specifically the write-ups she received that led to her termination. (CE 3:53) When asked whether the lapses were the norm for her, claimant replied that she wasn't sure why she struggled with the tele-sitting position, but that she was very bored staring at monitors. (CE 3:53) She also expressed different circumstances in which she felt that she had moments of confusion, increased headaches, and forgetfulness that were not characteristic of her. (CE 3:53 to 55) She explained that struggling with memory, her confusion, and her inability to manage things like driving, organizing, finances had led to an increase in her depression. (CE 3:56) During the interview with Dr. Patra she would drift off and not finish sentences. She complained of residual headaches, mental exhaustion, sensitivity to noise, and lack of patience. (CE 3:59)

Dr. Patra noted the claimant had a long-standing history of depression and anxiety. She had been diagnosed with major depressive disorder in the past and had an evaluation in 2014 for possible concentration problems. (CE 3:60) She tested slightly below average on the Montreal Cognitive Assessment Test. (CE 3:62) The questionnaires administered showed claimant suffered from moderate clinical depression and moderate generalized anxiety from the answers and responses she gave. (CE 3:62)

Dr. Patra pointed to the Diagnostic and Statistical Manual of Mental Disorders; Fifth Edition (DSM-V), which lay out criteria for mild neurocognitive disorder. (CE 3:66) There is evidence of traumatic brain injury if one or more of the following exist:

1) Loss of consciousness.

2) Posttraumatic amnesia.

3) Disorientation and confusion.

4) Neurological signs (neuroimaging demonstrating injury; new onset seizures; marked worsening of pre-existing seizures; visual field cuts; anosmia; hemiparesis).

(CE 3:66)

Based on claimant's self-report of disorientation and confusion, Dr. Patra opined claimant had sustained a mild traumatic brain injury suffered at the workplace on December 18, 2017. (CE 3:65-66)

The diagnostic criteria for post-concussive syndrome include occurrence of head trauma that has caused significant cerebral contusion (the evidence of contusion being loss of consciousness, posttraumatic amnesia or post traumatic seizures). Claimant did not have a significant cerebral contusion, however, Dr. Patra does not point this out in his report, but instead elides the first criteria.

In reviewing Dr. Tranel's report, Dr. Patra believed that it represented a point in time when claimant was still employed and had not yet suffered a decline. (CE 3:70) He disagreed with Dr. Tranel that claimant's cognitive abilities were commiserate with her intellectual abilities, and instead believed that the inconsistent and variable symptom reports were the result of cognitive difficulties that claimant was experiencing following the alleged closed head injury. (CE 3:71) Dr. Tranel gives a long and thoughtful explanation of his conclusions and the basis of those conclusions including medical literature references. (CE 3:72-73) One of the medical literature papers provide a "practical method for individual clinicians to determine causation following traumatic injury." (CE 3:72) Three criteria must be met. First, there must be a biologically plausible or possible link between the exposure and the outcome. Id. Second, there must be a temporal relationship between the exposure and the outcome. Id. Third, there must not be a more likely or probable alternative explanation for the symptoms. Id.

While Dr. Patra's conclusion appears well-reasoned, Dr. Tranel later points out the biggest flaw in that is the temporal connection between the exposure and the outcome. The outcome, which is the cognitive deficits and depression that Dr. Patra found, did not begin to appear until sometime later during 2018 and into 2019. Dr. Patra agreed that claimant's condition had declined since Dr. Tranel examined the claimant and when Dr. Patra examined the claimant.

The lack of temporal connection combined with the low impact of the head trauma and lack of supportive imaging renders Dr. Patra's conclusions less probable. Dr. Patra opined that the varied presentation of claimant's condition was the result of her cognitive difficulties. However, headaches and migrating pain complaints are not dependent on a good memory, but are contemporaneous complaints about a current condition. For example, on February 20, 2020, claimant underwent an independent

medical evaluation with Robin Sassman, M.D. (CE 2) The evaluation took approximately 1 hour and 40 minutes. (JE 2:7) During this examination, Dr. Sassman did not record any neurological deficits. Headaches, fogginess, loss of memory were not included in the section regarding current symptoms, and there was no mention of any anxiety or depression. Dr. Sassman did not find the claimant suffered from confusion or difficulty in relating any symptomatology, and noted that the claimant was able to pinpoint the difference between the fibromyalgia pain and the post-injury pain. These sort of specific pain complaints do not support Dr. Patra's conclusions that claimant's varied pain complaints and inconsistent symptomatology reports are due to cognitive deficits. If she felt pain at the time of Dr. Sassman's examination, a report of that pain would not have been dependent on a past recollection as the pain was purportedly happening at the time of the examination.

