BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

DARRELL RAY REDDING,

Claimant,

vs.

FERGUSON ENTERPRISES, INC.,

Employer,

and

NATIONAL UNION FIRE INSURANCE CARRIER COMPANY OF PITTSBURG,

Insurance Carrier,
Defendants.

File Nos. 5056336, 5056337, 5056338

ARBITRATION DECISION

Head Note Nos.: 1803, 2507, 3000, 3002

STATEMENT OF THE CASE

These are proceedings in arbitration. The contested cases were initiated when claimant, Darrell Ray Redding, filed his original notices and petitions with the Iowa Division of Workers' Compensation. The petitions were filed on March 17, 2016. Claimant alleged he sustained work-related injuries on May 1, 2012; August 5, 2014 and November 3, 2015. (Original notices and petitions)

For purposes of workers' compensation, Ferguson Enterprises, Inc., is insured by National Union Fire Insurance Co. of Pittsburgh. Defendants filed their answers on April 13, 2016. In File No. 5056336, a first report of injury was filed on May 14, 2012. In File No. 5056337, the first report of injury was filed on September 12, 2014. In File No. 5056338, the first report of injury was filed on April 4, 2016.

The hearing administrator scheduled the case for hearing on August 29, 2017. The hearing took place at the Division of Workers' Compensation at 150 Des Moines Street in Des Moines, Iowa. The hearing commenced at 1:24 p.m. The undersigned appointed Ms. Jill Kruse, as the certified shorthand reporter. She is the official custodian of the records and notes. The hearing proceedings did not conclude on August 29, 2017 at 4:30 p.m. As a consequence, the matter was continued to October 18, 2017. The proceedings commenced at 1:23 p.m. and concluded at 2:55 p.m. Once again, Ms. Jill Kruse served as the certified shorthand reporter.

Claimant testified on his own behalf. Defendants called Mr. Nicholas Crawford and Ms. Debra Damge to testify. Joint Exhibits 1 through 9 were admitted. Claimant offered Exhibits 1 through 25. Defendants' Exhibits A through M were admitted. The parties submitted post-hearing briefs on December 14, 2017. The case was deemed fully submitted on that date.

STIPULATIONS FOR FILE NO. 5056336 (Date of injury May 1, 2012)

The parties completed the designated hearing report. The various stipulations are:

1. There was the existence of an employer-employee relationship at the time of the alleged injury;

2. Claimant sustained an injury on May 1, 2012 which arose out of and in the course of his employment;

3. The alleged injury is a cause of temporary disability;

4. Healing period benefits are no longer an issue;

5. The parties agree any weekly benefit rate should be paid at $397.41 per week;

6. If permanency is awarded, the disability is an industrial disability and the commencement date for any permanent partial disability benefits is May 22, 2013;

7. Defendants waive any affirmative defenses they may have had available to them;

8. Prior to the hearing, defendants overpaid temporary benefits due to the payment of benefits at the rate of $412.14 per week; and

9. The parties agree claimant has paid the costs listed in his attachment.

ISSUES FOR FILE NO. 5056336 (Date of injury May 1, 2012)

The issues presented are:

1. Whether claimant is entitled to permanency benefits for his work related injury on May 1, 2012;

2. If so, the extent of permanency benefits to which claimant is entitled;

3. Whether claimant is entitled to medical benefits pursuant to Iowa Code section 85.27;

4. Whether there has been an overpayment of TTD/TPD benefits pursuant to Iowa Code section 85.34(4); and

5. Whether Iowa Code section 85.34(7) is applicable.

STIPULATIONS FOR FILE NO. 5056337 (Date of injury August 5, 2014)

1. There was the existence of an employer-employee relationship at the time of the alleged injury;

2. Although entitlement to temporary benefits cannot be stipulated, claimant was off work from August 24, 2014 through September 3, 2014;

3. If permanency is awarded, the disability is an industrial disability;

4. If weekly benefits are awarded, the parties believe the weekly benefit rate is $398.87 per week;

5. Defendants have waived all affirmative defenses they may have had available to them; and

6. The parties agree the costs listed in the attachment have been paid by claimant.

ISSUES FOR FILE NO. 5056337 (Date of injury August 5, 2014)

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

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

3. Whether claimant is entitled to permanency benefits;

4. If so, the extent of those permanency benefits;

5. If permanency benefits are awarded, there is the commencement date at issue: Claimant maintains it is September 4, 2014; defendants state it is August 6, 2014;

6. Whether claimant is entitled to medical benefits pursuant to Iowa Code section 85.27; and

7. Whether Iowa Code section 85.34(7) is applicable.

STIPULATIONS FOR FILE NO. 5056338 (Date of injury November 3, 2015)

1. There was the existence of an employer-employee relationship at the time of the alleged injury;

2. Although entitlement to temporary benefits is not admitted, the parties agree claimant was off work from November 4, 2015 through June 4, 2016.

3. If weekly benefits are awarded, the parties stipulate the weekly benefit rate is $465.80 per week; and

4. The parties admit the costs listed in the attachment have been paid.

ISSUES FOR FILE NO. 5056338 (Date of Injury November 3, 2015)

1. Whether claimant sustained an injury on November 3, 2015 which arose out of and in the course of his employment;

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

3. Whether claimant is entitled to temporary benefits;

4. Whether claimant is entitled to permanency benefits;

5. If so, there is an issue as to the commencement date for those permanency benefits. Claimant maintains the commencement date is June 5, 2016; defendants state the commencement date is November 4, 2015;

6. Defendants assert the affirmative defense of lack of notice pursuant to Iowa Code section 85.23;

7. Whether claimant is entitled to medical benefits pursuant to Iowa Code section 85.27; and

8. Whether Iowa Code section 85.34(7) is applicable.

FINDINGS OF FACT

This deputy, after listening to the testimony of claimant and the other two witnesses at hearing, Mr. Nicholas Crawford and Ms. Debra Damge, after judging the credibility of each witness, plus after reading the evidence, and the post-hearing briefs, makes the following findings of fact and conclusions of law:

The party who would suffer loss if an issue were not established has the burden of proving the issue by a preponderance of the evidence. Iowa Rule of Appellate Procedure 6.14(6).

Claimant is 58 years old and married. He has two adult sons. Claimant has lived in the Waterloo area for approximately 13 years. He is right-hand dominant. (Transcript pages 10 through 11)

Claimant grew up in Waterloo and graduated from Central High School in 1976. (Tr., p. 12) After high school, claimant commenced employment at John Deere in Waterloo. He left the company in order to serve in the United States Army from 1978 through 1980. Claimant was honorably discharged with the rank of E3. (Tr., p. 14)

Claimant moved to the Minneapolis, Minnesota area after his military discharge. He worked at the Honeywell factory in Minneapolis where he worked on the production line for $8.00 or $9.00 per hour. The time period was from approximately 1979 through 1982. (Tr., pp. 79-82)

Next, claimant worked in Egan, Minnesota at the Sperry Univac facility. Claimant built circuits and parts. Claimant testified he earned between $9.00 per hour and $12.00 per hour. (Tr., p. 15)

Claimant terminated his position with Sperry Univac to move to Dallas, Texas. Claimant took a position as a building and yard maintenance person from 1986 through 1989. (Tr., pp. 15-16) Claimant left the position in order to move to Houston, Texas. (Tr., p. 16) In Houston, claimant worked for the West Houston Waterworks for approximately 8 months. (Tr. p, 26)

Claimant moved from Houston to Marshalltown, Iowa due to a family illness. From 1990 to 1994, claimant worked at the Swift Packing Plant in Marshalltown, Iowa. Claimant believed he earned approximately $12.00 per hour. (Tr., pp. 16-17) Claimant voluntarily terminated his position because he was living in Waterloo and the commute to and from the plant was too onerous. (Tr., p. 17)

The next position claimant held was at Waterloo Casting Service on Wagner Road in Waterloo, Iowa. (Tr., p. 17) Claimant described his work as "[c]hip and grind." (Tr., p. 17) The work was considered "piecework." (Tr., p. 17) The base pay was $8.00 per hour but the more claimant produced, the higher were his wages. (Tr., p. 17) Claimant was employed at Waterloo Casting Service from 1994 through 1996. (Tr., p. 17) The company closed, so claimant was left without employment. (Tr., pp. 17-18)

From 1998 through 2002, claimant returned to school to receive vocational training. (Tr., p. 18) Claimant testified about his various schooling opportunities:

> Q. (By Mr. Racette) Can you tell us about that, where you've gone to school after high school?

A. I went to Century College in White Bear Lake, Minnesota, for vocational training for machining. I went to South Central Technical College in Humboldt, Minnesota, where I received a small business diploma. And Hawkeye in Waterloo to continue my education to work towards an associate's degree.

Q. Do you remember what time frame you attended South Central and then Central community schools in Minnesota?

A. Between the years of 1998 to 2002.

Q. All right. And what time frame did you attend the Hawkeye Tech?

A. Hawkeye in 2010 to early 2011.

Q. Did you receive any certificate from Hawkeye Tech in what you were studying?

A. Because of the recession, I needed - - I still need a few credits to get my AA, and I haven't returned to school as of yet.

Q. Was that in small business? Is that what you were studying?

A. Small business management.

Q. What's been your goal in life?

A. My goal is to someday have my own business.

(Tr., pp. 12-13)

In 2002, claimant returned to the Waterloo area. He commenced employment with Bertch Cabinets. (Tr., p. 18) He worked at Bertch from 2002 through 2008. Claimant's job duties included: working in the rough mill, driving a forklift, he was a dock worker, and he worked in shipping and receiving. (Tr., p. 18) When claimant left Bertch Cabinets, he was earning $13.50 per hour. (Tr., p. 19) Claimant voluntarily terminated his employment to take a position with Weyerhaeuser/International Paper Company. Claimant left International Paper Company in 2011 due to company-wide lay-offs of employees. (Tr., p. 19)

From International Paper Company, claimant went to Ferguson Enterprises, Inc. (Tr., p. 19) Claimant commenced his employment on November 28, 2011.

PRIOR MEDICAL HISTORY

Claimant has a protracted medical history prior to his employment at Ferguson. Claimant suffers from a seizure disorder. In 1990 he had a head injury following a seizure. (Joint Exhibit 2, page 13) Claimant reported the following history on October 18, 2011:

> Seizure disorder after a head injury 1990 and then had recurrent seizure in 2001. Doesn't remember what his seizures where [*sic*] like. But states that he has mild seizures where he looses [*sic*] his breath but no LOC.

(Jt. Ex. 2, p. 13)

In 1993, claimant was involved in a motor vehicle accident. (Jt. Ex. 2, p. 12) Claimant reported chronic low back pain secondary to the accident. (Jt. Ex. 2, p. 12) Despite the objective medical evidence in claimant's progress notes, claimant testified he did not have any low back pain following the 1993 accident. (Tr., pp. 88-89) Moreover, claimant testified, he did not recall being involved in an accident in 1993. (Tr., p. 89)

Claimant had a prior work-related injury to his low back while he was working at Waterloo Casting in 1995. (Ex. H, p. 56) In his answer to Interrogatory No. 12 from defendants, claimant wrote:

> Claimant recalls making a work comp claim against Premiere or Waterloo Casting that arose out of a 1995 incident. This was a low back, and Claimant settled it, but he does not remember the amount or details of the settlement.

(Ex. H, p. 56)

Claimant experienced back problems in 2000. He underwent an x-ray in July of 2000. The results showed "[d]egenerative disk [d]isease L5-S1." (Jt. Ex. 2, p. 40) Later in the same year, MRI testing occurred. The results showed:

> At L4-L5, there [is] mild thickening of the ligamentum flavum and mild broad-based posterior disk bulge causing mild secondary narrowing of the bilateral neural foramen. The neural elements are abutted by disc material bilaterally. Mild spinal canal stenosis is present.

(Jt. Ex. 2, p. 40)

Claimant underwent oral and epidural steroids which helped temporarily. (Jt. Ex. 2, pp. 12-13) On December 5, 2000, claimant saw Michael Sethna, M.D. for a

neurosurgery evaluation. (Jt. Ex. 2, p. 13) Dr. Sethna recommended back surgery for claimant. (Jt. Ex. 2, p. 13) Claimant underwent an L5-S1 hemilaminectomy on February 7, 2001. (Jt. Ex. 2, p. 13) Subsequent to undergoing the hemilaminectomy, claimant treated with Amarnath Kathresal, M.D. The physician prescribed physical therapy. (Jt. Ex.2, p. 13)

Claimant reported he had a previous back surgery at Methodist Hospital in St. Paul, Minnesota in 2002. (Jt. Ex. 1, p. 4) Claimant represented he did fairly well following the 2002 surgery. (Jt. Ex. 1, p. 4)

Magnetic Resonance Imaging, MRI testing, occurred in 2003. (Jt. Ex. 2, p. 13) At L4-L5, the results showed:

> At L4-L5, there [*sic*] mild thickening of the ligamentum flavum and mild broad-based posterior disc bulge causing mild secondary narrowing of the bilateral neural foramen. The neural elements are abutted by disc material bilaterally. Mild spinal canal stenosis is present.

(Jt. Ex. 2, p. 13)

MRI testing of the C-spine occurred on October 1, 2003. The results showed:

> IMAGING: C-spine MRI 10/1/03: there is a very mild disc bulge at C5/C6; however there is no significant central canal narrowing; all nerve roots exit freely

(Jt. Ex. 2, p. 13)

Claimant related he was doing well with respect to his cervical spine. His medical provider advised him to wean off narcotic medications. (Jt. Ex. 2, p. 13)

On December 31, 2009, claimant presented to the emergency room at Allen Memorial Hospital in Waterloo. Claimant had been rear-ended in a motor vehicle accident on the day prior. The driver had struck claimant at approximately 30 miles per hour. (Jt. Ex. 2, p. 13) Medical providers injected claimant with 60 mg of Toradol and 60 mg of Norflex. (Jt. Ex. 2, p. 13) The medical providers prescribed 20 tablets of 5 mg Vicodin, and 15 tablets of 10 mg Flexeril. (Jt. Ex. 2, p. 14)

A CT scan of the cervical spine was taken. The impressions from the results were:

> Impression, there is showed [*sic*] straightening of the C-spine with loss of the normal lordotic curvature suggesting muscle spasm. There is no evidence of fracture or subluxation. There is [*sic*] moderate cervical spondylitic changes.

(Jt. Ex. 2, p. 14)

There was a CT scan of the lumbar spine. The overall impressions of the results were:

> Impression: There are bulging disc [*sic*] at L3-4 L4-5 and L5-S1. At L4-5 there is mild compression of the thecal sac diffusely. It is difficult to evaluate L5-S1 because of [*sic*] the images are very noisy. No focal disc protrusion is readily appreciated. There is no evidence of fracture in this patient with history of injury.

