BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

SAIDE BOTELLO-DESILVA, Claimant, vs. IAC IOWA CITY LLC, Employer, and AMERICAN ZURICH INS. CO., Insurance Carrier, Defendants.	File No. 5047339 R E M A N D D E C I S I O N Head Notes: 1108.50; 1402.40; 1803; 1803.1; 2601.10

STATEMENT OF THE CASE

This matter is before the Iowa Workers' Compensation Commissioner on remand from the Polk County Iowa District Court, following a decision dated October 21, 2018.

This matter was initially heard on September 24, 2015. An arbitration decision was filed on December 18, 2015. That decision found, in part, that claimant was due 4.4 weeks of permanent partial disability benefits for an injury to the lower extremity. The decision also found, in part, that claimant had failed to carry her burden of proof she sustained a work-related hip or back injury.

The arbitration was appealed within the agency. The appeal decision affirmed the arbitration decision.

A petition for judicial review was filed. The ruling on the petition for judicial review was filed January 16, 2018. It remanded the case back to this agency to make more detailed findings of fact and conclusions of law concerning the opinions of Cory Christiansen, M.D.

A remand decision was filed by this agency on May 7, 2018. That decision found that the opinions of Dr. Christiansen were not convincing and did not support claimant's argument she sustained a work-related injury to her hip or back.

A petition for judicial review was filed regarding the remand decision. A ruling on the petition for judicial review was filed on October 21, 2018. It again remanded the

case back to the agency. It appears the second remand requires the agency to consider all of the evidence and reconcile competing evidence.

The second remand decision was delayed, in part, while trying to get the record returned from the district court.

ISSUES

The district court remanded this case back to the agency a second time to consider all of the evidence and to "reconcile competing evidence." The second remand also required this agency to issue a decision to indicate to the claimant ". . . precisely what facts have been found." (Ruling on Petition for Judicial Review, pages 2-3)

Arguably, the underlying arbitration decision, the appeal decision, and the first remand decision meet that requirement. In an effort to comply with this second remand from the district court, it appears the central issue on remand is whether the claimant carried her burden of proof that the injury on February 14, 2011, caused a permanent disability to her hip, back, or neck.

FINDINGS OF FACT

The deputy workers' compensation commissioner who wrote the arbitration decision did a good job of stating the findings of fact in this case. The findings of fact for this remand decision will merely attempt to highlight relevant facts in this case.

Claimant's prior medical history is relevant. In April of 2007, claimant was evaluated for right hip and knee pain. Records indicate claimant had right hip pain for one year with no known injury. (Exhibit A, p. 2) X-rays taken at that time showed no significant osteoarthritic changes. (Ex. A, p. 2) There is no record claimant had any permanent impairment or permanent restrictions regarding the 2007 problems with the right hip and knee.

On February 14, 2011, claimant sustained a work injury. Claimant testified, at hearing and in deposition, she slipped on a mat and fell, landing in a splits position. Claimant said she ". . . landed on the ground." (Transcript p. 43; Ex. 26, Deposition p. 23)

Claimant testified she also injured her right hip at the time of injury. (Tr. pp. 66, 68; Ex. 26, Depo. p. 27) Claimant testified that after her fall, she never walked again with a normal gait. (Tr. p. 56)

On February 14, 2011, claimant was evaluated at Mercy Occupational Health. Claimant twisted her leg when she slipped. She rated her pain as a "20" out of 10, where 10 is excruciating pain. Claimant was assessed as having a knee strain. She was given a hinge knee splint and prescribed Toradol for pain. (Ex. 8, pp. 74-76)

Claimant began physical therapy beginning on February 17, 2011. Notes from that initial visit indicate claimant injured her right knee. Claimant indicated she slipped on a floor mat, twisted her knee, but "she did not fall." Claimant was noted to have a mild antalgic gait. (Ex. 27, p. 280)

A physical therapy note from February 24, 2011, indicated claimant attended three physical therapy appointments. Claimant's right knee was improving. Claimant had a non-antalgic gait. (Ex. 27, p. 281)

Claimant returned to Mercy Occupational Health on March 22, 2011, and reported no changes in her symptoms. An MRI of the knee was recommended. On April 13, 2011, an MRI showed a full-thickness cartilage deficit in the central portion of the lateral femoral condyle. Claimant was referred to an orthopedic surgeon. (Ex. 8, pp. 86-94)

