BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

ALEVIA GREEN, Claimant, vs. NORTH CENTRAL IOWA REGIONAL SOLID WASTE AGENCY, Employer, and IMWCA, Insurance Carrier, Defendants.	File No. 5042527 APPEAL DECISION FILED APR 11 2016 WORKERS' COMPENSATION Head Note No.: 1800

Claimant Alevia Green appeals from an arbitration decision filed on December 19, 2014. Defendants North Central Iowa Regional Solid Waste Agency, employer, and its insurer, IMWCA, respond to the appeal. The case was heard on October 6, 2014, and it was considered fully submitted on November 21, 2014, in front of the deputy workers' compensation commissioner.

The deputy commissioner found claimant failed to carry her burden of proof that she sustained permanent disability resulting from a stipulated work injury which occurred on or about April 30, 2012. The deputy commissioner found claimant is not entitled to temporary disability benefits beyond what has already been paid by defendants. The deputy commissioner found claimant is not entitled to penalty benefits pursuant to Iowa Code section 86.13. The deputy commissioner also found claimant is not entitled to medical benefits pursuant to Iowa Code section 85.27 beyond those medical benefits already paid.

Claimant asserts on appeal that the deputy commissioner erred in finding claimant failed to carry her burden of proof that she sustained permanent disability resulting from the stipulated work injury. Claimant asserts the deputy commissioner erred in not finding claimant is permanently and totally disabled, either under an industrial disability analysis or under an odd-lot analysis, as a result of the injury. Claimant also asserts the deputy commissioner erred in failing to award the requested medical benefits.

Defendants assert on appeal that the deputy commissioner's decision should be affirmed in its entirety.

Having performed a de novo review of the evidentiary record and the detailed arguments of the parties, I reach the same analysis, findings, and conclusions as those reached by the deputy commissioner.

Pursuant to Iowa Code sections 86.24 and 17A.5, I affirm and adopt as the final agency decision those portions of the proposed arbitration decision filed on December 19, 2014, which relate to issues properly raised on intra-agency appeal with the following analysis:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The parties stipulated that claimant sustained an injury on April 30, 2012, which arose out of and in the course of her employment with defendant-employer. Claimant was working indoors at defendant-employer's recycling center when she was struck from behind by the large door of a roll-off recycling truck which had swung open. (Transcript pages 23-24) While some of the medical records suggest the door struck claimant's head, it was conclusively established that the door actually struck claimant's upper back and the back of her right shoulder, not her head. (Tr. pp. 24, 55-56)

When she was hit by the door, claimant fell to the floor and was rendered unconscious very briefly. (Ex. 4, p. 1) By the time EMS arrived, claimant was already alert and oriented. (Id.; Ex. 5, p. 8) The emergency personnel determined there were no lacerations to claimant's head. (Ex. 4, p.1; Tr. p. 56)

Claimant was transported by EMS to Trinity Regional Medical Center (TRMC) in Fort Dodge. Upon admission, claimant complained of a headache and light sensitivity, but denied any nausea, vomiting or light-headedness. (Ex. 5, pp. 3, 8) However, a CT scan of claimant's head taken at TRMC on the day of the accident was questionable for an intracranial frontal lobe hemorrhage (Ex. 5, p. 10), so claimant was taken that same day to Iowa Methodist Medical Center (IMMC) in Des Moines.

Another CT scan of claimant's head was performed at IMMC on May 1, 2012, the day after the accident. This second CT scan demonstrated claimant had no hemorrhage or any other abnormality. (Ex. 6, p. 12; Ex. D, p. 62) On May 1, 2012, claimant reported only a mild headache, with no other symptoms or complaints. (Ex. 6, p.20)

On May 2, 2012, claimant was evaluated at IMMC by John Piper, M.D., neurosurgeon, who noted claimant's normal head CT scan and lack of any cognitive problems or issues. (Ex. 6, p. 33) Based upon the examinations and findings while claimant was at IMMC, it was determined there was no need for claimant to participate in IMMC's inpatient rehabilitation program for closed-head injuries. (Ex. 6, pp. 13, 46) Consequently, when claimant was discharged from IMMC on May 2, 2012, the only

recommendation was that she followup with Dr. Piper in two weeks. (Ex. D, p. 62) Apparently the follow-up evaluation with Dr. Piper never took place.

On May 2, 2012, while claimant was at IMMC, she was also evaluated by Robert Rondinelli, M.D., physical medicine and rehabilitation specialist. (Ex. 6, pp. 13, 68) Claimant returned to Dr. Rondinelli for re-evaluation on May 17, 2012. When claimant returned to Dr. Rondinelli, she had a number of new complaints. Dr. Rondinelli noted the following, in pertinent part:

> She now returns having been seen by a primary MD and requesting further evaluation. She now has global headaches, diffuse anxiety, and distress; which she cannot characterize well. She apparently has some swallowing problem but denies choking. She complains of a dry throat and things "just are not right." She has photophobia, global headaches, and a semi-positive review of systems. She is tearful during the interview, and it is difficult to extract a reliable and consistent history.
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> PHYSICAL EXAMINATION: I examined her briefly. The pupils are equal and reactive to light and accommodation. Extraocular movements are intact with no nystagmus. Gaze is conjugate. Tongue is midline. Her tone is symmetric. Coordination shows no gross dysmetria. Deep tendon reflexes are mildly brisk, but she does have a few beats of clonus at the ankles bilaterally, which is abnormal. There is mild spreading of lower extremity treflexes bilaterally as well. Her strength is nonfocal. She shows self inhibition to movement, and with distraction I could improve her effort with same. Her gait is dysfunctional with significant nonphysiological elements. She has decreased arm swing and maintained a protective posture of her right upper extremity.
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> ASSESSMENT: Based upon the above presentation, Ms. Green is approximately 17 days post grade 3 concussion with escalating anxiety and dysfunction with a global headache, labile effect, and dysfunctional behavior consistent with emotional dysregulation and symptom magnification. I cannot rule out underlying pathology at this time.
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> PLANS: I contacted Dr. Thorson in the emergency room, and he is agreeable to evaluating the patient further at this time. She may require a repeat head CT and reassurance and anxiolytic treatment. She may require an urgent or emergent referral to psychiatry. I will be happy to see her back in followup after clarification of the above to determine if she has some sequelae of a postconcussive nature in need of further specific therapies. I cannot rule out medication-seeking behavior or other secondary gain at this time

(Ex. 6, pp. 68-69)

Immediately following Dr. Rondinelli's evaluation on May 17, 2012, claimant was examined by Ryan Thoreson, D.O., in the IMMC Emergency Department. (Ex. 6, p. 70-76) Dr. Thoreson determined claimant's neurologic changes did not fit within anything specific, so he recommended further psychiatric and neurologic evaluation. (Id.)

On May 29, 2012, claimant had her first examination with Charles Mooney, M.D., occupational medicine specialist at McFarland Clinic in Ames. Dr. Mooney noted the following, in pertinent part:

> ASSESSMENT:
>
> 1. Status post closed head trauma with loss of consciousness and post-concussive syndrome. Certainly all of her symptoms are not consistent with injury and there appears to be significant psychological overlay. It is unusual for someone to be complaining of anxiety and depression symptoms this early after a head trauma and her symptoms appear to be at least moderately exaggerated.
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> 2. Symptoms of right shoulder pain. She does appear to have a contusion to the upper trapezius and this may be contributing to her symptoms. She is significantly guarding her shoulder motion which may delay recovery and rehabilitation.
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> PLAN: I had a lengthy discussion with Ms. Green and her sister who was present after the initial assessment as well as her nurse case manager, Marsha Armstrong. It is my opinion that her neurologic symptoms, complaints of memory deficit, and speech changes are not completely consistent with expected recovery and I have recommended a neuropsychology evaluation to include testing to better delineate her findings.
>
> Further she should have consultation with a local neurologist and I have recommended she be evaluated by Dr. Kitchell regarding medication intervention for disturbance in sleep and mood in the setting of post concussive syndrome.
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> She requested pain medications and anxiety medications, which I have declined. I specifically informed her that I would not recommend the use of strong opiates as they would further affect her complaints of mood disturbance. I did provide her tramadol 50 mg 1 to 2 q. 8 hours if needed for pain. Recommended over-the-counter Tylenol or Advil and continued physical therapy. I do not feel that additional intervention regarding her sleep disturbance or mood disturbance is warranted at this time prior to neurological and neuropsychological consultation.

> After discussion with her case manager, it is evident she will be referred to Dr. Jim Andrikopoulos for neuropsychiatric evaluation. I concur with this as he can perform specific testing which will definitely aid in her diagnosis.
>
> WORK STATUS: It is my opinion she may not return to work at this time. I will see her back after consultations are obtained.
>
> I did encourage Ms. Green to try to begin as normal activities at home as possible including outings with her sister for shopping, walking, etc.

(Ex. 9, p. 5)

The first evaluation of claimant by Michael Kitchell, M.D., took place on June 8, 2012. (Ex. 10, pp. 1-2) Dr. Kitchell advised claimant that 99 percent of those who sustain similar injuries recover fully. Dr. Kitchell reassured claimant there was no indication of any permanent brain damage. Dr. Kitchell noted that neuropsychological tests would be helpful. (Ex. 10, p.2)

Jim Andrikopoulos, Ph.D., ABPP, performed a neuropsychological evaluation of claimant on June 27, 2012. Dr. Andrikopoulos stated the following, in pertinent part, in his detailed, 28-page report:

> 5) With the above caveats in mind, below are observations regarding the clinical interview that suggest [claimant's] symptoms are not wholly consistent with the typical course of a post-concussive syndrome and suggest the fabrication and or exaggeration of symptoms.
>
> a) The severity of the patient's complaints (as outlined in the Cognitive Symptoms section of this report (see the second and fifth paragraphs of that section) is out of proportion to a mild head injury.
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> b) The number of symptoms the patient complained of is greater than would be expected. Patients with mild head injury, whiplash or concussion do not have this many symptoms so [sic] three months post injury. The patient complained of over 30 symptoms (of the 50 asked).
>
> c) Patients in litigation report more symptoms when asked directly than they volunteer. The patient volunteered few symptoms (i.e., headache, right arm pain and dizziness) when the question of what symptoms the patient has was posed in an open-ended format. ("Tell me all the symptoms you still have as a result of the accident?"). but admitted to over 25 more when asked directly about specific post-concussive symptoms.
>
> d) Most (all except 3 of the 30 symptoms) of the cognitive and physical complaints reported by this patient are getting worse or remained the same without improvement. This is inconsistent with what would happen in mild head injury, concussion or whiplash injury. The rule of thumb in

cases of post-concussive syndrome is that patients get better. In the most extensive clinical interview regarding their symptoms completed to date, this patient's symptoms have not improved. In fact, they have gotten worse, or in some cases have remained the same. Symptoms arising from a traumatic injury (e.g., head injury, stroke, etc) generally improve, not worsen.