Dr. Patra's diagnosis of mild traumatic brain trauma is the basis for his conclusion that claimant's depression was aggravated by the work injury. (CE 3:73)

Dr. Norton testified by way of deposition. (See e.g. CE 8) He reaffirmed his opinion that claimant's depression had worsened following the December 18, 2017, work injury. (CE 8:29) He based his opinion on the changes he had seen in that her functional level was decreased from pre-injury state. Id. He opined that the decline was progressive, but that it was variable, ups and downs. (CE 8:32) In the past, however, when she would go through depression she would function. She was able to work and be social, but her depression had deepened to the point that there was almost nothing she enjoyed. (CE 8:38) He opined that her intellect or ability to process information at work had also declined and attributed it to her work injury. Id. When pressed on cross-examination, however, he admitted that there could be a myriad of reasons why her intellect may have decreased from the time he worked with her until the time of Dr. Tranel's testing. (CE 8:39)

On May 13, 2019, APNP Addison completed an opinion letter on the causation issue of claimant as it related to her head injury. Ms. Addison concluded that claimant's current symptoms of fogginess, lack of focus, and mental status changes were not related to the work injury. (JE 2:80) This was due, in part, to Dr. Tranel's opinions of September 26, 2018, and October 28, 2018, and claimant's pre-incident symptomatology. (JE 2:80) Ms. Addison was most concerned about claimant's polypharmacy, lack of communication between all providers, and medications being prescribed without interdisciplinary management. (JE 2:80) Ms. Addison also noted that while Dr. Hunt and Ms. Miller diagnosed claimant with post-concussive syndrome, claimant had a significant history of pre-existing psychiatric problems such as major depression and anxiety, and those pre-existing conditions had not been communicated to all providers. (JE 2:80) Further, the inconsistent presentation of symptoms to the

providers had complicated the diagnosis of both the magnitude and chronicity of claimant's symptoms according to Ms. Addison. (JE 2:81) Ms. Addison provides a few examples:

- 2017 June: Advanced Pain Management Clinic documents headaches and memory loss.
- 2017 September: Dr. Norton, psychiatrist, notes "neck and back pain have worsened but she is seeing a new specialist in the pain clinic now."
- 2018 January: Ms. Bronson [*sic*], APNP-DNP, seeing claimant for pain management of non-work-related issues. Ms. Bronson [*sic*] felt claimant was neurologically intact with normal affect, but that she had gait disturbances, headaches, and neck pain.
- 2018 February: Ms. Bronson's [*sic*] notes contain no sign of abnormal neurological symptoms, but that claimant was reporting mental status changes, fogginess and balance problems. Claimant explained she had not previously told Ms. Bronson [*sic]* about the head injury in December, 2017, because she was treating with employee health. However, claimant did not begin treating at employee health until February 2018.

(JE 2:81)

During the April 12, 2019, visit between Ms. Addison and claimant, claimant complained of difficulty focusing and misplacing of items. (JE 2:81) The two also discussed claimant's issues with distractibility. (JE 2:81) Claimant verbalized understanding and stated, "I figured you all would be letting me go this week." (JE 2:81)

Ms. Addison adopted Dr. Tranel's conclusions that claimant did not have signs or symptoms of post-concussive syndrome and that she had normal brain functioning. (JE 2:82)

In response to an inquiry from defendants' counsel, Ms. Addison wrote another letter outlining her opinions regarding the claimant's injury on December 18, 2017, and the symptoms of forgetfulness, fogginess, and balance. (JE 2:86) Objective results included the ability to do serial sevens down to 44 without mistakes and with a rapid response, ability to follow simple and complex commands, no cervical spine tenderness. (JE 2:87)

Claimant did exhibit tenderness over the left cervical paraspinal muscles and her pain increased with compression of the cervical spine, but decreased with distraction. (JE 2:87) She had good range of motion, equal and symmetric muscle strength and sensation. (JE 2:87) She had no problem with her gait. Id.

Ms. Addison reiterated the following:

> Summary: Concussion related headaches is [*sic*]a frequent complaint in the general population; employee did not suffer loss of consciousness and did not receive acute medical care. Subsequently, weeks later, she began to report various symptoms such as headaches, mental fogginess, balance problems, and neck pain. Brain MRI on 2/22/2018 did not show acute changes or any trauma-related abnormalities. This CNA employee of Finley Hospital, has claimed she has had complaints of neurological type symptoms and mental status changes. The interpretation of her complaints and symptoms is complicated by the fact that she has significant history of pre-existing psychiatric problems, major depression, and anxiety; many of the reports from all providers were inconsistent and showed major discrepancies between the nature of the initial injury and the chronicitiy of her symptoms.