On April 28, 2011, claimant was evaluated by Thomas Dean, PA, with the Steindler Orthopedic Clinic. Claimant indicated she slipped on a mat, caught herself, but did not fall. Claimant was assessed as having a right knee twisting injury. (Ex. 9, pp. 105-107)

Claimant returned to Steindler Clinic on May 25, 2011, and was evaluated by Cory Christiansen, M.D., an orthopedic surgeon. Claimant indicated she slipped on a mat, caught herself, and twisted her right knee. Claimant was given a right knee injection. She was found to have a normal gait. (Ex. 9, p. 108)

On September 14, 2011, claimant returned to Dr. Christiansen with continued symptoms. Surgery was discussed and chosen as a treatment option. Claimant asked to delay surgery due to various family matters. (Ex. 9, p. 111)

Claimant testified at hearing she did not recall delaying surgery. (Tr. p. 60)

On February 7, 2012, claimant underwent right knee surgery performed by Dr. Christiansen. Surgery consisted of a right knee anterior cruciate ligament (ACL) ganglion cyst excision and a right femoral chondroplasty. (Ex. 9, pp. 115-116)

Claimant saw Dr. Christiansen in follow up on April 25, 2012. Claimant was walking more normally. Claimant was returned to work on light duty after two weeks. Claimant was continued on physical therapy. (Ex. 9, p. 120)

On June 5, 2012, physical therapy notes indicate claimant had some anterior right knee pain. Claimant reported anterior and lateral right hip pain for the last month. Claimant indicated her right hip felt better after physical therapy, but it flared up when she returned to work. (Ex. 14, p. 210)

On June 6, 2012, claimant returned to Dr. Christiansen. Claimant's knee pain was basically gone. Claimant developed right hip pain and left ankle issues. Claimant was given a right hip injection. (Ex. 9, p. 121)

Claimant returned to Dr. Christiansen on July 25, 2012. Claimant had been assessed as having right-sided trochanteric bursitis with right anterior knee pain and left ankle pain. Claimant's sharp right hip pain was gone. Claimant indicated she could live with the pain in the right hip. Claimant was returned to work without restrictions. (Ex. 9, p. 122)

In a September 17, 2012, letter, Dr. Christiansen noted that claimant had developed left ankle pain. He did not find a direct correlation between claimant's left ankle pain and her work injury. (Ex. B, p. 36)

In an October 22, 2012, letter, Dr. Christiansen opined the condyle lesion was the result of claimant's February 2011 injury. He did not feel claimant had returned to baseline and referred claimant to Fred Dery, M.D., pain specialist. Dr. Christiansen also noted "I do believe that her right hip pin [*sic*] is related to her initial injury based on my initial consultation on April 28, 2011. She complained of right-sided buttock pain that radiated down the posterolateral aspect of her thigh to her knee. I diagnosed her with right hip abductor weakness at that time." (Ex. 1)

Claimant was evaluated by Dr. Dery on October 31, 2012. Claimant indicated increased knee pain following surgery. Dr. Dery was uncertain of the cause of claimant's knee pain and ordered an ultrasound. (Ex. 9, pp. 128-129)

Claimant returned to Dr. Dery on December 5, 2012. The ultrasound of claimant's right knee was unremarkable. Claimant was assessed as having right knee pain of a questionable etiology. (Ex. 9, p. 131)

On December 13, 2012, Dr. Dery performed a right hip injection on claimant. (Ex. 9, p. 134)

Claimant returned to Dr. Dery on January 4, 2013. Claimant indicated her right hip was 25 percent better following the injection. An MRI of the right hip was recommended. (Ex. 9, p. 135)

On January 19, 2013, claimant underwent an MRI of the right hip. The MRI findings were unremarkable. (Ex. B, p. 41)

Claimant returned to Dr. Dery on February 6, 2013. Claimant had right knee pain and gait disturbance causing right knee pain. Dr. Dery opined claimant's right hip pain would subside once her right knee felt better and she was not changing her gait to compensate for knee pain. (Ex. 9, p. 137)