When a patient does not respond to treatment, it generally means one of three things. One is that the diagnosis is not accurate and the patient is being treated for the wrong thing. This seems unlikely since concussion is a very common condition that many doctors treat. The second possibility is that the patient's symptoms are refractory to treatment. It is very improbable that a minor injury would result in refractory symptoms, as post-concussive symptoms are common symptoms subject to treatment. The third possibility, and the one that seems most probable, is that the patient is not getting better because they are not truly having the symptoms that they report, or they are not as severe as the patient reports. This may explain the "lack of improvement."

e) One of the most salient features of a malingered interview is the qualitative aspect of the patient's responses. A reading of the Patient Interview sections gives a flavor of the defensiveness and ambiguity that characterize the patient's responses.

The feigned interview is characterized by inordinately long pauses with vague, vacillating and contradictory answers. The symptoms volunteered often lack detail. Questions can be met with tangled and confused explanations or even non-responsiveness. There may be many "I don't know" responses to basic questions such as symptom onset or course. The patient narrative lacks flow and is awkward. Coming up with believable symptoms is difficult. The reason is when asked about a symptom they do not have, they must decide on the spot if it is a symptom they want to endorse. This results in disproportionately prolonged pauses in some cases. This long pause becomes especially notable when the symptom the patient is being asked about is straightforward. If the patient manages to do this without hesitation, they are then faced with the even more difficult task of providing the onset and course of the symptom, never mind coming up with an incident illustrating the symptom. It can take multiple queries to obtain an answer. The patient may say the symptoms are hard to describe or explain or might even admit, "I know it does not make sense." Such statements do not arise from the inability to articulate the problem, but the realization that they are not communicating the symptoms in a believable manner.

f) In regard to the vagueness of the interview, notable were the contradictory statements regarding her symptoms in course of the

interview. For example she reported initially problems with multiplication tables (she could not give me the answer to two single digit multiplication problems) but denied that she can no longer do these problems on paper. In the neuropsychological interview she reported her pain had not improved but in the Pain Interview, she reported that treatment did result in improvement. On the Neuropsychological Interview she reported that her pain has affected her relationship with her kids (when she was asked about family stress). She reported the same thing in the Employment Interview. Yet when asked in the Pain Interview if her pain has affected her relationship with her family and friends she said no. After stating that her phonophobia has improved she volunteered that "Everything has gotten better" contradicting the Neuropsychological Interview in which the overwhelming number of her symptoms have not improved. Variability, not only in test performance, but in the reporting of symptoms, is one of the hallmarks of malingering.

g) In trauma, symptoms onset should be temporally related to the injury, especially cognitive, motor and sensory symptoms. Memory, language, episodes of confusion, speech problems, change in her taste, and tremor (to name a few symptoms) began in June and tingling at the end of June. This does not make any "neurological sense."

h) In cases of possible malingering, patients may report symptoms that may be idiosyncratic and not typical of post-concussive syndrome. She reported some severe symptoms in the form of not being able to recall the day of the week, the names of people she knows very well and no recall of the whole day before. What is idiosyncratic is when I asked her for the frequency she reported that each of these rather severe symptoms happened to her only twice. Three different symptoms occurring on only on [sic] two occasions is a little peculiar.

i) There is a discrepancy between self-reported memory loss and preserved memory on formal testing. Simply put, a patient complaining of not recalling what happened the whole of the previous day (she reported this happened twice) will not pass tests of recent memory. This patient's memory (delayed recall) was intact.

j) If we assume this level of psychological distress and claimed impairment this severe, then not seeking psychiatric treatment needs explanation. One parsimonious explanation is that she is not suffering from the level of distress she claims. The over-reporting of psychiatric symptoms on the personality testing is the best evidence of this.

k) In cases where exaggerated or malingered symptoms are present, we find that no disinterested party has observed these symptoms aside from the patient, their family, or friends. I term this the "unverifiable source"

phenomenon – the patient's symptoms cannot be verified independent of self-report. This patient's (sic) was asked who else observed her symptoms and she responded, "I am not around people."

l) In cases of possible malingering a select number of symptoms reported by the patient are chosen and the patient is asked when they first reported them, to whom, and if they have been provided with any explanation for why they have those symptoms. Unexplained symptoms, assuming a competent examiner, can mean a couple of things: what the patient has is rare or is not real. The symptoms that are chosen for this inquiry are symptoms that are believed to not exist or are exaggerated. She could not tell me who she reported the memory and multiplication problems to as well as the tremor and speech problems.

m) When a patient has unexpected impairment on a select number of tests, they are shown the results and asked if this is a problem that they had before the injury. The cognitive domains that are chosen for this inquiry are impairments that cannot be expected to be the result of the injury, either because such an injury would not result in such severe impairment, or the impairment does not make any neuroanatomical sense given what we know about the injury. In this case we have a mild head injury. The patient had a low average fund of knowledge as measured by the Information subtest. (e.g., Who was the President during World War I) and a 4th grade reading level. She was read some easy information subtests items she missed and she reported that this is something she would have known before the accident. She reports that her reading level represents a decline. Loss of these two cognitive abilities would be associated with catastrophic brain injuries, not a mild head injury. These complaints are factitious. In this particular case, given her poor academic achievement this is likely pre-existing. She chose to attribute it to the injury, possibly out of embarrassment, but in the context of the litigation malingering would be the more salient reason.

n) As outlined above, the personality testing supports the likelihood that the patient's subjective symptoms are exaggerated.

