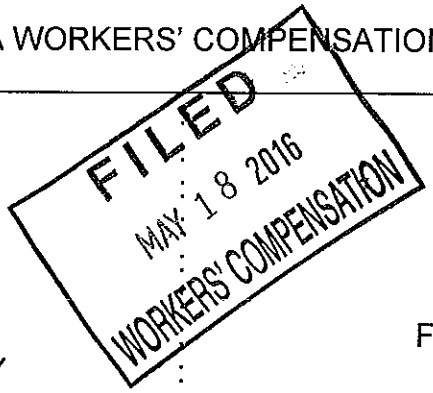
BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER



CHRISTOPHER LAIDLAW,

Claimant,

vs.

COGNIZANT TECHNOLOGY SOLUTION SERVICES, LLC,

Employer,

and

AMERICAN ZURICH INSURANCE,

Insurance Carrier,
Defendants.

File No. 5043159

ARBITRATION

DECISION

Head Note No.: 1100

STATEMENT OF THE CASE

Claimant, Christopher Laidlaw, filed a petition in arbitration seeking workers' compensation benefits from Cognizant Technology Solutions Services, LLC, employer, and American Zurich Insurance, insurance carrier, both as defendants, as a result of an alleged injury sustained on December 1, 2012. This matter came on for hearing before Deputy Workers' Compensation Commissioner, Erica J. Fitch, on October 21, 2015, in Des Moines, Iowa. The record in this case consists of joint exhibits A through O and the testimony of the claimant. The parties submitted post-hearing briefs, the matter being fully submitted on December 7, 2015.

ISSUES

The parties submitted the following issues for determination:

1. Whether claimant sustained an injury on December 1, 2012 which arose out of and in the course of his employment;

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

3. The extent of claimant's industrial disability.

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

FINDINGS OF FACT

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

Claimant was 32 years of age at the time of hearing. He resides in Marion, Iowa. Claimant is single and has one minor child. Claimant obtained his GED in 2000 and subsequently earned an associates' degree in 2013. Claimant is right-hand dominant. (Claimant's testimony; Exhibit N, page 3)

Claimant's employment history begins with enlistment in the US Army in 2001. At that time, claimant completed basic training and was sent to advanced individual training for combat medic instruction. Claimant testified he passed his training, but was involved in an altercation prior to graduation. As a result, he was discharged from the service. Thereafter, claimant worked as a telemarketer, performed collections for a bank, and engaged in self-employment attempting collections of debts of various companies. In his self-employment, claimant earned approximately $800.00 per week. (Ex. A, Depo. Tr. pp. 59-61; Ex. N, p. 4)

Claimant reenlisted in the US Army in 2005. From 2005 to 2009, claimant engaged in an active duty assignment as a human resource specialist; he earned $800.00 per week. Due to familial responsibilities, at the end of his active duty contract, claimant enlisted in the Army Reserves. (Ex. A, Depo. Tr. pp. 67-69) He thereafter worked in customer service for an insurance company, earning $560.00 per week. In 2012, claimant began work at ING, earning $560.00 per week. (Ex. N, p. 5)

Claimant's relevant medical history includes a right knee injury sustained in military service in 2005. Thereafter, claimant continued to suffer with chronic knee pain. (Ex. J, pp. 69, 71-72) In August 2010, claimant aggravated his knee pain while running. (Ex. J, pp. 71-72) Claimant proceeded to receive medical treatment at the VA of his knee symptoms and was diagnosed with a strain in September 2010. An orthopedic evaluation was suggested, with claimant to utilize Vicodin in the interim. (Ex. J, pp. 37-39) Due to claimant's reportedly poor reaction to Vicodin, claimant received a prescription for oxycodone/Percocet. (Ex. J, pp. 30-33, 69-71)