Claimant returned to Dr. Dery on May 29, 2013. Medication had not improved claimant's knee symptoms. Dr. Dery noted claimant continued to have hip pain, probably due to the way she was walking. He opined claimant's gait abnormality was due to knee pain. Dr. Dery recommended another MRI of the right knee. (Ex. 9, p. 140)

Claimant returned to Dr. Christiansen on June 19, 2013. The MRI of claimant's right hip was normal. The MRI of claimant's right knee was consistent with a stress reaction. Claimant was put on crutches and taken off work. She was prescribed physical therapy for hip abductor strengthening. (Ex. 9, p. 143)

Claimant was seen in physical therapy on June 21, 2013. Claimant had hip pain that began in February of 2012 following surgery. Claimant was prescribed exercises to improve hip and knee pain. (Ex. F)

On August 29, 2013, claimant was evaluated by James Pape, M.D., regarding her back pain. An MRI of the lumbar spine was ordered. (Ex. 10, pp. 167-177)

Claimant returned to Dr. Pape on September 11, 2013. The MRI did not show any stenosis or neural impingement. It did show a disc bulge at the L5-S1 levels. (Ex. 10, p. 180)

On September 24, 2013, claimant was seen in the emergency department at Mercy Hospital in Iowa City for chronic back pain and right hip pain. Claimant had right hip pain for one year. X-rays of the right hip were normal. (Ex. A, pp. 29-31)

Claimant returned to Dr. Dery on October 24, 2013, with complaints of continued right hip pain. A spinal cord stimulator (SCS) was discussed. Claimant wanted to proceed with the psychological evaluation for implantation of the SCS. (Ex. 9, pp. 147-149)

Notes from a nurse case manager, Yvonne Savoy, indicated she attended the October 24, 2013, meeting regarding a spinal cord stimulator. The notes reflect Dr. Dery associated claimant's hip pain with a gait problem that occurred as a result of her knee pain. (Ex. 15, pp. 226-227)

Claimant underwent a psychological assessment for the SCS in December 2013. Following the assessment, claimant was recommended to proceed with the SCS. (Ex. 13, pp. 197-200)

On February 28, 2014, claimant had an MRI of the thoracic spine. The MRI was unremarkable. (Ex. B, pp. 46-47)

A trial SCS began on June 3, 2014. (Ex. 9, p. 151)

Claimant returned to Dr. Dery on June 11, 2014. Claimant indicated the SCS helped with her leg pain but the claimant had soreness and stiffness in her back. Dr. Dery did not recommend placement of the SCS. (Ex. 9, pp. 152-153)

On June 18, 2014, claimant was evaluated by Ernest Perea, M.D. Claimant was now complaining of thoracic back pain radiating up to the cervical spine and down to the right hip. Claimant was returned to work without restrictions. (Ex. 8, pp. 94-97)

Claimant returned to Dr. Dery on July 2, 2014, with complaints of neck pain, right leg pain, and right hip pain. Claimant mentioned thoracic area pain only after Dr. Dery had mentioned it to her. Claimant was assessed as having leg and right knee pain secondary to a work injury. He also opined that claimant had "poor coping mechanisms." Dr. Dery had nothing more to offer and he found claimant at maximum medical improvement (MMI). Dr. Dery also noted "[a]ny impairment that she does have is based mainly on her knee pain and related to symptoms without objective findings." (Ex. 9, pp. 154-155; Ex. B, p. 49) Dr. Dery recommended claimant see Chandan Reddy, M.D., at the University of Iowa Hospitals and Clinics (UIHC).

On August 4, 2014, claimant was evaluated by Dr. Reddy. Claimant said she fell at work and did the splits. Claimant had pain in her buttocks going down into her right leg and foot. Claimant had thoracic pain. Dr. Reddy recommended claimant to Ludwig Gutmann, M.D., for EMG and nerve conduction studies. (Ex. 11, pp. 182-184)

On August 21, 2014, claimant saw Dr. Gutmann. He recommended EMGs and nerve conduction studies. Testing was performed and results were found to be normal. (Ex. 29)

On October 9, 2014, claimant was evaluated by Elahi Foad, M.D., at the University of Iowa Hospitals and Clinics. On exam, claimant had Waddell's signs. Dr. Foad had no suggestions for pain management. He found claimant at MMI. He assessed claimant as having a myofascial pain syndrome. (Ex. 11, pp. 185-191)

Claimant returned to Dr. Dery on October 22, 2014, with complaints of thoracic back pain, right hip pain, and knee pain. On exam, Dr. Dery found no objective findings for the cause of claimant's pain.

