BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

MARY BETH UNDERWOOD, Claimant, vs. ALLEGIS GROUP, INC. d/b/a TEKSYSTEMS, Employer, and INDEMNITY INSURANCE COMPANY OF NORTH AMERICA, Insurance Carrier, Defendants.	File No. 5050221 A R B I T R A T I O N D E C I S I O N Head Note Nos.: 1100, 1108, 1402.40, 3001

STATEMENT OF THE CASE

Claimant, Mary Beth Underwood, filed a petition in arbitration seeking workers' compensation benefits from Allegis Group, Inc. d/b/a Teksystems, employer, and Indemnity Insurance Company of North America, insurance carrier, both as defendants, as a result of an alleged injury sustained on November 11, 2013. This matter came on for hearing before Deputy Workers' Compensation Commissioner Erica J. Fitch. The record in this case consists of joint exhibits 1 through 40, claimant's exhibits 1 through 22, defendants' exhibits A through L, and the testimony of the claimant.

ISSUES

The parties submitted the following issues for determination:

1. Whether claimant sustained an injury arising out of and in the course of employment on November 11, 2013;

2. Whether the alleged injury is a cause of temporary disability and, if so, whether claimant is entitled to temporary disability benefits from January 16, 2014 through February 7, 2014;

3. Whether the alleged injury is a cause of permanent disability and, if so, the extent of any industrial disability;

4. The commencement date for permanent disability benefits, if ordered;

5. The rate of compensation;

6. Whether defendants are responsible for medical expenses found in Exhibits 19 and 22, as well as medical mileage found in Exhibit 17;

7. Whether claimant is entitled to reimbursement of an independent medical examination performed by Dr. Bansal;

8. Whether defendants are entitled to credit under Iowa Code section 85.34(7);

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

10. Specific taxation of costs.

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.

FINDINGS OF FACT

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

Claimant was 47 years of age on the date of hearing. She is single and the mother to an adult son. She resides in Adel, Iowa, with her father. Claimant graduated high school in 1990. (Claimant's testimony) Claimant earned a bachelor's degree in psychology in 1994. She subsequently participated in continuing education courses to maintain her social work license. Thereafter, claimant took a number of computer, project management, and office management related coursework; she did not earn any particular certifications. Claimant also successfully completed an accelerated course in Microsoft engineering; she did not take the test required to earn a certification. (Claimant's testimony; DEF, pp. 27-28) In 2001, claimant began work in the IT field and proceeded to hold various positions as an IT analyst, project coordinator, and business system analyst. (DEF, pp. 32-33)

Claimant's relevant medical history is extensive and the evidentiary record is voluminous, despite efforts by counsel to limit the number of records submitted to only those which were most relevant. Over the years, claimant has treated with two personal physicians: Gregory McKernan, D.O. and Jose Angel, M.D. She also regularly was evaluated by Laura Dankof, ARNP, a nurse in Dr. Angel's practice. (Claimant's testimony) In addition to conditions unique to claimant personally, claimant's family

history is positive for schizophrenia in her mother and one brother. (JE29, pp. 306-307; JE35, p. 364)

In 2005, claimant was struck in the head at work by what she described as a stress ball with a hard inner core. (Claimant's testimony) The evidentiary record denotes the date of injury as July 12, 2005. She initially sought medical care with Scott Fackrell, D.O., on July 13, 2005. (JE19, p. 266)

At a follow up appointment on July 15, 2005, Dr. Fackrell noted claimant had been struck near the left ear by a "very soft and very light" ball. She complained of disorientation, nausea, and dizziness, which Dr. Fackrell described as "way out of proportion" to the type of injury which could have resulted from being struck by the ball claimant brought to show him. He described the ball as so light and soft that it was "almost incapable" of causing injury. Dr. Fackrell indicated claimant may, however, have sprained muscles in her neck when startled by the ball striking her. Following examination, Dr. Fackrell assessed a cervical strain with headache out of proportion to any injury she could have sustained. He ordered a CT scan, which revealed an incidental finding of arachnoid cyst in the left temporal area. Dr. Fackrell opined he was certain the cyst was not the cause of claimant's pain. He recommended observation and time; if symptoms persisted, a neurological consult would be ordered. (JE19, p. 266)

Claimant continued to follow up with Dr. Fackrell and also underwent consultation with neurologist, Muhammad Shoaib, M.D., on July 20, 2005. On July 21, 2005, claimant returned to Dr. Fackrell, who noted claimant presented with a "host of symptoms which become more and more bizarre as time goes by." Dr. Fackrell assessed possible conversion hysteria. He expressed reservation making such a diagnosis, but indicated the case was "becoming more bizarre as time goes by." He indicated claimant was struck by a very soft, light object, which he did not believe could have done serious damage to claimant's head. He opined claimant may have suffered some muscular injuries, but her symptoms were out of proportion to any type of injury she could have suffered. Dr. Fackrell opined claimant displayed anxiety which required treatment; he prescribed alprazolam. Otherwise, he deferred to specialist, Dr. Shoaib. (JE19, p. 267)

On August 3, 2005, claimant presented to neurosurgeon, David Boarini, M.D. Dr. Boarini reviewed claimant's MRI and opined it revealed a small arachnoid cyst. Despite claimant's symptoms, Dr. Boarini opined he did not believe the cyst was symptomatic or otherwise related to the "minor head injury." Dr. Boarini informed claimant that the cyst did not require treatment beyond a follow up scan in six to eight months. Given claimant's pain symptoms, Dr. Boarini did recommend a pain clinic evaluation. (JE20, p. 268)

Claimant was evaluated by neurosurgeon, Matthew Howard, M.D. Dr. Howard opined claimant suffered a minor closed head injury which led to identification of an incidental arachnoid cyst. Dr. Howard opined claimant's symptoms were not related to the cyst and declined to recommend surgery. (JE24, p. 276)

On February 15, 2008, Mayo Clinic neurosurgeon, Frederic Meyer, M.D., reviewed claimant's head imaging and opined the results were consistent with a benign left temporal arachnoid cyst. Dr. Meyer also opined the cyst was not causing any pressure on claimant's brain. He indicated he would "never" recommend surgery for this issue, as arachnoid cysts in this location were not uncommon. Dr. Meyer further opined it was quite uncommon for such a cyst to cause symptoms. (JE29, p. 290) Claimant subsequently provided additional information for Dr. Meyer to consider. Dr. Meyer authored a second medical note on March 5, 2008. Thereby, Dr. Meyer indicated he would be quite reluctant to recommend surgery due to concern that surgery would not improve any of claimant's described symptoms. (JE29, p. 291)

Claimant sought further evaluation of the arachnoid cyst, including seeking with California-based physician, Hrayr Shahinian, M.D. On March 27, 2008, claimant underwent surgical intervention at Brotman Medical Center in Culver City, California. Dr. Shahinian performed left supraorbital craniotomy and endoscopic resection of claimant's arachnoid cyst. (JE22, pp. 272-273)

Claimant testified her symptoms returned several months following surgery. (Claimant's testimony)

On September 30, 2008, claimant underwent neuropsychological evaluation with Jim Andrikopoulos, Ph.D. Dr. Andrikopoulos assessed neuropsychological findings indicative of some difficulties with motor strength and fine motor dexterity of the left hand, but no cognitive difficulties. Dr. Andrikopoulos found no cognitive impairment. He opined claimant's personality testing indicated gross over-reporting of physical symptoms. (JE23, pp. 274-275)

On October 14, 2008, claimant returned to Dr. Howard. Dr. Howard noted claimant had undergone surgical intervention on the arachnoid cyst. Thereafter, her symptoms reportedly improved until August 2008, at which point all her symptoms returned. Symptoms included fatigue, dizziness, vertigo, head and neck pain, hand numbness, puffiness, neck stiffness, difficulty concentrating, and periods of inability to move. Dr. Howard opined imaging of September 10, 2008 revealed recurrence of the cyst, which was of similar size as it had been in 2005. Dr. Howard found a normal neurological examination. Thereafter, he opined claimant's symptoms were not referable to the cyst and declined to recommend surgery. He recommended a neurology consultation, as well as a second opinion from a neurosurgeon at the Mayo Clinic. (JE24, p. 276)

Claimant again sought evaluation of the cyst in California. On December 22, 2008, claimant underwent surgical intervention on the recurrent arachnoid cyst at Cedars-Sinai Medical Center. John Yu, M.D., performed a craniotomy with arachnoid cyst removal. (JE25, p. 277) Claimant testified the surgeon cut a nerve and blood vessel during surgery, causing hemorrhage and resulting in brain damage and trigeminal neuralgia. (Claimant's testimony)

Claimant subsequently required treatment for resulting symptoms. On May 7, 2009, claimant presented to physiatrist, Karen Keinker, M.D. Dr. Keinker recommended physical therapy of the left side of claimant's face and head, due to continued swelling, drainage, and pain. She also referred claimant to psychologist, Dr. David Beeman, for his brain retraining program. (JE26, pp. 279-280) Claimant returned to Dr. Keinker in follow up on December 31, 2009. Dr. Keinker noted claimant had learned of recurrence of the arachnoid cyst in July 2009 and reported fatigue, nausea, headaches, left temple swelling, tightness and sensitivity of her face, slow cognition, balance difficulties, and intracranial pressure. (JE26, p. 281) Dr. Keinker ordered continued facial therapy and recommended increased physical activity, specifically walking. (JE26, p. 282)

Claimant continued to receive periodic care and evaluation related to the arachnoid cyst. Ms. Dankof referred claimant to neurologist, Paul Babikian, M.D., for evaluation. Claimant presented to Dr. Babikian on May 11, 2011 with complaints of headache, memory and concentration difficulties, numbness, swelling and decreased sensation of the left side of her head, cramps, tremors, imbalance, dizziness, loss of smell, trouble walking, and muscle weakness. (JE27, p. 284) After history and neurologic examination, Dr. Babikian assessed: gait disturbance of unclear etiology; abnormal brain MRI with arachnoid cyst, for which he was uncertain if surgery was indicated; and complaints of memory and cognitive difficulties, for which neuropsychological testing was warranted. Dr. Babikian recommended obtaining claimant's prior medical records and ordered a new brain MRI, EEG, and neurocognitive testing. (JE27, p. 285) Claimant underwent the recommended EEG on May 27, 2011, which was read as abnormal, with intermittent infrequent focal slowing in both hemispheres. (JE32, p. 327)

At hearing, claimant testified she believed being struck by the stress ball "created a secondary arachnoid cyst" on her brain. She testified her understanding was that the incident caused the cyst. (Claimant's testimony)

On October 24, 2011, claimant began work at defendant-employer as a quality assurance analyst II. (CE10, p. 73; DEF, p. 33) Her work primarily involved software testing, performed seated at a computer. (Claimant's testimony)

On August 27, 2012, claimant was involved in a rear-end motor vehicle accident. Claimant was seen in the emergency department, where she was diagnosed with cervical/cardiothoracic sprain. (JE36, pp. 369-371)

On August 31, 2012, claimant presented to Ms. Dankof in follow up of the motor vehicle accident. Claimant complained primarily of pain from her left shoulder blade/neck down to her low back, primarily on the left side. Other complaints included dizziness, headache, and nausea. (JE31, p. 314) Ms. Dankof noted claimant was not taking the Naprosyn prescribed in the emergency room. She issued prescriptions for cyclobenzaprine and physical therapy. (JE31, p. 316)

At Ms. Dankof's referral, claimant was seen by Kurt Smith, D.O., for orthopedic evaluation of back and neck pain. Dr. Smith examined claimant on November 1, 2012, at which time claimant reported onset of mid and low back pain, as well as neck pain. The onset of symptoms was noted as a rear-end motor vehicle accident two months prior. (JE28, p. 287) Following examination, Dr. Smith assessed sprain/strains of the cervical, lumbar, and thoracic spines; unspecified myalgia; and acute pain due to trauma. He opined claimant's existing treatment regimen was appropriate and should continue. (JE28, p. 289)

At the referral of Dr. Angel, claimant presented to the Mayo Clinic neurology department on February 7, 2013 and was evaluated by Daniel Drubach, M.D. Dr. Drubach found a normal neurological examination. He opined many of the described symptoms were consistent with a diagnosis of postconcussive syndrome. He ordered a repeat MRI to evaluate the arachnoid cyst, issued a neurosurgical referral, referred claimant to the brain rehabilitation program, and referred to an internist for evaluation of hypertension. (JE29, p. 294)

That same date, claimant was evaluated by Billie Schultz, M.D., of the brain rehabilitation program at Mayo Clinic. Following examination, Dr. Schultz opined claimant presented with significantly elevated blood pressure and agreed with Dr. Drubach's referral for additional evaluation. She also recommended an overnight oximetry due to difficulty with sleep and fatigue. Dr. Schultz agreed claimant's complaints were consistent with postconcussive type symptoms; she desired to await the findings of the additional referrals prior to making treatment recommendations. Dr. Schultz did order a neuropsychologist evaluation to determine if and what treatment would be indicated. (JE29, pp. 298-299)

On February 12, 2013, claimant presented to Dr. Angel in follow up of the Mayo Clinic appointments. Claimant reported more frequent ringing in her ears and headaches, as well as recent development of abdominal pain with nausea and diarrhea. Dr. Angel noted claimant's blood pressure was high. Dr. Angel opined claimant's cognitive difficulties, hypertension, fatigue, low stamina, and heat intolerance were all related to the arachnoid cyst. (JE31, p. 317)