X-rays of the right knee were unremarkable. (Ex. J, pp. 2-3, 69-71) An MRI of right knee showed no evidence of meniscal tear, ACL injury, or PCL injury. There was questionable increased signal at the femoral insertion of the lateral collateral ligament. (Ex. J, pp. 1-2) The MRI was reviewed by VA orthopedic staff in November 2010 and opined to be essentially negative. Claimant initially refused to undergo a corticosteroid injection; staff denied his request for Percocet. (Ex. J, pp. 14-15) Later in the month of November, claimant informed VA medical staff he had been using "fake pot" to relieve his pain. The provider noted feeling uncomfortable treating claimant for complaints of pain without objective findings, while claimant demonstrated signs of abuse. (Ex. J, p. 16) Claimant returned to the VA in early December 2010. Claimant again refused an injection and requested Percocet. Claimant's request was denied. (Ex. J, p. 16)

Claimant ultimately underwent a steroid injection in February 2011 and received prescriptions for Motrin and Percocet. (Ex. J, pp. 66-67)

Review of claimant's medical records reveals he underwent x-rays of his back in January 2012. X-rays of the thoracic spine showed no abnormalities; x-rays of the lumbar spine revealed possible L5 spondylolyses. (Ex. J, pp. 50-51)

VA records dated May 7, 2012 note claimant presented for evaluation with complaints of right shoulder pain for two months. Claimant did not describe any recent shoulder injury. (Ex. J, p. 57) X-rays were ordered. Claimant was directed to use Flexeril and Motrin; a request for Percocet was declined. (Ex. J, p. 58) Following x-rays, claimant was evaluated by another provider at the VA. This provider noted claimant complained of right shoulder pain for three to four months. The provider opined claimant's x-rays were negative and assessed a right shoulder rotator cuff sprain. (Ex. J, pp. 48-49)

At his deposition, claimant recalled going to the VA for right shoulder soreness in May 2012, but did not attribute the symptom to any activity. Rather, claimant testified it was likely just muscle fatigue. (Ex. A, Depo. Tr. pp. 27-29) At evidentiary hearing, claimant testified he did not suffer a shoulder injury on this date, but rather had injured his back playing softball. He described the location of the pain as "under" his shoulder, below his shoulder blade in the middle of his back. Claimant testified the pain lasted approximately three to four days prior to seeking care, not three to four months. (Claimant's testimony)

In September 2012, claimant presented to the VA for evaluation after a friend had kicked him in the ribs. X-rays revealed no bony pathology. Claimant was assessed with a chest wall contusion and provided medication. (Ex. J, pp. 47, 52-53)

Claimant's medical history also includes a diagnosis of medication-treated depression, dating to at least December 2010. (Ex. J, p. 10) Claimant received care of his mental health conditions through the VA. In January 2011, claimant was diagnosed by VA psychiatry staff with major depressive disorder. (Ex. J, pp. 4-5) In October 2011, claimant submitted to a voluntary overnight admission to the psychiatric service. (Ex. J, pp. 73-74) His course of care has included periodic follow-up, psychotherapy and medications. (Ex. J, pp. 75-85)

In 2009, claimant filed an application for disability benefits with the Department of Veterans Affairs. On December 1, 2012, he received an award decision finding him entitled to VA benefits as a result of his mental health and right knee conditions. (Ex. A, Depo. Tr. pp. 79-80) As a result of the major depression and generalized anxiety disorder, claimant was found 70 percent disabled. As a result of the right knee chondromalacia patella and tendinitis, claimant was found 10 percent disabled. (Ex. J, p. 45)

On January 3, 2012, claimant began work as a client changes coordinator for ING, processing changes on insurance policies. (Ex. A, Depo. Tr. pp. 10-11; Ex. M, pp. 1-2) Due to corporate restructuring, effective August 16, 2012, claimant transitioned to employment with defendant-employer. Claimant's work duties remained the same, processing changes in life insurance policies; his job title was policy/plan service coordinator. Claimant's work was done at a desk and was not physical in nature. He earned $14.02 per hour and worked a minimum of 40 hours per week. (Claimant's testimony; Ex. A, Depo. Tr. pp. 10-11, 13; Ex. M, pp. 3-5)