Dr. Dery noted: "[s]he has nebulous subjective complaints of thoracic pain and lumbar pain and hip pain and leg pain and knee pain without any obvious underlying etiology." Dr. Dery also noted:

> I had to explain to her multiple times with review of her previous treatments that at this point I do not think that she should pursue any further treatment because [it] is just likely that she'll have more subjective complaints. Without any obvious objective findings I don't know what her issue is with the pain that she is experiencing at such a great degree other than that she has very poor coping mechanisms.

(Ex. 9, p. 159)

Claimant underwent a functional capacity evaluation (FCE) on November 24, 2014 with E3 Work Therapy Services. Test results were found to be invalid due to inconsistent performance by claimant. Notes indicate claimant's higher pain reports during testing were not consistent with minimal pain behaviors. Testing indicated claimant had a smooth gait pattern. (Ex. I)

In an October 22, 2014, note, Dr. Dery noted he reviewed claimant's FCE results. Dr. Dery indicated, "I have nothing further to offer her at this point since she has exhausted reasonable conservative options and has had multiple subjective complaints afterwards without any objective findings." (Ex. B, p. 53)

In an undated record, Dr. Dery found claimant had a one percent permanent impairment of the body as a whole, converting to a two percent permanent impairment of the lower extremity of her right knee. Dr. Dery limited claimant to lifting up to 30 pounds with no more than ten minutes of sitting per hour. (Ex. 2, pp. 2-3)

In a May 14, 2015, report, Robin Sassman, M.D., gave her opinions of claimant's condition following an independent medical evaluation (IME). Claimant noted pain in the neck and a cracking sensation in her neck since the implementation of the SCS. Claimant had an electric shock feeling in her thoracic area. She complained of pain in the buttocks and right hip down to the right leg and into the great toe. She indicated her right leg gave out and buckled, causing her to almost fall. (Ex. 4, p. 18)

Dr. Sassman opined that claimant's right knee and hip pain were due to the February 14, 2011, injury when claimant slipped on a mat and did the splits. In the process, claimant twisted her right knee and hip. (Ex. 4, p. 21)

Dr. Sassman opined that claimant's left ankle symptoms were due to a gait issue. (Ex. 4, p. 21) Dr. Sassman opined that claimant's cervical, thoracic, and lumbar pain were caused by implementation of the SCS. (Ex. 4, p. 22)

Dr. Sassman found claimant reached MMI on January 6, 2015. Dr. Sassman found that claimant had seven percent permanent impairment of the right knee. Dr. Sassman found claimant had ten percent permanent impairment of the right lower extremity due to the right hip injury. Dr. Sassman also found claimant had five percent permanent impairment each for the cervical, thoracic, and lumbar spine. The combined values for all the injuries opined by Dr. Sassman resulted in 19 percent permanent impairment of claimant's body as a whole. (Ex. 4, pp. 22-23) Dr. Sassman restricted claimant to pulling, pushing, and carrying 20 pounds rarely. (Ex. 4, p. 23)

CONCLUSIONS OF LAW

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 Rule of Appellate Procedure 6.14(6).

The claimant has the burden of proving by a preponderance of the evidence that the alleged injury actually occurred and that it both arose out of and in the course of the employment. Quaker Oats Co. v. Ciha, 552 N.W.2d 143 (Iowa 1996); Miedema v. Dial Corp., 551 N.W.2d 309 (Iowa 1996). The words "arising out of" referred to the cause or source of the injury. The words "in the course of" refer to the time, place, and circumstances of the injury. 2800 Corp. v. Fernandez, 528 N.W.2d 124 (Iowa 1995). An injury arises out of the employment when a causal relationship exists between the

injury and the employment. Miedema, 551 N.W.2d 309. The injury must be a rational consequence of a hazard connected with the employment and not merely incidental to the employment. Koehler Electric v. Wills, 608 N.W.2d 1 (Iowa 2000); Miedema, 551 N.W.2d 309. An injury occurs "in the course of" employment when it happens within a period of employment at a place where the employee reasonably may be when performing employment duties and while the employee is fulfilling those duties or doing an activity incidental to them. Ciha, 552 N.W.2d 143.