(Ex. F, pp. 73-75)

Claimant returned to Dr. Mooney for re-evaluation on August 8, 2012. In his report for that evaluation, Dr. Mooney noted the following, in pertinent part:

Since I have seen her last, she has completed a course of physical therapy. These records were faxed to me and they are reviewed. There is significant discrepancy in performance and her pain complaints. She had physical therapy from 5/14/12 through 7/18/12 without substantial improvement.

She continues to complain of headaches, pain in her neck, pain in her right shoulder and pain in her arm. Her initial conversation with me states that she is absolutely unchanged and "the same" since my initial consultation.

I have also received consultation that was performed with Dr. Kitchell. He felt that she had evidence of some mild post-concussive symptoms and headache. She has been taking nortriptyline and occasional Midrin for her pain complaints. She reports headaches nearly daily. She also continues to report difficulty with memory, and concentration.

Neuropsychology evaluation was performed by Dr. Andrikopoulos and although his complete assessment is not available, he did provide a letter dated today. He has no recommendations for further assessment and treatment from a psychological or cognitive standpoint, noting there are significant inconsistencies and over reporting of symptoms.

. . .

ASSESSMENT: Status post cervical strain, head trauma and right shoulder strain. There was significant variation throughout the physical therapy course. There is significant variation in her pain complaints and evidence of symptom magnification based on her neuropsychiatric testing. It is my opinion that she is now 90 days post-injury, has an essentially normal physical examination and no objective findings to correlate with her ongoing complaints.

Symptoms of postconcussive syndrome persist with complaints of headache. Again, neuropsychiatric testing does not correlate well as there evidence (sic) of symptom magnification. I will leave any additional treatment regarding her postconcussive symptoms to Dr. Kitchell and have recommended that she be reassessed by him.

Medical case management meeting was held with nurse case manager, Marsha Armstrong. It is my opinion that Ms. Green has reached maximum medical improvement as it relates to the injury of 04/30/12, pending Dr. Kitchell's concurrence.

WORK STATUS: It is my opinion based on her physical examination that she can return to work without restriction at this time. I do not anticipate any further followup here.

(Ex. 9, pp. 9-10)

Claimant returned to Dr. Kitchell on August 30, 2012. In his report for the evaluation, Dr. Kitchell noted the following, in pertinent part:

> Alevia returned for followup of her headaches. She reports that since she was started on the Nortriptyline and Midrin she has had improvement. Her headaches are not as severe and she does not have photophobia any more. She still has a little sensitivity to noise and sensitivity on her scalp to touch. She has complained of some occasional dizziness, but she says where she is working it is very hot and she has to sit down sometimes to keep from getting more dizzy. Her anxiety, she says, has definitely improved with the help of some Zoloft. She is currently taking 50 mg per day. She is now taking Nortriptyline 30 mg at bedtime and Midrin on a p.r.n. basis every 4 hours.
>
> . . .
>
> I believe Alevia is improving with regard to her migraine headaches. I told her that with this much improvement I am very optimistic that she will eventually get over these headaches. I will increase her Nortriptyline to 35 mg q.h.s. for a week, and then she will take 50 mg q.h.s. She will continue to use the Midrin on a p.r.n. basis. I encouraged her as before to stay active, and I told her again that she should try to be active rather than rest very much. With her cognitive testing results showing no evidence of any acquired brain injury, but with low, probably premorbid scores, the only major finding of her neuropsychological testing was gross over reporting of her symptoms, probably in the context of her workers' compensation claim. Dr. Andrikopoulos did not have any other suggestions for treatment.
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> I will see her again on a p.r.n. basis if there are other neurological questions or concerns.

(Ex. 10, pp. 3-4)

Following Dr. Kitchell's evaluation on August 30, 2012, there was a five-month gap in treatment followed by re-evaluation by Dr. Mooney on February 5, 2013. In his report for that evaluation, Dr. Mooney noted the following, in pertinent part:

> She now presents for reevaluation with numerous complaints, including complaining of pain in her right shoulder going down her arm, pain into the palm of her hand, being sore with movement. Feels that she is weak, feels like she is intermittently numb, and is also now complaining of low back pain. She feels that her right calf feels numb and it is restless at night. She thinks that her migraines are getting worse, and she has anxiety symptoms and chronic fatigue.
>
> She denies any re-injury or new injury. She has been able to maintain her regular activities, and currently is working in her previous employment.

She is not reporting any new medications. She has not sought additional outside treatment.

She was evaluated by Dr. Kitchell who felt that her neurologic symptoms related to the concussion were resolving. He did recommend ongoing treatment for migraine with nortriptyline at night when he saw her last in 2012.

PHYSICAL EXAMINATION: Today reveals her cervical range of motion to be smooth and fluid. She rotates 70 degrees left and 70 degrees right, flexes 45 degrees, and extends 40 degrees. She does not demonstrate paracervical spasm. She does guard her right shoulder. She does not demonstrate any distinct tenderness or triggering into the trapezius.