During his employment with ING and subsequently, defendant-employer, claimant was the recipient of corrective/disciplinary actions. In July 2012, claimant received a written warning for entering incorrect start times. He was also warned for attendance issues, with defendant-employer's records noting claimant used four weeks of paid time off in the seven months since beginning employment in January 2012. (Ex. M, p. 28) On November 29, 2012, defendant-employer "coached" claimant with respect to attendance issues and his need to log in and out. (Ex. M, p. 30)

Claimant has participated in mixed martial arts (MMA) fighting dating to at least 2003. In 2003, claimant participated in 10 amateur and 2 professional MMA fights. Thereafter, claimant continued to intermittently participate in training for the sport and returned to daily training in early 2012. By his deposition testimony, claimant estimated beginning training in approximately May and continuing pre-injury until late November. At evidentiary hearing, claimant denied beginning his training as early as May 2012. While he generally focused on the boxing element of MMA, he also participated in wrestling and jujitsu training. (Claimant's testimony; Ex. A, Depo. Tr. pp. 29-33, 41, 43-43)

Claimant alleges he sustained a work-related injury on Saturday, December 1, 2012, while performing an overtime shift. (Claimant's testimony; Ex. A, Depo. Tr. pp. 14-15) At his deposition on May 17, 2013, claimant testified at the time of his injury, he believed he was going on break or to get a coffee. (Ex. A, Depo. Tr. p. 15) Claimant indicated he attempted to open a time-delayed door:

> I just put my hand on it lazily and stepped back, and when I stepped back, the door didn't move. My arm kind of – my shoulder at least just kind of made a little rip and pop noise and stayed with the door.

(Ex. A, Depo. Tr. p. 15)

Claimant testified he felt an immediate, sharp pain in his right shoulder, at a level 7 on a 10-point scale. He indicated the pain subsequently lessened to a level 6, but persisted at that pain level. (Ex. A, Depo. Tr. pp. 18-19) Claimant testified the injury occurred between 12:00 and 12:15 p.m. (Ex. A, Depo. Tr. p. 16) With respect to the timing of the injury, claimant indicated that immediately prior to going on break, he had sent a message to a friend. Claimant testified that message was sent at "like 12:01... so it was just probably shortly after that... If – if my life depended on it, I would say it

would be about 12:05 to 12:10." (Ex. A, Depo. Tr. p. 16) Claimant acknowledged working about 7 ½ hours that day. He expressed belief he got to work around 8:00 a.m. or 9:00 a.m. and worked until possibly 4:00 p.m. to 6:00 p.m. He reported the event the following Monday. (Ex. A, Depo. Tr. pp. 20-21)

At evidentiary hearing, claimant testified he sustained the alleged injury near the end of his scheduled shift. He estimated he was injured between 4:00 p.m. and 5:00 p.m., at the end of his shift. Claimant testified in order to exit the time-delayed door, employees were required to hold down the door handle for two seconds before the door would unlock. Claimant testified he stepped back and attempted to open the door, but the door stayed closed and "yanked" his right shoulder. Claimant testified he suffered with an immediate, sharp pain at a level 6 or 7. The following Monday, claimant testified he sent an email to his manager and reported the incident. (Claimant's testimony)

The evidentiary record contains video recorded by defendant-employer of the entrance/exit door utilized by claimant on December 1, 2012. Throughout the day of December 1, 2012, claimant is observed utilizing the door multiple times per day, as both an entrance and exit. At 12:05 p.m., claimant is observed opening the door with his right arm. He pauses slightly and then proceeds through the door. Claimant subsequently returns through the door at 12:12 p.m. and proceeds to use the door several additional times throughout the day. At 6:02 p.m., claimant is observed exiting the door, using his right arm to pull the door toward him. The undersigned observed only a slight pause in claimant's movement, with claimant then fully opening and proceeding through the door. Claimant proceeded through the door with his right arm hanging and swinging slightly as he walked out of camera view. (Ex. O)