On February 15, 2013, claimant returned to the Mayo Clinic. She was evaluated by Jeffrey Smigielski, Ph.D. Following examination and records review, Dr. Smigielski opined claimant's presentation was suggestive of postconcussive symptoms. When he presented this opinion to claimant, claimant expressed a "strong opinion" her symptoms were related to a "rare symptomatic" arachnoid cyst. After discussing causation at

length, Dr. Smigielski noted claimant held her opinion quite strongly and appeared to dismiss alternative explanations. Dr. Smigielski opined claimant might benefit from cognitive rehabilitation, but did not believe such care was essential or appropriate long-term. (JE29, p. 301)

That same day, claimant was evaluated by internist, Jason Szostek, M.D. Following history and examination, Dr. Szostek assessed: hypertension; arachnoid cyst; and fixed medical ideas. He noted claimant associated her arachnoid cyst with concerns for brain swelling and hypertension. Dr. Szostek explained there was no evidence of brain swelling at that time and opined he did not attribute claimant's hypertension to any intracranial process. Dr. Szostek informed claimant that her hypertension represented a major medical concern; he expressed concern for claimant's well-being. As a result, he ordered laboratory testing and recommended evaluation by a hypertension expert. (JE29, p. 307)

Also on February 15, 2013, claimant was evaluated by neurosurgeon, Richard Marsh, M.D. Following records review, Dr. Marsh informed claimant he did not believe the arachnoid cyst was responsible for her symptoms and did not require further surgical intervention. Dr. Marsh noted claimant expressed "very fixed and clear ideas" about the cyst, specifically that it caused elevated pressure in her head and in turn, hypertension and other symptoms. Dr. Marsh rejected claimant's opinions. He offered, however, to review all MRI and CT scans and contact claimant thereafter. (JE29, p. 308)

After undergoing this series of evaluations on February 15, 2013, claimant returned to Dr. Drubach. Dr. Drubach assessed: cognitive disorder, not otherwise specified; arachnoid cyst, status post two surgical treatments; and possible postconcussional syndrome. Dr. Drubach noted Dr. Schultz felt claimant's symptoms could be attributable, at least in part, to postconcussional syndrome. He also noted Dr. Marsh did not relate claimant's symptoms to the cyst. Dr. Drubach indicated claimant expressed strong disagreement with Dr. Marsh's opinion and questioned his experience with such cysts. Dr. Drubach expressed belief many of claimant's symptoms could be explained by her history of traumatic brain injury. He indicated he was personally uncertain whether the cyst could be contributing, but expressed significant respect for Dr. Marsh's opinion. Dr. Drubach ultimately opined no further workup was necessary. (JE29, p. 309)

On February 28, 2013, claimant presented to Dr. Angel in follow up of a recent emergency department visit due to uncontrolled hypertension. Claimant also complained of headaches, lethargy, fatigue, and decreased concentration. Dr. Angel assessed hypertension, probably secondary to the arachnoid cyst. He ordered a series of labs and recommended evaluation by claimant's previous surgeon. (JE31, pp. 319-320) Claimant continued to follow up with Dr. Angel, including a visit on March 14, 2013, when he prescribed Lisinopril for hypertension and again recommended consultation with her surgeon. (JE31, pp. 321-322)

On August 8, 2013, claimant presented to Ms. Dankof with primary complaints of back pain, ranging from the neck to hip. Claimant also complained of head pain, face swelling, blurred vision, memory problems, nausea, and dizziness. Claimant indicated she suffered with all these symptoms since the motor vehicle accident of August 2012 but they had recently worsened. Ms. Dankof issued a physical therapy order for the neck and back complaints. (JE31, pp. 323, 325) Claimant resumed physical therapy sessions. (JE34, pp. 344-351)

On August 14, 2013, claimant engaged in a telephone consultation with Dr. Shahinian. He ordered an MRI flow study. (JE30, p. 312) Claimant underwent the recommended brain MRI on August 30, 2013. The radiologist read the results as stable compared to the November 2012 study and specifically noted encephalomalacia was again seen, likely representing residue of prior surgery or trauma. (JE31, p. 326; JE32, p. 329)

Claimant returned to Dr. McKernan on August 29, 2013 with complaints of headaches, onset one year prior due to motor vehicle accident. Additional complaints included back pain, dizziness, lightheadedness, nausea, and weakness. (JE37, p. 380) Dr. McKernan assessed headache, back pain, and neck pain; he performed osteopathic manipulation. (JE37, pp. 382-383)

On October 25, 2013, claimant returned to Dr. McKernan. On this occasion, she reported a primary complaint of memory loss onset 1 ½ years prior, as well as associated headaches. (JE37, p. 384) Dr. McKernan recommended a decrease in T3 treatment, with claimant to return in two weeks for evaluation of back and head symptoms. (JE37, p. 386) Claimant returned to Dr. McKernan on October 28, 2013 with complaints of fatigue and back pain. (JE37, p. 387) Dr. McKernan performed osteopathic manipulation. (JE37, p. 389)

Throughout summer and fall 2013, claimant pursued acupuncture treatment of complaints of left-sided head pain. (See JE33, pp. 332-334) Claimant also continued physical therapy sessions, up through and including, November 7, 2013. (JE34, p. 351) Claimant testified her symptoms related to the August 2012 motor vehicle accident improved over this time. She denied having any permanent work restrictions. (Claimant's testimony)

On November 11, 2013, claimant was leaving work at defendant-employer after completing her shift. As she walked to her car, she slipped on a patch of ice and fell to the ground. Claimant testified her left leg bent behind her. She was able to sit up, but could not stand. She called to coworkers, who were able to help her stand and get into her vehicle. Claimant testified she drove home, where she applied ice to both knees, ankles, and her left low back. (Claimant's testimony)

Claimant reported the event to defendant-employer on November 12, 2013. (CE8, p. 65) Supervisor, Dennis Young, authored an incident notice, noting claimant slipped and fell on ice while leaving work the prior day. He further noted there were no

witnesses to the fall itself, but claimant was observed on the ground thereafter. (CE9, p. 67) Three coworkers authored witness statements indicating they heard claimant call for help and went over to help claimant stand. (CE9, pp. 68-70)

At the time of the alleged injury, claimant continued to work for defendant-employer as a quality assurance analyst II, earning $38.60 per hour. (CE10, p. 73; DEF, p. 33) Claimant's weekly hours worked varied. (See CE15, p. 86)

Claimant argues her gross average weekly wage is $1,447.50. To reach this computation, claimant reviewed the 13 weeks preceding the alleged injury and excluded 4 of those weeks as unrepresentative. During those 4 weeks, claimant worked 28.75, 30.50, 28.50, and 28.00 hours. During the remaining 9 weeks utilized in the computation, claimant worked 34.00 to 40.00 hours per week. (CE15, p. 86) Claimant seeks to exclude 4 of the 13 weeks preceding the alleged injury from computation of her gross average weekly wage. She seeks to exclude 31 percent of the 13 weeks, arguing working between 28 and under 34 hours is unrepresentative.

Defendants argue claimant's average weekly wage is $1,345.80[1]. Defendants used claimant's earnings in each of the 13 weeks prior to the alleged work injury. Defendants did not exclude any weeks, arguing all the included weeks are representative. (DED, p. 21)

Claimant's payroll register with check dates from August 9, 2012 through December 12, 2013 was included in evidence. Review of the ledger reveals that over the 66 weeks preceding claimant's alleged injury, claimant's weekly paid hours ranged from 12 to 40 hours. (DEB, pp. 2-15) Review of the payroll ledger reveals claimant frequently worked greater than 28, but less than 34, hours per week. During the 20 weeks prior to claimant's alleged injury, claimant worked in that range of hours 40 percent of the time (8 weeks). During the 66 weeks prior to claimant's alleged injury, claimant worked in that range of hours 36 percent of the time (24 weeks). (See DEB, pp. 2-15)

On November 13, 2013, claimant authored an email to naturopathic pharmacist, Ned Looney, NMD. Thereby, claimant detailed a history of two brain injuries in the prior eight years: when she was struck in the head by a ball which "created a cyst" on her brain and required two surgeries; and a motor vehicle accident which caused whiplash injuries to her neck and back muscles. Claimant indicated a cousin had suggested she contact Dr. Looney to determine if he had any treatment options to "wake up" her brain or otherwise begin the healing process. (JE6, p. 138)

[1] The approved hearing report denotes defendants believe claimant's average weekly wage is $1,350.80. Defendants' Exhibit D, page 21, argues an average weekly wage of $1,345.80. Review of the specific rate calculation corresponds with an average weekly wage of $1,345.80. Therefore, I conclude the hearing report contains a scrivener's error and defendants' average weekly wage computation is $1,345.80.

As a result of the November 11, 2013 incident, defendants authorized care with Concentra Medical Centers (Concentra). On November 14, 2013, Judith Nayeri, D.O., evaluated claimant and noted a history of injury November 11, 2013. Claimant reported she slipped on ice and injured both legs, neck, and back. Claimant reported an immediate onset of pain, described as chronic, mild, and sore. Claimant also complained of dizziness and nausea, which Dr. Nayeri opined was probably related to claimant's blood pressure. (JE1, p. 1) On examination, Dr. Nayeri noted: no apparent distress; normal gait; normal hip range of motion in all planes, with negative FABERE and Figure 4 test; normal hip exam bilaterally; normal cervical range of motion in all planes, but slight pain with rotation to the left; tenderness to palpation of the left paraspinous area; mildly positive diffuse lower back pain of the left L4-L5 paraspinous area; and positive straight leg test bilaterally in the supine position. (JE1, pp. 1-3)

Following history and examination, Dr. Nayeri assessed: lumbar strain; cervical strain; and knee contusion. Claimant was directed to use ibuprofen or Naprosyn and apply ice to the affected areas. Dr. Nayeri indicated claimant could not participate in physical therapy until her blood pressure was under control; Dr. Nayeri indicated claimant "may call" once blood pressure levels were under control. (JE1, p. 4) Dr. Nayeri indicated claimant was not released from care, but could perform regular duties. (JE1, pp. 5, 9)

Later the same day, November 14, 2013, claimant presented to Dr. McKernan, with complaints of an ongoing headache, onset three days prior. He noted additional findings of decreased energy, dizziness, nausea, vision change, and weakness. Dr. McKernan noted a trigger of trauma, falling on ice; he also noted increasingly frequent episodes of hypertension due to pain from the fall. He also noted a trigger of arachnoid cyst. (JE2, p. 32) Additional reported symptoms included neck and back pain. (JE2, p. 33) Dr. McKernan authored a list of "[p]roblems," including: back pain, onset August 15, 2013; headache due to old concussion, onset August 29, 2013; neck pain, onset August 29, 2013; hypertension due to intracranial pressure; motor vehicle accident; seizure disorder; subarachnoid cyst, onset June 25, 2013; and tremor, onset October 25, 2013. (JE2, pp. 35-36) Following examination, Dr. McKernan performed osteopathic manipulation. (JE2, p. 34) He recommended recheck following improvement in pain levels. (JE2, p. 35)

Claimant returned to Dr. McKernan on November 21, 2013. Claimant complained of hypertension, lumbar pain, and mid-neck pain, which Dr. McKernan noted began several years prior. (JE2, p. 37) Dr. McKernan performed osteopathic manipulation and prescribed enalapril maleate to treat claimant's high blood pressure. (JE2, p. 39)

On November 21, 2013, claimant sought evaluation with Dr. Looney. Claimant reported she sought evaluation due to "slow thinking" and the feeling that "her brain was never fully awake." Dr. Looney noted claimant's history of concussion, seizures, arachnoid cyst with surgical intervention, whiplash from motor vehicle accident, thyroid condition, and fall on ice in November 2013. Dr. Looney assessed lymphatic

congestion and possible heavy metal toxicity of the pituitary. He recommended a plan encouraging adrenal and lymphatic drainage. (JE6, p. 137)

On December 6, 2013, claimant returned to Dr. Nayeri. Claimant reported improvement in symptoms, but continued left lumbosacral pain. Dr. Nayeri noted she previously held off on prescribing physical therapy due to high blood pressure; however, claimant had continued the course of physical therapy she was participating in due to a prior motor vehicle accident, as the same body parts were injured. (JE1, p. 11) On examination, Dr. Nayeri noted: negative straight leg testing; normal lumbar range of motion; improved lumbar range of motion; mildly positive diffuse lower back pain at left L5; and normal cervical range of motion. (JE1, pp. 11-12) Dr. Nayeri placed claimant at maximum medical improvement (MMI) and released claimant from care, without restrictions, to return as needed. (JE1, pp. 12, 14, 16)

Claimant resigned her employment with defendant-employer effective December 15, 2013 for a business analyst position at Quality Consulting, Inc. (QCI). In that role, claimant earned $50.00 per hour. (CE10, p. 73; DEA, p. 1; DEC, p. 18; DEF, p. 34) Claimant represented her employment with defendant-employer ended on December 6, 2013, after her project was placed on hold and contractors were being let go. (DEF, p. 33) Claimant's QCI pay stub with a check date of January 3, 2014 is in evidence and reveals claimant worked 64.50 hours; however, the pay period start and end date are both listed as January 3, 2014. (DEC, p. 18; DEK, p. 1)