The claimant has the burden of proving by a preponderance of the evidence that the injury is a proximate cause of the disability on which the claim is based. A cause is proximate if it is a substantial factor in bringing about the result; it need not be the only cause. A preponderance of the evidence exists when the causal connection is probable rather than merely possible. George A. Hormel & Co. v. Jordan, 569 N.W.2d 148 (Iowa 1997); Frye v. Smith-Doyle Contractors, 569 N.W.2d 154 (Iowa App. 1997); Sanchez v. Blue Bird Midwest, 554 N.W.2d 283 (Iowa App. 1996).

The question of causal connection is essentially within the domain of expert testimony. The expert medical evidence must be considered with all other evidence introduced bearing on the causal connection between the injury and the disability. Supportive lay testimony may be used to buttress the expert testimony and, therefore, is also relevant and material to the causation question. The weight to be given to an expert opinion is determined by the finder of fact and may be affected by the accuracy of the facts the expert relied upon as well as other surrounding circumstances. The expert opinion may be accepted or rejected, in whole or in part. St. Luke's Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); IBP, Inc. v. Harpole, 621 N.W.2d 410 (Iowa 2001); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995). Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417 (Iowa 1994). Unrebutted expert medical testimony cannot be summarily rejected. Poula v. Siouxland Wall & Ceiling, Inc., 516 N.W.2d 910 (Iowa App. 1994).

The most recent district court remand decision required this agency to reconcile competing evidence. (Remand Decision, p. 2) Arguably, this requirement was met with the arbitration decision, the first appeal decision, and the first remand decision. However, this remand decision will attempt, again, to reconcile competing evidence.

Claimant testified in deposition and in hearing that she injured herself when she slipped on a mat, fell and landed on the ground in a "splits" position. (Tr. p. 47; Ex. 26, Depo. p. 23) Claimant also testified at hearing and in deposition she injured her right hip at the same time she slipped on the mat. (Tr. pp. 66, 68; Ex. 26, Depo. p. 27)

Claimant was initially evaluated at Mercy Occupational Health at the time of the injury. There was nothing in the medical records from that visit that indicates claimant did the splits, fell to the ground, or injured her right hip. (Ex. 8, pp. 74-76)

Claimant was seen in physical therapy on February 17, 2011. Notes from this visit indicated that claimant twisted her knee, "but she did not fall." There was nothing in

the record indicating claimant landed in the splits position or injured her right hip. (Ex. 27, p. 280)

Claimant was evaluated by Dr. Dean on April 28, 2011. At that time, claimant indicated that she slipped, caught herself, but did not fall. There is no reference to claimant doing the splits or injuring her right hip. (Ex. 9, pp. 105-107)

Claimant saw Dr. Christiansen on May 25, 2011. Claimant said she slipped on a mat and caught herself, but did not fall. There is no reference at this visit to claimant doing the splits when the injury occurred. (Ex. 9, p. 108)

As noted, claimant testified she hurt her right hip at the same time she slipped on the mat at work. (Tr. pp. 66, 68; Ex. 26, Depo. p. 27) There is no evidence claimant had a traumatic right hip injury. The few records that refer to claimant's right hip during this period reference hip issues due to an irregular gait, and not a traumatic injury. Records from February 2011, May 2011, October 2011, and April 2012 all reflect that claimant had a normal gait. (Ex. 27, p. 281; Ex. 9, p. 108; Ex. 9, p. 113; Ex. 14, p. 209)

Claimant's reports of when her right hip pain began vary. Claimant told Dr. Sassman her right hip pain started on the date of injury. (Ex. 4, p. 21) On June 5, 2012, claimant reported right hip pain developing over the last month. (Ex. 14, p. 210) On June 21, 2012, claimant noted hip pain began in February 2012. (Ex. F, p. 66) On September 24, 2013, claimant indicated right hip pain for a year. (Ex. A, pp. 29-30)

Claimant has had numerous diagnostic tests regarding her hip and back. In January 2013, claimant had an MRI of the right hip. Findings from that MRI were unremarkable. (Ex. B, p. 41)

