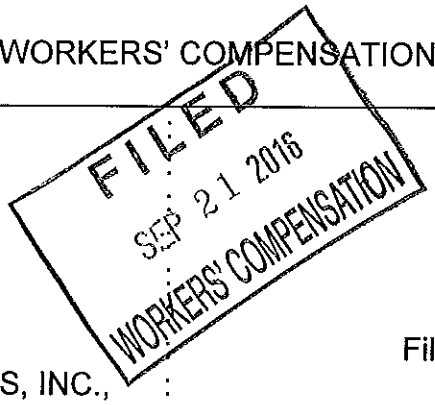
BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER



JACK MALLOY,

Claimant,

vs.

TEAM STAFFING SOLUTIONS, INC.,

Employer,

and

ACCIDENT FUND GENERAL INSURANCE COMPANY,

Insurance Carrier,
Defendants.

File No. 5049519

ARBITRATION

DECISION

Head Note Nos.: 1108.50, 1402.40

STATEMENT OF THE CASE

Jack Malloy, claimant, filed a petition in arbitration seeking workers' compensation benefits from Team Staffing Solutions, Inc., and their workers' compensation carrier, Accident Fund General Insurance Company. Hearing was held on May 31, 2016. Presiding at the hearing was Deputy Workers' Compensation Commissioner Erin Q. Pals.

Claimant, Jack Malloy, was the only witness who testified live at trial. The evidentiary record also includes claimant's Exhibits 1-6 and defendants' Exhibits A-D. With regard to claimant's Exhibits 1-6 all pages were admitted into evidence with the exception of page 47 which was withdrawn by claimant's counsel and page 46 which was only admitted for the limited purposes allowed under Iowa Code section 86.11. The parties submitted a hearing report at the commencement of the evidentiary hearing. On the hearing report, the parties entered into certain stipulations. Those stipulations are accepted and relied upon in this decision. No findings of fact or conclusions of law will be made with respect to the parties' stipulations.

The parties requested the opportunity for post-hearing briefs which were submitted on July 1, 2016.

ISSUES

The parties submitted the following issues for resolution:

1. Whether claimant sustained an injury on November 5, 2014, which arose out of and in the course of employment?

2. Whether the alleged injury was the cause of temporary disability?

3. Whether the alleged injury was the cause of permanent disability?

4. If the injury was permanent, what, if any, industrial disability did claimant sustain?

5. Whether claimant is entitled to reimbursement for an IME under Iowa Code section 85.39?

FINDINGS OF FACT

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

Mr. Malloy alleges that he sustained a compensable injury to his right shoulder when he fell at work on November 5, 2014. Defendants dispute that claimant injured his right shoulder and further contend that any right shoulder problems he is experiencing were preexisting.

Defendants submitted evidence of treatment Mr. Malloy received prior to the work injury. At hearing Mr. Malloy admitted that prior to the work injury in question he had been diagnosed with fibromyalgia, diabetes, and arthritis. Additionally, his primary care provider had been prescribing him hydrocodone. The records indicate that Mr. Malloy was experiencing right arm and shoulder pain. He underwent cervical x-rays on May 29, 2014. The x-rays revealed degenerative changes in the spine with neural foraminal stenosis on the right at C4-5 and C5-6. At that time he was taking Percocet. He was referred to Dr. Davis. Consideration was given to soft neck restrains and physical therapy if he failed to improve. (Exhibit 5, pages 202-05; Testimony)

Mr. Malloy was also seen on June 4, 2014, for an urgent visit due to severe pain in the right side of his neck, shoulder, and arm radiating down to the lateral hand. The notes indicate that he had been unloading gravel at his mother's home. It was felt he was experiencing radicular pain due to excessive activity and muscle spasm which was entrapping the nerve. Physical therapy was recommended. He was to follow-up as needed. (Ex. 5, pp. 206-208)

Mr. Malloy was seen again on June 24, 2014, with severe pain in the right side of his neck radiating across the right shoulder and down the right arm particularly laterally

to the base of the right hand. He reported he had been unable to perform any work for six weeks and was miserable. The notes indicate that they had been trying to get an MRI approved but it had been denied. (Ex. 5, pp. 210-11)