(Jt. Ex. 2, p. 14)

Claimant underwent right hip x-rays. There were no acute abnormalities. There was no significant interval change since a prior study occurred on July 2, 2009. (Jt. Ex. 2, p. 14)

Claimant underwent another MRI of the cervical spine on May 10, 2010. (Jt. Ex. 2, p. 14) The results were:

> [S]howed mild to moderate disc space narrowing at C5-6. The cervical spinal cord signal also appears to be within normal limits. There is some straightening of the cervical spine which can be seen as a normal variant or related to muscular spasm. No significant disc protrusions. There is some uncovertebral joint hypertrophy on the left at C. 5/6 [*sic*] with mild to moderate neural foraminal narrowing on the left at this level. Remainder of the cervical neural foramina are patent. No spinal stenosis is seen.
>
> Cervical spine x-ray 5/10/10 showed mild degenerative changes.

(Jt. Ex. 2, p. 14)

On July 23, 2010, claimant underwent an anterior cervical discectomy at C5-6. (Jt. Ex. 2, p. 12) Claimant reported the pain in his neck subsided somewhat, but he continued to experience left shoulder pain. (Jt. Ex. 2, p. 12)

On September 21, 2010, claimant presented to Iowa Spine and Brain Institute in Waterloo, Iowa. (Jt. Ex. 1, pp. 1-2) Claimant was complaining about a left rotator cuff tear and pain at the back of his neck. He informed the medical providers he was working at International Paper Company as a machine operator. (Jt. Ex. 1, p. 2) Claimant's level of pain was 7/10 for the back of the neck and 8/10 for the left shoulder. Claimant desired pain pills. (Jt. Ex. 1, p. 2) Meleah Jensen, PA-C , diagnosed a left rotator cuff tear. (Jt. Ex. 1, p. 3)

On October 7, 2010, claimant underwent MRI testing at the Veterans Administration Medical Center. There were some degenerative changes at L4-L5 and L5-S-1. The changes were:

> L4-L5: There is a mild diffuse posterior disc bulge with focal central disc herniation with annular tear. There is bilateral facet arthropathy and ligamentum flavum thickening all resulting in mild spinal canal stenosis. There is mild bilateral neuroforaminal narrowing.
>
> L5-S-1: There is loss of the intervertebral disc space with discogenic endplate changes. There is a diffuse posterior disc bulge with mild spinal canal stenosis. There is moderate to severe bilateral neuroforaminal narrowing.

(Jt. Ex. 2, p. 16)

On January 5, 2011, claimant underwent a left labral debridement and distal clavicle excision due to significant impingement and AC arthritis. The surgery was performed by Gary Knudson, M.D. at Covenant Medical Center.

On January 26, 2011, claimant returned to Iowa Spine and Brain Institute. Timothy Ryken, M.D., treated claimant for low back pain and right hip and leg pain to the right knee. Claimant complained of occasional numbness and tingling. (Jt. Ex. 1, pp. 4-5) Claimant explained he had experienced his problems for 7 or 8 months. (Jt. Ex. 1, p. 5) Claimant described his pain level as 6/10. He also informed the physician that he was already taking hydrocodone-acetaminophen capsules 1 or 2 by mouth every 6 hours as needed for his left shoulder. (Jt. Ex. 1, p. 4) Claimant believed his shoulder surgery and rehabilitation were interfering with his ability to get proper treatment for his back. (Jt. Ex. 1, p. 4) He did have physical therapy for his left shoulder and low back. (Jt. Ex. 1, p. 4)

On March 22, 2011, claimant saw Bruce L. Baridon, D.O., in order to obtain a Department of Transportation vehicle "handicapped sticker" due to back pain. (Jt. Ex. 2, p. 19) The physician deemed the handicap to be temporary in nature. (Jt. Ex. 2, p. 19)

On March 30, 2011, claimant reported to the emergency department of the Veterans Administration Healthcare System. (Jt. Ex. 2, p.25) His chief complaint was chronic low back pain. (Jt. Ex. 2, p. 30) In his history, claimant reported:

> Patient presents reporting acute on [*sic*] chronic back pain. Has been having increasein [*sic*] pain since he had lumbar steroid injections performed locally about 2 weeks ago. Pain is in the low back and radiates to the right hip. No weakness. No bowel or bladder incontinence. Worse with long periods of standing or walking. No new recent injury.

(Jt. Ex. 2, p. 30)

Claimant was advised to follow up with his primary care physician if he needed any additional pain medications. (Jt. Ex. 2, p. 32) Claimant also received a referral from physical therapy for a TENS unit. (Jt. Ex. 2, p. 32) Claimant testified he did not purchase a TENS unit until four weeks prior to the date of the hearing. (Tr. p. 94)

On March 31, 2011, claimant presented to Waverly Health Center. (Jt. Ex. 3, pp. 146-147) He wanted to commence treatment with Jon Hennings, ARNP, a medical provider he had seen on prior occasions. Claimant explained about his left rotator cuff repair that he had undergone on January 5, 2011. The nurse wrote in the clinical notes:

> Patient has an extensive history of cervical spine issues[,] thoracic and lumbar spine issues. Patient has been involved in a motor vehicle accident that caused some of his discomfort. Patient is recently recovering from rotator cuff surgery to his left shoulder and fusion of cervical spine. Patient needs to have surgery on his lumbar spine but is waiting until his shoulder and fusion of cervical spine. Patient needs to have surgery on his lumbar spine but is waiting until his shoulder is slightly more healed. Patient does need refill of pain medications today. Please refer to patient's documentation for other chronic and current issues and health concerns including hypothyroidism, hypertension, and chronic bronchospasms.

(Jt. Ex. 3, p. 146)

After conducting a physical examination of claimant, the nurse practitioner found claimant had decreased range of motion in the left arm secondary to rotator cuff surgery; decreased range of motion of the cervical spine because of the cervical spine fusion; and decreased range of motion of the low back, including flexion, extension, and turning rotation of the hip because of spinal issues at the level of the lumbar spine. (Jt. Ex. 3, p. 146) Claimant described his level of pain as 4/10. The nurse discontinued claimant's Vicodin and prescribed Percocet. (Jt. Ex. 3, p. 147)

On April 11, 2011, claimant returned to the Iowa Spine and Brain Institute. (Jt. Ex. 1, p. 7) He complained of low back pain and right hip pain. Claimant reported low back pain for two to three years. (Jt. Ex. 1, pp. 7-8) Claimant reported he had recently received a lumbar spine injection from Gayathry M. Inamdar, M.D. The injection did not provide much relief. (Jt. Ex. 1, p. 7) Physician Assistant Jensen treated claimant. She diagnosed claimant with:

1. Lumbago.

2. Lumbar disk degeneration.

3. Lumbar spinal stenosis.

4. Status post anterior diskectomy and fusion, C5-6.

PLAN:

1. Follow up in two to three months['] time.

2. Evaluation of right hip with Dr. Knudson.

DISCUSSION: We will follow up with the patient in two to three months['] time as he feels he will need this time to recoup from his shoulder surgery and he would ideally like to have any sort of surgical intervention on his back in the summer as it does not interfere with his course work as he has been taking some classes. We in the meantime will have him meet with Dr. Knudson as he does have some pain with internal and external rotation of his hip and with standing describes pain in the hip area into the groin just to ensure that this is not a hip pathology that is causing his problems there. We will see him back earlier in the summer then to make plans for surgery.

(Jt. Ex. 1, pp. 9-10)

During cross-examination, claimant had no recall regarding low back pain and right hip pain of a 7 to 8 month duration during April of 2011. (Tr., pp. 91-92) This period preceded claimant's employment at Ferguson Enterprises, Inc.

On May 2, 2011, claimant returned to see Dr. Baridon at the Veterans Affairs Outpatient Clinic. (Jt. Ex. 2, p. 35) Claimant reported his pain was better following his left shoulder surgery in January 2011. Nevertheless, claimant requested another prescription for tramadol. (Jt. Ex. 2, p. 35)

On May 19, 2011, claimant visited Dr. Knudson because of problems with the right hip. (Jt. Ex. 4, p. 192) Claimant reported the problem as newly occurring. Dr. Knudson opined:

Seems to be in the Lrochanleric [*sic*] region or a little bit higher. May be referred from his back. He is receiving injections. He does have some limited motion in the lumbar spine. He has pain in the trochanteric region and superior to this area, quite significant. He does not seem to have any significant groin pain with gentle motion of the hip, nor does that seem to aggravate his pain dramatically.

P: I spent over 25 minutes with Darrell today. The majority of this time direct counseling. – reviewed x-rays, AP pelvis, AP/Lateral right hip obtained today showing lumbar degenerative change, hip joints well maintained without significant abnormality.

(Jt. Ex. 4, p. 192)

Claimant agreed to proceed with physical therapy. (Jt. Ex. 4, p. 192) During his cross-examination, claimant had no recall of receiving physical therapy for his low back. (Tr. p. 99)

On May 27, 2011, claimant returned to the Waverly Health Center to see Nurse Practitioner Hennings. (Jt. Ex. 3, p. 148) Claimant complained of a neck disorder with symptoms, rotator cuff symptoms, and low back pain. Claimant informed the nurse about engaging in physical therapy for his low back and hip. (Jt. Ex. 3, p. 148) The nurse ordered 30 tablets of Percocet. (Jt. Ex. 3, p. 148) Claimant believed he was scheduled for back surgery on June 11, 2011. (Jt. Ex. 3, p. 148) Claimant's primary reason for visiting with the nurse was to have paperwork completed for a disability hearing. (Jt. Ex. 3, p. 148)

During the arbitration decision, claimant was asked about having paperwork completed by the nurse practitioner for a disability hearing. Claimant had no recall of ever asking for paperwork to be addressed or applying for Social Security Disability. (Tr. pp. 100-101)

Claimant presented to Dr. Knudson on June 16, 2011. Claimant admitted his right hip was doing better after having injections and undergoing physical therapy for his low back. (Jt. Ex. 4, p. 193) Dr. Knudson noted there was much less pain around the left hip trochanteric region with reasonable range of motion. (Jt. Ex. 4, p. 193) Dr. Knudson diagnosed claimant with mild right hip pain, and mild right hip trochanteric bursitis. (Jt. Ex. 4, p. 193)

Claimant returned to the Waverly Health Center on June 28, 2011. He was still complaining of low back pain and requested a refill of his Endocet tablets. (Jt. Ex. 3, p. 149)

On July 21, 2011, Dr. Delbridge evaluated claimant because of the motor vehicle accident he sustained on December 31, 2009. (Ex. H, p. 54) According to claimant's answer to defendants' Interrogatory No. 8, Dr. Delbridge rated claimant as having a 10 percent permanent impairment to the body as a whole due to a cervical fusion. The same evaluating physician also rated claimant as having an additional 5 percent permanent impairment rating to the left upper extremity due to an aggravation of the left shoulder's pre-existing problems. A 15 percent impairment to the left upper extremity equated to 9 percent to the body of the whole under the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition. Dr. Delbridge did restrict claimant from lifting no more than 50 pounds on a maximum basis and 20 pounds on a repetitive basis. (Ex. H, p. 54)

Claimant returned to the Waverly Health Center on August 29, 2011. Nurse Hennings explained the medical opinions expressed by Dr. Delbridge to claimant. (Jt. Ex. 3, p. 150) Nurse Hennings confirmed claimant had a long history of back pain, neck and shoulder pains which were exacerbated by his 2009 motor vehicle accident. (Jt.

Ex. 3, p. 150) Claimant also requested a refill prescription for his Percocet. (Jt. Ex. 3, p. 150)

CLAIMANT'S EMPLOYMENT AT FERGUSON ENTERPRISES, INC.

Claimant commenced his employment at Ferguson on November 28, 2011. The company is a wholesale distributor of plumbing supplies. The company is located in Waterloo and it employs approximately 160 to 180 employees. Initially, claimant was hired to work as an Order Picker Operator. Claimant described in detail his job duties during direct examination. (Tr., pp. 20-21) He testified he lifted between 5 to 75 pounds. (Tr. p. 21) If claimant lifted any weight greater than 50 pounds, he exceeded the restrictions imposed by Dr. Delbridge from the prior motor vehicle accident.

In the job description for the order picker operator, the lifting requirements were: "Lifting up to 20 lbs constantly, 50 lbs frequently; 100 lbs occasionally". (Ex. 4, p. 18) Claimant testified 80 percent of his time was devoted to lifting. (Tr., p. 21)

Claimant testified he passed a pre-employment physical examination in order to obtain his position with Ferguson. (Tr., pp. 144-145) Claimant testified the physical occurred at Occupational Health at Allen Hospital in Waterloo. (Tr., p. 144) Claimant testified he passed the pre-employment physical. (Tr., p. 145) Claimant's memory was not accurate.

Ms. Debra Damge, Human Resource Manager at Ferguson, testified on October 18, 2017. She testified about company pre-employment physical examinations. Ms. Damge testified:

> Q. (By Mr. Thill) Mr. Redding testified today that he went through a pre-employment physical as a condition of his employment at the distribution center. Is that true?
>
> A. Our company does not require pre-employment physicals unless you're applying for a driver position, which would be a delivery driver or over-the-road driver.
>
> Q. Did you have a chance to look through Mr. Redding's file to see if there was any evidence if he ever had a pre-employment physical?
>
> A. There is no evidence of a physical in his file.
>
> Q. The job that Mr. Redding applied for, was it considered an associate/fork truck driving position?
>
> A. Yes.

Q. What type of pre-employment testing, if any, do those associates go through at Ferguson at the time Mr. Redding was hired in 2011?

A. Okay. Our pre-employment requirements are a criminal background check and a drug screen.

Q. After completing those tests, Mr. Redding was hired?

A. Yes. He would go through training to be on the job.

Q. At the last - - or the first session of the hearing with Mr. Redding, we talked about a 50-pound restriction that was recommended by Dr. Delbridge before he was hired at Ferguson Enterprises. Do you have any recollection, Deb, if that work restriction was presented to Ferguson at the time of hire?