At evidentiary hearing, claimant testified the video was accurate and showed him entering and exiting his work area. Claimant attempted to explain the discrepancy in his deposition testimony, evidentiary hearing testimony, and the video depiction by testifying he knew the injury occurred at the end of his shift but he had not recalled exactly what time his shift ended. Claimant testified the video time-stamped at 6:02 p.m. revealed him subtly stutter on his feet and look down at his shoulder due to the sensation of pain. (Claimant's testimony)

Following the alleged work injury, claimant continued to work for defendant-employer. On some days, he testified he was irritable and short with people due to his pain. (Claimant's testimony; Ex. A, Depo. Tr. pp. 22-23)

On or about December 15 to December 17, 2012, claimant engaged in MMA training. Claimant testified he sparred, but was unable to hold up his right arm to protect himself and was also unable to punch with his right arm. As a result, claimant testified he was on the receiving end of a large number of punches to his face. (Claimant's testimony; Depo. Tr. pp. 32, 37)

Effective December 21, 2012, defendant-employer terminated claimant's employment. On December 19, 2012, claimant authored two emails to a coworker wherein he referred to her as "lazy." (Ex. M, pp. 36-37) Defendant-employer's records describe the coworker as "very upset and in tears" as a result of claimant's behavior. (Ex. M, p. 36) Defendant-employer terminated claimant for misconduct on the basis of the unprofessional emails which were viewed as harassing and in violation of company standards. This incident was noted as the second instance of misconduct by claimant in a six-month period. (Ex. M, p. 34) Claimant testified he and the coworker in question were friends and he was joking. (Claimant's testimony; Ex. A, Depo. Tr. pp. 23-24)

Claimant testified prior to his termination, he requested medical treatment of his right shoulder through defendant-employer, but no care was arranged. After his termination, claimant testified he telephoned defendant-insurance carrier directly and requested care; medical evaluation was promptly scheduled. (Claimant's testimony; Ex. A, Depo. Tr. p. 50)

On December 24, 2012, claimant presented to Iowa Methodist Occupational Health for evaluation by Richard Bratkiewicz, M.D. Claimant reported while working on December 1, 2012, he attempted to open a time delayed door with his right arm. Dr. Bratkiewicz noted claimant "pulled hard and wrenched" with his right shoulder, leading to immediate pain. Claimant denied any improvement in pain since that date. Dr. Bratkiewicz noted claimant did not report any prior problems with his right shoulder. Following examination, Dr. Bratkiewicz assessed a right shoulder strain, but also expressed belief claimant suffered with a rotator cuff tear. Accordingly, he ordered an MRI of the right shoulder. In the interim, Dr. Bratkiewicz recommended use of ibuprofen and imposed restrictions against lifting over 10 pounds or working overhead with the right arm. (Ex. E, pp. 1, 4)

Claimant underwent the recommended MRI of the right shoulder on January 2, 2013. The radiologist opined the results revealed increased signal, leading him to conclude an AC joint sprain might be present and he was unable to exclude a SLAP tear. The radiologist opined an MRI arthrogram may be warranted to further evaluate the diagnosis. (Ex. C, p. 1)

On January 8, 2013, claimant returned to Dr. Bratkiewicz. Following review of the MRI results, Dr. Bratkiewicz opined it revealed a SLAP lesion. As the radiologist had recommended an MRI arthrogram, Dr. Bratkiewicz ordered the test in order to better define the anatomy of claimant's injury. (Ex. E, p. 3) Prior to undergoing the MRI arthrogram, claimant returned to Dr. Bratkiewicz on January 29, 2013 with complaints of increased pain. Dr. Bratkiewicz issued a prescription for Vicodin and restricted claimant from lifting, pushing or pulling over 10 pounds. (Ex. E, pp. 5-6)