On July 17, 2014, he was seen at Great River Health Systems with severe pain in his neck and right parascapular area with radiation numbness and tingling in his arm and into some fingers. He reported that this had been going on for the past six weeks. Evidently, the pain started after he was shoveling some rock. He was assessed as having intervertebral disc disorder of cervical region with myelopathy. The plan was to proceed with an anterior cervical discectomy decompression. (Ex. 4, pp. 48-64) On July 23, 2014, Dr. Foster performed a cervical fusion at C6-C7. (Ex. 4, p. 89; Testimony) During his hospital stay Mr. Malloy developed some complications including delirium, paranoia, and hyper-respiratory failure. (Ex. 4; Testimony)

On August 1, 2014, Mr. Malloy was seen by Dr. Wilson for follow up of his anterior cervical fusion. He reported that the numbness and pain in his right arm was nearly completely gone except for the ulnar aspect of his right hand. He was to continue to follow Dr. Foster's orders regarding activity and follow up in one month. (Ex. 5) Mr. Malloy continued with his follow up care.

On September 8, 2014, Mr. Malloy was seen by orthopedic surgeon, Christopher Depuis, M.D. Mr. Malloy complained of right shoulder pain which radiated to the elbow, forearm, wrist, and hand. He reported that the pain started five years ago after a fall. He also complained of stiffness and weakness of the biceps, triceps and forearm. The assessment was shoulder pain and shoulder impingement syndrome. Mr. Malloy's subacromial joint of his shoulder was injected. (Ex. 5, pp. 226-29)

On September 15, 2014, Mr. Malloy underwent a head CT. The results were normal. (Ex. 5, p. 234)

Mr. Malloy returned to Dr. Dupuis on September 17, 2014 and reported that the injection was only helpful for a couple of days. An MR arthrogram of the right shoulder was recommended. (Ex. 5, pp. 235-38)

Mr. Malloy returned to the doctor's office on October 6, 2014, but they were still waiting for approval from Medicaid for the MR arthrogram. At that time he was taking several medications including Gabapentin, Flexeril, Tramadol, and Oxycodone. The shoulder range of motion was as follows: flexion 160 degrees, external rotation 90 degrees, abduction 80 degrees. Examination of the biceps revealed a positive Speed's test. Dr. Dupuis' assessment was shoulder pain, shoulder impingement syndrome, and SLAP lesion. Mr. Malloy reported that he would be starting a new job on October 9, 2014 at Siemens, which would involve a lot of repetitive motion with his right shoulder and he wanted another shoulder injection. Dr. Dupuis gave him another injection. Once again the doctor requested an MR arthrogram of the right shoulder. (Ex. 5, pp. 239-242)

Mr. Malloy testified that he was at work on November 5, 2014, when he slipped on resin and fell. He landed on his right shoulder and believes he lost consciousness. His co-worker had to wake him up. He testified that his right arm would not work. They had to cut the right sleeve off of his shirt because they could not get his arm pulled out of the sleeve. A Siemens report of injury was completed by Dan Davis on November 5, 2014. Claimant testified that this form had to be completed for him because he was not able to write. (Ex. 2, pp. 45-46)

On November 5, 2014, Mr. Malloy was seen in the emergency room of Fort Madison Community Hospital. He reported that he had fallen a number of feet while at work striking his head, back, and right shoulder. He reported that he was unconscious for a period of time. X-rays were taken. Mr. Malloy was seen by Mark O'Brien, D.O. who felt he had sustained a head injury. He was released home with pain medication. He was taken off of work until Monday. (Ex. 1, pp. 1-31; Ex. 5, p. 247-50)

Mr. Malloy returned to see Dr. Dupuis on November 10, 2014. The notes indicate that Mr. Malloy presented for follow-up right shoulder discomfort from fall five days ago. He was assessed as having shoulder pain, shoulder impingement syndrome, and SLAP lesion. Mr. Malloy was restricted to no reaching above his shoulders and no lifting over 20 pounds. The clinical note indicates that he had a recent history of shoulder pain and had two previous injections which provided temporary relief. The notes further state that he had scheduled an MR-A but he cancelled it because he wanted to try working and did not have time for surgery and recovery. (Ex. 1, pp. 32-35; Ex. 5, pp. 243-246)