A. We were not aware of that work restriction.

(Tr. pp. 164-165)

Just several days after claimant commenced his employment at Ferguson, claimant returned to the Waverly Health Center on December 1, 2011. (Jt. Ex. 3, p. 151) Claimant requested another 30 day prescription for Percocet. (Jt. Ex. 3, p. 151) Claimant voiced complaints about low back pain, rotator cuff syndrome and his neck disorder with symptoms. (Jt. Ex. 3, p. 151) Claimant stated he wanted to delay his low back surgery until January of 2012 because he had just started his new position. (Jt. 3, p. 151)

On January 26, 2012, claimant returned to Nurse Practitioner Hennings. Claimant reported he had visited the emergency room at Allen Hospital due to chest pain. Testing was within the normal range. Then claimant explained he thought he pulled a muscle while working. He expressed concern about his shoulder and back pain. Claimant requested another refill of his Percocet. (Ex. 3, p. 153) The nurse noted claimant was using his medication beyond the recommended dosage. The pain medication should have lasted 45 days or longer. It lasted 30 days. (Jt. Ex. 3, p. 153) Nevertheless, the nurse practitioner refilled the prescription for the Percocet. (Jt. Ex. 1, p. 153)

On the same date as claimant visited with Nurse Practitioner Hennings, claimant was provided with a verbal warning from his supervisor, John Kline, for having 5 separate instances of pathway/picking errors in the past month. (Ex. F, p. 8) Claimant was issued a written warning on February 14, 2012, for having 3 separate instances of picking errors in the past month. (Ex. F, p. 9) He was also issued a verbal warning because on February 13, 2012, he neglected to unhook a battery cable from a piece of equipment which resulted in repairs of $75.00. (Ex. F, p. 10) He was written

up six days later causing a forklift accident due to his own negligence and provided with a written warning. (Ex. F, p. 11)

On March 26, 2012, claimant returned to see Nurse Practitioner Jennings. Claimant requested pain medication for his left shoulder and continued back pain. (Jt. Ex. 3, p. 155) Nurse Jennings assessed claimant's condition as:

1. Rotator cuff syndrome NOS . . . .

2. NECK DISORDER/SYMPT[OMS] NOS . . . .

3. CHRONIC PAIN SYNDROME . . . .

(Jt. Ex. 3, p. 156)

Claimant described his left shoulder pain at 2-3/10 and his back pain at 4-6/10. The nurse refilled claimant's prescription for Percocet. Nurse Jennings also referred claimant to physical therapy at Allen Hospital. (Jt. Ex. 3, p. 156)

On April 5, 2012, claimant parked his order picker # 8 in the equipment row and left it powered on while he went to lunch at 3:00 a.m. (Ex. F, p. 12) He was given a written warning on April 10, 2012. He was also placed on a management monitoring plan to ensure compliance with company policies and procedures. (Ex. F, p. 12)

DATE OF INJURY: May 1, 2012

Claimant testified he was lifting heavy objects when he felt a pull, a pop in his left side. (Tr. p. 35) Exhibit 6, pages 21-22 is the accident investigation report for occupational injuries at Ferguson Enterprises, Inc. Claimant reported he sustained injuries to his left hip and back due to lifting. (Ex. 6, p. 21) Claimant testified he had immediate and excruciating pain. He was unable to complete his shift. He did complete the incident report on the date of the work injury. (Ex. 6, p. 21)

Defendants sent claimant to Occupational Medicine & Wellness at Wheaton Franciscan Healthcare for medical treatment on the day of the work injury. (Jt. Ex. 5, p. 194) Claimant reported numbness and tingling on the left side. (Jt. Ex. 5, p. 194) He also complained of lower left back pain and pain with movement of his left foot. (Jt. Ex. 5, p. 195) James Haag, PA-C, determined claimant was unable to work. Physical therapy was ordered. (Jt. Ex. 5, p. 197) On May 14, 2012, claimant complained he had shooting pains running down both of his legs. (Jt. Ex. 5, p. 198)

Claimant underwent MRI testing of the lumbar spine on May 21, 2012. The major results showed:

> Degenerative narrowing of the L4-5 disk. Degenerative bulging of the annulus at L4-5 with a very small posterior midline disk protrusion. Mild

narrowing of the L4 neural foramen bilaterally with preservation of fat about the exiting nerve roots. Mild facet and ligamentum flavum hypertrophy with no acquired bony narrowing of the central spinal canal.

Severe degenerative narrowing of the L5-S1 disk. Diffuse degenerative bulging of the annulus at L5-S1 with no evidence or a recurrent disk herniation. Enhancing epidural fibrosis about the proximal right S1 nerve root ventral to the thecal sac. Bulging annulus from posterior and posterior lateral bony spurring results in at least moderate acquired narrowing the L5 neural foramen bilaterally but no central canal stenosis.

(Jt. Ex. 5, p. 199)

Claimant returned to Nurse Hennings on May 24, 2012. (Jt. Ex. 3, p. 157) Claimant reported his pain level for his low back and left hip was 5/10. The nurse filled claimant's prescription for Percocet.

Claimant presented to the physician's assistant, James Haag on May 30, 2012. Mr. Haag diagnosed claimant with lumbar strain and severe degenerative disk disease at L5-S1. (Jt. Ex. 5, p. 200) Claimant was released to restricted duty. Claimant was precluded from lifting, carrying, pulling or pushing more than 5 pounds on an occasional basis. He could bend rarely. He was to sit, stand, and walk as needed on an alternate basis. (Jt. Ex. 5, p. 200) Mr. Haag prescribed 30 tablets of 50 mg of Ultram. (Jt. Ex. 5, p. 201)

On June 25, 2012, claimant returned to see Mr. Haag for a follow-up evaluation of claimant's lumbar strain and degenerative changes at L5-S1. (Jt. Ex. 5, p. 202) Claimant reported he had also been treating with a chiropractor. (Jt. Ex. 5, p. 202) Mr. Haag continued the work restrictions of lifting/carrying/pushing/pulling up to 10 pounds on an occasional basis. Additionally, claimant was to bend/reach and twist only occasionally. Finally, claimant was to alternate sitting, standing and walking as needed. (Jt. Ex. 5, p. 202) Mr. Haag suggested a pain clinic to claimant. The physician's assistant prescribed hydrocodone for claimant's pain. (Jt. Ex. 5, p. 202)

Pursuant to Mr. Haag's referral, claimant presented to the Allen Pain Clinic where he was examined by Ashar Afzal, M.D. Claimant reported his 2002 back surgery with pain down the right leg and into his right foot. (Jt. Ex. 6, p. 12) Claimant also reported a history of left shoulder surgery, and cervical spine surgery. (Jt. Ex. 6, p. 214) Dr. Afzal conducted a thorough physical examination of claimant's lumbar spine. The physician detailed the examination in his report of August 7, 2012. Dr. Afzal wrote:

EXAMINATION: Patient is awake, alert, and oriented in time, place, and person. Patient is seated in the chair and did not appear to be in any

acute distress. Pupils were equal and reactive to light. Conjunctivae negative for jaundice or pallor.

Gait was nonantalgic. He had restriction in lumbar flexion and extension. Both maneuvers would reproduce his pain. Lumbar flexion was restricted up to 60 degrees and extension was less than 10 degrees. Inspection of the back did not reveal any swelling, bruises, or induration suggestive of recent infection or injury. He did not appear to have any significant scoliosis on palpation of the spinous processes. He had marked tenderness over deep palpation of the lumbar facets, worse on left side but also on the right side. Deep palpation of the posterior superior iliac spine consistent and sacroiliac joints were negative for reproduction of pain. Examination of the paraspinal musculature and also the piriformis, gluteal, and quadratus lumborum was negative for presence of any trigger point. Examination of the skin did not reveal hyperesthesia, hyperalgesia, or tactile allodynia. Chest was clear to auscultation. Both 1st and 2nd heart sounds were audible.

Facet provocation maneuver with lumbar spine extension and lateral rotation. Examination of the lower extremities did not reveal any motor or sensory deficits in plantar flexion, dorsiflexion, knee extension and flexion, hip flexion, and extensor hallucis longus. Deep tendon reflexes were difficult to elicit on each side. Straight leg test was negative.

Internal and external rotation of the hips were [*sic*] negative for reproduction of pain. Patrick's maneuver was slightly restricted indicative of sacroiliac joint dysfunction.

MRI of the lumbar spine shows scar tissue in the anterior epidural space at L4-5. He has advanced disk degenerative [*sic*] at L-4 and L-5 levels. Arthritic changes present in lumbar facets bilaterally.

IMPRESSION: Acute on chronic low back pain. The patient has had history of low back pain but his symptoms have improved. His most recent symptoms are secondary to repetitive nature of his work done during the time description that he states. It could have very well been secondary to deep pain arising from his facet joints and facet mediated pain.

PLAN: I had a detailed discussion with Mr. Redding. I think that he is a good candidate for intra-articular facet injections in order to break the cycle of pain. Most tender facet joints would be L4-5 and L5-S1 as determined on examination. We will obtain prior authorization for the procedure and we will schedule him to our clinic.

(Jt. Ex. 6, pp. 214-215)

Claimant returned to the Allen Pain Clinic on August 13, 2012 for follow-up of the low back pain with radiating pain down both legs and the left pain traveling further down than the right leg. (Jt. Ex. 6, p. 216) Claimant had facet injections between L-4 and L-5-S-1 on the left side. (Jt. Ex. 6, pp. 219-221) Claimant was ambulatory when he left the pain clinic. (Jt. Ex. 6, p. 219)

There was a follow-up appointment on September 18, 2012. (Jt. Ex. 6, p. 222) Claimant reported the injections lasted only a short time. However, the injections did reduce claimant's pain by 50 percent. (Jt. Ex. 6, p. 223) Dr. Afzal diagnosed claimant with:

(1) Lower back pain.

(2) Lumbar facet-mediated pain.

(3) Possible lumbar radiculopathy.

(Jt. Ex. 6, p. 223)

Claimant underwent repeat lumbar facet injections on October 17, 2012. (Jt. Ex. 6, p. 224) Dr. Afzal encouraged claimant to follow up with David Kirkle, M.D., the workers' compensation physician.

On October 24, 2012, claimant returned to see the physician's assistant, Mr. Haag. (Jt. Ex. 5, p. 204) Claimant explained to the nurse on duty:

> NURSE INTERVIEW: Darrell's primary problem is pain located in the Lt. hip. He describes it as sharp. He considers it to be intense. It has been about 25 weeks since the onset of the pain. Darrell says that it seems to be constant. He has noticed that it is made worse by sitting and bending. It is improved with heat, exercise and medications. He feels it is improving slightly. His pain level is 4 at rest, 7 at worse/10.

(Jt. Ex. 5, p. 204)

Claimant was released to restricted duty. He was not to lift more than 10 pounds. He could bend up to 30 minutes per hour. (Jt. Ex. 5, p. 204)

On November 14, 2012, claimant returned to see Dr. Afzal. Claimant reported most of his pain had returned despite the two sets of lumbar facet injections. (Jt. Ex. 6, p. 230) Claimant described his pain as: "It is mostly on the left side of the lower back with radiation into the hip and buttock. He is also complaining of pain going down into the groin." (Jt. Ex. 6, p. 230) On physical examination, Dr. Afzal observed marked tenderness over deep palpation of the left sacroiliac joint, but no trigger point identified.

(Jt. Ex. 6, p. 230) The physician also observed pain on palpation of the lumbar facets. Dr. Afzal recommended radiofrequency ablation of the facets on the left side at L4-5 and L5-S1 and to perform an intra-articular sacroiliac joint injection on the same day. (Jt. Ex.6, p. 230) According to Dr. Afzal, if these treatment modalities helped with claimant's symptoms, then claimant would be at maximum medical improvement. (Jt. Ex. 6, p. 230) Dr. Afzal opined claimant could return to work with the restrictions recommended by Mr. Haag. (Jt. Ex. 6, p. 230)

Claimant returned to Mr. Haag on November 28, 2012. (Jt. Ex. 5, p. 206) Claimant described his primary problem as pain in the left hip. (Jt. Ex. 5, p. 206) Claimant reported feeling worse rather than better. He described burning pain in the left hip and left leg. Claimant described his resting pain level at 5/10 and his worst pain at 8/10. (Jt. Ex. 5, p. 206) Claimant reported his pain has become worse since he returned to work. (Jt. Ex. 5, p. 206) Mr. Haag diagnosed claimant with sprains/strains; pre-existing severe degenerative changes of the lumbar spine. (Jt. Ex. 5, p. 206)

On December 3, 2012, Rachel M. Ruedin, claims case manager for Liberty Mutual Insurance Company, sent a letter to claimant. The claims case manager notified claimant that claimant had been released to return to work with restrictions and his employer could accommodate claimant in the workplace. The effective date of the return to work was November 19, 2012. (Ex. 7, p. 23) According to Ms. Damge's testimony, claimant returned to light duty work until he was later released to full duty work on June 4, 2013. (Tr., pp. 165-166)

On December 28, 2012, claimant presented to Nurse Hennings. (Jt. Ex. 3, p. 159) Claimant requested a prescription for pain medication and a note for his employer explaining claimant was visiting his medical provider. (Jt. Ex. 3, p. 159) Claimant complained of low back and left shoulder complaints. (Jt. Ex. 3, p. 159) Claimant did not discuss left hip and left leg pain.

On January 25, 2013, claimant returned to see Nurse Hennings. Claimant complained of low back and left shoulder pain and discomfort. (Jt. Ex. 3, p. 161) Claimant desired a refill of his Percocet medication. (Jt. Ex. 3, p. 162) Claimant's work restrictions were continued as previously set. (Jt. Ex. 3, p. 162)

On February 15, 2013, claimant presented as a walk-in patient at the office of Dr. Baridon, D.O., at the Veterans Administration Healthcare System. Claimant reported left shoulder pain with increased intensity after working at the distribution center. (Jt. Ex. 2, p. 37) Claimant related his pain was 4 on an analog scale of 1 through 10. Claimant related he took 1 tablet of tramadol but the medication did not work to alleviate his pain. (Jt. Ex. 2, p. 37) Claimant was informed he would benefit more from taking Naprosyn with food. His prescriptions were renewed. (Jt. Ex. 2, p. 37)

Claimant received a left-sided sacroiliac joint injection on or about February 28, 2013. (Jt. Ex. 6, p. 233) Claimant also complained of low back pain and left shoulder pain. (Jt. Ex. 3, p. 164) He exhibited no edema at the extremities. (Jt. Ex. 3, p. 164) Nurse Hennings diagnosed claimant with chronic pain syndrome. The nurse practitioner refilled a prescription for Percocet. (Jt. Ex. 3, p. 164)

On March 4, 2013, claimant signed and dated a revised work schedule. (Ex. 9, p. 25) He agreed he would work from Monday through Friday during the hours of 12:00 p.m. through 3:30 p.m. (Ex. 9, p. 25) Claimant was assigned the following duties:

> 1. Break down cardboard boxes, insert cardboard into shredder.
>
> 2. Operate cardboard shredder using proper safety precautions and ensure gaylords are filled properly with shredded cardboard.
>
> 3. Clean and sweep the UPS work area as directed within the stated restrictions.
>
> 4. All duties must be performed with adherence to the restrictions imposed by Occupational Medicine and Wellness, and associated health care providers.

(Ex. 9, p. 25)

Claimant returned to the Allen Pain Clinic on May 6, 2013. (Jt. Ex. 6, p. 241) Dr. Afzal noted the two sacroiliac joint injections on the left side had helped claimant tremendously. (Jt. Ex. 6, p. 241) In Dr. Afzal's plan for treatment, he opined:

> PLAN: Today our plan was to actually call him MMI which I will still do. I think the majority of his symptoms are musculoskeletal in nature and he has received appropriate treatments from it including physical therapy and injections. For one last time I will again inject into the SI joint since for the past few days his symptoms have been getting worse but other than that he needs to see his workman [*sic*] comp. case manager for his restrictions or no restrictions to be defined. Followup [*sic*] to our clinic will be on an as needed basis.