(JE 2:88)

Ultimately, Ms. Addison confirmed that she did not find a causal connection between claimant's work injury and her symptomology and that claimant had no ongoing impairment arising of the December 18, 2017, work incident. (JE 2:88)

On March 5, 2020, claimant underwent an IME with Rick Garrels, M.D., specifically for her back and spine. (Ex D:3) Dr. Garrels diagnosed claimant with right shoulder sprain and temporary aggravation of a pre-existing low back condition arising out of the encounter with the aggressive patient on June 22, 2016, and scalp laceration and post-concussive syndrome following the incident where claimant struck her head on the corner of a cabinet on December 18, 2017. (Ex D:3)

On examination claimant exhibited tenderness in the lower cervical and thoracic paraspinal musculature and along the upper buttock and bilateral sacroiliac joints. (Ex D:6) The rest of her examination was essentially normal including range of motion tests. (Ex D:6) Dr. Garrels did not believe claimant sustained any permanent impairment arising out of the 2016 injury or the 2017 injury. (Ex D:4)

On March 19, 2020, Dr. Tranel wrote a follow-up letter after a review of Dr. Patra's report. (Ex B:3) He disagreed with Dr. Patra's conclusions and reaffirmed his previous opinions that neither the depression or anxiety of the claimant were related to the work injury and neither had claimant sustained a long lasting, permanent neurological dysfunction from hitting her head on a cabinet at work. (Ex B:3) Claimant did not have any normal indicators of a concussion, let alone a more severe brain injury. (Ex B:3)

After claimant went through a series of evaluations, she was sent back to Dr. Tranel for a second opinion. (Ex C) Dr. Tranel examined and re-tested claimant on August 4, 2020, and issued a new report on August 14, 2020. (Ex C:3) Claimant showed a variable decline in several areas of cognitive functioning, especially concentration, attention and memory. (Ex C:8) She complained of high levels of depression, anxiety and general psychological distress of a magnitude greater than she had presented with during her 2018 evaluation. (Ex C:8) However, Dr. Tranel maintained that none of these issues were related to the work injury. (Ex C:9) Possible other causes could include the types of medications that claimant was taking as several prescriptions were known to have side effects that adversely affect cognitive functioning. (Ex C:9) Dr. Tranel recommended pain management and psychological treatment, but noted that these symptoms were not related to the work injury. (Ex C:9)

At hearing, claimant's son, Christopher Mueller, a 42-year-old CPA living in Golden Valley, Minnesota, testified on behalf of his mother. Prior to the onset of the pandemic, he would see his mother approximately every two months. He spoke on the phone with her 2 to 4 times per week.

He testified that claimant suffered from fibromyalgia for many years, but she successfully managed a household of six people on her own. After her work injury, Mr. Mueller felt that claimant had an increased loss of memory and disorientation. When they visited in person, she would have difficulty finding things which he found uncharacteristic. It took her nine hours to drive home because she had gotten lost. During various phone calls, it was obvious to Mr. Mueller that claimant was having other memory problems. Her balance was off and she was often found sleeping in a chair. He noticed speech changes wherein she would mix or slur her words. She began to receive negative feedback at work which diminished her confidence. She was maintaining three different checkbooks and would often lose a checkbook. He had to remind her to pay bills and had, in fact, paid off credit card loans and car loans on her behalf. He had encouraged the claimant to file for Social Security disability. On cross-examination he admitted that he had not seen his mother more than five times in three years. He was not aware of any clinical diagnoses preceding her work injury.

After hitting her head against a cabinet door in December, 2017, claimant began receiving disciplinary notices. On June 12, 2018, she received one for leaving the telesitter unattended and failed to give a report to other staff about patients who were being monitored. (Ex F:1) She received a second one on February 20, 2019, for failure to note/report patient events. (Ex F:2) On April 11, 2019, claimant received a third warning for failing to monitor patients and notifying incorrect staff members leading to patient safety issues. (Ex F:3) On April 16, 2019, claimant received three more complaints and was dismissed on April 17, 2019. (Ex F:4)

She obtained new employment with Trinity Health Senior Communities as an evening shift CNA earning $17.28 per hour on July 23, 2019. (Ex G:4-12) Her pre-employment physical noted that no work accommodations were needed. (Ex G:6) Her work was observed during an initial period of employment, and Leslie Stiefel signed off that claimant had passed all work duties such as dressing and undressing a patient, transferring patients, monitoring nutrition, recording vital signs and all other tasks required of a CNA. (Ex G:16)

CONCLUSIONS OF LAW

The first issue is whether claimant's chronic myofascial pain in her neck, shoulders, and low back with radiation down the arms and legs is related to her work injury of June, 2016. As stated in the findings of fact, Dr. Sassman's opinions are given low weight. Claimant's injury occurred in June, 2016, and she had no significant complaints outside of a chiropractor's treatment until March, 2017. During that period of time, claimant was seen by several practitioners for various pain complaints including her low back.