Claimant underwent right shoulder MRI arthrogram on January 31, 2013. The radiologist read the results as revealing a SLAP tear of the posterior superior labrum. (Ex. G, pp. 1-2) On February 5, 2013, claimant returned to Dr. Bratkiewicz, who opined the MRI arthrogram revealed a SLAP lesion/labral tear. Accordingly, he assessed a

torn labrum and issued a referral for orthopedic evaluation. He imposed restrictions of a maximum lift, push or pull of 10 pounds and no overhead activities. (Ex. E, pp. 7-8)

On February 19, 2013, claimant presented to Iowa Ortho for evaluation with Stephen Ash, M.D. Claimant reported he injured his right shoulder on December 1, 2012 while attempting to open a door. Dr. Ash indicated claimant sustained a "traction force" to his right upper extremity, with claimant complaining of shoulder and trapezius pain, as well as occasional numbness and tingling of his hand. Claimant denied any prior shoulder problems or medical evaluation of the right shoulder. (Ex. D, p. 12)

On examination, Dr. Ash noted tenderness of the AC joint and trapezius, as well as notable scapular dyskinesis. (Ex. D, p. 13) Dr. Ash opined claimant's x-rays revealed no sign of fracture and the MRI revealed an intact rotator cuff. He noted the radiologist also noted the possible existence of a superior labral tear. Dr. Ash assessed right shoulder pain with secondary scapular dyskinesis and a rotator cuff sprain. Dr. Ash informed claimant he may have a simple rotator cuff strain or a possible superior labral tear. He recommended a course of conservative care, including use of ibuprofen, physical therapy, and work restrictions of a maximum 2-pound lift with the right upper extremity. (Ex. D, pp. 14-15)

Claimant participated in physical therapy at Physiotherapy Associates from February 20, 2013 to March 13, 2013. (Ex. F, pp. 1-17)

Claimant returned to Dr. Ash on March 14, 2013 with reports of unchanged pain. Dr. Ash assessed a right shoulder traction injury and recommended continued conservative care, including continued physical therapy and use of Naprosyn. Dr. Ash imposed restrictions of a maximum 2-pound lift with the right upper extremity and avoidance of repetitive reaching above the head with the right arm. (Ex. D, pp. 4-5)

Claimant resumed physical therapy sessions from March 22, 2013 through April 10, 2013. (Ex. F, pp. 18-25)

On April 11, 2013, claimant returned to Dr. Ash and denied improvement in symptoms. Dr. Ash performed a subacromial injection and recommended performance of a home exercise program. He also imposed a restriction of a maximum 2-pound lift with the right upper extremity. (Ex. D, pp. 6-8)

On May 9, 2013, claimant returned to Dr. Ash and reported relief for approximately two days following subacromial injection. (Ex. D, p. 17) Dr. Ash indicated he was "not optimistic" that surgical superior labral repair would lead to resolution of claimant's symptoms. He recommended a functional capacity evaluation (FCE) and maintained the 2-pound lifting restriction pending completion of the FCE. (Ex. D, p. 18)

Claimant participated in an FCE on May 22, 2013 with Charles Goodhue, M.D., P.T. Mr. Goodhue found claimant gave maximal, consistent effort and further opined

the results of the FCE were valid as a basis for determination of claimant's abilities. (Ex. I, pp. 1-2) Mr. Goodhue opined claimant demonstrated moderate deficits in waist-to-overhead lifting and left single upper extremity carry. He found claimant demonstrated significant deficit in elevated work. However, Mr. Goodhue found claimant demonstrated significant ability in right single upper extremity carry. (Ex. I, p. 2)