(Jt. Ex. 6, p. 241)

Claimant tolerated the third injection well. He was discharged home in stable condition. (Jt. Ex. 6, p. 241)

On May 22, 2013, claimant's work schedule at Ferguson Enterprises was revised again. (Ex. 10, p. 26) The hours were changed from Monday through Friday from

10:00 a.m. through 6:30 p.m. Claimant was provided with additional duties too. They included:

- Inspect all UPS and FEDEX shipments for product accuracy and condition
- Sort, audit, and package product from the conveyor, pallets, totes and barneys
- Merge containers together or repackage product as appropriate
- Scan packages and process shipments using Highjump system
- Correctly weigh and label packages
- Coordinate appropriate packaging and delivery mode based on shipping instructions
- Load packages from conveyor onto appropriate pallet for shipment
- Break down cardboard boxes, insert cardboard into shredder.
- Operate cardboard shredder using proper safety precautions and ensure gaylords are filled properly with shredded cardboard.
- Clean and sweep the UPS work area as directed within the stated restrictions.
- All duties must be performed with adherence to the restrictions imposed by Occupational Medicine and Wellness, and associated health care providers

(Ex. 10, p. 26)

On May 24, 2013, claimant returned to Nurse Hennings with reports of chronic pain. (Jt. Ex. 3, p. 166) The nurse noted neck pain, post-surgical pain, arthritis and low back pain. (Jt. Ex. 3, p. 166) The nurse continued prescribing Percocet for claimant. (Jt. Ex. 3, p. 167)

Claimant presented to Mr. Haag on May 29, 2013 with a dull ache in his low back and his left hip. (Jt. Ex. 5, p. 208) Claimant described the symptoms as "minimal." (Jt. Ex. 5, p. 208) He said the pain varied with activity. He indicated he had numbness and tingling on the left side. He believed his condition was improving and he described his level of pain as 2/10. (Jt. Ex. 5, p. 208) Claimant reported he was working only 3.5 hours per day. Mr. Haag noted claimant was taking Naproxen and hydrocodone. (Jt. Ex. 5, p. 208)

Mr. Haag physically examined claimant on May 29th. The physician's assistant found:

> Lumbar Spine: Pain on motion is present over the left sacroiliac joint. Pain to palpation is present over the left sacroiliac joint. Range of motion is limited. A deformity is not present. Lasegue's straight leg raising sign is negative. Spasm is not present, no change.

(Jt. Ex. 5, p. 208)

Work restrictions were increased. Claimant was able to lift up to 35 pounds. He could bend up to 30 minutes per hour. (Jt. Ex. 5, p. 208)

On June 4, 2013, Mr. Haag completed a "Patient Visit Summary and Instructions." (Jt. Ex. 5, p. 211) Mr. Haag diagnosed claimant with sprains and strains and pre-existing severe degenerative change. The physician's assistant opined claimant was at maximum medical improvement. Mr. Haag also rated claimant as having a zero percent permanent impairment rating. (Jt. Ex. 5, p. 211) A copy of the report was sent to the employer. (Jt. Ex. 5, p. 212)

On the following day, Ms. Damge, the Human Resource Administrator issued a letter to claimant explaining it was time for claimant to resume full duties. Claimant was informed he would be placed in the position of:

> **Fulltime DC UPS Associate**
>
> **Monday – Friday 11:30 am - 8:00 pm**
>
> **Effective Date: Monday, June 10, 2013**

(Ex. 11, p. 27)

On June 12, 2013, claimant returned to see Mr. Haag. Claimant indicated his primary problem was a dull ache in his left hip. (Jt. Ex. 5, p. 210) Claimant described the pain as "[l]ight to medium." (Jt. Ex. 5, p. 210) He rated his pain as 3/10. (Jt. Ex. 5, p. 210) Once again, Mr. Haag conducted a physical examination. He found:

> Lumbar Spine: An abrasion is not present. Bruising is not present. Erythema is not present. An open wound is not present. Pain on motion is not present. Pain to palpation is not present. A rash is not present. Swelling is not present. Range of motion is normal.

(Jt. Ex. 5, p. 210)

Mr. Haag diagnosed claimant with sprains and strains; pre-existing severe degenerative changes. The physician's assistant determined claimant had reached

maximum medical improvement on June 12, 2013. Claimant was discharged from care. (Jt. Ex. 5, p. 210)

Claimant did return to the position of DC UPS Associate for Ferguson Enterprises, Inc. on June 10, 2013. Claimant performed the essential duties and responsibilities that were detailed in the job description. (Ex. 5, p. 19) Claimant described some of his job duties during direct examination. He testified:

> Q. (By Mr. Racette) Okay. Can you tell us what your duties consist of in that job?
>
> A. Shipping and packaging products for bill.com, amazon.com, Fed Ex, Speedy Delivery, and UPS.
>
> Q. Can you tell us, Mr. Redding, physically how that worked? Were you standing? How did things come to you? Where did you put them? Can you just describe that?
>
> A. Well, they came on a conveyor belt. And some products are brung [*sic*] in on a - - order pickers bring them in and sit them down. We stage them in the staging area. And then they're put up onto the rollers. Then we package them, weigh them, print out labels and everything, and then they're put on a conveyor belt and sent to the end of the line where a person removes them and puts them on pallets.
>
> Q. What do you do? Do they come to you using a conveyor belt?
>
> A. They come to us in plastic containers or on pallets or on carts with wheels on them.
>
> Q. And the size of the packages, do they vary, I assume?
>
> A. From large to small.
>
> Q. Are you lifting them off the conveyor belt and putting them somewhere else?
>
> A. Off of the conveyor belt onto another conveyor belt, off of the pallet on the floor onto the beginning conveyor belt.
>
> Q. Is that steady, consistently done the entire shift?
>
> A. Correct.
>
> Q. What are the weights you're lifting in that position?

A. Anywhere from - - the light line could be anywhere from 0 pounds to 45 or 50 pounds.

Q. Is that the line you usually worked?

A. We rotated.

Q. What's [*sic*] the other lines?

A. We go from light line, double box heavy.

Q. What's double box? What are they?

A. Double box you basically do a lot of sinks, like porcelain sinks that have to be packed in a box with - - They have to have pads on the bottom, pads on all four sides, two pads on the top. And you basically - -

Q. Okay. I don't care about - - How much do they weigh? What's a sink weigh?

A. Anywhere from 25, 30 pounds up to 150 pounds.

Q. What's the heavy line? What's on that?

A. On the heavy line we do plumbing parts. Some sinks. It's just a variety of different items. And they call it heavy because they're larger items. And some of them are marked. When they reach a certain poundage, it's a two-person lift, and so you have two people there. If you need assistance, then we both would, you know.

(Tr., pp. 23-25)

Claimant visited Nurse Hennings on July 25, 2013. Claimant reported he was only working a temporary job while he was in the process of filing for disability. (Jt. Ex. 3, p. 168) That was not an accurate statement. At the time, claimant was working full time as a DC UPS Associate at Ferguson. Nurse Hennings diagnosed claimant with chronic pain syndrome due to neck pain, post-surgical pain, arthritis, and low back pain. (Jt. Ex. 3, p. 168) The nurse practitioner provided claimant with a refill for Percocet. (Jt. Ex. 3, p. 169)

Claimant returned to Nurse Hennings on September 23, 2013. He presented for a diabetic check. (Jt. Ex. 3, p. 170) Again, claimant reported he was working a temporary job while he was filing for disability. However, he was still working full time at Ferguson. The nurse practitioner noted claimant's low back and left shoulder were at baseline. (Jt. Ex. 3, p. 171) Claimant did receive a prescription for Percocet. (Jt. Ex. 3, p. 171)

On October 13, 2013, claimant was given a documented verbal warning by his supervisor for incurring 8.5 incidents of personal absence in the prior 12 months. (Ex. F, p. 15) The attendance issues included tardiness. Claimant requested a review with Ms. Damge. (Ex. F, p. 15)

On November 25, 2013, claimant visited with Nurse Hennings again. Claimant wanted to discuss his overall physical condition. (Jt. Ex. 3, p. 172) Claimant reported he experienced worsening pain in his left shoulder. He stated he remained active but he was sure had done something to his shoulder but he just could not recall what the specific activity had been. (Jt. Ex. 3, p. 172) Nurse Hennings noted claimant had undergone left shoulder surgery on January 5, 2011. (Jt. Ex. 3, p. 172) Hennings noted mild to moderate pain in the left shoulder. (Jt. Ex. 3, p. 172) There was decreased range of motion and a mild impingement sign. (Jt. Ex. 3, p. 172) Claimant described his left shoulder pain as 3-4/10. The right and left shoulders were injected with Depo-Medrol 80 mg/Lidocaine 2 percent 1 ml. The patient tolerated the procedure well. Claimant received a refill for Percocet. A work note was provided for claimant. (Jt. Ex. 3, p. 173)

Claimant returned to work on November 26, 2013. He received a documented verbal warning for making an inappropriate comment to a female co-worker. (Ex. F, p. 17)

On January 24, 2014, claimant returned to Nurse Practitioner Hennings. Claimant requested a prescription for Percocet. (Jt. Ex. 3, pp. 174-175) Claimant also requested physical therapy for his left shoulder and back. Once again, Nurse Hennings noted the etiology of claimant's chronic pain was neck pain, post-surgical pain, arthritis, low back pain. Hennings indicated claimant was working only a temporary job while he was in the process of filing for disability. Again, this was inaccurate as claimant was working full time at Ferguson. (Jt. Ex. 3, p. 174) A referral to Allen Hospital for physical therapy was made for the left shoulder and low back. (Jt. Ex. 3, p. 175)

The Human Resource Administrator and claimant's supervisor placed claimant on a performance improvement plan on April 29, 2014. (Ex. F, p. 18) Claimant scored an overall rating of 2.57 out of a possible 3.0 on his 2014 annual review. (Ex. F, p. 18) Management officials devised a development plan to assist claimant with improving his individual work performance. Management wanted claimant to meet the required standards for UPS Associate. (Ex. F, p. 18) Claimant's performance was scheduled to be reviewed on May 29, 2014. (Ex. F, p. 18)

On May 14, 2014, claimant visited the Veterans Affairs Outpatient Clinic. (Jt. Ex. 2, pp.54-60) Claimant reported he had lingering shoulder and low back pain at times. He rated his pain at 2/10. (Jt. Ex. 2, p. 58) Claimant was advised to quit smoking, and to exercise. (Jt. Ex. 2, p. 58) He participated in a depression screening. The result was negative. (Jt. Ex. 2, p. 60)

On June 4, 2014, claimant received another "Performance Improvement Plan." (Ex. F, p. 19) Claimant's productivity levels had greatly improved over the course of the prior month. They were:

5/27 100.34%

5/19 99.71%

5/12 125.91%

5/5 113.10%

4/28 103.53%

(Ex. F, p. 19)

On June 27, 2014, claimant returned to Nurse Practitioner Hennings for a refill of his Percocet. (Jt. Ex. 3, p. 176) Again it was reported claimant was working a temporary job while he was in the process of filing for disability. (Jt. Ex. 3, p. 176) Hennings diagnosed claimant with:

1. Chronic pain syndrome . . . .

2. Low back pain . . . .

3. Rotator cuff syndrome NOS . . . .

(Jt. Ex. 3, p. 177) Nurse Hennings refilled the prescription for the Percocet but advised claimant to make an appointment for the shoulder injection. (Jt. Ex. 3, p. 177)

Date of Alleged Injury: August 5, 2014

Claimant alleges he tripped over a box on August 5, 2014 and fell on his back while he was working for Ferguson as a DC UPS Associate. (Ex. 12, p. 28) Claimant described how the incident occurred during his direct examination. He testified:

> Q. (By Mr. Racette) Can you describe for us what occurred at that time.
>
> A. Well, I was working in heavy. The reach truck sometimes brings products in, and sometimes they bring it in on pallet jacks. I was processing some products on the line, because you have to pack them up yourself. They come on crates. You put them in a box. I turned around, and somebody had placed a box behind me. But it was too late for me to shuffle around it.

So my immediate reaction was to try to jump over it because here's an iron rail on my left side. I've got this box here and the pallets that I'm processing in in maybe a 2 or 3 feet space, and I dreaded tripping over that and hitting that rail, so I tried to jump over that. And I end up trying to compensate myself with my hand and landing on my back and my butt. And I kind of went back like this. And my back and my head kind of hit the floor.

Q. Did your neck snap in that process, or did you just hit your head, or how was that?

A. I just kind of snapped back like that, bam, when I hit the floor, yes.

Q. Okay. You're showing your neck moving back quickly?

A. Right.

Q. Okay. Now, were you able to get up by yourself after that happened?

A. No.

Q. How did you get up?

A. One of my team members came over and helped me up.

Q. Who was that?

A. Her name was Nisha [*sic*].

Q. Were you hurting anywhere after you fell?

A. All over. My back, neck, shoulders. I tried to get up, but I couldn't.

Q. And did you report what happened to anybody, to a supervisor?

A. My team leader.

Q. And who was that at the time, do you remember?

A. Nick. Nick Crawford.

Q. Nick Crawford? Okay. What did Nick Crawford - - what did you tell him, or what was the conversation that you recall?

> A. If I recall, it was on a Friday or a Thursday. He said, well, just - - You know, it was at the end of the shift. "Let me know how you feel, and we'll just go from there, and you can just let me know how you feel."

(Tr., pp. 55-57)

Claimant testified he did not fill out an incident report initially. (Tr., p. 57) The record shows claimant completed an "Accident Investigation for Occupational Injuries" on August 19, 2014. (Ex. 12) Claimant reported an injury to his back and hip. He did not report an injury to his neck. (Ex. 12, p. 29) Claimant declined medical treatment. (Ex. 12, p. 30)

Ms. Neisha Harris completed a statement regarding claimant's accident investigation. She wrote:

> Darell [*sic*] Redding was talking and when He turned around he tripped over a box and fell on his back, I then walked over and helped him up.

(Ex. 12, p. 31)

Mr. Nick Crawford completed a statement regarding claimant's accident investigation. He wrote:

> I was notified on August 5th, 2014 of the incident. He told me that he had tripped over a box and landed flat on his back. Neisha Harris witnessed the incident and went over to pick/help him up. I asked him if he was ok and if he needed to seek medical help. He declined the help and told me that he could finish the day because there wasn't a lot of pain. I asked him the rest of the week if his back was in pain and if he was feeling better. He responded and said there was a little soreness, but nothing too serious. This past week 8/11-8/15 his back was feeling better and he mentioned that he was able to mow the grass and fix a leaking faucet in his house. On the week of 8/18 he noticed that his production rate was low from the week of the accident and he brought up to me that it was because of his back. I then had him fill out an injury report form on 8/19/14.

(Ex. 12, p. 32)

On August 24, 2014, claimant presented to the emergency room of Covenant Medical Center. He complained of left-sided neck pain that had started on Friday morning. Claimant reported he had awakened on Friday morning and his neck felt as if he had slept in an awkward position. Claimant informed the staff he took 2 Ibuprofen and his pain was worse on the 24th. Claimant explained the pain radiated down his left

arm and left leg. He experienced pain when he walked. Claimant described the pain as "pinching, burning, and aching." (Jt. Ex. 8, p. 256)

Claimant explained in detail the nature of his pain. The nursing notes stated:

> PAIN
>
> Patient complains of pain affecting cervical spine[.] Pain described as sharp. Dull nature to the pain. The pain is described as tightness. The pain is deep. Pain is constant. The patient has received verbal instruction and/or educational material relating to their pain, its treatment goals, expectations, and care. Patient verbalized understanding.
>
> Additional description of the pain: 10 on rt, left 7-8, is able to move better at this time. Report to Sam RN on floor. No questions at this time. Wife at bedside.