On January 3, 2014, claimant presented to Dr. McKernan with complaints of neck pain and back pain. Claimant reported an onset of neck symptoms two months' prior; no trigger was noted. Additional symptoms included fatigue, diaphoresis, occasional headache, memory loss, myalgias, and restricted range of motion of the cervical spine. (JE2, pp. 42-43) Claimant also reported undergoing multiple treatments with "her Naturopath" for adrenal fatigue and muscle aches. Claimant reported relief with use of T3. Dr. McKernan performed osteopathic manipulation. (JE2, p. 45)

At physical therapy on January 9, 2014, claimant reported she was "miserable" after starting a new job, with increased stress causing a return of dizziness and nausea. She also complained of left-sided back pain. (JE34, pp. 352-353)

Claimant returned to Dr. Nayeri for recheck on January 15, 2014 due to reported lack of further improvement. Claimant complained of low back, neck, and bilateral knee pain, particularly noticeable in the left low back and left knee. (JE1, p. 17) Following examination, Dr. Nayeri assessed a lumbar strain and left knee contusion. She prescribed ibuprofen 800 mg, Skelaxin, and a course of physical therapy. She released claimant to regular duties. (JE1, p. 18)

On January 16, 2014, claimant presented to Ms. Dankof. Claimant reported a history of three traumatic brain injuries within the last eight years, the most recent of which during a November 2013 fall on ice. Claimant reported back and neck pain, as

well as increased insomnia, memory loss, dizziness, nausea, weakness, and fatigue. Ms. Dankof noted claimant's blood pressure was not controlled. (JE3, p. 76)

Following examination, Ms. Dankof noted claimant's history of traumatic brain injury and arachnoid cyst. She described claimant as more symptomatic over the prior few weeks, following the November fall; but also indicated claimant denied striking her head during the fall. Additionally, Ms. Dankof noted increased stress after claimant recently started a new job. Ms. Dankof opined claimant's recent symptoms were concerning for worsening of the cyst or possible seizure disorder. Due to the complex nature of claimant's case, Ms. Dankof recommended MRI and EEG testing, followed by neurological evaluation. To address claimant's high blood pressure, Ms. Dankof recommended a trial of chlorthalidone. She directed claimant not to drive until a seizure disorder could be ruled out. (JE3, p. 80) Ms. Dankof subsequently excused claimant from work from January 16, 2014 through January 31, 2014. (CE21, p. 214)

Per Ms. Dankof's order, claimant underwent a brain MRI on January 28, 2014. Results were read as stable compared to a brain MRI of August 30, 2013. (JE3, p. 81; JE4, p. 97) That same date, claimant underwent a normal EEG. (JE4, p. 99)

Claimant returned to Ms. Dankof on January 31, 2014 to review her test results. At that time, Ms. Dankof opined claimant's MRI was stable and assessed: arachnoid cyst; cerebromalacia; fatigue; memory lapses or loss; staring spells; and tingling/paresthesia. Following receipt of claimant's EEG results, Ms. Dankof opined the test was normal. Claimant was released to return to work while awaiting neurological evaluation. (JE3, p. 86)

Claimant testified she was off work per Ms. Dankof's orders from January 16, 2014 through February 6, 2014. (Claimant's testimony) Claimant's pay stubs from QCI all follow the same format: the pay period start date, end date, and check date are the same. (DEK, pp. 2-3) Claimant's QCI pay stub with a check date of January 17, 2014 reveals claimant was paid for 72.75 hours for the period with start and end dates of January 17, 2014. (DEK, p. 2) The pay stub with a check date of January 31, 2014 revealed claimant was paid for 62.25 hours for the period with start and end dates of January 31, 2014. (DEK, p. 3) Claimant disputed she worked during the claimed period and testified her pay from QCI was issued one month behind when she worked the hours. (Claimant's testimony)

At physical therapy on February 13, 2014, claimant reported she had been feeling "awful." Claimant indicated she recently returned to work six hours per day after being off for two weeks. Claimant indicated she was suffering with a number of symptoms she related to her "head injury," such as dizziness, high blood pressure, and inability to concentrate. (JE34, p. 353) The outpatient questionnaire from this visit noted an onset of symptoms on August 27, 2012 after claimant's vehicle was rear-ended, resulting in a whiplash injury. (JE34, p. 354)

On February 14, 2014, claimant returned to Dr. Nayeri. On that date, claimant complained of low back pain and spasms, going into the hip area. Dr. Nayeri noted claimant had been receiving treatment with her own physician and physical therapist. She opined claimant had a "significant history which may account for some of the issues" and recommended obtaining claimant's old medical records. In the progress note portion of Dr. Nayeri's record, the described hip pain is localized to the right hip; however, the history portion of the note localizes the pain to the left lower back, lumbar region, and SI joint. (JE1, p. 24) The nursing notes localize the pain to claimant's left hip. (JE1, p. 28)

On examination, Dr. Nayeri noted mildly positive diffuse lower back pain to palpation of the left L5 and sciatic area. Dr. Nayeri described the examination findings as "overreaction" and inconsistent with prior examination. (JE1, p. 25) Dr. Nayeri assessed a lumbar strain and left sciatica. She released claimant to regular duty, prescribed physical therapy, recommended assignment of a case worker, and return within one month. (JE1, pp. 25-27)

Due to headache complaints, claimant presented to personal neurologist, Heike Schmolck, M.D., of Mercy Ruan Neurology Clinic. On February 19, 2014, Dr. Schmolck noted a history of fall on the ice in November, with claimant denying she struck her head. Dr. Schmolck noted claimant "certainly had a whiplash injury," as well as injured her back and hip. Claimant complained of headaches, light and sound sensitivity, difficulty with focus and attention, and nausea with fatigue. Dr. Schmolck noted claimant had not adjusted well to her new job position and became "so stressed out" in January that she had taken two weeks off. Claimant also reported involvement in a motor vehicle accident several months prior to the November fall, but reported she had recovered well, stopped physical therapy, and had been "practically headache free." Claimant denied any cognitive symptoms related to the motor vehicle accident. Dr. Schmolck also noted claimant's 2005 head injury and discovery of an arachnoid cyst. (JE5, p. 100)

Following neurological examination, Dr. Schmolck assessed: memory lapses or loss; cognitive skills – attention and concentration activities; and chronic tension-type headache. Dr. Schmolck opined the whiplash injury with fall accounted for claimant's unresolved headaches and neck pain. Dr. Schmolck described claimant's cognitive symptoms as "more difficult to explain." (JE5, p. 103) Dr. Schmolck indicated such symptoms had been studied in the context of whiplash injuries and also acknowledged a likely component or stress and anxiety. Ultimately, Dr. Schmolck opined there was "no doubt" in her mind that claimant's symptoms were causally related to the November fall. In her analysis, she highlighted the near resolution of prior symptoms before the fall. She further expressed belief the arachnoid cyst was not relevant, nor likely to become relevant, as the cyst was most likely congenital in nature. Dr. Schmolck prescribed Gabapentin and cognitive rehabilitation. (JE5, p. 104)

Claimant returned to Dr. Looney on March 3, 2014. Claimant reported she utilized Gabapentin for pain and sleep, but it yielded side effects of drowsiness and poor thinking into the following day. Dr. Looney instead recommended use of Gaba Calm to help initiate sleep. He recommended physical assessment by Michael Jackson, M.D. (JE6, p. 136)

On March 10, 2014, claimant returned to Dr. Schmolck. Claimant's primary complaint was of significant fatigue and the feelings of being overworked and overwhelmed at work. Claimant confirmed she had been undergoing cognitive therapy. She reported that use of Gabapentin resulted in sedation and potentially increased pain. Dr. Schmolck noted claimant also complained at length regarding "several smaller issues." (JE5, p. 105) Following examination, Dr. Schmolck ordered a lower dosage of Gabapentin and continued cognitive therapy. (JE5, p. 108)

Due to continued complaints, defendants referred claimant for evaluation with Michael Jackson, M.D. Claimant initially presented to Dr. Jackson on March 19, 2014. At that visit, Dr. Jackson noted chief complaints of exhaustion, dizziness, nausea, weakness, and head pain. Claimant indicated she had experienced these symptoms since a fall on the ice on November 11, 2013. During the fall, claimant indicated she also injured her bilateral knees and right shin, as well as "'reinjured'" her back and neck which had been previously injured in a motor vehicle accident. Dr. Jackson detailed claimant's motor vehicle accident in August 2012 and subsequent physical therapy. He noted that just as claimant had reached a point of doing well post-accident, she suffered the November 11, 2013 fall and re-aggravated her symptoms. Dr. Jackson also noted claimant's history of arachnoid cyst, status post two surgeries. (JE6, p. 119)

At the time of evaluation with Dr. Jackson, claimant reported cognitive activities resulted in increased exhaustion and she was unable to tolerate more than approximately four hours of work per day, down from six hours per days a couple weeks prior. Additional reported symptoms included: decreased memory; inability to concentrate; intermittent numbness and tingling of the right upper and lower extremity; stabbing pain in the head, with occasional numbness and pins and needles sensation; low back pain; and neck pain. (JE6, p. 120)

On examination, Dr. Jackson noted: tenderness to palpation in the left cervical paraspinals; minimal pain on palpation of the upper trapezius, rhomboids, and levator scapulae musculature; and slight tenderness to palpation of the mid left thoracic paraspinals. He assessed cervicothoracolumbar strain/sprain secondary to slip and fall, and history of previous head injury and arachnoid cyst. Due to claimant's exhaustion and fatigue, Dr. Jackson imposed a four-hour per day work restriction for the remainder of the week and then removed claimant from work for two weeks, corresponding to the period of March 24 through April 7, 2014. During this time, Dr. Jackson recommended focus upon cognitive therapy and increased the frequency of such sessions to thrice weekly. He recommended claimant continue to use Gaba Calm and ordered a trial of Duexis for headaches. (JE6, pp. 121, 125-126)

Due to Dr. Jackson's removal of claimant from work, defendants commenced payment of temporary total disability benefits. (Claimant's testimony)

On March 27, 2014, a prescription was authored for physical therapy of cervicothoracolumbar strain/sprain secondary to slip and fall. The prescription appears to bear the signature of Dr. Jackson. (JE7, p. 139)

On April 3, 2014, claimant returned to Dr. Jackson for follow up appointment. Claimant reported continued headaches with associated nausea, as well as episodes of left eye blindness. She relayed improvement of neck pain with physical therapy, but slower progress with back complaints. Additionally, claimant's fatigue complaints persisted and she lacked readiness to return to work. Claimant indicated she had a consultation scheduled with Dr. Shahinian to evaluate the arachnoid cyst. Following examination, Dr. Jackson expressed agreement with the pending consultation with Dr. Shahinian and also ordered neuropsychiatric evaluation. In the interim, Dr. Jackson recommended continued medication use and removed claimant from work for an additional two weeks. (JE6, p. 127)

Claimant presented to Mercy Ruan Neurology Clinic on April 16, 2014 and was seen by Meghan Kinnetz, NP. Claimant complained of continued cognitive impairment, physical fatigue, and headaches. Ms. Kinnetz noted claimant was receiving evaluation and care of her complaints by multiple medical providers and had recently been taken off of Gabapentin due to intolerable side effects. Ms. Kinnetz noted claimant was placed on a 50 percent work schedule at her last visit with Dr. Schmolck, but another physician had provided a full duty work release. (JE5, p. 109) As claimant was receiving care from multiple physicians regarding her complaints, Ms. Kinnetz indicated her care would focus upon the assessed chronic tension-type headaches. She recommended use of B2, magnesium, and butterbur herbal supplement. She deferred to the other treating providers regarding any need for work restrictions. (JE5, p. 112)

On April 17, 2014, claimant authored email correspondence to Arnold Menezes, M.D., professor and vice chairman of the University of Iowa Hospitals and Clinics (UIHC) Department of Neurosurgery. She detailed her history of arachnoid cyst with surgical intervention, as well as described subsequent injuries and existing symptoms. She inquired whether it would be of benefit for her to make an appointment at UIHC or whether she should seek to return to Cedar Sinai in California. Dr. Menezes replied and commented that arachnoid cysts were notorious for recurring and noted claimant appeared to demonstrate both neurological and other comorbidities. While UIHC was a tertiary neurosurgical center, Dr. Menezes recommended claimant reach out to Cedar Sinai, as the providers already possessed an understanding of claimant's conditions. (JE8, pp. 140-141)

On April 18, 2014, claimant returned to Dr. Jackson with continued reports of fatigue. Claimant had not yet undergone neuropsychological evaluation, but had undergone consultation with Dr. Shahinian, with test results pending. Dr. Jackson opined claimant was doing very well in terms of her neck and low back, noting claimant

seemed to have made a breakthrough in her treatment of these symptoms. Examination revealed only mild tenderness to palpation of the left upper thoracic paraspinals; no significant tenderness of the cervical or lumbar paraspinous musculature was found. Dr. Jackson noted spinal range of motion within functional limits and noted no complaints of SI joint pain. Following examination, Dr. Jackson recommended: continued evaluation with Drs. Shahinian and Looney; continued medication use; neuropsychological evaluation; and continued off work status. (JE6, pp. 129-130)