Mr. Goodhue opined claimant demonstrated the ability to function in the upper end of the medium physical demand category of work. He limited claimant to only occasional elevated work, but indicated claimant would have no such restriction if able to elevate his body so as to allow the work to be performed at or below shoulder level. (Ex. I, p. 3) He noted claimant demonstrated the following abilities: maximum floor-to-waist lifts of 100 pounds rarely, 85 pounds occasionally, 65 pounds frequently, and 45 pounds constantly; maximum waist-to-overhead lifts of 60 pounds rarely, 45 pounds occasionally, 30 pounds frequently, and 20 pounds constantly; maximum right carry of 80 pounds rarely, 65 pounds occasionally, 50 pounds frequently, and 35 pounds constantly; maximum left carry of 65 pounds rarely, 50 pounds occasionally, 35 pounds frequently, and 20 pounds constantly; and maximum front carry of 90 pounds rarely, 70 pounds occasionally, 50 pounds frequently, and 30 pounds constantly. (Ex. I, p. 7)

On May 30, 2013, claimant returned to Dr. Ash. Claimant reported a worsening of his symptoms. Dr. Ash assessed a right shoulder traction injury and right shoulder pain. He reviewed claimant's FCE results and released claimant to return as needed, to work under the permanent restrictions outlined in claimant's FCE. (Ex. D, pp. 9-11)

Defendants' counsel authored a fill-in the blanks letter, completed by Dr. Ash on June 12, 2013. By the letter, Dr. Ash confirmed review of claimant's deposition testimony wherein he stated he was injured between 12:05 and 12:10 p.m., as well as the time-stamped video of claimant at defendant-employer's property. Dr. Ash indicated his diagnosis was right shoulder pain. He agreed that more likely than not, the work injury as described was not the cause of claimant's pain complaints or need for continued medical attention. He opined claimant's MMA activities could have aggravated claimant's existing shoulder pain as described in medical records as early as May 2012. Dr. Ash opined claimant had achieved maximum medical improvement (MMI) and had sustained zero ratable permanent impairment. (Ex. B, pp. 1-2)

In 2013, claimant left the Army Reserves. (Claimant's testimony) As of his deposition in May 2013, claimant testified he received $2,921.00 per month in VA disability benefits. As he was not then working, his VA benefits were not offset by income. (Ex. A, Depo. Tr. pp. 79-80, 82)

Per the arranging of claimant's former counsel, claimant presented for independent medical evaluation (IME) with Stanley Mathew, M.D. on January 10, 2014. Dr. Mathew issued a 3-page report of his findings and opinions dated January 20, 2014. Dr. Mathew noted claimant developed severe right shoulder pain when he attempted to open a stuck door, using "over 30 pounds of body weight." (Ex. H, p. 1) Dr. Mathew

summarized the medical care which followed the alleged work injury. Dr. Mathew described claimant's pre-injury medical history as essentially negative. (Ex. H, pp. 1-2)

Dr. Mathew also interviewed claimant, who complained of right shoulder pain at a level 6 on a 10-point scale. Claimant reported his pain could lessen with rest, but worsened with overhead activities, pushing, pulling, or lifting. Claimant also complained of some weakness of the shoulder girdle. Dr. Mathew noted claimant used minimal pain medications and occasional anti-inflammatory medications. Additionally, Dr. Mathew performed a physical examination. (Ex. H, p. 2)

Following history and examination, Dr. Mathew assessed right shoulder rotator cuff tendinitis, right shoulder superior labrum anterior and posterior tear, and chronic right shoulder pain. He opined these conditions "were caused and substantially aggravated exacerbated" by the alleged work injury. Dr. Mathew opined claimant had achieved MMI. Based upon deficits in range of motion and strength of the shoulder, Dr. Mathew opined claimant sustained a permanent impairment of 15 percent right upper extremity, or 10 percent whole person. Dr. Mathew recommended permanent restrictions of avoidance of lifting more than 10 pounds and no repetitive overhead activities, pushing, or pulling. Dr. Mathew also noted claimant's pain might worsen over time as traumatic arthritis sets in and accordingly, would likely benefit from chronic pain management. (Ex. H, p. 3)

Claimant testified in 2014, he sought additional right shoulder treatment at the VA. He testified he underwent SLAP tear repair in July 2014 and subsequently participated in physical therapy. Claimant testified the VA physician adopted the restrictions recommended by Dr. Mathew. He had no additional follow-up appointments scheduled as of the date of evidentiary hearing. (Claimant's testimony)

Claimant testified he continues to suffer with symptoms of his right shoulder. At the time of evidentiary hearing, claimant testified his pain was a level 1 on a 10-point scale. However, he continues to suffer with flares in his symptoms every few days. During those events, he suffers from a throbbing pain at a level 5 or 6. The throbbing generally resides after 30 to 45 minutes. Claimant testifies he uses ibuprofen and babies his shoulder; the symptoms then resolve. Claimant testified the flares can occur without an inciting activity or with activities such as overhead movement, pushing, pulling, or reaching.