Range of motion of the bilateral shoulders is normal in abduction, flexion, internal, and external rotation. Rotator strength is 5/5 on the left, and she demonstrates breakaway after initial 5/5 on the right. She does not demonstrate significant impingement findings. I do not really isolate symptoms into the bicep or into the rotator mechanism. She complains of more axillary pain. There is no palpable muscle spasm or mass. Scapular range of motion appears normal without crepitus. She does not demonstrate crepitus in the shoulder joint with Hawkins or Neer's testing.

Examination neurologically reveals that she has normal deep tendon reflexes in the biceps, triceps, brachioradialis, and deltoid. Her grip strengths are measured by Jamar dynamometer with non-bell curve findings on the right and left. On the right setting 1 is 18 pounds, setting 2 is 40 pounds, setting 3 is 40 pounds, setting 4 is 42 pounds, setting 5 is 40 pounds; and on the left setting 1 is 55 pounds, setting 2 is 70 pounds, setting 3 is 50 pounds, setting 4 is 85 pounds, and setting 5 is 75 pounds. She does not demonstrate loss of sensation to light touch or pinprick.

Manual muscle testing of wrist extension and flexion on the right reveals breakaway. She does not demonstrate cogwheeling. She demonstrates breakaway with biceps flexion strength on the right compared to the left. Lower extremity neurologic examination reveals normal deep tendon reflexes at the knee and ankle. She has no neural tension findings. Thoracolumbar motion is essentially normal. She is able to get fingertips within 20 cm of the floor. She does not demonstrate neural tension findings or weakness to hallucis testing, dorsiflexion or plantar flexion of the feet, and she is able to squat and heel-toe walk without difficulty. Romberg test is negative. Cranial nerves II through XII appear intact. Funduscopic examination is normal. She does not demonstrate any nystagmus. Three of five Waddell's findings are positive.

ASSESSMENT: Complaints of headache, neck pain, and right shoulder pain. She has an essentially normal examination with nonphysiologic findings and no evidence of neurologic dysfunction to suggest radicular pain.

PLAN: My findings were discussed with Ms. Green. She requested an MRI of the right shoulder. I could find no indication to pursue an MRI as based on her examination an MRI is unlikely to provide any diagnosis that would be amenable to intervention based on a normal examination. I do not see any evidence that she has radicular symptoms, and her complaints are out of proportion to her findings, which are significantly inconsistent.

I would not recommend additional imaging or intervention. I did discuss that she could use p.r.n. ibuprofen for her headaches, and recommending normal activities. Discussed that second opinion could be pursued through a discussion with her claim adjuster.

Previous opinion of MMI is unchanged.

Followup here will be p.r.n.

(Ex. 9, pp.17-18)

Despite Dr. Mooney's stated opinion that an MRI was not necessary, claimant had an MRI of her cervical spine on March 25, 2013. As Dr. Mooney suspected would be the case, that MRI was unremarkable. (Ex. 12, p. 8) An MRI of Claimant's brain taken on June 25, 2013, also was unremarkable. (Ex. B, p. 55)

At the direction of her attorney, claimant underwent an independent medical evaluation (IME) on April 23, 2013, with Robin Sassman, M.D., occupational medicine specialist in Ankeny. (Ex. 18) In her report, Dr. Sassman stated claimant's diagnoses for the work injury are:

1. Head trauma.
2. Cervicalgia.
3. Right shoulder pain.
4. Headaches.

(Ex. 18, p. 7)

Dr. Sassman stated claimant has ten percent impairment of the whole person for the head trauma, three percent impairment of the whole person for headaches, five percent impairment of the whole person "due to nonverifiable radicular complaints," and

six percent impairment of the right upper extremity which converts to four percent of the whole person for the right shoulder. Dr. Sassman's individual impairment ratings combine for a single whole body impairment rating of 20 percent. (Ex. 18, pp. 7-8)

Dr. Sassman recommended permanent restrictions for claimant of limited lifting, pushing, pulling and carrying to 20 pounds rarely from floor to waist, 20 pounds occasionally from waist to shoulder and 20 pounds rarely over the shoulder. Dr. Sassman recommended that claimant rarely crawl or kneel and that she not walk on uneven surfaces or climb ladders. Dr. Sassman recommended that claimant rarely use stairs. Dr. Sassman also recommended that claimant limit upper extremity activities such as gripping and grasping to at, or below, shoulder height on an occasional basis. Dr. Sassman stated she would not recommend travel for claimant, nor the use of vibratory or power tools. (Ex. 18, p. 8)

At the direction of her attorney, claimant underwent a neuropsychological evaluation with Dan Rogers, Ph.D., neuropsychologist in Fort Dodge on December 16, 2013. In his report for that evaluation, Dr. Rogers opined that as a result of the work incident, claimant did sustain a significant brain injury, which Dr. Rogers believed was evidenced by small hemorrhages in both sides of the frontal lobes of claimant's brain. (Ex. 19, p. 3)

At the request of defendants' attorney, Dr. Kitchell issued a report on March 31, 2014, in which he stated the following, in pertinent part:

> In reviewing her records, I think it is quite clear that Ms. Green did not sustain any intracranial hemorrhage or any significant brain damage from the accident of 04/30/12. The records clearly state that she was hit in the back of the head and she did have a brief loss of consciousness with a brief period of amnesia following the head trauma. It is quite clear from the records that the original concern about her head CT scan showing some questionable small "hyperintensities" actually was not a hemorrhage, but actually an artifact because of her hyperostosis frontalis interna. I believe the main reason she was transferred to Des Moines was not her clinical status, but this questionable CT scan. I reviewed the notes from Dr. Piper, the neurosurgeon, who even on the 1st evaluation was not convinced that there was any intracranial hemorrhage. He said it was "hard to tell" whether these findings were due to any hemorrhage or an artifact. In fact, Dr. Piper did not find any significant abnormalities other than that she was a little amnestic for what had occurred right after her head injury. He said that otherwise her memory was fairly good.
>
> She was also seen by other physicians in Des Moines. Dr. Rondinelli saw her during her original hospital stay at Iowa Methodist and there were definite signs that he noted also on her subsequent examination on 05/17/12 of some "nonphysiological" abnormalities. He also felt that she

had "symptom magnification" and she had a "semi-positive review of systems."

Dr. Thoreson, who also saw her on 05/17/12 in the Emergency Department in Des Moines, felt that she had "psychosomatic factors." He found that she gave a very poor effort and she had some slurring in her speech that he did not think was due to an organic problem.

The key finding in this case is that the repeat CT scan on 05/01/12 at Iowa Methodist as well as a repeat scan on 05/17/12 at Methodist Hospital in Des Moines showed no evidence of any intracranial hemorrhage or swelling. This means that the questionable findings of 04/30/12 were not due to a hemorrhage or any trauma but were simply an artifact. If she had a hemorrhage on 04/30/12, the repeat scan the next day would have shown not only the hemorrhage but would have shown some swelling around the region of the hemorrhage.

You had asked me to review both Dr. Rogers' neuropsychological report and Dr. Andrikopoulos' report and I can state unequivocally that I disagree with Dr. Rogers' conclusions. He bases his conclusions on the erroneous impression that there was some intracranial hemorrhage and some definite signs of intracranial damage. Dr. Rogers' results of his neuropsychological testing are simply consistent with Alevia Green's poor performance in her early years. She is clearly of below average intellect and clearly has some learning disabilities. Those findings that Dr. Rogers cited on her cognitive testing are simply related to her lifelong history of low intellect and poor cognitive performance.

With regard to Dr. Andrikopoulos' report, I do believe there is evidence to support his concerns that Alevia has evidence of exaggeration, fabrication, and "over-reporting of symptoms." She had this tendency when I saw her, when Dr. Rondinelli saw her, and when Dr. Thoreson saw her. These multiple somatic complaints are an indication of some symptom magnification and psychosomatic problems, or what I would also agree are nonphysiological disturbances in her function.

In conclusion, therefore, there is simply no evidence that Ms. Green had anything more than a minor concussion with a brief loss of consciousness and a brief period of amnesia. These types of minor concussions occur frequently in athletes and though we certainly want to avoid any further concussions in those cases, they are certainly not an indication of any permanent neurological injuries. There is simply no evidence that her head CT scan showed any abnormalities. The original scan simply showed artifact and the subsequent scans prove that there was no hemorrhage or contusional brain injury.

> This patient definitely has some exaggeration, symptom magnification, and nonphysiological findings that are related to her behavior and are not related to any brain injuries.

(Ex. C, pp. 58-59)

When Dr. Kitchell was deposed by defendants on September 24, 2014, (Ex. A), he gave the following testimony regarding his opinion that claimant did not sustain a permanent brain injury:

1. Upon his examination of claimant on June 14, 2012, claimant showed no sign of head trauma, such as lumps or bumps on her head. (Ex. A, p. 3 – Deposition p. 12)

2. "I did feel that there was some problem with her cooperation and with her being as straightforward as most patients would be. And so I suggested looking for some possible personality disorders that could be playing a role in these multiple physical complaints because I didn't find much on way of an objective abnormality on her exam, yet she had a lot of complaints." (Ex. A, p. 4 – Dep. pp. 14-15)

3. "Basically everything that I checked, which is her cranial nerves, her speech, her coordination test, her balance and reflexes were all normal; in other word, her exam was, again, normal. (Ex. A, p. 5 – Dep. p. 17)

4. When questioned about his clinical note for his second evaluation of claimant on August 30, 2012, Dr. Kitchell stated, "What I mentioned there was with her cognitive testing results that she had, there was no evidence of any acquired brain injury, but she did have some problems with her intellect before this accident, and so the only major finding with Dr. Andrikopoulos's report was that there were some signs that she was over-reporting her symptoms, and probably in the context of a workers' compensation claim." (Ex. A, p. 5 – Dep. p. 18)

5. When questioned about the validity of Dr. Andrikopoulos' opinions and findings, Dr. Kitchell stated, "It was definitely consistent with what I had seen on the previous exam where there was some exaggeration or lack of full cooperation." (Ex. A, p. 5 – Dep. p. 18)

6. Regarding the findings of the three CT scans, the one performed on the date of the injury, the second one performed on May 1, 2012, the day after the injury, and the third CT scan performed on May 17, 2012, Dr. Kitchell testified, "So the fact that there was no bleeding and there was no swelling on the CAT scan the very next day, plus Dr. Piper, the neurosurgeon, even questioned whether that was bleeding or whether it was just the bone, it is very clear that there was no hemorrhage, there was no swelling, there was no significant brain injury. And,

again, the third CAT scan that was done on May 17 shows no hemorrhage, no bleeding, no swelling. (Ex. A, p. 6 – Dep. pp. 22-23