(Jt. Ex. 8, p. 257)

The primary diagnoses were:

> 1. Torticollis . . . .
>
> 2. Cervical disc disorder with radiculopathy . . . .
>
> 3. Multiple-level cervical spondylosis with radiculopathy . . . .
>
> 4. Cervical radiculopathy . . . .

(Jt. Ex. 8, p. 259)

Claimant was admitted to the hospital on August 24th. MRI testing of the cervical spine occurred on the same day. Robert Wells, M.D., determined the following:

> IMPRESSION:
>
> 1. No fracture or acute bone destruction.
>
> 2. Multilevel cervical spondylosis.
>
> 3. Central C3-4 disk herniation and a right paracentral C4 osteophyte cause dural displacement and effacement of subarachnoid fluid adjacent to the cord. There is no cord edema or gliosis.
>
> 4. Left C5-6 neural foraminal narrowing by posterolateral vertebral body osteophytes.

5. Anterior vertebral body fusion at C5-6, with no evidence of hardware failure or disk prosthesis migration.

(Jt. Ex. 8, p. 263)

Claimant also had a CT scan of the cervical spine. The findings showed:

Vertebral alignment: Straightening of the normal cervical lordosis without subluxation.

Vertebral body heights: Maintained.

Intervertebral disks: Findings of anterior body fusion of the C5 and C6 vertebra with hardware. A prosthetic disk is seen at the former C5-6 disk level. No findings of hardware failure or loosening. Loss of intervertebral disk height is mild at C3-4. Remaining cervical intervertebral disk heights are maintained.

Spinal canal: Posterior vertebral osteophytes are seen at C4, C5, C6 and C7. Relative narrowing of the spinal canal at the C3-4 level due to posterior bulging disk material and vertebral osteophytes.

Neural foramina: High-grade narrowing left neural foramen at C5-6 by marginal vertebral osteophyte. The right C3-4 neural foramen is also narrowed.

Other: No cervical spine fracture is identified. Atlantodens interval appears normal.

IMPRESSION:

Findings of anterior interbody fusion of the C5 and C6 vertebra with superimposed multilevel degenerative spondylosis. No fracture or subluxation is identified.

(Jt. Ex. 8, p. 264)

Claimant spoke to the attending physician, Christina I. Pasarin, M.D. Claimant provided a slightly different medical history concerning his neck and right shoulder pain. He reported:

[P]revious lumbar laminectomy, ACDF C5-6 for left cervical radiculopathy in 2010. The patient presented to the emergency room with pain in the right side and back side of his neck, radiating to the right shoulder for a couple of days. He reports trauma by falling with some injury to posterior neck and shoulders around August 5. He had neck stiffness and shoulder

> discomfort for a couple of weeks, which seems to subside spontaneously. For the past two days, has had severe stiffness and pain in the posterolateral right side of the neck and right shoulder. This morning, required help from his spouse to get out of the bed. There is pain radiating to the upper border of right trapezius muscle and right shoulder and weakness with attempt to elevate his arm. He has paresthesias in the right hand with rotation and flexion of the neck anterior and to the right. No hand weakness. With the same rightward movement of the neck, he would have some paresthesias in the right lower extremity. No incontinence. No falls. Denies fever, chills. No difficulty swallowing.

(Jt. Ex. 8, pp. 269-270)

Claimant also saw Timothy Ryken, M.D. on August 24, 2014. Claimant reported a somewhat different history of his pain to Dr. Ryken. Claimant reported:

> Mr. Darrell Redding is a very pleasant 55-year-old male with history of pain in posterior aspect of neck radiating to the right shoulder. His discomfort has been exacerbated in terms of frequency, intensity and duration since the patient fell about 20 days ago. The patient said that before he fell, he had neck stiffness and shoulder discomfort that comes and goes for a couple of weeks. The patient did have previous surgery ACDF at C5-C6 which was done July, 2010 and the patient was doing well and was discharged from neurosurgery service. He reported that while he turned his head to the right he does have some tingling and numbness in the tips of his fingers and pain is aggravated in his neck. He described his pain as constant, annoying ache with episodes that are punctuated by sharp, stabbing pain. Denies any weakness or any symptoms in his left upper extremity. No bladder or bowel problems. No difficulty walking. Denies fever and chills. No recent history of falls.

(Jt. Ex. 8, pp. 273-274)

Dr. Ryken found no tenderness to palpation over the lumbar spine. (Jt. Ex. 8, p. 274) The physician diagnosed claimant with:

1. Cervicalgia.

2. Multi-level cervical spondylosis.

3. Central C3-C4 disc herniation with right paracentral C4 osteophyte.

4. Stenosis of C3-C4 neuro foramen.

5. Status post anterior cervical discectomy and fusion at C5-C6.

(Jt. Ex. 8, p. 275)

Dr. Ryken made several recommendations for claimant. They included:

RECOMMENDATIONS:

1. Patient does not require neurosurgical intervention at this time.

2. Physical therapy with traction, strengthening of cervical spine recommended.

3. Cervical epidural injection and Dr. Inamdar was consulted from pain management for this procedure.

4. Followup with neurosurgery in four weeks

5. Out of work for 7 days.

(Jt. Ex. 8, p. 275)

On September 4, 2014, claimant presented to David Kirkle, D.O., at the Occupational Medicine Clinic at Wheaton Franciscan Hospital. (Jt. Ex. 7, p. 246) Claimant described the occurrence of his August 5, 2014 work injury as follows:

PATIENT'S DESCRIPTION OF INJURY: Working packing boxes on the line, and object got placed behind him, he turned and tried to kick it, and it was heavy so it didn't move, so he tried jumping over it and ened [*sic*] up falling on back on cement. Landed on buttocks, back and head.

(Jt. Ex. 7, p. 246)

Claimant also complained of neck pain. He stated to Dr. Kirkle:

CURRENT CHIEF COMPLAINT Darrell's primary problem is pain located in the neck. It has been 29 days since the onset of the pain. Darrell says that it seems to be constant. He has noticed that it is made worse by movement. He feels it is improving. His pain level is 4/10. Worked the following week after fell [*sic*], pain continued to increase, was seen in CMC ER on 8/24/2014 and was admitted to CMC hospital. On 8/23/2014 got neck injection from Dr. Inamdar. Was released from hospital 8/26/14. Had MRI and CAT 8/25/2014.

Dr. Kirkle conducted a physical examination of claimant's cervical spine on September 4, 2014. The physician found:

EXAMINATION:

Cervical Spine: An abrasion is not present. Bruising is not present. Erythema is not present. An open wound is not present. Pain on motion is present over the upper cervical spine. Pain to palpation is not present. A rash is not present. Swelling is not present. Range of motion is slightly limited in rotation. DTR 2/4 = grip strength = Decreased sensation is not present.

(Jt. Ex. 7, p. 247) Claimant questioned whether claimant's neck condition was work related. (Jt. Ex. 7, p. 247) Dr. Kirkle opined there were discrepancies between the various medical histories claimant had presented to several physicians. (Jt. Ex. 7, p. 248)

Dr. Kirkle diagnosed claimant with:

1. Disc Disorder with Myelopathy, Cervical Spine

2. Degenerative Disc Disease, Cervical Spine

3. Postlaminectomy/fusion C5-6, Cervical Spine

(Jt. Ex. 7, p. 247)

Dr. Kirkle returned claimant to restricted duty. Claimant was precluded from lifting over his head more than five pounds. Claimant was prohibited from reaching over his head and from working over his head. Claimant was allowed to bend or twist his neck up to ten minutes per hour. (Jt. Ex. 7, p. 247) Dr. Kirkle referred claimant to neurosurgery and to a pain management clinic. (Jt. Ex. 7, p. 248)

Claimant was dissatisfied with Dr. Kirkle's decision to return claimant back to restricted duty work. Claimant complained to Lisa Geary, RN, Nurse Case Manager at Wheaton Franciscan Healthcare. (Ex. 15, p. 42) Claimant provided an alternative explanation for his neck symptoms on August 24, 2014. He thought he had neck swelling as a reaction from taking Gabapentin. (Ex. 15, p. 42) Claimant stated his neck symptoms were going to interfere with his ability to lift over his head and he could not return to work. (Ex. 15, p. 42) Dr. Kirkle did visit with claimant again but the physician did not change his opinion about claimant returning to restricted duty work.

On September 4, 2014, claimant applied for leave under FMLA for the period he was hospitalized. According to the testimony of Ms. Damge, the FMLA leave was approved by someone in corporate headquarters. (Tr., p. 168)

Claimant commenced physical therapy on September 5, 2014. (Jt. Ex. 7, p. 251) The therapist assessed claimant's condition as: "Right cervical discomfort with some

radiating pain and numbness into the right upper extremity with painful range of motion and tenderness to palpation." (Jt. Ex. 7, p. 253)

On the following day, claimant visited Nurse Practitioner Hennings. (Jt. Ex. 3, p. 178) Claimant reported he had been in the hospital for three days commencing on August 24, 2014. Claimant attributed his hospitalization to a reaction to Gabapentin. (Jt. Ex. 3, p. 178) Claimant also reported another trip to the hospital on September 3, 2014 because he could not breathe and he developed a rash. (Jt. Ex. 3, p. 178) Claimant neglected to mention he had been hospitalized for cervical issues with symptoms radiating into the right upper extremity. It is surprising claimant would not mention those symptoms when he had just discussed them on the day prior. (Jt. Ex. 3, pp. 178-179)

On September 19, 2014, Dr. Kirkle issued his opinion letter relative to the cause of claimant's cervical pain. (Jt. Ex. 7, p. 255) Dr. Kirkle wrote:

> Darrell had presented to occupational therapy on September 04, 2014 with cervical pain. The story he told me at that time was that he had a fall on or about August 05, 2014 or August 06, 2014. He was working on the line and he kicked a box back to move it, it was behind him and he tripped over it and landed on the cement; landing on his buttocks, back and head. He said at that time he had some discomfort off and on for a couple weeks then it went away and then on approximately August 24, 2014 he woke up and could not move and ended up going to the emergency room. He was seen in the emergency room, had CT and MRI of his neck; was in the hospital and had an injection from Dr. Inamdar which helped him tremendously.
>
> After being seen there he was referred on to neurosurgery. He had already seen the neurosurgery PA while he was in the ER. We also referred him to pain management. There were some discrepancies in the history. At the time he was seen in the ER on August 24, 2014 the note said he told them he slept on it wrong and pinched a nerve and that is what caused his pain. He did mention that he had a fall in August, but denies any other trauma and did not say anything about he thought that was the cause of his injury. The note from PA Rozek, the neurosurgery PA, states that he actually had stiffness and pain in his shoulder two weeks prior to his fall and when I mentioned this to the patient he got very upset with me. Then I looked at the H&P from his admission to the hospital and at that time the history I got from Dr. Pasarin's note was similar to what he told me; he had had a fall around August 05, 2014 and he had some discomfort and stiffness in his shoulder for a couple weeks which then disappeared and then on about August 22, 2014 or so he started having much more pain to the point when he woke up on August 24, 2014 he could not move his neck.

> Therefore, with the different discrepancies here and his prior history of left cervical surgery and injury, I cannot say with over 50% assuredness that his fall was the cause of his injury because of the discrepancies of the histories.

(Jt. Ex. 7, p. 255)

On October 3, 2014, claimant visited the Veterans Administration Outreach Clinic. Dr. Baridon examined claimant for a spike in his blood sugars. (Ex. 2, p. 64) Claimant told Dr. Baridon that he fell at work in August and injured his neck. As a consequence, claimant was given an injection and placed on a Medrol dose pack. Dr. Baridon indicated the neck pain had resolved. The physician did recommend tramadol for shoulder and chronic low back pain. (Jt. Ex. 2, p. 65)

On October 24, 2014, claimant saw Nurse Practitioner Hennings again. (Jt. Ex. 3, p. 183) Claimant requested a refill for his pain medication and a steroid shot for his left shoulder. Claimant reported the pain level in his left shoulder at 3-4/10. (Jt. Ex. 3, p. 183)

With respect to claimant's low back, Nurse Hennings wrote:

> **Plan:**
>
> **1. Low back pain**
>
> Notes: Patient will continue with current medication and treatment plan. Patient would like to go back to full duty as he thinks most of his restrictions he [*sic*] been working [*sic*] under now better. She [*sic*] was placed on restrictions through occupational health but he is no longer seeing occupational health doctor and before he gets released to regular duty from here he does want to check with his lawyer. Pending what his lawyer says, I am fine with releasing him back to regular duty.
>
> **2. Rotator cuff syndrome NOS**
>
> Notes: Left shoulder injected. Patient tolerated injection well, see procedure report.
>
> 3. . . . .
>
> **4. CHRONIC PAIN SYNDROME**
>
> Refill Percocet-10/325 tablet, 325 mg-10 mg, 1 tab(s), orally, every 6 hours, prn, 30 days, 120, Refills 0.
>
> Notes: Pain medication was refilled as listed above.