Claimant returned to Dr. Jackson on May 2, 2014. Dr. Jackson noted that following evaluation, Dr. Shahinian did not recommend further surgery and instead recommended claimant take time to heal from her accumulative brain trauma, specifically beginning with the December 2008 surgery and damaged further in the 2012 motor vehicle accident. Dr. Jackson noted claimant continued to benefit from physical therapy of her cervical, thoracic, and lumbar spine. Claimant reported some improvement in fatigue until a recent increase, with accompanying nausea, loss of balance, and dizziness. Claimant indicated she spoke to a representative of the AMEN Clinic, who recommended a SPECT scan and hyperbaric oxygen treatment to promote brain healing. Dr. Jackson recommended continued off work status while he sought to review all of claimant's medical records. He noted that a causation opinion needed to be made and this would be done following review of medical records. (JE6, p. 131)

Claimant's employment with QCI ended in early May 2014. (CE10, p. 73; DEC, p. 19) Per a QCI representative, claimant had been hired to provide services to a particular client and that client no longer needed her services. As a result, claimant's employment was separated. She did not quit, nor did QCI fire her for cause. (DEC, p. 20)

Claimant returned to Ms. Dankof on May 12, 2014 regarding chronic fatigue. Ms. Dankof noted claimant's fatigue had worsened over the prior year "following whiplash and then a fall." Ms. Dankof recommended further evaluation of cortisol levels, as well as potential gluten sensitivity. (JE3, p. 91)

Following a session on May 27, 2014, claimant's physical therapist indicated it would be appropriate to discontinue physical therapy, as claimant's back symptoms had resolved. If symptoms flared, physical therapy could resume. (JE3, p. 356)

On May 30, 2014, claimant returned to Dr. Jackson. He noted claimant had recently been discharged from physical therapy after meeting all goals. Claimant reported some weakness, as well as unchanged fatigue and skin rashes of unknown etiology. Claimant expressed interest in pursuing hyperbaric oxygen treatments for brain healing. Dr. Jackson noted claimant had follow up evaluations scheduled with a neurologist and a specialist in Iowa City. (JE6, p. 135) Following examination, Dr. Jackson placed claimant at MMI from her cervical, thoracic, and lumbar sprain/strains. He released claimant to work without restrictions with respect to her musculoskeletal

injuries. Dr. Jackson discharged claimant from his care and referred her to neurology regarding ongoing cognition and fatigue complaints. (JE6, pp. 133, 135)

On June 11, 2014, claimant returned to Ms. Kinnetz at Mercy Ruan Neurology Clinic in follow up of headache complaints. Ms. Kinnetz indicated claimant was "extremely interested" in pursuing hyperbaric oxygen therapy, but was unable to find a physician to issue such a referral. Claimant reported she had undergone cognitive therapy, but was deemed too high functioning to continue, per her therapist. Ms. Kinnetz noted claimant was scheduled for neurocognitive testing the following month. Claimant also reported she had lost her job due to her physical and cognitive complaints and was struggling financially. (JE5, p. 113)

Ms. Kinnetz noted claimant was previously placed on B2, magnesium, and butterbur, but had discontinued their use on advise of another practitioner who was attempting to identify the cause of a rash on claimant's body. Claimant declined additional pharmacological interventions for headaches. (JE5, p. 113, 116) Ms. Kinnetz expressed belief depression contributed to claimant's symptoms; claimant expressed resistance to this concept and denied need for antidepressant medication. Ms. Kinnetz encouraged claimant to continue cognitive therapy, potentially with another therapist. She also recommended claimant reach out to the Brain Injury Alliance regarding additional resources. Claimant was advised to follow up with Dr. Schmolck following neurocognitive testing, if desired. (JE5, p. 116)

On June 12, 2014, claimant returned to Dr. Angel and requested to discuss hyperbaric therapy and a referral to endocrinology. (JE3, p. 92) Following examination, Dr. Angel assessed: fatigue; nausea; arachnoid cyst; episode of memory loss; and hypertension. (JE3, p. 95) Dr. Angel noted claimant's history of arachnoid cyst, diagnosis of postconcussive syndrome, and documented low cortisol levels. He opined claimant exhibited "cognitive deficits that [were] fairly consistent with executive processes." Dr. Angel opined claimant's "functional status deteriorated" following the November 2013 fall. He recommended referral for neurocognitive testing and to Dr. Bhargava, due to the possibility of pituitary dysfunction. (JE3, p. 96)

On July 3, 2014, Dr. Jackson authored an updated work-status form. Thereby, he opined claimant remained at MMI and could work without restrictions with respect to her musculoskeletal injuries. He recommended continued follow up with neurology regarding cognition and fatigue. (JE6, p. 134)

At defendants' referral, on July 30, 2014, claimant presented to neuropsychologist, Daniel Tranel, Ph.D., of UIHC, for an independent medical evaluation (IME) related to the November 2013 fall. Dr. Tranel reviewed extensive medical records and summarized those records in his 32-page August 4, 2014 report. (DEI, pp. 64-85) Dr. Tranel noted claimant's medical records after the November 2013 fall revealed she did not strike her head, did not lose consciousness, and did not experience posttraumatic amnesia. He found no medical evidence that claimant sustained a traumatic brain injury or concussion in the incident and further opined the

mechanism of fall was "not plausible for a significant brain injury." He found no evidence claimant sustained a permanent neurological injury in the incident. (DEI, pp. 62, 94)

Dr. Tranel administered a neuropsychological evaluation, including clinical interview, tests, and procedures. (DEI, pp. 86-92) He opined claimant's performances fell within normal expectations on symptom validity. (DEI, p. 92) Dr. Tranel opined the evaluation results yielded normal cognitive performances. He identified many of claimant's abilities were above average, with average to superior intellectual abilities, as well as normal memory, speech and language, perception, construction, attention, concentration, orientation, and executive functioning. (DEI, pp. 62, 92-93, 94) He opined these results were consistent with the prior neuropsychological assessments of Dr. Campbell in 2006 and Dr. Andrikopolous in 2008. Dr. Tranel opined the neuropsychological examination confirmed claimant had intact, normal neurological status, without indication of brain damage related to the November 2013 fall. He further opined claimant did not present with any cognitive or behavioral deficits related to the incident. (DEI, pp. 62, 94)

Dr. Tranel opined claimant self-reported a level of symptoms consistent with minimal depression and anxiety. On a broader measure, Dr. Tranel identified a profile "notable for profound overemphasis and over-reporting of symptoms." Clinical scale elevations yielded results significant for intense somatic focus and emotional turmoil. (DEI, p. 93)

Following evaluation, Dr. Tranel opined claimant's medical records indicated claimant had a somatic symptom disorder of longstanding nature, predating the November 2013 fall by many years. He opined this condition directly contributed to a number of medical events and outcomes over the preceding decade. Dr. Tranel highlighted the July 2005 work injury where claimant developed a number of physical, cognitive, and psychiatric symptoms despite being struck by a ball "so soft and light that it was entirely implausible" for it to have caused a head injury or traumatic brain injury. He noted contemporaneous imaging revealed an incidental arachnoid cyst, which local providers opined was asymptomatic and did not require surgery. Despite these opinions, claimant located willing surgeons in California and during the second surgery, a complication arose, namely a hemorrhage, that produced parenchymal injury in the left frontal and temporal regions. He opined these represented the only areas of parenchymal damage in claimant's brain. (DEI, pp. 63, 94-95)

From a neuropsychological standpoint, Dr. Tranel opined claimant's primary diagnosis was somatic symptom disorder, which predated the incident. Dr. Tranel ultimately opined claimant "does not have any diagnosis or condition related to" the fall in November 2013. He further opined the incident did not aggravate any preexisting conditions. He opined claimant had achieved MMI and would have done so within approximately one week of the incident, on or about November 18, 2013. Dr. Tranel expressed belief claimant did not demonstrate any problems, nor did she require any further testing or treatment, related to the incident. He believed claimant capable of

working at the same level as prior to the November 13, 2013 fall and she did not require restrictions related to the incident. (DEI, pp. 63, 95) Dr. Tranel further recommended:

> [Claimant] should be firmly disabused of any notion that she has permanent brain damage or dysfunction related to the 11/11/13 incident. She is susceptible to iatrogenic influences from well-intentioned experts, and it is critical that she be provided accurate information that is based on facts in the medical record (and not her self-report). Conservative management with reassurance and support are indicated.

(DEI, pp. 63, 95)

Following receipt of Dr. Tranel's report, defendants denied further liability and thereafter, declined authorization of additional medical care. Following notice, defendants ceased payment of temporary total disability benefits. (Claimant's testimony)

On August 6, 2014, pursuant to a referral from Dr. Angel, claimant presented to Teck Khoo, M.D., for evaluation of potential pituitary dysfunction. Dr. Khoo indicated he was uncertain why claimant was being seen from a hormonal standpoint. Following examination, Dr. Khoo assured claimant there was no radiologic or biochemical evidence of hormonal problems. (JE38, pp. 393-395)

Claimant was involved in a motor vehicle accident on August 8, 2014. At the time of the accident, claimant was sitting at a stop sign and her vehicle was struck from behind. She was transported to the emergency room with complaints of a stiff neck, headache, and dizziness. (JE9, p. 152; JE36, pp. 372-374) Claimant underwent a cervical spine CT, which revealed no fracture or dislocation. (JE9, p. 154) A head CT yielded stable results as compared to a prior February 2013 exam. (JE9, p. 155) Claimant was diagnosed with no serious injury following the motor vehicle accident. (JE36, p. 374)

At the orders of Dr. Angel, claimant underwent a cervical MRI on August 11, 2014, which revealed mild degenerative changes without significant central canal or neural foraminal compromise. (JE9, p. 156) Claimant returned to Dr. Angel the following day, August 12, 2014. At that time, claimant reported mild increase in headache and increased fatigue. (JE10, p. 160) Dr. Angel examined claimant and reviewed the imaging results. He opined claimant was stable and no intervention was required. (JE10, pp. 163-164)

Claimant testified her physical and neurological symptoms worsened following the motor vehicle accident. She testified her neurological symptoms returned to baseline after approximately three weeks. (Claimant's testimony)

On October 9, 2014, claimant presented to UIHC neurologist, E. Torage Shivapour, M.D. Claimant sought evaluation of pain, vertigo, fatigue, nausea, memory

loss, and numbness/weakness of the extremities. Dr. Shivapour detailed claimant's history of being struck in the head in 2005, arachnoid cyst with surgical intervention, 2012 motor vehicle accident, partial seizure events, and November 2013 fall on ice. During the November 2013 fall, claimant reported no loss of consciousness and that she did not strike her head. Claimant also disclosed involvement in an August 2014 motor vehicle accident and subsequent worsening of her symptoms. (JE8, pp. 147-148) Following review of testing and neurologic examination, Dr. Shivapour opined the cause of claimant's neurological status was unclear. He indicated the location of the arachnoid cyst did not explain her symptoms. Dr. Shivapour indicated he had no further treatment or testing to provide; he advised claimant to seek other opinions due to her expressed interest in undergoing functional imaging such as a SPECT or PET scan. (JE8, p. 151)

At the referral of Ms. Dankof, on October 15, 2014, claimant presented to Iowa Ortho. Kurt Smith, D.O., evaluated claimant for complaints of mid and low back pain, radiating to the left thigh. Dr. Smith noted the context of complaints as a motor vehicle accident in August 2014. (JE11, p. 223) Dr. Smith performed a physical examination and reviewed claimant's prior diagnostic studies. Thereafter, he assessed a lumbar sprain/strain. Dr. Smith ordered continued therapy and a lumbar spine MRI. (JE11, pp. 235-236) Per the orders of Dr. Smith, claimant underwent a lumbar spine MRI on October 22, 2014. The results were read as revealing: mild degenerative changes in the lower lumbar spine with mild disc bulging at L4-L5 and L5-S1, without visible focal disc herniation or high-grade central canal or neural foraminal stenosis; and atrophy of the posterior paraspinals musculature. (JE9, p. 157)

At the referral of Dr. Angel, on October 22, 2014, claimant presented to UIHC endocrinologist, Joseph Dillon, M.D., due to concern of pituitary damage following multiple head traumas. (JE8, p. 142) Following physical examination and laboratory tests, Dr. Dillon found no evidence of hormonal dysfunction and opined no follow up appointment was required. (JE8, pp. 145-146)

On October 28, 2014, claimant presented to the University of Nebraska Medical Center (UNMC) for evaluation of pituitary/hypothalamic dysfunction with Andjela Drincic, M.D. Dr. Drincic noted claimant's history of 2005 head injury, arachnoid cyst with surgical intervention, 2012 motor vehicle accident, and November 2013 fall on ice. Dr. Drincic described the November 2013 fall as a cervical whiplash injury, without reported head injury. Claimant reported progressively worsening fatigue dating to 2012; she also noted some cognitive dysfunction, memory issues, and difficulty learning. (JE12, p. 245)

Dr. Drincic performed a physical examination and reviewed claimant's laboratory results and recent brain MRI. Dr. Drincic indicated claimant's cognitive complaints could possibly be due to traumatic brain injury or hypopituitarism. (JE12, pp. 246-247) She opined claimant's complaints were common consequences of traumatic brain injury, which is best treated by an interdisciplinary team. Dr. Drincic ordered a pituitary hormone panel and glucagon stimulation testing. She referred claimant for

neurosurgical evaluation of the arachnoid cyst and psychiatry for care specific to traumatic brain injury. Dr. Drincic indicated she would try to obtain claimant's neurocognitive testing results and discuss her treatment options with other providers. (JE12, p. 248)