A lumbar MRI showed no evidence of significant central or foraminal stenosis. (Ex. 11, p. 182) An EMG of claimant's lower extremity was negative for evidence of neuropathy or radiculopathy. (Ex. 11, p. 182)

Ultrasound testing of claimant's pelvis, hip, and legs was negative. (Ex. 11, p. 186)

Claimant showed Waddell's signs in an October 2014 exam at the UIHC, suggesting a non-organic or psychological rationale for claimant's pain. (Ex. 11, p. 190)

Claimant underwent an FCE in November 2014. Claimant's testing was found to be invalid and claimant's performance was found to be inconsistent. (Ex. I)

Dr. Dery treated claimant for approximately two years. Of all the practitioners in the record who treated claimant, Dr. Dery has the most experience with claimant's condition, her history, and her medical presentation.

In October 2014, after treating claimant for two years and using various modalities to treat claimant's symptoms, Dr. Dery noted,

> She has nebulous subjective complaints of thoracic pain and lumbar pain and hip pain and leg pain and knee pain without any obvious underlying etiology . . . .
>
> I had to explain to her multiple times with review of her previous treatments that at this point I do not think that she should pursue any further treatment because [it] is just likely that she'll have more subjective complaints. Without any obvious objective findings I don't know what her issue is with the pain that she is experiencing at such a great degree other than that she has very poor coping mechanisms.

(Ex. 9, p. 159)

In a November 2014 note, Dr. Dery indicated he reviewed claimant's invalid FCE. At that time, Dr. Dery opined, "[s]he has purely subjective complaints at this point without any objective findings" (Ex. B, p. 54)

As detailed above, there are numerous inconsistencies with claimant's testimony, compared to medical records and diagnostic testing. Claimant's testimony regarding the mechanism of her injury is incompatible with the medical records made during the time of the injury. Claimant's testimony of how and when she allegedly injured her right hip conflicts with the medical records. Diagnostic testing of claimant's hip and back are unremarkable. Claimant's FCE was invalid. Claimant's exams suggested non-organic reasons for her symptoms. Dr. Dery, who treated claimant for two years, indicated claimant had a lack of objective findings for her complaints and her symptoms were nebulous and subjective. Because of the numerous conflicts and inconsistencies with claimant's testimony at hearing and in deposition, and in the medical records, it is found claimant is not credible.

Three experts have opined regarding the causation of claimant's hip and back condition. Dr. Sassman evaluated claimant on one occasion for an IME. Dr. Sassman found that claimant's right hip problems were causally connected to her February 2011 slipping injury. She also opines that claimant's cervical, thoracic, and lumbar issues are related to placement of a temporary SCS. (Ex. 4, pp. 21-22)

Dr. Sassman's opinions regarding causation and permanent impairment are problematic, for a number of reasons. Dr. Sassman bases her opinions on causation, in part, that claimant had no prior problems with her hips. (Ex. 4, pp. 19, 21) This is not the case. Claimant had treatment for her right hip in 2007, after nearly a year of hip pain. (Ex. A, p. 2) Dr. Sassman also forms her opinions regarding causation of the alleged right hip injury with the mechanism of injury where claimant did the splits and twisted her hip after she slipped on a mat. (Ex. 4, p. 21) Records at the time of injury do not indicate claimant did the splits, but caught herself and did not fall. There is no evidence in the record of a traumatic hip injury. (Ex. 27, p. 280; Ex. 9, pp. 105-108; Ex. 8, pp. 74-76)

As noted, claimant had numerous diagnostic tests regarding her right hip and lower back, all of which were unremarkable. Dr. Sassman offers no analysis of how claimant had an unremarkable MRI, and other diagnostic testing regarding the right hip and lower back, yet has permanent impairment for the right hip and lower back. Claimant had an invalid FCE. She showed Waddell's signs. Dr. Dery opined that claimant's complaints were nebulous and largely subjective. There is no discussion in Dr. Sassman's opinion regarding causation and permanent impairment regarding any of these findings in the records.

Dr. Sassman found claimant had a permanent impairment to the cervical, thoracic, and lumbar spine based upon a temporary placement, of approximately one week, of the leads for the SCS. Records indicate these leads were placed only at the T-8 level. (Ex. 9, p. 151) There is no explanation in Dr. Sassman's report as to how the placement of a temporary lead for one week at the T-8 levels caused claimant to experience thoracic, lumbar or cervical pain and permanent impairment.