(Jt. Ex. 3, p. 184)

Nurse Practitioner Hennings released claimant to return to work without restrictions effective November 4, 2014. (Ex. B, p. 4) Claimant returned to Covenant Clinic and Melissa Oltmann, ARNP, on November 19, 2014 for "medical reasons." (Ex. C, p. 5) Claimant was excused from work on the day of his medical appointment. He was returned to work on November 20, 2014. (Ex. C, p. 5) Claimant returned to full duty work in the DC UPS position. (Tr., p. 112) He had no special accommodations or assistance on the job. (Tr., p. 112)

On November 20, 2014, claimant was given a "Documented Verbal Warning" from his supervisor for having 8 incidents of absence in the past 12 months. (Ex. F, p. 20) Those incidents included 2 times when claimant was tardy. (Ex. F, p. 20) Claimant was placed on a monitoring program. (Ex. F, p. 20)

Claimant returned to Nurse Hennings on December 26, 2014. His chief complaint was left shoulder pain. Claimant was requesting a refill of his pain medication. (Jt. Ex. 3, p. 185) The Percocet was used to control the patient's chronic rotator cuff syndrome, his cervical spine disorder and his lumbar disc disease. (Jt. Ex. 3, p. 186)

On January 26, 2015, claimant's productivity level was documented at 76.83 percent. The level was just slightly below the 83 percent performance level. (Ex. F, p. 21) During the week of February 2, 2015, claimant's performance level was at 73.95 percent. (Ex. F, p. 22) During the week of February 9, 2015, claimant's productivity level was at 82.1 percent. Claimant was just slightly below his goal. (Ex. F, p. 23) On February 13, 2015, claimant was counseled by his supervisor and the HR Administrator about treating co-workers in a professional and courteous manner. (Ex. F, p. 24)

Claimant had his annual performance review on May 15, 2015. He scored below the standard 3.0 for the second year in a row. (Ex. F, p. 25) Claimant was provided with certain areas of conduct where claimant needed to improve. They included:

Attendance

Productivity

Acceptance of Direction from Leads

Compliance with Policy

Professional Conduct/Communication

Safety Compliance and Safe Behavior

(Ex. F, p. 25)

On August 21, 2015, members of management at Ferguson conducted a follow-up review of the performance improvement plan initiated on May 15, 2015. (Ex. F, p. 26; Tr., p. 173) Claimant was provided feedback concerning where he had improved and where he needed to direct more improvement. (Ex. F, pp. 26-27) Claimant's productivity was not a portion of the Performance Improvement Plan in August of 2015. (Ex. F, pp. 26-27; Tr., p. 174)

Claimant sought medical care at People's Community Health Clinic on September 8, 2015. (Ex. D, p. 6) Melissa Oltmann, ARNP, released claimant to return to work on September 9, 2015. (Ex. D, p. 6)

On September 24, 2015, claimant presented again at the Waverly Health Center. Daniel Koos, M.D. treated claimant for increasing pain in the left shoulder and left upper back. (Jt. Ex. 3, p. 187) Claimant reported he and his co-workers engage in group stretches both before work begins and after the lunch break. Claimant also admitted he occasionally lifts weights. (Jt. Ex. 3, p. 187) Dr. Koos refilled the prescription for Percocet. The physician referred claimant to a pain clinic for a possible trigger point injection into the left infraspinatus muscle. (Jt. Ex. 3, p. 189)

Date of Alleged Injury: November 3, 2015

According to Ms. Damge, claimant last worked inside the plant on November 2, 2015. (Tr., p. 174) There had been an insubordination incident on the 2nd which involved claimant and the shipping lead. (Tr., p. 175) Ms. Damge called claimant on the morning of November 3, 2015 and informed him not to report for work because his employment file was being reviewed in light of the events that occurred on the prior evening. (Tr., p. 175) Ms. Damge placed a second call to claimant on November 3, 2015. (Tr., p. 176) The human resource administrator informed claimant, the general manager had decided to terminate claimant due to the insubordination incident on the previous evening. (Tr., p. 176)

Ms. Damge testified; claimant never reported any work injuries to her when she telephoned him on November 3, 2015.

Later, on the afternoon of November 3, 2015, claimant called the general manager to explain what had occurred on the evening of November 2, 2015. However, the general manager refused to reinstate claimant.

Claimant testified he assumed he was being terminated because of his low production rate. (Tr., p. 72) He testified on direct examination:

> A. He told me that my production rate was low and that "We're going to terminate your position at Ferguson."

(Tr., p. 73)

Claimant alleges he suffered a cumulative injury to his neck, low back, hip, and left shoulder as a result of his continuing to work as a DC UPS operator from the end of October 2014 until he was terminated on November 3, 2015. (Ex. H, pp. 46-50; Tr., p. 70) Claimant described the injury as: "A cumulative. Probably." (Tr., p. 70)

During his February 14, 2017 deposition, claimant was asked about the nature of his work injury on November 3, 2015. Claimant testified as follows:

> Q. (By Mr. Thill) Okay. Your last date of injury that you have in your claim is November 3, 2015; can you tell me if you had an injury on that day or something else happened.
>
> A. Say that again.
>
> Q. Sure. Can you tell me - - let me just ask you this: Tell me how you were hurt on November 3, 2015.
>
> A. Lifting - - lifting in - - doing some lifting.
>
> Q. As a DC UPS operator?
>
> A. Correct.
>
> . . . .
>
> Q. After you were injured while lifting on November 3, 2015, did you talk to Brian about the injury, or did you talk to somebody else at Ferguson?
>
> A. No; I received a phone call from Ferguson and told me to stay at home, and I got a call later in the day telling me that my position at Ferguson was terminated.
>
> Q. Did those calls take place on November 3, 2015, or some day thereafter?
>
> A. The next day; I think. Yeah.

(Ex. L, pp. 117-118)

The evidence establishes claimant did not work on November 3, 2015. He could not have injured himself while lifting on November 3, 2015. Business records for Ferguson Enterprises, Inc. do not show any time worked by claimant on the 3rd. Claimant earned no wages.

Subsequent to his termination, claimant received unemployment benefits through Iowa Workforce Development. Claimant estimated he received benefits from four to six

months. During the time he received unemployment insurance benefits, claimant did seek employment from other establishments. He stated he tried to find employment within the restrictions established by Dr. Kirkle.

On December 22, 2015, claimant visited Dr. Koos. Claimant was experiencing a cough and chest congestion. He also requested a refill of his Percocet. (Jt. Ex. 3, p. 190) Claimant informed Dr. Koos about having four injections into his left shoulder during the month of November. (Jt. Ex. 3, p. 190)

On April 20, 2016, claimant returned to see Dr. Baridon at the Veterans Administration Outpatient Clinic. (Jt. Ex. 2, p. 75) This appointment occurred more than 5 months after claimant had been terminated by management at Ferguson. Claimant told the doctor he had been terminated because his productivity was not up to par. (Jt. Ex. 2, p. 75) Claimant explained he was seeing the physician for pain management for his neck, shoulder, and back pain. Claimant described his level of pain as 4/10 but he did not indicate where he was experiencing the pain. Claimant emphasized the pain in his left shoulder was worse than it had been on prior occasions. This appeared to be an odd statement since claimant had not been employed at Ferguson for 5 months. (Jt. Ex. 2, p. 75) Dr. Baridon informed claimant the prescription for Percocet would be the last refill unless claimant performed a drug screening. The physician also prescribed duloxetine to assist claimant in weaning off the narcotic pain medication. (Jt. Ex. 2, p. 83) Dr. Baridon suggested physical therapy and a pain clinic for claimant. (Jt. Ex. 2, p. 83)

On May 19, 2016, claimant returned to the Veterans Administration Outpatient Clinic. (Jt. Ex. 2, p. 86) His chief complaint was left shoulder pain. (Jt. Ex. 2, p. 86) Claimant stated he had no specific injury that he could recall. (Jt. Ex. 2, p. 86) Claimant was reluctant to discuss his use of oxycodone for pain control. (Jt. Ex. 2, p. 86) Claimant reported he was unemployed and he had two work injuries that were in pending litigation. (Jt. Ex. 2, p. 88) Claimant did not detail what type of injuries he sustained, when the injuries occurred, or what type of symptoms he was experiencing. (Jt. Ex. 2, p. 88) With respect to his left shoulder, Katharine M. Staniforth, ARNP, assessed claimant's condition as:

> Musculoskeletal exam: Left upper extremity is with a 2+ radial pulse. Sensation present to light moving touch, C5-T2. He has forward elevation to 170, abduction 150, external rotation 30, internal rotation to L5. Rotator cuff strength is universally 5/5. He has no obvious deformity or discoloration. He has no tenderness to palpation of the AC joint. Negative cross body adduction. No tenderness to the proximal insertion of biceps tendon. Negative Speed's, negative Yergason's. He does have slightly positive impingement signs, Neer and Hawkins. He has no tenderness to palpation in the musculature in the body of the trapezius.

(Jt. Ex. 2, p. 87)

> ASSESSMENT: This is a 56-year-old male with past medical history significant for chronic neck and shoulder pain, status post anterior cervical discectomy C5-6 and two left shoulder arthroscopic subacromial decompressions, also more recently a distal clavicle resection. Never had great results with any of those surgeries. He continues to be on narcotic medications, oxycodone 10 mg four times every day for years. Clinical exam is unremarkable. His motion is well preserved. His strength is well preserved. The main pain that he has seems to be in the body of his trapezius muscle, likely related to guarding. He also has some pain related to impingement.

(Jt. Ex. 2, p. 88)

Nurse Staniforth injected the left shoulder posterior subacromial space with 8 ml of 1 percent lidocaine and 20 mg of Kenalog. Claimant tolerated the procedure well. (Jt. Ex. 2, p. 88)

From May through early August of 2016, claimant was employed by ManpowerGroup, Inc. (Ex. J, pp. 70-71) Claimant's gross earnings for the time period he worked equaled $4,775.40. (Ex. J, p. 71) He worked at Green Line Polymers in Waterloo, Iowa. Claimant worked on the wash line. His contract was cancelled.

Claimant obtained temporary employment with Express Services. (Ex. L, p. 93; Tr., pp. 77-78) Claimant was assigned to Hawkeye Corrugated in Cedar Falls, Iowa. He worked as a helper. He also worked at a business known as Control. (Tr., pp. 77-78)

On June 30, 2016, claimant walked into the Veterans Affairs Outpatient Clinic and demanded pain medication for his back and left shoulder pain. (Jt. Ex. 2, p. 98) He was in an angry mood and threatened to call the director. (Jt. Ex. 2, p.98) Seana M. Poage, R.N., noted:

> Tramadol was discontinued by his provider 2/01/2016 as veteran was receiving Oxycodone/APAP locally, violation of Pain Agreement noted that date. Query of Iowa PMP 6/24/2016 indicates several prescriptions by different providers for Oxycodone/APAP in the past few months. Surrogate will not renew Tramadol, veteran should make an appointment to review pain medication use and pain control with PCP.

(Jt. Ex. 2, p. 98)

Claimant did see Dr. Baridon later on June 30, 2016 for pain management. Claimant reported to the physician, "strained my back last Friday or Saturday." (The Friday and Saturday before the appointment would have been June 23, 2016 and June 24, 2016.) Claimant reported his level of pain was 4/10. He had been working

12 hour days and 3 days per week. Claimant reported he strained his back while lifting. (Jt. Ex. 2, p. 91) He did not mention what he had been lifting when he strained his back. Dr. Baridon prescribed indomethacin and cyclobenzaprine. (Jt. Ex. 2, p. 96)

On August 1, 2016, claimant telephoned the Veterans Affairs Outpatient Clinic. He requested narcotic medication. Claimant spoke with Susan Toneff, BSN, at the clinic. (Jt. Ex. 2, p. 99) Claimant informed the nurse he had been prescribed "Duloxetine 20 mg" just several weeks prior by medical personnel at the Veterans Administration. The nurse checked claimant's records but the last appointment claimant had at the Veterans Administration Outpatient Clinic had been on June 30, 2016 when Dr. Baridon had prescribed indomethacin and cyclobenzaprine. (Jt. Ex. 2, p. 99) Claimant was adamant he had been seen since June 30, 2016. (Jt. Ex. 2, p. 99)

Dr. Baridon examined claimant on August 2, 2016. (Jt. Ex. 2, p. 100) The physician diagnosed claimant with acute chronic back pain. (Jt. Ex. 2, p. 100) Claimant stated he had been doing well until just a few days prior to his appointment. (Jt. Ex. 2, p. 100) Dr. Baridon prescribed 40 tablets of 50 mg of tramadol with no refills. (Jt. Ex. 2, p. 100)

On September 16, 2016, Dr. Baridon and claimant spoke over the telephone about claimant's complaints of left shoulder pain. (Jt. Ex. 2, p. 101) Claimant reported he had an increase in left shoulder pain. (Jt. Ex. 2, p. 102) He told Dr. Baridon he had two weeks remaining on his probationary period before he would be hired full time at his new place of employment. (Jt. Ex. 2, p.102) He indicated once he had health insurance, he would go elsewhere for medical treatment. (Jt. Ex. 2, p. 102) Dr. Baridon prescribed tramadol 5200 mg to be taken 4 times per day and etodolac 400 mg tablets to be taken twice a day with food. (Jt. Ex. 2, p. 103)

Claimant returned to the outpatient clinic on September 22, 2016. Claimant stated his pain was no better than on his previous visit. However, on this occasion, claimant was speaking about his right shoulder and not his left shoulder. Claimant rated the shoulder pain at 4/10. Claimant reported the tramadol was not helping with the pain and was causing diarrhea. (Jt. Ex. 2, pp. 104, 107) Dr. Baridon did prescribe 40 tablets of hydrocodone with no refills. (Jt. Ex. 2, p. 113)

On October 16, 2016, claimant called from the emergency room Care Nurse Triage regarding the onset of new symptoms. (Jt. Ex. 2, p. 116) Claimant reported severe pain in the neck, left shoulder, and left arm with a pain level of 10/10. (Jt. Ex. 2, p. 117) Claimant felt as if he could not move. (Jt. Ex. 2, p. 117) Claimant denied any injury prior to the onset of the symptoms. (Jt. Ex. 2, p. 117) Claimant was told to seek treatment at an emergency room. (Jt. Ex. 2, p. 117)

Claimant was admitted to Covenant Medical Center on October 17, 2016. (Jt. Ex. 2, p.118) The physicians at Covenant ordered both CT scans and MRI testing of the cervical spine. (Jt. Ex. 2, p. 118) The test results showed a left paracentral disc

protrusion at C6-C7. (Jt. Ex. 2, p. 126) Claimant received a steroid injection. (Jt. Ex. 2, p. 126) Claimant reported tramadol was not working for pain control. (Jt. Ex. 2, p. 121) Physicians at Covenant Medical Center would not prescribe anything stronger. Claimant contacted the Veterans Administration Outpatient Clinic. He requested Vicodin but he was not given a prescription. (Jt. Ex. 2, p. 121) Claimant set an appointment with the Veterans Administration Outpatient Clinic for October 27, 2016. However, he cancelled his appointment. (Jt. Ex. 2, pp. 122-123)

Claimant did return to the Veterans Administration Outpatient Clinic on November 9, 2016. (Jt. Ex. 2, p. 123) Claimant reported he needed a refill on his tramadol for his alleged neck and shoulder symptoms. (Jt. Ex. 2, p. 123) Claimant also reported he was not taking his etodolac because it made him "itch." (Jt. Ex. 2, p. 123) Nevertheless, on November 14, 2016, claimant's prescription for etodolac was increased from 200 mg capsules to 400 mg capsules. (Jt. Ex. 2, p. 124)

On December 15, 2016, claimant returned to the Veterans Administration Outpatient Clinic with left shoulder complaints. (Jt. Ex. 2, p. 125) Claimant reported he had no private health insurance. He indicated he was experiencing pain on the left side of his neck, his left shoulder, and low back. (Jt. Ex. 2, p. 127) He also described some pain in his right shoulder. (Jt. Ex. 2, p. 127) Claimant reported:

> Nothing seems to help. Tramadol doesn't help. Etodolac doesn't help. There are times when it is so hard to move that it is hard for him ot [*sic*] move or walk. Gabapantin [*sic*] helped but caused a rash. Hydrocodone doesn't help much[.] [O]xycodone does help the pain.