Claimant thereafter returned to Dr. Smith on November 5, 2014. Dr. Smith opined claimant's MRI revealed degenerative changes of the lower lumbar region. He opined claimant's back and gluteal symptoms were related to a muscular strain and should improve with time. Dr. Smith indicated claimant could follow up as needed. (JE11, pp. 239)

On November 10, 2014, claimant returned to Dr. Drincic for glucagon stimulation test. Dr. Drincic noted the initial laboratory results were not suggestive of major pituitary dysfunction. (JE39, p. 401) Dr. Drincic expressed belief claimant's symptoms were part of traumatic brain injury symptomatology. She issued a referral to Dr. Travis Groft, described as a specialist in the neuropsychiatric consequences of traumatic brain injury. (JE39, p. 403)

On December 9, 2014, claimant returned to Dr. Angel with continued complaints of headaches, nausea, inability to sleep, fatigue, and memory issues. Claimant reported an ability to read, but inability to recall details. (JE10, p. 165) Following examination, Dr. Angel assessed subarachnoid cyst, multiple closed head injuries, and symptoms out of proportion to MRI findings. He noted claimant had been evaluated by neurology and no intervention was recommended; he indicated claimant was treated more as a headache patient during that evaluation. (JE10, p. 168) Dr. Angel indicated UIHC recommended a referral to the Cleveland Clinic, which he described as not an option. Dr. Angel opined claimant's workup at UNMC showed mild nonspecific neuroendocrine changes and referred for neurosurgical evaluation. Dr. Angel also mentioned evaluation for traumatic brain injury and consult with Madonna Lincoln Roscoe, as potential next steps. Dr. Angel limited claimant to 4-hour work days, 5 days per week. He noted claimant was a possible candidate for Social Security Disability benefits and indicated a second opinion from a disability physician could be an option. (JE10, p. 169)

At the referral of Dr. Drincic, on December 11, 2014, claimant presented to psychologist, Roger Riss, Psy.D., of Madonna Rehabilitation. Mr. Riss opined his findings were largely consistent with those of Dr. Tranel and other providers which identified overall intact neurocognitive abilities. (JE35, p. 36) He recommended psychological counseling as a component of claimant's medical care. (JE35, p. 368)

On December 16, 2014, claimant's former attorney authored a letter to Dr. Angel. Thereby, counsel detailed opinions claimant indicated had been expressed by Dr. Angel at a December 9, 2014 medical appointment. The opinions included: the fall of November 11, 2013 represented a significant and material aggravation of the brain cyst with worsened symptomatology; the symptoms Dr. Angel had treated since that date were attributable to the aggravation; and all said treatment and referrals for care were

reasonable and necessary in treatment of the aggravation. Permanent restrictions were also denoted as: working 4 to 6 hours per day, 4 to 5 days per week; the need to take 2 to 3 hour breaks as needed; and it is best to work in a low stress environment. Dr. Angel signed the letter, indicating his agreement with the expressed opinions. (CE4, p. 59)

At the referral of Dr. Drincic, claimant presented to the UNMC neurosurgery department on December 17, 2014. At that time, claimant was examined by Leslie Hellbusch, M.D. and Melissa Rasmussen, PA. Claimant reported a history of 2005 head injury and arachnoid cyst with two surgical interventions. Claimant reported redevelopment of related symptoms and progressive worsening of complaints over the prior three to four years. Claimant attributed the worsening to multiple head injuries "from motor vehicle accident and slipping and falling on ice." Claimant also disclosed a history of three partial seizures. (JE13, p. 249) Dr. Hellbusch ordered an updated brain MRI, but informed claimant a number of her symptoms were related to endocrine abnormalities rather than the arachnoid cyst. Dr. Hellbusch indicated claimant could return following receipt of the MRI, her endocrine studies, prior neuropsychological testing, and sleep study. (JE13, p. 251)

Claimant underwent a sleep study on January 7, 2015 at the direction of Dr. Angel. (JE14, p. 253) Per the orders of Dr. Angel, claimant underwent a brain MRI on January 22, 2015. The radiologist observed little interval change as compared to the January 2014 study. (JE9, p. 158; JE10, p. 170) Claimant returned to Dr. Angel on February 5, 2015 for MRI review. Dr. Angel reviewed the MRI and opined it revealed little interval change. He noted a copy of the disc containing the MRI films and the accompanying report would be sent to UNMC. Dr. Angel indicated he would defer to the evaluating neurosurgeon. (JE10, pp. 171, 175)

On March 2, 2015, Dr. Angel and claimant discussed hyperbaric oxygen therapy. Claimant indicated she intended to participate in a Louisiana State University (LSU) study. Dr. Angel expressed belief this was a "good idea." (JE10, p. 176) On March 13, 2015, claimant returned to Dr. Angel in follow up of neuralgia complaints. Claimant had not begun use of previously prescribed medication and stated she felt more fatigued than usual, but would be starting hyperbaric treatments and should not begin a new medication at this time. Dr. Angel expressed support for claimant's pursuit of hyperbaric treatment and held off on a new medication regimen. (JE10, p. 177)

On June 16, 2015, claimant underwent a SPECT study. The reading physician identified a pattern of defect which could be compatible with traumatic brain injury and recommended correlation to anatomic imaging. (JE15, p. 254) Claimant underwent repeat SPECT study on October 19, 2015. The results were read as similar to the prior examination, with the exception of a slightly more depressed right basal ganglion. (JE15, p. 255)

Paul Harch, M.D., reviewed claimant's SPECT studies of June and October 2015. In review of the June 2015 scan, Dr. Harch observed a constellation of findings

consistent with history of traumatic brain injury and resection of arachnoid cyst. (JE17, p. 264) Dr. Harch also reviewed the October 2015 scan and compared it to the study of June 2015. He offered an impression of homogenous, near normal, SPECT brain blood flow scan, with marked improvement after hyperbaric oxygen therapy. (JE17, p. 263)

Claimant presented to Ms. Dankof on March 4, 2016 in follow up of a February 2016 fall at home. Complaints of increased "[traumatic brain injury] symptoms," including headaches, fatigue, dizziness, and nausea were noted. (JE10, p. 186) Due to claimant's history of head injuries and increase in symptoms, Ms. Dankof ordered a brain MRI. (JE10, p. 190)

Per the orders of Ms. Dankof, claimant underwent a head MRI on March 22, 2016. The radiologist opined the study revealed stable encephalomalacia changes of the left temporal and left inferior frontal lobes, probably posttraumatic, but no new abnormalities. (JE9, p. 159; JE10, p. 191)

Following the brain MRI, claimant returned to Dr. Angel on April 7, 2016. Dr. Angel noted increased and persistent complaints of fatigue, dizziness, nausea, and headaches following the February 2016 fall. (JE10, p. 192) Following examination and review of claimant's hyperbaric treatment records, Dr. Angel opined claimant demonstrated an arachnoid cyst with "recent small injury" which likely caused a flare in symptoms. He indicated claimant appeared to be responding positively to hyperbaric oxygen treatments. (JE10, p. 195)

On April 13, 2016, claimant returned to Dr. McKernan. Dr. McKernan noted claimant presented for care of her neck and back pain and had suffered a fall at home in February 2016. During that fall, claimant struck her knees and face, causing a black eye, swollen nose, left eye hemorrhage, and a cracked bone and blood vessel damage around the right eye. (JE2, p. 54) In discussion of symptoms, claimant complained of muscle pain, decreased range of motion, stiffness, neck pain, back pain, and hip pain. (JE2, p. 55) Dr. McKernan performed osteopathic manipulation. (JE2, p. 56)

Dr. Angel authored a letter dated May 10, 2016, whereby he opined claimant had been compliant with treatment. (CE5, p. 61) He opined claimant was not capable of working full time and demonstrated decreased processing, which worsened under high stress situations. With unpredictable waxing and waning symptoms, Dr. Angel noted periods where claimant was almost completely incapacitated from cognitive function. He also noted claimant suffered from acute episodes of fatigue with intermittent pain, which improved following breaks of 10 to 15 minutes. (CE5, p. 62)

Claimant returned to Dr. Angel on September 22, 2016. Claimant reported a number of improvements in her symptomatology following hyperbaric oxygen treatment. (JE10, p. 197) Dr. Angel opined claimant's condition had improved. (JE10, p. 201)

On October 11, 2016, claimant presented to Dr. McKernan with reports of left hip and back pain. The back pain was denoted as localized in the left lower back, radiating down the left leg. (JE2, p. 60) Dr. McKernan performed osteopathic manipulation and recommended application of moist heat packs. (JE2, pp. 62-63)

Claimant returned to Dr. McKernan on February 7, 2017 with complaints of left hip, buttock, and low back pain. Dr. McKernan assessed low back pain and cervicalgia; he performed osteopathic manipulation. (JE37, pp. 390-392)

Claimant applied for Social Security Disability benefits, alleging disability beginning March 24, 2014. Her claim was denied initially in November 2014 and again on reconsideration in March 2015. Claimant filed a request for hearing and a hearing was held on February 9, 2017. Thereafter, claimant's application for Social Security Disability benefits was denied by an administrative law judge's decision, issued March 30, 2017. (DEG, pp. 35, 38) The presiding administrative law judge authored an 18-page decision, by which he determined claimant demonstrated the following severe impairments: cervicalgia; coronary artery disease; hypersomnia; trigeminal neuralgia; somatoform disorder; and history of traumatic brain injury. (DEG, p. 40) He ultimately found claimant had not been under a disability within the meaning of the Social Security Act. (DEG, pp. 38, 55) Claimant requested review of the administrative law judge's decision and submitted reasons she disagreed with the decision. Following review, the appeals council determined the supplied reasons did not provide a basis for changing the decision and denied claimant's request for review. (DEG, p. 56)

From April 26, 2017 through July 21, 2017, claimant underwent outpatient speech therapy treatment with speech-language pathologist Courtney Huber of On With Life Outpatient Neurorehabilitation. Treatment centered on cognitive-communication deficits related to a medical diagnosis of post-concussive syndrome. At the time of her discharge, claimant had begun volunteering at a parish, completing clerical work. Claimant tracked her fatigue and stamina symptoms from July 20, 2017 through August 22, 2017 and provided those logs to Ms. Huber for review. Ms. Huber did so and authored a status note on August 28, 2017. Thereby, Ms. Huber noted a shift of three-hour length exacerbated claimant's symptoms of exhaustion, weakness, dizziness, and nausea, to a degree she was forced to cancel her next volunteer shift. As a result, Ms. Huber recommended claimant limit her shift length to 1.5 hours, which could be gradually increased in the event claimant's symptoms improved. (CE7, p. 64)

On February 16, 2017, claimant returned to Dr. Angel. Claimant indicated she finished hyperbaric oxygen treatment in December and had since noticed increased fatigue, dizziness, and headaches. (JE10, p. 202) Dr. Angel prescribed medication for encephalomalacia. He raised the possibility in cognitive therapy due to "problems with executive processing." Dr. Angel also expressed concern about achieving control of claimant's hypertension. (JE10, p. 206)

On April 3, 2017, claimant telephoned Dr. Angel's office with complaints of SI joint pain. Claimant reported her hip popped during physical therapy the prior day and her muscles were now so tight she could not walk. Dr. Angel prescribed Skelaxin. (JE10, pp. 207-208)

Claimant returned to Dr. Angel on April 17, 2017 to discuss cognitive rehabilitation. (JE10, p. 209) Following examination, Dr. Angel opined the arachnoid cyst was stable and he did not recommend an additional MRI or surgical intervention. Due to worsened cognitive deficits, he referred claimant to On With Life for speech and occupational therapy. He also recommended recheck of claimant's blood pressure two to three times per week due to hypertension. (JE10, p. 213)

On June 23, 2017, claimant returned to Ms. Dankof with complaints of "major fatigue," dizziness, balance issues, ringing in ears, and shakiness. (JE10, p. 214) Ms. Dankof ordered a series of laboratory studies. (JE10, pp. 218-219) Claimant returned to Dr. Angel on June 30, 2017. Claimant reported improvement, but continued fatigue. Dr. Angel noted claimant's blood pressure had increased over the previous months. (JE10, p. 220) Dr. Angel ordered medication to treat hypertension, as well as hormone testing per Ms. Dankof. He also recommended claimant continue cognitive therapy. (JE10, pp. 223-224)

Claimant sought vocational assistance with Iowa Workforce Development. (Claimant's testimony) By a determination dated August 18, 2017, Iowa Vocational Rehabilitation Services placed claimant in the "most significantly disabled" waiting list category. (CE6, p. 63) She was released from the program in December 2017, as she was unable to tolerate the required 20 hours of work per week. (Claimant's testimony)

On September 7, 2017, claimant presented to Dr. Angel. Claimant reported suffering with "ice pick" headaches with associated dizziness and impacted balance. (JE10, p. 225) Claimant reported improvement in headaches compared to three years prior. Dr. Angel indicated claimant had failed multiple hypertensive medications and prescribed a trial of verapamil. (JE10, pp. 225, 229)

On January 24, 2018, claimant telephoned Ms. Dankof's office with questions about her progesterone dosage. Ms. Dankof opined the dosage was not too high and recommended endocrinology evaluation given claimant's lab findings and history of head injuries. (JE10, p. 230) Pursuant to Ms. Dankof's referral, on February 8, 2018, claimant was seen by Nancy Kane, M.D., for evaluation of possible pituitary issues. Following examination, Dr. Kane assured claimant her testing revealed no radiologic or biochemical evidence of hormonal issues. (JE38, pp. 396-399)