Mr. Malloy returned to the occupational clinic on November 17, 2014; he was seen by Mary C. Bentler, PAC. He reported that he felt worse than he did last week due to too much activity at work. He felt that his right shoulder was "messed up." According to the notes, Mr. Malloy said that he previously had problems with his right shoulder that required surgery but he did not want to pursue surgery at that time. At this visit Mr. Malloy demanded an MRI of his right shoulder and low back. PAC Bentler recommended physical therapy for his right shoulder and low back. At the time of this visit he was taking 4-5 Percocet per day for his fibromyalgia and arthritis. However, he reported that the medication did not help with his new pain complaints. (Ex. 1, pp. 36-39)

On December 17, 2014, Mr. Malloy returned to see PAC Bentler. He reported that he liked attending physical therapy and felt that the TENS unit was especially beneficial for his back and shoulder. However, he continued to have significant pain which he rated as a 6. He was returned to work with restrictions of no bending, no squatting, no reaching above the shoulders with the right arm, no lifting greater than 20 pounds. He reported that his recent job duties included handling clothes at Salvation Army. He was referred to orthopedics due to his limited progress. (Ex. 1, pp. 40-44)

The next note or report in the file is dated May 18, 2015 from Dr. Neiman who issued a report to claimant's counsel. Dr. Neiman's report was based on his

examination of Mr. Malloy and a review of at least some of the records. Dr. Neiman felt Mr. Malloy had not yet reached MMI. He recommended an MRI scan of the right shoulder. He also recommended an MRI of his head. Despite the fact that Dr. Neiman felt he needed additional treatment, he provided him an impairment rating. (Ex. 6)

On June 19, 2015, R.D. Foster, M.D. issued a report to defense counsel. Dr. Foster is the physician who performed Mr. Malloy's C6-C7 neck fusion. The report indicates that Dr. Foster had reviewed several records with regard to Jack Malloy. After reviewing the information provided to him by the defendants' attorney, Dr. Foster opined that Mr. Malloy's complaints were related to his right shoulder, not his cervical spine. Thus, there was no material cause for complaints to his cervical spine. Furthermore, Dr. Foster felt that Mr. Malloy did not have a work injury to his cervical spine. Also, he did not sustain any permanent impairment to his cervical spine, nor did he require any additional treatment, or work restrictions. (Ex. C) Claimant does not contend that he injured his neck at the time of the November 5, 2014 fall.

On June 30, 2015, Dr. Dupuis signed a letter authored by defense counsel. By signing the letter Dr. Dupuis agreed that the letter accurately depicted his opinions. The letter indicates that it was his opinion that the November 5, 2014 work incident was not a material factor that caused or aggravated Mr. Malloy's right shoulder condition(s). Further, it was the doctor's opinion that the work incident was not a material causally contributing factor for the need for future treatment. Additionally, the doctor indicated that the work incident did not cause any permanent impairment, nor did it necessitate any permanent restrictions. (Ex. B)

Mr. Malloy testified that at some point he was seen by Atiba Jackson, M.D.

On November 4, 2015, defense counsel sent a letter to Dr. Jackson. Dr. Jackson signed a letter authored by defense counsel. By signing the letter he verified that the letter accurately reflected his opinions. The letter indicates that it was the defendants' understanding that he had been treating Mr. Malloy's right shoulder including arthroscopic rotator cuff debridement and repair with biceps tenotomy and subpectoral biceps tenodesis on June 18, 2015. The letter also states that Dr. Jackson had recently discussed Mr. Malloy's conditions with Dr. Foster, the cervical spine surgeon. The letter indicates that it was Dr. Jackson and Dr. Foster's opinions that Mr. Malloy's right shoulder complaints and treatment were not related to the work injury of November 5, 2014. His opinions were based on Mr. Malloy's significant pre-work injury issues and treatment. (Ex. A)

At hearing Mr. Malloy testified that he talked to Dr. Jackson about the November 6, 2015 letter. Apparently, Dr. Jackson had no recollection of the letter and asked Mr. Malloy to have his attorney write him a letter. On May 25, 2016, Dr. Jackson signed a letter authored by claimant's counsel. By signing the letter the doctor indicated that the statements in the letter were true. The letter states, "as far as the shoulder is concerned, this is a different situation and he would have had a substantial aggravation to the shoulder causing injury and causing the need for more surgery." (Ex. 7, p. 1)

The letter then asked for Dr. Jackson's opinion on the amount of permanent partial disability sustained by Mr. Malloy. I note that Dr. Jackson did not fill in the area left for him regarding permanent impairment. (Ex. 7) It is not clear if Dr. Jackson did not read the entire letter, did not notice the blank left for him to complete, or if he felt it was not an appropriate time to address permanency. There simply is no explanation for the incomplete letter.