Claimant is not currently employed; he is enrolled at the University of Iowa, majoring in social work. At the time of evidentiary hearing, claimant was enrolled in 9 credit hours. His grade point average is a 2.0. Claimant expects to graduate in 2017. (Claimant's testimony)

In July 2015, claimant rejoined the Army Reserves. Claimant testified he holds a position in human resources; he earns approximately $500.00 per month in the Reserves. Claimant receives $3,015.00 per month in VA disability benefits. Claimant admits his VA benefits would be impacted by a return to gainful employment, but

testified he does not want to remain dependent on these benefits for life. (Claimant's testimony)

At the time of hearing, claimant was polite and personable; his demeanor gave the undersigned no independent reason to doubt claimant's veracity. However, review of the evidentiary record as a whole, including comparing claimant's testimony at deposition and evidentiary hearing, leads the undersigned to question claimant's veracity.

Claimant's medical records denote claimant sought treatment at the VA in May 2012. The contemporaneous medical records indicate a complaint of right shoulder pain, deny a specific mechanism of injury and denote symptoms present for two months by one notation and by three to four months by another notation. At deposition, claimant did not attribute the right shoulder pain to any specific injury, but rather to muscle fatigue. At evidentiary hearing, claimant testified to a specific mechanism of injury while playing softball. He indicated symptoms had been present for a couple days, as opposed to months, and that those symptoms were actually present in his back, "below" his shoulder blade. Claimant's deposition and hearing testimony also vary with respect to claimant's participation in MMA training contemporaneous to the May 2012 medical appointment.

Claimant's contemporaneous medical records provide generally consistent details regarding the etiology and location of claimant's injury. Claimant's deposition testimony similarly denied a specific injury. However, at evidentiary hearing, claimant provided a specific account as to the cause and onset of symptoms, as well as locating the injury to a body part not mentioned in claimant's medical records. This shift from uncertainty to absolute certainty after the passage of three years is questionable.

Most troubling to the undersigned is the variation present in the record with respect to claimant's accounts of the mechanism and timing of his alleged December 1, 2012 injury. At deposition, claimant testified with specificity regarding the timing of his injury. Claimant testified he believed he was going on break, messaged a friend at 12:01 p.m., and shortly thereafter, sustained the alleged injury. Claimant testified the injury occurred between 12:00 and 12:15 p.m. Claimant agreed he worked until 4:00 to 6:00 p.m., meaning he would have returned to work for a minimum of 4 hours after the injury. At hearing, claimant initially testified the injury occurred at the end of his shift, likely between 4:00 and 5:00 p.m. Following review of the video of the entrance/exit door, claimant identified the time of injury as 6:02 p.m., when he left work for the day.

I am able to reconcile claimant's initial testimony at evidentiary hearing with his testimony following review of the video. In each scenario, claimant sustained the injury at the end of a work day, with that work day ending within an approximately two-hour period. I am unable, however, to reconcile claimant's hearing testimony with his deposition testimony. By claimant's deposition testimony, claimant provided a very specific window of time during which the injury allegedly occurred. Claimant bolstered his testimony with details of a time-specific conversation with a friend. Most

troublesome with respect to the discrepancy is claimant's deposition testimony indicating claimant worked for an additional four to five hours after the work injury, as opposed to his hearing testimony which indicated the event occurred at the end of a work shift. When one then compares this disparate testimony with video of the alleged event, with no obvious signs of injury, I am left with further doubt regarding the occurrence of a work injury in any of the timeframes testified to by claimant.