Claimant returned to Dr. McKernan on March 6, 2018. Claimant reported recurrent left low back pain with left leg radiation which dissipated, but returned due to fatigue. (JE2, p. 66) Osteopathic manipulation was again performed. (JE2, p. 68)

At the referral of her attorney, claimant underwent an independent neuropsychological evaluation with clinical neuropsychologist, David Demarest, Ph.D., of On With Life. As elements of the evaluation, claimant participated in clinical interview and comprehensive neuropsychological testing on May 23 and May 25, 2018. Dr. Demarest performed a review of claimant's medical records. He noted he did not have copies of neuropsychological evaluations previously performed by Dr. Susan Andrews. (CE3, pp. 46-48)

Dr. Demarest interviewed claimant independently and in conjunction with her father and son. Claimant also underwent a battery of neuropsychological testing over a two-day period. Dr. Demarest noted his time in evaluation, interview, records review, testing, feedback, and report writing, at no less than 15.5 hours. (CE3, p. 48) Dr. Demarest noted the clinical interviews lasted 3 hours; he detailed the content of said interviews. (CE3, pp. 48-52)

Dr. Demarest opined validity testing did not indicate frank malingering or less than optimal effort. (CE3, p. 52) Dr. Demarest opined claimant's test scores fell in the moderate clinical depression range, as well as the severe clinical anxiety range. (CE3, pp. 53-54) He found claimant's intellectual status fell no lower than average, with some skills falling in or above the high average range. (CE3, pp. 53-56) Dr. Demarest opined he found "very little, and not compelling data… for postulation of organic memory dysfunction." He further opined there was not data to support findings of cognitive impairment or postconcussional syndrome. (CE3, p. 56)

Dr. Demarest opined the inclusion of traumatic brain injury in claimant's medical records was not well-established. He posited the inclusion had perhaps resulted from practitioners' opining without the benefit of all the evidence. Dr. Demarest opined neuropsychologists hold the unique position of making such determinations after review of all the relevant data. He identified consistency amongst four evaluating neuropsychologists in opining there was, or may well be, psychological overlay in claimant's case. He further opined that factors such as sleep disturbance, mood disturbance, and pain might be relevant in understanding claimant's cognitive inefficiency. Dr. Demarest noted evidence of brain dysfunction on MRI/CT scans, but opined the findings appeared to reflect chronic and stable encephalomalacia following cyst removal. (CE3, p. 57)

Dr. Demarest expressed belief claimant appeared "convinced" she suffered with brain injury, despite neuropsychological data which "broadly" did not support her conclusion. (CE3, p. 58) Dr. Demarest referenced an email authored by claimant in support of his opinion. Therein, claimant referred to herself as a "BI (brain injury) survivor with a history of at least six brain injuries from various accidents." (CE3, p. 57)

Dr. Demarest opined claimant's mood, pain, and sleep difficulties did not help claimant's cognitive efficiency and required intervention. He also recommended discussion of psychotropic medication to treat anxiety and depression, as it also related to pain and cognitive functioning. While frank malingering was not indicated on

examination, Dr. Demarest recommended consideration of possible conversion disorder. He described malingering as measuring more conscious factors, as opposed to unconscious psychological factors. (CE3, p. 57)

On June 1, 2018, claimant returned to Dr. McKernan with complaints of left low back pain, worsening over the prior six days. Dr. McKernan also noted radiation to the left leg. (JE2, p. 71) Dr. McKernan performed osteopathic manipulation and recommended stretching and ice massage. (JE2, p. 73)

Claimant's counsel arranged for claimant to undergo an independent medical evaluation (IME) with board certified occupational medicine physician, Sunil Bansal, M.D. Dr. Bansal examined and interviewed claimant on July 5, 2018; he authored a report containing his findings and opinions dated July 17, 2018. (See CE1)

As an element of his evaluation, Dr. Bansal performed a records review and authored an extensive summary of records, nearly 39 pages in length. (CE1, pp. 1-39) In the subjective portion of his report, Dr. Bansal noted claimant suffered an injury on November 11, 2013 when she slipped on ice, landing on her "back and left side." Dr. Bansal noted the fall resulted in injuries to claimant's head, neck, back, and left hip. (CE1, p. 39) Claimant reported continued and worsened fatigue, daily headaches, difficulty with concentration and memory, impacted balance and sleep, dizziness, and increased neurological problems following the injury. Claimant also reported constant left-sided neck pain, constant back pain radiating down her left leg, numbness of the left leg and foot, and constant left hip pain. (CE1, p. 40)

Dr. Bansal performed a physical examination. On examination, he found: tenderness to palpation over the left cervical paraspinals musculature, greater on the left; spasms over the left cervical paraspinals; tenderness to palpation over the lower lumbar paraspinals; tenderness to palpation into the left greater trochanter; positive McCarthy sign in internal and external rotation of the left hip; left trochanteric bursal swelling; and loss of sensory discrimination over the left 4th and 5th toes. Dr. Bansal also denoted measurements for range of motion of claimant's neck, back, and left hip. (CE1, pp. 41-42)

Following records review, interview, and examination, Dr. Bansal responded to discussion questions posed by claimant's counsel. Dr. Bansal was asked to focus upon conditions of claimant's head, neck, back, and left hip. In response to inquiry as to whether claimant had achieved MMI and if so, the extent of any permanent impairment, Dr. Bansal only addressed claimant's left hip. (CE1, p. 42)

With respect to causal connection between claimant's work injury and impacted body parts, Dr. Bansal opined:

> In my medical opinion, [claimant] presents as a complex case with significant prior and interim history related to a series of falls and accidents, resulting in significant neurologic, cervical spine, and lumbar

> spine related disability. The left hip has a clear etiologic relationship to the November 11, 2013 injury. This is based on a temporal relationship as well as mechanistic as she landed on her left side during the fall.

(CE1, p. 43)

Dr. Bansal opined claimant demonstrated swelling of the trochanteric bursa, consistent with trochanteric bursitis, as well as examination findings consistent with a labral tear. He opined the November 11, 2013 fall "onto her left side" was a significant contributing factor in claimant's left hip condition. Dr. Bansal further opined claimant's left hip condition was work-related. (CE1, p. 43) He recommended a diagnostic MRI of claimant's left hip, with the results potentially indicating a need for cortisone injections, physical therapy, and/or surgical intervention. Absent further treatment, placed claimant at MMI as of the date of his examination on July 5, 2018. (CE1, pp. 42, 44)

Dr. Bansal opined claimant sustained permanent impairment due to decrements in hip range of motion. By his charted findings, Dr. Bansal noted a 2 percent whole person impairment for external rotation; his narrative report denotes a total 4 percent whole person impairment. (CE1, p. 43) Dr. Bansal recommended restrictions of: no frequent bending, squatting, climbing, or twisting; no prolonged standing or walking greater than 60 minutes at a time; and avoidance of multiple steps, stairs, or ladders. He opined claimant's left hip condition did not prevent her from returning to her former work. (CE1, p. 44)

An invoice for Dr. Bansal's IME identifies a physical examination cost of $607.00 and a report cost of $3,361.00, for a total IME cost of $3,968.00. (CE18, p. 100)

Defense counsel provided updated medical records to Dr. Tranel for review. Following review, Dr. Tranel authored a supplemental report dated July 28, 2018. Thereby, Dr. Tranel noted claimant had undergone two comprehensive neuropsychological evaluations, with Dr. Riss and Dr. Demarest, since the date of his evaluation on July 30, 2014. He summarized the findings and opinions of these providers. Following review, Dr. Tranel opined their findings and conclusions were consistent with those he previously expressed. He noted both found essentially intact cognitive functioning and evidence of elevated somatic symptom reporting. (DEI, pp. 96-97)

Dr. Tranel indicated claimant's medical history contained five neuropsychological evaluations, all of which concluded claimant did not have cognitive impairments, but did have elevated somatic symptom reporting. He noted three evaluations had been performed post-November 2013 fall and made it "clear beyond any reasonable doubt" that claimant did not have any neuropsychological dysfunction related to the incident. (DEI, p. 97) Dr. Tranel went on:

> In fact, I would go so far as to say that in my many decades of practice as a clinical neuropsychologist, I have almost never seen this degree of

> replication and consistency in documentation of intact cognitive functioning by many different providers on many different occasions. The evidence for intact cognitive functioning is, in a word, incontrovertible.

(DEI, p. 97)

Dr. Tranel indicated his opinions remained unchanged from those expressed in his 2014 report. He opined claimant's medical records definitively and unequivocally documented claimant did not sustain any neuropsychological injury in the November 2013 fall. Accordingly, he found no basis to causally relate any subsequent neurologically-related treatment to the incident. (DEI, p. 97) Specifically, Dr. Tranel opined none of the neurological treatment since November 11, 2013 was causally related to the injury on that date, including hyperbaric treatment, care at On With Life, and any psychological/psychiatric treatment. (DEI, pp. 97-99) He also opined claimant's perceived endocrine problems or fatigue related to "brain injury" were not causally related to the November 2013 incident. (DEI, p. 98) Dr. Tranel opined, with increased certainty, that claimant had a somatic symptom disorder and presented as a "prototype, textbook example" of such. (DEI, p. 99)

Defendants' counsel conferenced with Dr. Jackson regarding claimant's care and the opinions offered by Dr. Bansal. Thereafter, on August 2, 2018, defense counsel authored a letter to Dr. Jackson purporting to summarize the content of their conference. Dr. Jackson signed the letter the same day, expressing agreement with the contained statements. By the letter, Dr. Jackson confirmed: he treated claimant for musculoskeletal complaints from March 19, 2014 to July 3, 2014; claimant was placed at MMI on May 30, 2014; and claimant sustained no permanent impairment and required no restrictions from a musculoskeletal standpoint. Dr. Jackson expressly disagreed with Dr. Bansal's opinion that claimant sustained a left hip injury as a result of the November 2013 fall which resulted in permanent impairment and a need for permanent restrictions. Dr. Jackson stated claimant did not complain of left hip pain or problems during the course of his treatment, nor did he find any left hip issues on physical examination. Dr. Jackson indicated diagnosis and treatment of hip conditions represented a significant component of his medical practice and accordingly, he would have identified such a condition if it existed at the time of his treatment. He therefore opined claimant did not injure her left hip as a result of the November 2013 fall and that if such complaints currently exist, they were not related to the alleged work injury. (DEH, pp. 60-61)

At the referral of Ms. Dankof, claimant returned to Dr. Smith on August 3, 2018 with reports of low back and neck pain. Claimant complained of worsening low back pain with radiation to the left buttock, calf, and foot. Claimant also reported worsened bilateral lateral and posterior neck pain. (JE11, p. 240) Dr. Smith ordered MRIs of the cervical and lumbar spines. (JE11, p. 244) Claimant underwent a lumbar spine MRI on August 14, 2018. Results were read as revealing: multilevel spondylosis, greatest at L4-L5 and L5-S1; and atrophy of the posterior paraspinals musculature. (JE18, p. 265)

Claimant's counsel provided Dr. Bansal with additional medical records for review. After reviewing said records, Dr. Bansal authored a supplemental report dated September 5, 2018. (CE2, pp. 45-45A) Dr. Bansal noted a question had arisen regarding whether claimant had reported her left hip symptoms during her course of treatment with Dr. Jackson. Dr. Bansal indicated he could not say whether Dr. Jackson had addressed claimant's left hip; instead, he noted claimant reported hip complaints in a February 19, 2014 appointment with Dr. Schmolck. Dr. Bansal stood by the opinions included in his original IME report and again opined claimant's examination findings were consistent with labral pathology. (CE2, pp. 45A-45B)

Dr. Jackson authored a letter in response to Dr. Bansal, dated September 25, 2018. Dr. Jackson reviewed all his records regarding claimant's treatment. He indicated claimant did not report any complaints of hip pain, did not indicate hip pain on the questionnaire she completed, and no hip pathology was found on physical examination. Dr. Jackson again opined claimant did not injure her left hip or sustain a labral tear as a result of the November 2013 fall. He expressly disagreed with Dr. Bansal's opinion that claimant presented with such pathology attributable to the work injury, on the basis that a labral injury would have yielded immediate pain complaints. (DEL, p. 1)

Claimant has not worked since March 2014. (Claimant's testimony) By claimant's testimony, all her symptoms and conditions worsened or intensified following the November 11, 2013 incident. As of the date of hearing, claimant's primary complaint was of fatigue. With cognitive or physical activities, claimant testified she develops headaches, nausea, insomnia, and lack of balance. She also complained of back pain and hip pain, with the hip coming out of alignment. Claimant expressed belief that during her course of treatment, Dr. Jackson found her left hip was out of place. She testified that standing or walking for extended periods causes back and hip pain, as well as nerve pain in her feet and lower legs. Sitting results in left low back pain. (Claimant's testimony)

Claimant underwent significant medical treatment which she argues is related to the alleged work injury of November 11, 2013. Claimant submitted a medical expense summary with corresponding medical bills at Claimant's Exhibit 19, encompassing care from November 2013 to the date of hearing. The detailed expenses relate to care not authorized by defendants, totaling $107,539.98. (CE19, pp. 101-212) Claimant also submitted a summary of out-of-pocket expenses she incurred. Such expenses spanned the period of January 31, 2014 through January 4, 2017 and totaled $18,567.47. (CE22, pp. 215-224) Claimant also submitted an extensive request for medical mileage reimbursement, found in Claimant's Exhibit 17. The request encompasses both authorized and unauthorized care with providers from November 14, 2013 to the date of hearing. The grand total of requested mileage reimbursement is $8,775.98. (CE17, pp. 88-99)

Claimant's testified at length during evidentiary hearing. On direct examination, claimant displayed extensive and specific knowledge regarding her medical history and

conditions. On cross examination, however, claimant's testimony was much less clear; particularly, it seemed, when confronted with medical records which did not coincide with her specific recollections. Claimant's demeanor at hearing was acceptable and did not indicate a lack of veracity or intent to mislead.