It is claimant's burden to prove each element of her case in chief and the contemporaneous medical records do not show signs or symptoms of a neck injury until over nine months following the alleged injury date. Further, claimant has had long-standing fibromyalgia and was treated for low back pain in the months preceding the alleged injury date. Claimant has not carried her burden to prove that the physical complaints of pain in the low back and neck are related to an alleged work injury date of June, 2016. As a result of the lack of causation connecting the claimant's complaints of neck and low back pain to the June 2016 incident, the remaining issues pertaining to medical care and the IME are moot.

For File No. 5063813, claimant shall take nothing.

Turning to the injury date of December 18, 2017, claimant presents a complicated medical case, however, a few facts appear to be true. Claimant has a worsened mental and cognitive state today than she had prior to December, 2017.

Claimant relies on the opinions of Dr. Patra to prove that the December 18, 2017, work injury resulted in a closed head brain trauma. There are a few problematic issues with Dr. Patra's opinions.

First, Dr. Patra provides little explanation as to why claimant's brain trauma symptoms did not emerge until several weeks following the inciting incident. In fact, in Dr. Patra's opinion, he notes that there must be a temporal relationship between the exposure and the outcome. Claimant struck her head on December 18, 2017, and did not have complaints that warranted care until two months later on February 13, 2018.

Dr. Patra also notes that there must not be a more likely or probable alternative to claimant's symptoms, yet claimant was taking a complex battery of medications including fentanyl, hydrocodone and Norco. Dr. Patra does not explain nor explore the issues of polypharmaceuticals and the potential harmful side effects. Dr. Patra acknowledges claimant's long-standing history of major depressive disorder for which she was receiving treatment immediately prior to the work injury, and that condition could be responsible for periodic flares, but not the long-standing neurocognitive or post-concussive symptoms she exhibited prior to the work injury of December 18, 2017. Dr. Patra also does not account for claimant's 2019 pre-employment physical in which claimant exhibited only mild low back pain and no mental or cognitive issues which would impede her ability to perform as a CNA.

It is the pre-employment physical that supports Dr. Tranel's conclusions more than those of Dr. Patra's. Claimant did have major depressive disorder prior to her December 18, 2017, injury. She was taking stimulants prior to the work injury. She was also taking a variety of other prescription drugs including narcotics. The side effects of these drugs provide an alternate theory of explanation to claimant's cognitive decline. Because there is an alternate theory, Dr. Patra's conclusion is flawed as his own opinion requires no other more likely or probable alternative to claimant's symptoms. Stress was an obvious trigger for claimant's mental issues. When she was off work, she improved dramatically. At one point, she deemed herself to be 95% back to baseline, and when she went for the pre-employment physical in June 2019, claimant was deemed healthy and capable enough to be employed without restrictions as a CNA.

These aforementioned factors weigh heavily in the conclusion that claimant did not meet her burden of proof as it relates to her closed head injury.

Because causation has been denied, the other issues are rendered moot.

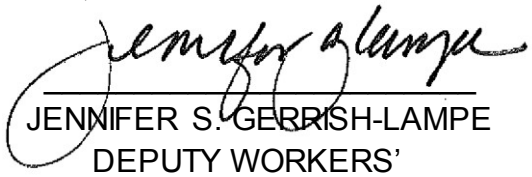
THEREFORE, IT IS ORDERED:

File Nos. 5063812 and 5063813:

Claimant shall take nothing.

Each party shall bear their own costs.

Signed and filed this ___5th___ day of March, 2021.



JENNIFER S. GERRISH-LAMPE
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served, as follows:

Mark Sullivan (via WCES)

Edward Rose (via WCES)

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 filed via Workers' Compensation Electronic System (WCES) unless the filing party has been granted permission by the Division of Workers' Compensation to file documents in paper form. If such permission has been granted, the notice of appeal must be filed at the following address: Workers' Compensation Commissioner, Iowa Division of Workers' Compensation, 150 Des Moines Street, Des Moines, Iowa 50309-1836. The notice of appeal must be received by the Division of Workers' Compensation 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 legal holiday.