(Jt. Ex. 2, p. 127) Dr. Baridon did prescribe oxycodone after claimant had a comprehensive drug screening. (Jt. Ex. 2, p. 134)

Roland A. Torres, M.D., a neurosurgeon, examined claimant on December 21, 2016. Dr. Torres reviewed claimant's October 17, 2016 cervical spine MRI and opined that it showed mild disc disease at C6-7. (Jt. Ex. 2, p. 140) Dr. Torres opined claimant would benefit from physical therapy and low impact aerobics. (Jt. Ex. 2, p. 140) Dr. Torres found no need for surgical intervention. (Jt. Ex. 2, p. 140)

Pursuant to Iowa Code section 85.39, claimant had an independent medical examination with Farid Manshadi, M.D. on January 6, 2017. (Ex. 1) Dr. Manshadi reviewed "a copious amount of medical records in regard to Mr. Redding." (Ex. 1, p. 1) The physician also physically examined claimant. Among other matters, Dr. Manshadi found:

> On examination BP is 130/80, pulse is 72, respirations 16. His lungs were clear to auscultation.

Reflexes were 2+ in the upper extremities and in both knees, depressed in the right ankle, and 1+ in the left ankle.

Neck range of motion showed rotation to the right was 20 degrees; rotation to the left was 42 degrees. Neck flexion was 33 degrees. Neck extension was 29 degrees. Tenderness over the left upper trapezius noted to palpation. Resisted left shoulder abduction was painful. Further, Neer and Hawkins were also positive on the left. Left shoulder range of motion was limited.

Using a Goniometer:

Left shoulder forward flexion was 120 degrees.

Left shoulder extension was 56 degrees.

Left shoulder abduction was 100 degrees.

Left shoulder external rotation was 50 degrees.

Left shoulder internal rotation was 45 degrees.

Left shoulder adduction was 42 degrees.

Also the left shoulder was tender to palpation over the left shoulder lateral and anterior joint area. Evidence of previous surgery noted in the left shoulder also. Tenderness to palpation over the bilateral SI joints noted with the left side being worse than the right side. Also tenderness over the origin of the glutei muscle also noted. Lumbar flexion was full. Lumbar extensions also was [*sic*] full. Lateral bending to the left was much better than to the right. Spinous processes were nontender to palpation in the lumbosacral area. Paraspinals were nontender in the lumbosacral area. Straight leg raising was positive on the left at 40 degrees, and negative on the right. Left leg was shorter than the right leg. Positive Patrick's sign on the left, negative on the right. There was a slightly reduced sensation to light touch in the left L3 and S1 in comparison to the right. Gait showed antalgia on the left.

DISCUSSION: After reviewing the provided medical records and evaluation and examination of Mr. Redding, it appears that Mr. Redding has had previous issues with his left shoulder as well as with his neck and low back. In fact, he has had surgeries for all three prior to his work injuries while working at Ferguson. However, Mr. Redding still was able to work in a heavy labor type of work at Ferguson. However, after the work injuries of 05/01/12 and then 08/05/14 it appears that Mr. Redding's symptomatology has gotten significantly worse.

As such, I believe Mr. Redding does have partial permanent impairment as a result of these work injuries including to his neck, left shoulder and low back.

Specifically in regard to his neck, I used the American Medical Association's Guides to the Evaluation of Permanent Impairment, 5th Edition, Chapter 15, Page 392, Table 15-5 and he falls under DRE Cervical Category 2 and I assign six (6) percent impairment of the whole person as he has reduced neck range of motion as well as disc disease in the cervical region.

In regard to his left shoulder, I used the American Medical Association's Guides to the Evaluation of Permanent Impairment, 5th Edition, Chapter 16, pages 475-479 and as such, I assign twelve (12) percent impairment of the left upper extremity.

Finally, in regard to his low back injury, I used the American Medical Association's Guides to the Evaluation of Permanent Impairment, 5th Edition, Chapter 15, Page 384 and he falls under DRE Lumbar Category 2 and I assign five (5) percent impairment of the whole person.

I also believe Mr. Redding should have permanent restrictions in regard to the above-mentioned injuries. I recommend for Mr. Redding to avoid any activity which requires repetitious reaching, shoulder height or overhead activities. He is also to avoid any activity which requires repetitious bending or twisting at his waist. He is not to lift more than 20 to 30 pounds.

Further, in regard to any future medical treatment, in regard to the left shoulder, I recommend an MRI of the left shoulder and then treat accordingly, and left shoulder arthroscopic surgery cannot be entirely ruled out.

In regard to his back issues, epidural steroid injections may be an avenue and if that fails, acupuncture may also be an avenue. If all conservative measures fail, surgical treatment cannot be entirely ruled out either.

In regard to his neck, no further treatment is indicated at this point.

(Ex. 1, pp. 4-5)

On February 13, 2017, claimant requested a refill of his pain medication. (Jt. Ex. 2, p. 145) He contacted Dr. Baridon by e-mail message. (Jt. Ex. 2, p. 145)

As of February 14, 2017, claimant was working at Con-Trol Container Repair in Waterloo, Iowa. He was on a temporary assignment through Express Services, Inc. (Ex. L, p. 85) Claimant was still employed by Express Services, Inc. at Con-Trol Container on October 18, 2017, the second day of claimant's arbitration hearing. Claimant testified in his deposition he was not working under any restrictions. (Ex. L, p. 95) At the time of day two of the arbitration hearing, claimant was earning $13.00 per hour. (Ex. M, pp. 139) Claimant testified most of the jobs he obtained through Express Services, Inc., involved standing. (Tr., p. 160)

On February 22, 2017, Dr. Kirkle reviewed claimant's October 17, 2016 CT scan and MRI results. The physician opined:

> Having reviewed all this, I believe there was a questions [*sic*] as to whether the 8/5/2014 injury was an exacerbation versus aggravation of his chronic neck pain. Not knowing whether the C3-5 disc protrusion was preexisting and with all of his history of worsening neck pain prior, a case can be made that it was preexisting. His most recent issue is a new disc protrusion at the C6-7 area, which was definitely not related to his work at Ferguson that ended in November 2015 and he had told the ER that he did not have an injury. This makes the fact that his C3-4 disc protrusion may not have been injury instigated more reasonable.

(Ex. A, p. 3)

Dr. Kirkle also disagreed with the impairment ratings provided by Dr. Manshadi. (Ex. A, p. 3) Dr. Kirkle explained why he differed in opinion from Dr. Manshadi. Dr. Kirkle wrote:

> Dr. Manshadi's impairment ratings, I believe, are based on his pre-existing chronic neck issues, rather than his work comp injury which was treated with an epidural injection and then eventually returned back to full duty. His impairments on the right shoulder and lumbar are also based on his pre-existing chronic problems, which was not involved in his work comp injury of 8/5/2014 or 11/3/2015. His recommendations as to restrictions are pertinent, but not due to his work comp injury, but ongoing chronic pain and degenerative disease. I believe the VA may wish to restudy his left shoulder, but not due to any injury, but due to see if any further surgery from his chronic pain is warranted.

(Ex. A, p. 3)

RATIONALE AND CONCLUSIONS OF LAW

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).

A personal injury contemplated by the workers' compensation law means an injury, the impairment of health or a disease resulting from an injury which comes about, not through the natural building up and tearing down of the human body, but because of trauma. The injury must be something that acts extraneously to the natural processes of nature and thereby impairs the health, interrupts or otherwise destroys or damages a part or all of the body. Although many injuries have a traumatic onset, there is no requirement for a special incident or an unusual occurrence. Injuries which result from cumulative trauma are compensable. Increased disability from a prior injury, even if brought about by further work, does not constitute a new injury, however. St. Luke's Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); Ellingson v. Fleetguard, Inc., 599 N.W.2d

440 (Iowa 1999); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995); McKeever Custom Cabinets v. Smith, 379 N.W.2d 368 (Iowa 1985). An occupational disease covered by chapter 85A is specifically excluded from the definition of personal injury. Iowa Code section 85.61(4) (b); Iowa Code section 85A.8; Iowa Code section 85A.14.

While a claimant is not entitled to compensation for the results of a preexisting injury or disease, its mere existence at the time of a subsequent injury is not a defense. Rose v. John Deere Ottumwa Works, 247 Iowa 900, 908, 76 N.W.2d 756, 760-61 (1956). It the claimant had a preexisting condition or disability that is materially, aggravated, accelerated, worsened or lighted up so that it results in disability, claimant is entitled to recover. Nicks v. Davenport Produce Co., 254 Iowa 130, 135, 115 N.W.2d 812, 815 (1962); Yeager v. Firestone Tire & Rubber Co., 253 Iowa 369, 375, 112 N.W.2d 299, 302 (1961).

When an expert's opinion is based upon an incomplete history it is not necessarily binding on the commissioner or the court. It is then to be weighed, together with other facts and circumstances, the ultimate conclusion being for the finder of the fact. Musselman v. Central Telephone Company, 154 N.W.2d 128, 133 (Iowa 1967); Bodish v. Fischer, Inc., 257 Iowa 521, 522, 133 N.W.2d 867 (1965).

The weight to be given an expert opinion may be affected by the accuracy of the facts the expert relied upon as well as other surrounding circumstances. St. Luke's Hospital v. Gray, 604 N.W.2d 646 (Iowa 2000).

Expert testimony may be buttressed by supportive lay testimony. Bradshaw v. Iowa Methodist Hospital, 251 Iowa 375, 380; 101 N.W.2d 167, 170 (1960).

The commissioner as trier of fact has the duty to determine the credibility of the witnesses and to weigh the evidence. Together with the other disclosed facts and circumstances, and then to accept or reject the opinion. Dunlavey v. Economy Fire and Casualty Co., 526 N.W.2d 845 (Iowa 1995).

With respect to his low back symptoms, claimant has failed to meet his burden of proof that he sustained a permanent injury to his low back on May 1, 2012; August 5, 2014; or November 3, 2015. Claimant testified he did not have prior low back symptoms similar to those experienced after May 1, 2012. (Tr., p. 41) The greater weight of the medical evidence does not support claimant's statement. Claimant was in a motor vehicle accident in 1993 and complained of chronic low back pain. (Jt. Ex. 2, pp. 12, 40) Claimant also sustained a low back injury while working for Waterloo Casting in 1995. (Ex. H, p. 56)

Claimant continued to have back symptoms in 2000 for which claimant sought treatment. (Jt. Ex. 2, pp. 12, 40) X-rays showed degenerative disk disease at L5-S1. Claimant underwent a L5-S1 hemilaminectomy on February 7, 2001. (Jt. Ex. 2, p. 13)

MRI testing on February 5, 2003 revealed "mild thickening of the ligamentum flavum and mild broad-based posterior disc bulge causing mild secondary narrowing of the bilateral neural foramen." (Jt. Ex. 2, p. 13)

In December of 2009, claimant was involved in another motor vehicle accident. He complained of neck, back and hip pain. (Jt. Ex. 2, p. 13) A CT scan revealed bulging discs at L3-4, L4-5 and L5-S1. At L4-5 there was mild compression of the thecal sac diffusely. There was also osteophytic spurring. (Jt. Ex. 2, p. 14)

MRI testing of the lumbar spine occurred on October 7, 2010. (Jt. Ex. 2, pp. 15-16) There were degenerative changes at L4-L5 and L5-S1. Claimant complained of low back pain radiating down his right hip to the right knee. (Jt. Ex. 1, pp. 4-5) He also found himself in the emergency room on March 30, 2011 because of low back pain radiating down his right hip to the right knee. Claimant denied any new injury. (Jt. Ex. 2, pp. 25, 30) On the following day, claimant saw his treating nurse practitioner. He noted claimant had decreased range of motion at the low back including flexion, extension and turning rotation of the hip due to spinal issues. (Jt. Ex. 3, p. 146)

On May 27, 2011, claimant reported low back symptoms. (Jt. Ex. 3, p. 148) Claimant underwent a lumbar back injection on June 16, 2011. (Jt. Ex. 4, p. 193)

Claimant was scheduled for back surgery. However, he cancelled it due to his employment at Ferguson. Claimant continued to treat at the Waverly Health Center for back pain. (Jt. Ex. 3, pp. 151, 153, 155) Claimant relied on the nurse practitioner to refill claimant's prescriptions for narcotic pain medications.

Claimant alleged he permanently injured his low back and left hip as a result of a traumatic incident that occurred on May 1, 2012 when he was lifting a box. (Ex. 6, pp. 21-22) MRI testing was taken on May 21, 2012. The results for L4-5 and L5-S1 areas are basically the same results as those results found after the October 7, 2010 MRI were revealed. (Jt. Ex. 5, p. 199)

Claimant saw Dr. Afzal at Allen Pain Clinic on August 7, 2012. Claimant reported pre-existing back issues but he told the physician, his back issues had completely resolved prior to the lifting incident on May 1, 2012. That was not an accurate statement. Claimant neglected to mention all the other events that affected his back prior to the lifting incident. (Jt. Ex. 6, p. 214)

On October 24, 2012, claimant saw Physician's Assistant Haag for follow-up care. (Jt. Ex. 5, p. 204) Mr. Haag found normal range of motion of the spine. (Jt. Ex. 5, p. 204) Claimant continued to report back pain in November 2012 and March 2013. (Jt. Ex. 6, p. 230; Jt. Ex. 3, p. 163) Nurse Hennings opined claimant's musculoskeletal system was at baseline by March 28, 2013. (Jt. Ex. 3, p. 164)

On May 6, 2013, Dr. Afzal reviewed claimant's latest MRI test results. The physician discussed the results with claimant. (Jt. Ex. 6, p. 241) Dr. Afzal opined:

> He does have degenerative disk disease at L4 and L5 levels. Appears to have slightly worse neuroforaminal narrowing on the right side although his symptoms are mostly on the left side.

(Jt. Ex. 6, p. 241) Dr. Afzal determined claimant was at maximum medical improvement on May 6, 2013. The physician released claimant from care. Claimant was told to return on an as-needed basis. (Jt. Ex. 6, p. 241)

Claimant saw Mr. Haag on June 12, 2013. Again there was normal range of motion of the spine. (Jt. Ex. 5, p. 210) Mr. Haag placed claimant at maximum medical improvement with respect to his lumbar spine. (Jt. Ex. 5, p. 210) Claimant was discharged from care. (Jt. Ex. 5, p. 210)

On September 23, 2013, claimant returned to Nurse Hennings. Claimant's musculoskeletal system was documented to be at baseline. (Jt. Ex. 3, p. 171)

On May 14, 2014, claimant visited the Veterans Administration Outpatient Clinic. He reported he had lingering shoulder and low back pain at times. On the day of his exam, his pain was 2/10. (Jt. Ex. 2, p. 58) Claimant returned to the same clinic on April 20, 2016. He was seeking oxycodone for neck, shoulder and back pain. Claimant reported his pain level at 4/10. He misinformed Dr. Baridon as to the cause for his termination. Claimant reported the cause was absenteeism due to pain. Such was not the reason. Claimant was terminated for insubordination and unprofessional conduct towards his supervisor. Claimant attempted to receive a prescription for narcotic pain medication. The request was denied. (Jt. Ex. 2, p. 75)

On June 30, 2016, claimant returned to the Veterans Administration Outpatient Clinic. He reported a lifting injury that resulted in a back strain. Claimant requested pain medication. (Jt. Ex. 2, p. 91) At the time, claimant was working for Manpower. Claimant had another incident in August 2016. (Jt. Ex. 2, p. 100) Claimant reported his back had been doing well until just a few days prior. (Jt. Ex. 2, p. 100)

On the first day of his arbitration hearing, claimant testified his back pain was near his tailbone. (Tr., p. 84) He testified:

> A. It comes and goes. It never goes away.
>
> Q. What level was that at? What's that go from?
>
> A. I guess it depends on the day, the time, or any activity I've done. But right now I would say 2.
>
> Q. Okay. What does it go to?