Claimant's pattern of testimony is reconcilable with a broader pattern of behavior in her medical care, even predating the alleged November 11, 2013 work injury. Following the 2005 stress ball incident, Dr. Fackrell described claimant's complaints as out of proportion and bizarre; he raised the possibility of conversion hysteria. Despite specialists opining the discovered arachnoid cyst was incidental, claimant repeatedly expressed belief the stress ball incident caused the cyst. During her course of care following the August 2012 motor vehicle accident, claimant was evaluated at the Mayo Clinic. Three evaluating physicians noted claimant demonstrated clear, fixed medical ideas. Dr. Smigielski noted claimant held her opinions quite strongly and appeared to dismiss alternative explanations. Dr. Szostek opined claimant demonstrated fixed medical ideas. Dr. Marsh, similarly, noted very fixed and clear ideas. When neurosurgeon, Dr. Marsh, disagreed with claimant's opinions, she questioned his experience in treating arachnoid cysts.

Claimant has also undergone a number of neuropsychological evaluations, each yielding consistent results. In 2008, Dr. Andrikopoulos opined claimant demonstrated gross over-reporting of symptoms. Following the alleged November 11, 2013 injury, claimant was evaluated by Drs. Tranel and Demarest. Dr. Tranel noted profound overemphasis and over-reporting of symptoms. He diagnosed somatic symptom disorder of a longstanding nature; he described claimant as a prototype, textbook example of that diagnosis. He further opined claimant's diagnosis directly contributed to a number of medical events and outcomes over the preceding decade. He also described claimant as susceptible to iatrogenic influence from well-intentioned experts. Dr. Demarest raised the possibility of a conversion disorder and noted claimant appeared convinced she suffered with brain injury, despite neuropsychological data which broadly did not support her conclusion.

Given this medical and neuropsychological background, I am unable to find claimant a credible witness. While I do not find any intentional action on the part of claimant to mislead this court or her medical providers, her testimony cannot be relied upon absent external corroboration.

CONCLUSIONS OF LAW

The first issue for determination is whether claimant sustained an injury arising out of and in the course of employment on November 11, 2013.

The party who would suffer loss if an issue were not established has the burden of proving that issue by a preponderance of the evidence. Iowa R. App. P. 6.14(6).

The claimant has the burden of proving by a preponderance of the evidence that the alleged injury actually occurred and that it both arose out of and in the course of the employment. Quaker Oats Co. v. Ciha, 552 N.W.2d 143 (Iowa 1996); Miedema v. Dial Corp., 551 N.W.2d 309 (Iowa 1996). The words "arising out of" referred to the cause or source of the injury. The words "in the course of" refer to the time, place, and circumstances of the injury. 2800 Corp. v. Fernandez, 528 N.W.2d 124 (Iowa 1995). An injury arises out of the employment when a causal relationship exists between the injury and the employment. Miedema, 551 N.W.2d 309. The injury must be a rational consequence of a hazard connected with the employment and not merely incidental to the employment. Koehler Electric v. Wills, 608 N.W.2d 1 (Iowa 2000); Miedema, 551 N.W.2d 309. An injury occurs "in the course of" employment when it happens within a period of employment at a place where the employee reasonably may be when performing employment duties and while the employee is fulfilling those duties or doing an activity incidental to them. Ciha, 552 N.W.2d 143.

A personal injury contemplated by the workers' compensation law means an injury, the impairment of health or a disease resulting from an injury which comes about, not through the natural building up and tearing down of the human body, but because of trauma. The injury must be something that acts extraneously to the natural processes of nature and thereby impairs the health, interrupts or otherwise destroys or damages a part or all of the body. Although many injuries have a traumatic onset, there is no requirement for a special incident or an unusual occurrence. Injuries which result from cumulative trauma are compensable. Increased disability from a prior injury, even if brought about by further work, does not constitute a new injury, however. St. Luke's Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); Ellingson v. Fleetguard, Inc., 599 N.W.2d 440 (Iowa 1999); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995); McKeever Custom Cabinets v. Smith, 379 N.W.2d 368 (Iowa 1985). An occupational disease covered by chapter 85A is specifically excluded from the definition of personal injury. Iowa Code section 85.61(4) (b); Iowa Code section 85A.8; Iowa Code section 85A.14.

Defendants do not dispute that claimant fell while leaving work on November 11, 2013. Claimant reported the fall the day after the event and three witnesses authored statements that they observed claimant on the ground and helped her to stand. Defendants, however, contest the incident resulted in any injury to claimant. Review of the medical records authored by authorized providers, Drs. Nayeri and Jackson, refute defendants' contention. Three days after the fall, Dr. Nayeri assessed lumbar and cervical strains, as well as a knee contusion; she began a course of care. Ultimately that course of care led to Dr. Jackson. Dr. Jackson assessed cervicothoracolumbar strain/sprain and offered care, including removing claimant from work. Dr. Jackson ultimately opined claimant achieved MMI on May 30, 2014 for cervical, thoracic, and lumbar sprains/strains.

The medical records of these authorized providers establish claimant sustained musculoskeletal injuries as a result of the undisputed fall on November 11, 2013. It is therefore determined that claimant met her burden of proving she sustained an injury on November 11, 2013, arising out of and in the course of her employment.

The next issue for determination is whether the alleged injury is a cause of temporary disability and, if so, whether claimant is entitled to temporary disability benefits from January 16, 2014 through February 7, 2014.

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).

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

Healing period compensation describes temporary workers' compensation weekly benefits that precede an allowance of permanent partial disability benefits. Ellingson v. Fleetguard, Inc., 599 N.W.2d 440 (Iowa 1999). Section 85.34(1) provides that healing period benefits are payable to an injured worker who has suffered permanent partial disability until the first to occur of three events. These are: (1) the worker has returned to work; (2) the worker medically is capable of returning to substantially similar employment; or (3) the worker has achieved maximum medical recovery. Maximum medical recovery is achieved when healing is complete and the

extent of permanent disability can be determined. Armstrong Tire & Rubber Co. v. Kubli, Iowa App., 312 N.W.2d 60 (Iowa 1981). Neither maintenance medical care nor an employee's continuing to have pain or other symptoms necessarily prolongs the healing period.

Defendants paid claimant temporary disability benefits in accordance with Dr. Jackson's off work restriction, beginning in March 2014. There is no dispute with respect to these benefits. The dispute in this matter pertains to whether defendants are responsible for an additional, prior period of temporary disability benefits: January 16, 2014 through February 7, 2014. Therefore, I must determine if the work injury was a cause of temporary disability during the claimed period and, if so, whether claimant is entitled to temporary disability benefits during that period.

Claimant alleges she was off work from January 16, 2014 through February 7, 2014 pursuant to the order of personal provider, Ms. Dankof. Review of Ms. Dankof's contemporaneous medical record reveals she removed claimant from work due to neurological/cognitive symptoms. I must, therefore, determine if claimant has proven the neurological/cognitive symptoms were causally related to the work injury of November 11, 2013.

Ms. Dankof did not opine as to any causal relationship between the neurological symptoms and the work injury. Her contemporaneous record denotes multiple possible bases for the symptoms, including elevated blood pressure, traumatic brain injury after a fall, stress of a new job, possible cyst worsening, and possible seizure disorder.

Claimant argues the opinions of Drs. Schmolck and Angel are entitled to greatest weight. Claimant presented to neurologist, Dr. Schmolck on February 19, 2014. Dr. Schmolck's record indicates claimant missed work due to job-related stress. Dr. Schmolck opined claimant suffered a whiplash-type injury in the November 11, 2013 fall, which caused headaches and neck pain. She described claimant's cognitive symptoms as more difficult to explain, but ultimately opined the symptoms were also related to the whiplash-type fall. In her analysis, Dr. Schmolck highlighted a resolution of any of claimant's symptoms and denial of cognitive symptoms prior to the work injury. Dr. Angel, for his part, opined via a letter dated December 16, 2014, that the fall on November 11, 2013 was a significant and material aggravation of the arachnoid cyst, with worsened symptomatology.

I award no weight to Dr. Schmolck's opinions, as they are largely based on claimant's reports regarding the event and medical history. As set forth *supra*, I do not find claimant to be a credible witness. Additionally, claimant denied suffering cognitive symptoms following the 2012 motor vehicle accident. However, the medical records establish neurological symptoms were evaluated by a number of physicians during this time, including at the Mayo Clinic, with potential etiologies of postconcussive syndrome or arachnoid cyst. I also award no weight to the summary opinions of Dr. Angel, as he lacks any specialty in care of the brain, such as neurosurgery, neurology, or neuropsychology. No such provider opined claimant's injury resulted in aggravation of

the arachnoid cyst. Furthermore, throughout his care of claimant, Dr. Angel regularly offered opinions which support claimant's beliefs, but run contrary to the opinions of specialists. For these reasons, I award no weight to Dr. Angel's opinions.

Instead, I award greatest weight to the opinions of Drs. Tranel and Demarest, as supported by the findings of Dr. Riss.

Per the recommendation of Dr. Jackson, defendants sent claimant to Dr. Tranel in July 2014 for neuropsychological evaluation. Thereafter, Dr. Tranel opined there was no evidence of traumatic brain injury or concussion in the November 2013 fall and further, that the fall was not a plausible cause of significant brain injury. Dr. Tranel found: no evidence of permanent neurological injury in the fall; intact, normal neurological status, without indication of brain damage; and no cognitive or behavioral deficits related to the fall. He diagnosed somatic symptom disorder. Dr. Tranel specifically found no diagnosis or condition related to the fall and also opined the fall did not aggravate any preexisting conditions. He opined claimant would have achieved MMI by November 18, 2013.

Claimant was referred to Dr. Riss by her own providers. Dr. Riss opined claimant's neuropsychological testing revealed overall intact neurocognitive abilities. Dr. Demarest, claimant's chosen independent neuropsychologist, opined the data did not support findings of cognitive impairment or postconcussional syndrome. He opined the inclusion of a traumatic brain injury diagnosis was not well-established and the dysfunction seen on MRI/CT scans reflected chronic and stable encephalomalacia following cyst removal. He noted claimant appeared convinced she suffered with brain injury, despite neuropsychological data which broadly did not support her conclusion. He raised the possibility of conversion disorder.

Dr. Tranel reviewed the neuropsychological evaluations of both Drs. Riss and Demarest. He described the resulting findings and opinions as consistent, with essentially intact cognitive functioning and evidence of elevated somatic symptom reporting. Dr. Tranel opined the three evaluations post November 11, 2013 work injury established, beyond a reasonable doubt, that claimant did not have any neuropsychological dysfunction related to the fall. He went on to opine claimant did not sustain any neuropsychological injury in the fall, there was no basis to causally relate subsequent treatment to the incident, and any allegation of endocrine or fatigue problems was not related to the fall. Dr. Tranel described claimant as a textbook example of somatic symptom disorder.

Drs. Tranel and Demarest are specialists who performed extensive neuropsychological evaluations. These evaluations, as well as that of Dr. Riss, yielded consistent results. Both Drs. Tranel and Demarest independently found claimant did not demonstrate neurological injury, but rather, endorsed diagnoses of somatic conditions. As I provide greatest weight to the opinions of Drs. Tranel and Demarest, I find claimant has failed to prove she sustained neurological/cognitive injury in the November 11, 2013

fall. As a result, any time off work to treat such conditions per the order of unauthorized provider, Ms. Dankof, is not defendant's responsibility.

Assuming *arguendo*, that claimant's neurological symptoms were causally related to the work injury, claimant failed to prove, by a preponderance of the evidence that she was off work during the claimed period. The record contains claimant's paystubs from QCI, dated January 17, 2014 and January 31, 2014. On those dates, claimant was paid for 72.75 and 62.25 hours, respectively. While the stubs do not contain the specific pay period dates, it is claimant who bears the burden of proving she was off work during this period. Claimant's testimony that QCI paid one month behind and that she was off work during the claimed period is not sufficient to meet her burden. Claimant was not found to be a credible witness and offered no supportive documentation for her position, such as QCI payroll policies.

Claimant has failed to prove entitlement to temporary disability benefits for the period of January 16, 2014 through February 7, 2014.

The next issue for determination is whether the alleged injury is a cause of permanent disability and, if so, the extent of any industrial disability.

Claimant has alleged injuries to four body parts as a result of the November 11, 2013 work injury: neck, back, left hip, and head/neurological. When considering the questions of causation and permanent impairment, the opinions of medical providers are of paramount importance, particularly in instances when the claimant is not found to be a credible witness.