Mr. Malloy testified at hearing that he had another MRI the week before the hearing which showed two tears. Initially, the plan was just to clean up the shoulder and hope the tears would heal themselves. However, now the plan involved his biceps muscle and involves sewing the tears shut. Because the claimant had recently undergone surgery, the doctor wanted to wait a few months before having him undergo another procedure. (Testimony) Unfortunately, the evidentiary record in this matter does not contain the medical records from this last appointment. In fact, there are no treatment records from Dr. Jackson in evidence.

Mr. Malloy continues to experience a lot of pain and he cannot reach or put his arm above his head. He feels he cannot return to work because of his right arm. (Testimony)

The first issue that must be determined is whether claimant's right shoulder was materially aggravated by the slip and fall on November 5, 2014. There are several different expert opinions in this matter.

Dr. Foster's opinions concern the cervical spine; not the shoulder. (Ex. C) Therefore, his opinions are not terribly helpful in determining causation on the shoulder.

Dr. Jackson's opinions have not remained consistent and are, at best, ambiguous. Because we do not have any of his treatment records in evidence and because both of his opinions were authored by the attorneys in this case, it is difficult to give much, if any, weight to these opinions. Furthermore, based on the evidentiary record in this matter it is impossible to discern what history Dr. Jackson based his opinions on. I do not find the opinions of Dr. Jackson to be helpful in this case. (Ex. 7; Ex. A)

Dr. Neiman, a neurologist, was hired by claimant's attorney to perform an IME in May of 2015. It is not clear what, if any, medical records Dr. Neiman had which predate the November 5, 2014, injury. Dr. Neiman rendered several opinions in this case. However, because it appears that Dr. Neiman did not have a complete history of Mr. Malloy's pre-injury condition his opinions simply cannot be relied upon. Therefore, I do not find the opinions of Dr. Neiman to be persuasive.

Dr. Dupuis has opined that the November 5, 2014, work injury was not a material factor that caused and/or aggravated/worsened/accelerated his right shoulder conditions. Dr. Dupuis is in the unique position of having examined Mr. Malloy's right shoulder both before and after the work injury. Because he was able to examine

claimant's shoulder both before and after the work injury in question I give his opinions great weight. Furthermore, Mr. Malloy selected Dr. Dupuis to treat him, so it can hardly be said that Dr. Dupuis is somehow biased against him. Based on Dr. Dupuis' opinions and based on the evidentiary record as a whole, I find that Mr. Malloy did not carry his burden of proof to show the right shoulder was materially aggravated by the November 5, 2014 fall. Further, I find that claimant has failed to carry his burden of proof to show that the alleged work injury caused the need for any medical treatment nor did it cause any temporary or permanent impairment or restrictions.

The next issue to be addressed is whether claimant is entitled to reimbursement in the amount of $850.00 for the Dr. Neiman IME pursuant to Iowa Code section 85.39. The IME took place on May 18, 2015. I find that claimant has failed to show that an evaluation of permanent disability had been made by a physician retained by the employer prior to this time. Therefore, claimant has failed to show entitlement to reimbursement under Iowa Code section 85.39.

CONCLUSIONS OF LAW

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

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.

Based on the above findings of fact, I concluded that claimant failed to demonstrate that his right shoulder was materially aggravated by the November 5, 2014 fall.

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).

Based on the above, I concluded Mr. Malloy failed to carry his burden of proof to show that the work injury caused the need for any medical treatment, caused any temporary disability, or caused any permanent disability. Thus, claimant failed to show entitlement to any additional benefits.

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. Claimant failed to show that the employer had obtained a prior permanent disability rating. Therefore, I conclude claimant has not established a right to reimbursement under Iowa Code section 85.39.

ORDER

THEREFORE, IT IS ORDERED:

Claimant shall take nothing from these proceedings.

Defendants shall file subsequent reports of injury (SROI) as required by this agency pursuant to rules 876 IAC 3.1(2) and 876 IAC 11.7.

Signed and filed this 21st day of September, 2016.

ERIN Q. PALS
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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EQP/sam

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.