7. Dr. Kitchell reiterated that he disagreed with Dr. Rogers' conclusions and he explained why: "Dr. Rogers's impression was that she did have a significant brain injury and he attributed the low scores he found in a number of areas on her functioning, he attributed those low scores to this traumatic brain injury, but as I said, Dr. Rogers was under the impression that there was some bleeding in the brain, that there was some significant abnormality on the CAT scan, and that was simply just not true. (Ex. A, p. 6 – Dep. p. 24)

Claimant introduced into evidence at hearing a vocational assessment report from Kent Jayne, M.A., M.B.A, certified rehabilitation counselor. In his report, dated April 27, 2014, Mr. Jayne stated the following, in pertinent part:

> Ms. Green's cognitive limitations, her noncompetitive clerical abilities, and her psychological diagnosis and limitations as outlined by Dr. Rogers have rendered Ms. Green incapable of substantial gainful activity and competitive employment at the present time. Her residual services are so limited in quality, dependability, or quantity that a reasonably stable labor market for them does not exist. The sequelae of her injury wholly disables her from performing work that her pre-injury experience, training, education, intelligence, and physical capacities might otherwise permit her to perform.

(Ex. 23, p. 13)

I. Permanent Disability

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 Elec. 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.

The question of causal connection is essentially within the domain of expert testimony. The expert medical evidence must be considered with all other evidence

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

The burden of showing that disability is attributable to a preexisting condition is placed upon the defendants. Where evidence to establish a proper apportionment is absent, the defendants are responsible for the entire disability that exists. Bearce, 465 N.W.2d at 536-537; Sumner, 353 N.W.2d at 410-411.

This case involves a classic battle of expert witnesses. After reviewing all of the evidence, I affirm the deputy commissioner's finding that claimant did not meet her burden of establishing that the work injury of April 30, 2012, caused any permanent disability or loss of earning capacity. I base this on the following factors:

Symptom magnification and non-physiological complaints by claimant were observed and noted by Dr. Rondinelli and by Dr. Thoreson when they treated claimant at IMMC on May 17, 2012, less than three weeks after the injury occurred. (Ex. 6, pp. 68-69)

Dr. Mooney observed and noted symptom magnification and non-physiological complaints every time he evaluated claimant on May 29, 2012, on August 8, 2012, and on February 5, 2013, and Dr. Mooney found no evidence of a permanent brain injury or any permanent physical injury. (Ex. 9, pp. 3-5, 9-10, 17-18)

Dr. Kitchell also clearly observed and noted symptom magnification and he noted non-physiological complaints both times he evaluated claimant on June 8, 2012, and on August 30, 2012. Dr. Kitchell also found no evidence of a permanent brain injury. (Ex. 10, pp. 1-4)

When Dr. Andrikopoulos performed his neuropsychological evaluation and issued his report, he also reported evidence of symptom magnification by claimant. (Ex. F) Claimant attacks Dr. Andrikopoulos in her appeal brief because of his reputation for bias. Claimant also asserts Dr. Mooney and Dr. Kitchell based their opinions in this matter on Dr. Andrikopoulos' report. (Claimant's Appeal Brief, pp. 27-28) The undersigned acknowledges Dr. Andrikopoulos' reputation for bias, however I find in this particular case, while his opinions are consistent with the opinions of Drs. Rondinelli, Thoreson, Mooney and Kitchell, Dr. Andrikopoulos' opinions actually have no bearing on the outcome. It is clear from reading the records of Dr. Rondinelli, Dr. Thoreson, Dr.

Mooney and Dr. Kitchell that they base their opinions on their own observations made during their evaluations of claimant.

I give the greatest weight to the opinions of Dr. Kitchell, claimant's treating neurologist. As a neurologist, Dr. Kitchell is a highly-trained and reputable specialist who has more than 35 years of treating closed-head injuries on a regular basis. (Ex. A, pp. 1-2 – Dep. pp. 4-8) He is clear and consistent throughout his clinical notes, in his report, and in his deposition testimony in this matter. (See, e.g., Ex. 10 and Ex. A) His report of March 31, 2014, leaves absolutely no doubt that his own observations and his own treatment of claimant have convinced him claimant did not sustain a permanent brain injury. (See, e.g. Ex. C) Dr. Kitchell's opinions are objectively supported by the three CT Scans taken on April 30, 2012, the day of the injury, on May 1, 2012, the day after the injury, and on May 17, 2012, less than three weeks after the injury. (Ex. 5, p. 10; Ex. 6, p. 12, 34, 78) Dr. Kitchell's opinions are also objectively supported by the MRI of claimant's brain taken on June 25, 2013. (Ex. B, p. 55)

Most importantly, claimant does not provide opinions from another neurologist to counter Dr. Kitchell's position. Dr. Kitchell has stated in clear and detailed fashion why he is convinced claimant sustained only a mild concussion which completely resolved. (See, e.g., Ex. A; Ex. C; Ex. 10) No opinions from a similarly qualified expert have been introduced into evidence by claimant to rebut the opinions of Dr. Kitchell.