Claimant also testified he obtained further medical treatment in 2014, including a surgical SLAP repair and subsequent physical therapy. However, there are no corresponding medical records in evidence to confirm his testimony.

Given the inconsistencies as outlined *supra,* I find claimant was not a credible witness.

CONCLUSIONS OF LAW

The first issue for determination is whether claimant sustained an injury on December 1, 2012 which arose out of and in the course of his employment.

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

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

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

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

At evidentiary hearing, after review of the video evidence, claimant testified he sustained the alleged work injury at 6:02 p.m. As outlined *supra*, this is the third version of claimant's testimony regarding the timing of the work injury on December 1, 2012.

Review of the video evidence demonstrates claimant paused only slightly when he exited at 6:02 p.m. There is nothing prolonged or abrupt regarding claimant's exit. Claimant's right arm was used to open the door; however, there is no associated jerking of the arm or shoulder. Claimant testified he suffered with immediate level 6 or 7 pain, but he did not grab his arm or shoulder, shake his arm, or even pause for a prolonged period as one might expect of an individual who recently sustained an injury resulting in significant pain. Claimant did not display any need to pause or recover and simply walked through the door. While he is within the camera frame, claimant is seen walking with his right arm hanging at his side and swinging slightly as he walked. This is not behavior expected of someone who just suffered a painful event. At evidentiary hearing, claimant testified he viewed himself on video subtly stutter on his feet and then look at his right shoulder; I observed no such behavior or any other behavior indicative of an accident or painful experience.

Subsequent to the alleged work injury on December 1, 2012, claimant engaged in MMA training in mid-December. I am unconvinced an individual with persistent level 6 pain, as testified to by claimant, would have undertaken such a grueling activity. It was not until after this admitted training episode and claimant's subsequent termination, that claimant presented for medical care. Dr. Bratkiewicz's note of the initial evaluation on December 24, 2012 indicates claimant reported he "pulled hard and wrenched" his shoulder while attempting to open a door; this history is inconsistent with the video depiction of claimant's alleged injury.

Similarly, Dr. Mathew's IME notes a history of pulling on a stuck door with "over 30 pounds of body weight." While I admit to difficulty appropriately visualizing the exertion of a precise amount of bodyweight; I did not view claimant exert any notable amount of force in his attempt to open the door. Dr. Mathew causally related claimant's

complaints to the alleged December 1, 2012 work event; however, there is no evidence he had knowledge of claimant's May 2012 right shoulder evaluation, reviewed the corresponding video evidence, or had knowledge of claimant's MMA activities. Dr. Ash, on the other hand, had knowledge of each of these relevant facts and opined claimant's complaints were not work-related.

It is claimant who carries the burden of proof on this issue. It is determined claimant has failed to prove by a preponderance of the evidence that he sustained an injury arising out of and in the course of his employment on December 1, 2012. Having determined claimant failed to prove he sustained an injury arising out of and in the course of his employment, consideration of the issues of causation as to permanent disability and extent of industrial disability is unnecessary, as moot.

ORDER

THEREFORE, IT IS ORDERED:

Claimant shall take nothing from these proceedings.

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

Costs are taxed to claimant pursuant to 876 IAC 4.33.

Signed and filed this 18th day of May, 2016.

Erica J. Fitch

ERICA J. FITCH
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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Right to Appeal: This decision shall become final unless you or another interested party appeals within 20 days from the date above, pursuant to rule 876-4.27 (17A, 86) of the Iowa Administrative Code. The notice of appeal must be in writing and received by the commissioner's office within 20 days from the date of the decision. The appeal period will be extended to the next business day if the last day to appeal falls on a weekend or a legal holiday. The notice of appeal must be filed at the following address: Workers' Compensation Commissioner, Iowa Division of Workers' Compensation, 1000 E. Grand Avenue, Des Moines, Iowa 50319-0209.