Claimant established she sustained temporary injuries to her neck and back as a result of the work injury. However, Dr. Jackson opined the injuries resolved, without permanent impairment or need for permanent restrictions by May 30, 2014. These opinions are unrebutted, including by claimant's IME physician, Dr. Bansal. Accordingly, it is determined claimant has failed to prove the work injury was a cause of permanent disability to her neck and/or back, and no permanent disability benefits are awarded.

Dr. Bansal did opine claimant suffered permanent impairment as a result of the alleged injury to claimant's left hip. However, his opinion is refuted by that of Dr. Jackson, who specifically opined claimant did not suffer with a left hip injury as a result of the November 11, 2013 fall. I award the opinions of Dr. Jackson greater weight than those of Dr. Bansal. Dr. Jackson provided contemporaneous evaluation of claimant's musculoskeletal complaints and crafted a course of treatment for such complaints. He represented he evaluated claimant's left hip and found no conditions requiring treatment. This contemporaneous evaluation and care entitles Dr. Jackson's opinions to greater weight than those of Dr. Bansal, who evaluated claimant on only one occasion, over four years removed from the injury and subsequent to a number of potential intervening incidents. As I award greater weight to the opinions of Dr. Jackson, it is determined claimant has failed to prove the work injury was a cause of

permanent disability to claimant's left hip and no permanent disability benefits are awarded.

As set forth *supra*, claimant failed to prove a head/neurological injury as a result of the work injury. Furthermore, Dr. Tranel specifically opined claimant sustained no permanent impairment as a result of any alleged neurological injury and claimant's own IME physicians, Drs. Demarest and Bansal, did not quantify any permanent disability as a result of these symptoms. Accordingly, it is determined claimant has failed to prove the work injury was a cause of permanent neurological disability and no permanent disability benefits are awarded.

Claimant has failed to prove the work injury of November 11, 2013 is a cause of permanent disability. As claimant failed to establish an entitlement to permanent disability benefits, consideration of the issues of commencement date for permanent disability benefits and any credit under Iowa Code section 85.34(7) are unnecessary.

The next issue for determination is the rate of compensation.

Section 85.36 states the basis of compensation is the weekly earnings of the employee at the time of the injury. The section defines weekly earnings as the gross salary, wages, or earnings to which an employee would have been entitled had the employee worked the customary hours for the full pay period in which injured as the employer regularly required for the work or employment. The various subsections of section 85.36 set forth methods of computing weekly earnings depending upon the type of earnings and employment.

If the employee is paid on a daily or hourly basis or by output, weekly earnings are computed by dividing by 13 the earnings over the 13-week period immediately preceding the injury. Any week that does not fairly reflect the employee's customary earnings that fairly represent the employee's customary earnings, however. Section 85.36(6).

The parties dispute computation of claimant's gross average weekly wage. Claimant's calculation, as submitted at hearing, argues for a gross average weekly wage of $1,447.50. To reach this figure, claimant uses earnings from 9 of the 13 weeks preceding the work injury. She excludes 4 weeks, 31 percent of the 13 listed, as unrepresentative, as she only worked between 28 and 34 hours during those weeks and claimant believes they are not representative.

After review of the entirety of the record, I adopt defendants' calculation of claimant's gross average weekly wage. Claimant's computation considers only 9 weeks of earnings; she does not substitute argued representative weeks for the ones she excluded. Defendants, on the other hand, use 13 weeks in the computation, as statutorily outlined. Additionally, after review of claimant's enclosed pay records, I find the 13 weeks of earnings preceding the work injury are representative of claimant's customary earnings. Claimant's earnings during the 13 weeks preceding the injury

appear consistent with her prolonged pattern of work hours. Over those 13 weeks, claimant worked between 28 and 34 hours 31 percent of the time. Review of the 20 weeks prior to injury reveals claimant worked in this range of hours 40 percent of the time. In the 66 weeks prior to the injury, claimant worked in this range of hours 36 percent of the time. I, therefore, find the 13 weeks of earnings immediately preceding the injury are representative of claimant's customary earnings.

Claimant's gross average weekly wage is found to be $1,345.80. The parties stipulated claimant was single and entitled to one exemption. The proper rate of compensation is therefore, $757.52.

The next issue for determination is whether defendants are responsible for medical expenses found in Exhibits 19 and 22, as well as medical mileage found in Exhibit 17.

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

When dealing with unauthorized care, to be entitled to payment, claimant must establish the care was rendered on a compensable claim. That being established, claimant must establish that the care provided on the compensable claim was both reasonable and the outcome more beneficial than the care offered by the defendants. Bell Bros. Heating and Air Conditioning v. Gwinn, 779 N.W.2d 193, 206 (Iowa 2010).

Defendants authorized care or evaluation with Concentra, Dr. Jackson, and Dr. Tranel. Defendants are responsible and shall hold claimant harmless for any medical expenses causally related to this authorized medical care, including incidental medical mileage.

Claimant failed to prove compensable injury to her left hip and/or head/neurological. Any medical care and incidental expenses related to these conditions are not defendants' responsibility.

Claimant did prove she sustained temporary injury to her neck and back. To the extent claimant requests payment of expenses related to unauthorized care of these compensable musculoskeletal conditions, claimant's request fails. Defendants provided reasonable and prompt care of these complaints and there is no evidence the unauthorized care sought by claimant was more beneficial than that already provided by defendants. Accordingly, such expenses are not defendants' responsibility.

The expenses claimed by claimant and in evidence at Exhibits 17, 19, and 22, are extensive. If claimant believes these exhibits include expenses which are the responsibility of defendants per this decision and those expenses remain unpaid, claimant shall serve an updated list of such expenses upon defendants within 10 days of the date of this decision. If a dispute remains thereafter, either party may request a specific determination by a motion for rehearing.

The next issue for determination is whether claimant is entitled to reimbursement of an independent medical examination performed by Dr. Bansal.

Section 85.39 permits an employee to be reimbursed for subsequent examination by a physician of the employee's choice where an employer-retained physician has previously evaluated "permanent disability" and the employee believes that the initial evaluation is too low. The section also permits reimbursement for reasonably necessary transportation expenses incurred and for any wage loss occasioned by the employee attending the subsequent examination.

Defendants are responsible only for reasonable fees associated with claimant's independent medical examination. Claimant has the burden of proving the reasonableness of the expenses incurred for the examination. See Schintgen v. Economy Fire & Casualty Co., File No. 855298 (App. April 26, 1991). Claimant need not ultimately prove the injury arose out of and in the course of employment to qualify for reimbursement under section 85.39. See Dodd v. Fleetguard, Inc., 759 N.W.2d 133, 140 (Iowa App. 2008).

Claimant requests reimbursement of Dr. Bansal's IME expense. Defendants deny claimant is entitled to reimbursement on the basis defendants previously paid for claimant's IME with Dr. Demarest.

Claimant is limited to one reimbursable IME under section 85.39. Larson Mfg. Co., Inc. v. Thorson, 763 N.W.2d 842, 861 (Iowa 2009). Accordingly, claimant is not entitled to reimbursement of Dr. Bansal's IME, as defendants previously paid for claimant's IME with Dr. Demarest in connection with this proceeding.

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

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

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

It also is not unreasonable to deny a claim when a good faith issue of law or fact makes the employer's liability fairly debatable. An issue of law is fairly debatable if

viable arguments exist in favor of each party. Covia v. Robinson, 507 N.W.2d 411 (Iowa 1993). An issue of fact is fairly debatable if substantial evidence exists which would support a finding favorable to the employer. Gilbert v. USF Holland, Inc., 637 N.W.2d 194 (Iowa 2001).

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

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

Claimant argues entitlement to penalty benefits on the bases of underpaid temporary disability benefits and nonpayment of permanent disability benefits. No additional temporary disability benefits were found owing by this decision and thus, there is no basis for penalty benefits. Further, defendants prevailed on the issue of computation of gross average weekly wage; therefore, any alleged underpayment attributable to payment of temporary weekly benefits at a lesser rate of compensation was fairly debatable and does not support an award of penalty benefits. Finally, this decision awarded claimant no permanent disability benefits and thus, there is no basis for an award of penalty benefits due to nonpayment of permanent disability benefits.

The final issue for determination is a specific taxation of costs pursuant to Iowa Code section 86.40 and rule 876 IAC 4.33. Claimant requests taxation of the costs of: $100.00 filing fee; $6.74 service fee; $197.75 deposition fee; and $3,361.00 report fee of Dr. Bansal. (CE20, p. 213)

Iowa Code section 86.40 states:

> Costs. All costs incurred in the hearing before the commissioner shall be taxed in the discretion of the commissioner.

Iowa Administrative Code Rule 876—4.33(86) states:

> Costs. Costs taxed by the workers' compensation commissioner or a deputy commissioner shall be (1) attendance of a certified shorthand reporter or presence of mechanical means at hearings and evidential depositions, (2) transcription costs when appropriate, (3) costs of service of the original notice and subpoenas, (4) witness fees and expenses as provided by Iowa Code sections 622.69 and 622.72, (5) the costs of doctors' and practitioners' deposition testimony, provided that said costs do not exceed the amounts provided by Iowa

> Code sections 622.69 and 622.72, (6) the reasonable costs of obtaining no more than two doctors' or practitioners' reports, (7) filing fees when appropriate, (8) costs of persons reviewing health service disputes. Costs of service of notice and subpoenas shall be paid initially to the serving person or agency by the party utilizing the service. Expenses and fees of witnesses or of obtaining doctors' or practitioners' reports initially shall be paid to the witnesses, doctors or practitioners by the party on whose behalf the witness is called or by whom the report is requested. Witness fees shall be paid in accordance with Iowa Code section 622.74. Proof of payment of any cost shall be filed with the workers' compensation commissioner before it is taxed. The party initially paying the expense shall be reimbursed by the party taxed with the cost. If the expense is unpaid, it shall be paid by the party taxed with the cost. Costs are to be assessed at the discretion of the deputy commissioner or workers' compensation commissioner hearing the case unless otherwise required by the rules of civil procedure governing discovery. This rule is intended to implement Iowa Code section 86.40.

Iowa Administrative Code rule 876—4.17 includes as a practitioner, "persons engaged in physical or vocational rehabilitation or evaluation for rehabilitation." A report or evaluation from a vocational rehabilitation expert constitutes a practitioner report under our administrative rules. Bohr v. Donaldson Company, File No. 5028959 (Arb. November 23, 2010); Muller v. Crouse Transportation, File No. 5026809 (Arb. December 8, 2010) The entire reasonable costs of doctors' and practitioners' reports may be taxed as costs pursuant to 876 IAC 4.33. Caven v. John Deere Dubuque Works, File Nos. 5023051, 5023052 (App. July 21, 2009).

Claimant prevailed on her claim that she sustained an injury arising out of and in the course of her employment and as such, an award of costs is appropriate. The costs of filing fee ($100.00), service fee ($6.74), and deposition fee ($197.75) are allowable costs and are taxed to defendants. Claimant is not permitted to receive reimbursement for the full cost of Dr. Bansal's IME as a practitioner's report under rule 4.33. Rather, the Iowa Supreme Court has ruled only the portion of the IME expense incurred in preparation of the written report can be taxed. Des Moines Area Regional Transit Authority v. Young, 867 N.W.2d 839 (Iowa 2015). Dr. Bansal identified costs of $3,361.00 in conjunction with preparation of his written report. However, I do not find this cost reasonable for taxation to defendants. Dr. Bansal was asked to address four alleged conditions, yet his report only specifically addresses one of the conditions. I find $1,000.00 of Dr. Bansal's report fee is appropriate to tax to defendants as a practitioner's report.

Defendants are taxed with costs in the amount of $1,304.49 ($100.00 + $6.74 + $197.75 + $1,000.00 = $1,304.49).

ORDER

THEREFORE, IT IS ORDERED:

The parties are ordered to comply with all stipulations that have been accepted by this agency.

Claimant shall take nothing from these proceedings by way of additional periods of temporary disability benefits or any permanent disability benefits.

Defendants shall pay unto claimant the underpayment, if any, in temporary disability benefits resulting from a determination of claimant's proper rate of compensation as seven hundred fifty-seven and 52/100 dollars ($757.52).

Defendants shall pay accrued weekly benefits in a lump sum.

Defendants shall pay interest on unpaid weekly benefits awarded herein as set forth in Iowa Code section 85.30. Defendants shall pay accrued weekly benefits in a lump sum together with interest at the rate of ten percent for all weekly benefits payable and not paid when due which accrued before July 1, 2017, and all interest on past due weekly compensation benefits accruing on or after July 1, 2017, shall be payable at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two percent. See Gamble v. AG Leader Technology, File No. 5054686 (App. Apr. 24, 2018).

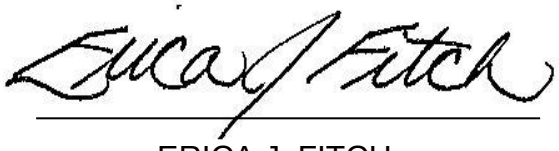
Defendants shall receive credit for benefits paid.

Defendants shall pay claimant's prior medical expenses submitted by claimant at the hearing as set forth in the decision.

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

Costs are taxed to defendants pursuant to 876 IAC 4.33 as set forth in the decision.

Signed and filed this __8th__ day of April, 2020.



ERICA J. FITCH
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served, as follows:

Robert Tucker (via WCES)

Aaron Oliver (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.