Dr. Sassman did not have a history of claimant's prior right hip pain. She did not know the true mechanism of claimant's February 2011 injury. She did not know, or ignored, the many inconsistencies in claimant's history, given by claimant, compared with the medical records. Dr. Sassman did not address unremarkable diagnostic testing. She offers no explanation how a temporary lead placed at claimant's T-8 level, for one week, caused claimant pain and permanent impairment at the cervical and lumbar area. Based upon these many issues, it is found that Dr. Sassman's opinions regarding causation and permanent impairment of the hip and back are not convincing.

In an October 22, 2012, note, Dr. Christiansen opined that claimant's right hip pain was related to claimant's February 2011 slipping injury at work. (Ex. 1)

The opinions of Dr. Christiansen are respected. However, when Dr. Christiansen gave this opinion in 2012, he did not have access to an unremarkable MRI regarding the claimant's hip. It appears Dr. Christiansen did not have access to claimant's testimony regarding her injury, which is inconsistent with the medical records. Dr. Christiansen did not have access to claimant's invalid FCE. He did not have access to Dr. Dery's opinions regarding claimant's subjective complaints. Because Dr. Christiansen did not have access to this information, because his opinions were made before the development of the record, and because he gives no opinion regarding permanent impairment, Dr. Christiansen's opinions are not convincing as to causation or permanent impairment of claimant's alleged hip injury.

Notes from a nurse case manager also suggest Dr. Dery causally relates claimant's hip problem to her February 2011 slipping injury. (Ex. 15, pp. 221-222) Those notes are not convincing evidence regarding the alleged causal connection between claimant's February 2011 slipping injury and her alleged hip problems for several reasons. First, the notes from the case manager, for the October 24, 2013, visits, are not reflected in Dr. Dery's medical records. (Ex. 9, pp. 147-149) Dr. Dery's October 24, 2013, medical records make no reference to causation of an alleged right hip injury.

Second, even if Dr. Dery does give that opinion in October 2013, it is clear from records made in October 2014 and November 2014 that Dr. Dery believed that there was no objective basis for claimant's "nebulous subjective complaints of pain." (Ex. 9, p. 159; Ex. B, p. 52) For this reason, notes from the case manager regarding Dr. Dery's alleged comments concerning causation between claimant's slipping injury and her alleged right hip injury are found not convincing.

I appreciate claimant's main language is Spanish. I also appreciate that claimant only went up to the sixth grade in Mexico. The record indicates claimant came to the United States as a young teenager and since that time has worked hard at different manual labor jobs to make a life for herself in this country. She is an admirable person. I also recognize that some treatment records reflect claimant had some temporary hip pain, at times, due to her knee condition.

However, claimant's testimony at hearing and in her deposition regarding her alleged hip and back condition conflicts with, and is incompatible with, the medical records in this case. Numerous diagnostic tests regarding claimant's hip and back are unremarkable. Claimant had an invalid FCE. She showed Waddell's signs on exam. Dr. Dery, who treated claimant for two years, found claimant's nebulous subjective complaints regarding her cervical, thoracic, and lumbar pain and hip pain, had no objective basis. The opinions of Dr. Sassman regarding causation of permanent impairment of claimant's hip and back pain are not convincing. Dr. Christiansen's opinions regarding causation between claimant's slipping injury in February 2011 and her alleged hip pain are not convincing. Based on all of this evidence, it is again found that claimant failed to carry her burden of proof that her February 2011 slipping injury caused an alleged hip or back injury, or resulted in any permanent impairment to her hip or back.

ORDER

THEREFORE, IT IS ORDERED:

The 2015 arbitration decision, finding that claimant failed to carry her burden of proof that a February 2011 slipping injury resulted in a work-related hip or a back injury, or that claimant sustained permanent impairment to her hip and back, is affirmed in full.

Signed and filed this 6th day of May, 2020.

Joseph S. Cortese II

JOSEPH S. CORTESE II
WORKERS' COMPENSATION
COMMISSIONER

The parties have been served, as follows:

Andrew William Bribriesco (via WCES)

James M. Ballard (via WCES)