Claimant introduced into evidence a report dated November 19, 2013, and treatment records from Janet Secor, D.O., claimant's primary care physician in Fort Dodge. (Ex. 13) In her report, Dr. Secor stated claimant "sustained significant life changing injuries while working at the Fort Dodge Recycling center on 5/30/12" which have caused claimant to have continuous debilitating headaches, depression and possible post-traumatic stress syndrome. However, I find Dr. Secor's report is not entitled to any weight for several reasons: Dr. Secor clearly is not qualified to render such an opinion. She refers to the work incident as occurring on May 30, 2012, when April 30, 2012, is the correct date of injury. There is no indication Dr. Secor ever reviewed any medical records or reports from IMMC, from Dr. Rondinelli, from Dr. Thoreson, from Dr. Mooney or from Dr. Kitchell. Dr. Secor reports that in the accident claimant was struck on the left shoulder blade by the metal door of the recycling bin, while claimant was actually struck on the right shoulder blade. Dr. Secor reports that on a daily basis Claimant experiences feelings of anxiety and doom, while Dr. Secor's own treatment records document there were a number of times claimant specifically denied any pain, any depression or any anxiety. (See Ex. 12, pp. 9, 14, 18, 24, 26, 27, 47, 48, 49, 60, 64, 65, 67)

I find Dr. Rogers' neuropsychological report is entirely unconvincing because his opinions are based on the mistaken belief that as a result of the work incident, claimant sustained a significant brain injury, which Dr. Rogers believed was evidenced by small hemorrhages in both sides of the frontal lobes of claimant's brain. (Ex 19, p. 3) Based on that incorrect understanding, Dr. Rogers believed claimant "experienced a significant head injury with resultant impairment of cognitive functions." (Ex. 19, p. 6) As stated by

Dr. Kitchell, Dr. Rogers' opinion clearly is wrong and claimant's low cognitive scores on Dr. Rogers' neurocognitive testing are simply the result of claimant's pre-injury intellectual limitations. (Ex. C, p. 59)

I find Kent Jayne's vocational report also is unconvincing because Mr. Jayne based his opinions regarding alleged occupational loss on Dr. Rogers' opinion that claimant sustained a serious brain injury. (Ex. 23, pp. 4-5)

Notwithstanding the issue of whether the accident of April 30, 2012, caused a permanent brain injury, claimant also asserts that the injuries to her right shoulder, back and neck caused permanent disability. The deputy commissioner did not rule on this specific point. Claimant supports her position in this regard with Dr. Sassman's IME report, which contains permanent impairment ratings for claimant's physical injuries. However, I find claimant did not carry her burden of proof that she has any permanent disability resulting from the injuries to her neck, back and right shoulder for the following reasons:

1. Drs. Rondinelli, Thoreson, Mooney and Kitchell all found symptom magnification and non-physiological reports of symptoms.

2. Dr. Mooney clearly indicates claimant has no permanent physical disability in his report for his last evaluation of claimant which took place on February 5, 2013.

3. Dr. Sassman's conclusions are based on claimant's subjective complaints as opposed to any objective findings. (Ex. 18, pp. 7-8)

Because I affirm the deputy commissioner's finding that claimant failed to carry her burden of proof that the work injury of April 30, 2012, caused permanent disability, there is no need to address whether claimant is entitled to permanent total disability benefits under either an industrial disability analysis or under an odd-lot permanent total disability analysis.

II. Temporary Disability Benefits

In the arbitration decision, the deputy commissioner found claimant is not entitled to any temporary disability benefits beyond what has already been paid to claimant by defendants. Claimant did not challenge this finding on appeal. Therefore, this issue is not addressed in this appeal decision.

III. Penalty Benefits

In the arbitration decision, the deputy commissioner found claimant is not entitled to any penalty benefits. Claimant did not challenge this finding on appeal. Therefore, this issue is not addressed in this appeal decision.

IV. Medical Benefits

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 16, 1975).

Claimant did sustain an injury arising out of and in the course of employment. However, the deputy commissioner found that defendants have paid, or they have reimbursed claimant, for all reasonable medical expenses incurred in the treatment of the work injury. I affirm the deputy commissioner's finding for the following reasons:

Since last being seen and released from care by Dr. Mooney on February 5, 2013, claimant has continued to seek medical care on her own through the Iowa Cares Program. (Ex. 18, p.4) This treatment primarily consists of visits by claimant to Community Health Center, her primary care provider, and also to Berryhill Center. Claimant admitted at hearing that this care has not been authorized by defendants and Iowa Cares pays for it. (Tr. pp. 96-97)

Claimant admitted at hearing that none of her authorized treating medical providers have indicated any need for additional medical treatment related to the work injury. (Tr. p. 96) Claimant's own IME doctor, Dr. Sassman made no recommendations for additional treatment necessitated by the work injury. (Ex. 18)

Based on the foregoing, I find any care or treatment not previously paid by defendants, or not previously reimbursed by defendants to claimant, was not authorized or necessary to treat the work injury. Furthermore, based on the opinions of the authorized providers, and even Dr. Sassman, defendants are not responsible for any ongoing or future medical care or treatment. I therefore affirm the deputy commissioner's finding that defendants are not responsible for any additional medical care or treatment beyond what has already been paid.

ORDER

IT IS THEREFORE ORDERED that the arbitration decision of December 19, 2014, is AFFIRMED in its entirety.

Claimant shall take nothing further.

Costs of the arbitration proceeding are taxed to defendants and claimant shall pay the costs of this appeal, including the cost of the hearing transcript, pursuant to rule 876 IAC 4.33.

Signed and filed this11th day of April, 2016.

Joseph S. Cortese II

JOSEPH S. CORTESE II
WORKERS' COMPENSATION
COMMISSIONER

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