A. It can go as high as me not being able to do anything at all. 4, 5.

(Tr., p. 84)

On the second day of the arbitration hearing, October 18, 2017, claimant testified:

Q. How about the low back? Is that continuing to bother you at this time or not?

A. Mildly.

Q. And when you say "mildly," where does it affect you? Do you have pain or motion loss with it?

A. Pain.

Q. Where is it?

A. In my - - Generally in my low back.

Q. Belt level, middle, right, left? Where at?

A. Probably just below belt level.

Q. In the middle?

A. Yes.

Q. Does that radiate into either leg?

A. Not at this time.

(Tr., pp. 151-152)

Claimant's testimony about never having left-sided low back symptoms prior to his employment at Ferguson is given no weight. (Tr., p. 41) The greater weight of the evidence establishes claimant has complained of continuous low back pain since 1993. Claimant did not sustain a permanent disability to his low back on May 1, 2012. Claimant's low back symptoms and the MRI test results establish he has had a protracted history of degenerative disc disease which was not materially aggravated by his three alleged work injuries. Additionally, the greater weight of the evidence demonstrates claimant was not working on November 3, 2015. He had been terminated for insubordination on the day prior, November 2, 2015.

Because claimant has failed to prove by a preponderance of the evidence that his low back symptoms were caused or materially aggravated by his employment at

Ferguson, claimant is not entitled to an award of workers' compensation benefits from the three alleged injuries.

The next issue for consideration is the left shoulder condition. Claimant has failed to prove he sustained a work injury to his left shoulder on any of the alleged dates of May 1, 2012; August 5, 2014; or November 3, 2015. As discussed in previous paragraphs, claimant did not work on November 3, 2015. He was no longer an employee of Ferguson on the November 3rd date. Therefore, claimant has failed to meet his burden of proof. None of his alleged symptoms were due to the alleged November 3, 2015 date.

It is interesting to note; claimant did not complain of any left shoulder symptoms as a result of the alleged lifting injury on May 1, 2012. He reported injuries to his low back and left hip. (Ex. 6, pp. 21-22) There are no left shoulder complaints until February 15, 2013. (Jt. Ex. 2, p. 37) Claimant explains 9 months later, "He complains of left shoulder pain that increases with working." (Jt. Ex. 2, p. 37) It is hard to imagine how a report made in February of 2013 relates back to an alleged lifting incident in May of 2012 when claimant did not even voice any concerns about the left shoulder in May of 2012.

On pages 152 and 153 of the transcript, claimant testified he injured his shoulder by lifting something but he could not recall what he was lifting. He went to the hospital in October of 2016. Claimant testified his left shoulder pain never subsided. Claimant described the pain as minimal at times and then the pain would spike to 3 or 4 out of 10 on an analog scale. The greater weight of the evidence establishes claimant has experienced left shoulder symptoms since his motor vehicle accident in December 2009. (Jt. Ex. 2, pp. 13, 50) Claimant also complained of neck, low back and right hip symptoms.

Claimant underwent a cervical discectomy on July 23, 2010. (Jt. Ex. 1, p. 9; Jt. Ex. 2, p. 12) In September 2010, claimant reported his left shoulder pain was 8/10 in severity. (Jt. Ex. 1, p. 2) Claimant was diagnosed with a left rotator cuff tear. (Jt. Ex. 1, p. 3) On January 5, 2011, claimant underwent a labral debridement and distal clavicle excision due to significant impingement and AC arthritis. (Jt. Ex. 2, p. 12)

Unfortunately, claimant's left shoulder pain did not abate following his surgery. Claimant found the need to request a prescription for Vicodin on March 31, 2011. (Jt. Ex. 3, p. 146) On July 21, 2011, Dr. Delbridge conducted an independent medical examination for claimant as a result of the December 2009 motor vehicle accident. (Ex. H, p. 54) Dr. Delbridge rated claimant's left shoulder as having a five percent permanent impairment to the body as a whole. (Ex. H, p. 54)

On January 26, 2012, claimant requested a prescription for Percocet. (Jt. Ex. 3, p. 153) The request for narcotic pain medication was several months prior to the date of the first alleged work injury. Then on March 26, 2012, claimant reported pain in his

left shoulder at the level of 2-3/10. Claimant requested Percocet. (Jt. Ex. 3, p. 155) The reports pre-dated any of the three alleged work injuries.

On August 5, 2014, claimant alleged he injured his left shoulder as a result of an incident at work where he tripped over a box. (Ex. L, p. 113; Tr., p. 56) However, on the face of his "Accident Investigation for Occupational Injuries," claimant indicated he only injured his back and hip. Claimant did not designate whether it was the right or left hip. (Ex. 12, p. 29) There was no mention of any left shoulder injury. Moreover, claimant declined any medical treatment. (Ex. 12, p. 30)

Claimant did not seek medical treatment until he presented to the emergency department at Covenant Medical Center on August 24, 2014. (Jt. Ex. 8) Claimant complained of **left sided neck pain**. He believed he had slept incorrectly on the left side of his neck. (Jt. Ex. 8, p. 256) Claimant did mention: "Had a fall in August but denies other trauma." (Jt. Ex. 8, p. 257) Claimant indicated his neck pain started two days prior to the day he entered the emergency room. (Jt. Ex. 8, p. 257) Claimant inaccurately reported he had no "prior history of chronic neck or back problems." (Jt. Ex. 8, p. 257) The statement was a total misstatement of claimant's medical history. (Jt. Ex. 8, p. 257)

Dr. Ryken examined claimant while he was in the hospital. Claimant complained of **neck pain radiating into the right shoulder**. (Jt. Ex. 8, p. 273) He admitted he had neck stiffness and shoulder discomfort before he fell. (Jt. Ex. 8, p. 274) MRI test results of the right shoulder showed claimant suffered from degenerative changes of the right acromioclavicular joint. (Jt. Ex. 8, p. 267)

On September 6, 2014, claimant returned to the Veterans Affairs Outpatient Clinic. (Jt. Ex. 2, p. 61) Claimant reported an increase in urination since the onset of a neck injury as a result of falling at work. (Jt. Ex. 2, p. 61) Even though claimant had previously complained of left shoulder symptoms, he reported no pain throughout his entire body. (Jt. Ex. 2, p. 63)

On the following day, claimant saw Dr. Kirkle at Covenant Medical Center. Claimant complained of **right cervical discomfort with some radiating pain and numbness into the right upper extremity**. (Ex. 7, p. 253) Claimant discussed jumping over a box at work and landing on his low back, coccyx region and the back of his head. (Jt. Ex. 7, p. 252)

On September 8, claimant visited with his nurse practitioner, Jonathan Hennings. (Jt. Ex. 3, p. 178) The nurse reported claimant's chronic low back pain, and left shoulder pain. (Jt. Ex. 3, p. 178) Claimant made no mention of right or left shoulder complaints. (Jt. Ex. 3, p. 178) Claimant was still taking Percocet. (Jt. Ex. 3, p. 178)

Claimant returned to the nurse practitioner on October 24, 2014 with **left shoulder pain**. Claimant rated the level of pain at 3-4/10. He requested a steroid shot

in the **left shoulder** and Percocet for pain. The nurse expressly noted the narcotic pain medications were being prescribed for claimant's chronic rotator cuff syndrome, cervical spine disorder, and chronic lumbar disc disease. (Jt. Ex. 3, p. 186) There was absolutely no mention that the prescriptions were being refilled because of any work related injury or condition. (Jt. Ex. 3, p. 186)

On September 24, 2015, claimant reported he had an increase in upper back and left shoulder symptoms after lifting weights. He requested pain medication. (Jt. Ex. 3, p. 187) Claimant did not report left shoulder symptoms again until December 22, 2015. (Jt. Ex. 3, p. 190) Claimant requested a refill on his Percocet. (Jt. Ex. 3, p. 190) He also reported he received four injections into the left shoulder in November of 2015. However, no medical evidence was produced to corroborate claimant's report. (Jt. Ex. 3, p. 190)

In April 2016, claimant returned to the Veterans Affairs Outpatient Clinic. Claimant reported to Dr. Baridon he was have difficulties managing his neck, **left shoulder,** and back symptoms. (Jt. Ex. 2, pp. 85) Claimant was given only a 10 day supply of oxycodone. (Jt. Ex. 2, p. 83) Claimant reported the symptoms in his **left shoulder** had worsened. However, claimant had not worked at Ferguson's since November 2, 2015. Dr. Baridon also prescribed duloxetine. (Jt. Ex. 2, p. 83)

On May 19, 2016, claimant underwent a subacromial injection of the **left shoulder**. (Jt. Ex. 2, p. 88) Claimant requested narcotic pain medication but the physician refused. (Jt. Ex. 2, p. 88) X-rays of the left shoulder demonstrated: "Mild degenerative changes of **left shoulder**." (Jt. Ex. 2, p. 89) (Emphasis added.)

Claimant returned to the Veterans Affairs Outpatient Clinic on June 30, 2016. He indicated he had strained his back on the previous Friday or Saturday. Claimant demanded narcotic pain medication. (Jt. Ex. 2, p. 91) The request was denied. Claimant was angry and threatened to call the director. (Jt. Ex. 2, p. 98) Claimant rated his back pain on the analog scale at 4-5/10. (Jt. Ex. 2, p. 97)

On September 16, 2016, claimant reported his **left shoulder** remained symptomatic. (Jt. Ex. 2, p. 101) Claimant was working for a different employer. He requested narcotic pain medication. (Jt. Ex. 2, pp. 102-103) Dr. Baridon refused to prescribe narcotic pain medication. (Jt. Ex. 2, p. 103)

On September 22, 2016, claimant was reporting **right shoulder pain.** (Jt. Ex. 2, p. 104) Claimant rated the pain on an analog scale at 4/10. (Jt. Ex. 2, p. 104) Claimant reported tramadol did not control pain and caused diarrhea. Claimant desired a stronger pain medication. (Jt. Ex. 2, p. 107) Claimant reported worsening **shoulder pain.** Dr. Baridon did prescribe Hydrocodone. (Jt. Ex. 2, p. 113)

On October 16, 2016, nearly one year following the last day claimant worked at Ferguson, he called the Veterans Affairs Medical Center to report he was in the

emergency room of a local hospital. He was experiencing a new set of symptoms. (Jt. Ex. 2, pp. 116-117) Claimant reported pain on the analog scale of 10/10 for his neck, **left shoulder and arm pain.** He had been experiencing the symptoms for the prior several hours. Claimant indicated he felt as if he could not move. (Jt. Ex. 2, pp. 116-117) At the time he experienced the symptoms, claimant denied he had sustained any injury. (Jt. Ex. 2, p. 117)

However, on day two of his arbitration hearing, claimant testified:

A. I try to stay under 25, 30 pounds, nothing extremely heavy.

Q. Why is it? Why do you do that? Have you had experiences where you've lifted something and it's hurt?

A. Yes.

Q. Tell us about that.

A. I had an experience where I lifted something that weighed 50 or 60 pounds. And after doing that, I basically ended up having to go to the hospital.

Q. That was in October of '16?

A. Yes.

Q. Was that for a job, or was that - - what were you doing?

A. Working.

(Tr., p. 152)

Claimant could not recall what he was lifting when he injured himself. (Tr., p. 153) He did not remember what he was doing when he sustained his injury. (Tr., p. 153)

The greater weight of the evidence establishes claimant's **left shoulder condition** began in 2009 subsequent to the motor vehicle accident he sustained. The condition resulted in surgical intervention. The shoulder symptoms were in existence at the time claimant commenced his employment with Ferguson in November 2011. Claimant's left shoulder and much later his right shoulder complaints were instruments used to obtain narcotic pain medications for his various bodily aches and pains.

One primary example of claimant's strong desire for narcotics occurred in the spring of 2011. On March 30, 2011, claimant requested hydrocodone 300 mg tablets. He received a prescription for 30 tablets from the doctor at the Veterans Affairs

Outpatient Medical Clinic. (Jt. Ex. 2, p. 26) On March 31, 2011, claimant presented to Nurse Practitioner Hennings for pain in his **left shoulder** and neck. Claimant requested and received Vicodin 10/325 tablets. He was allowed to take 1 tablet every 4 to 6 hours. (Jt. Ex. 3, p. 146) There were many other instances throughout the medical records where claimant was insistent the medical provider prescribe narcotics.

Because claimant has failed to meet his burden of proof that his **left or right shoulder symptoms** were caused or materially aggravated by his employment at Ferguson, claimant takes nothing in the form of workers' compensation benefits for the alleged injuries of May 1, 2012; August 5, 2014; or November 3, 2015.

The final claim is for an injury to claimant's neck. The greater weight of the evidence establishes claimant's neck symptoms are due to residual pain from claimant's 2009 motor vehicle accident and also due to an incident where claimant presented to the hospital emergency room on August 24, 2014 with reports he injured his neck because he had slept incorrectly on it. Additionally, claimant had an unexplained injury to his neck in October of 2016. Claimant has failed to prove his neck condition was caused or materially aggravated by working for Ferguson on May 1, 2012; August 5, 2014; or November 3, 2015.

Claimant has experienced neck symptoms as early as 2003. (Jt. Ex. 2, p. 13) Claimant underwent MRI testing of the cervical spine on October 1, 2003. The results showed a disc bulge at C5-6. (Jt. Ex. 2, p. 13) Claimant was advised to "wean off narcotic medication, or at least go to T#3, anti-inflammatories/[T]ylenol." (Jt. Ex. 2, p. 13)

As indicated earlier, claimant was involved in a motor vehicle accident in 2009. Claimant complained immediately of neck pain. (Jt. Ex. 2, p. 13) A CT scan of the neck was taken. The results showed a diffuse disc bulge at C3-4; mild intravertebral disc space narrowing; mild left-sided neural foraminal encroachment from spurring; posterior disc bulge at C6-7; and straightening of the C-spine with loss of lordotic curvature. Claimant also experienced muscle spasms. (Jt. Ex. 2, pp. 13, 50)

On May 10, 2010, claimant underwent MRI testing. The results showed "mild to moderate disc space narrowing at C5-6." (Jt. Ex. 2, p. 14) There were mild degenerative changes as well. (Jt. Ex. 2, p. 14) Claimant's neck pain did not resolve. As a direct consequence, he underwent an anterior cervical discectomy at C5-6 on July 23, 2010. (Jt. Ex. 2, pp. 9, 12) Claimant indicated the pain in his neck resolved but he continued to experience pain in his shoulder. (Jt. Ex. 2, p. 12) In September of 2010 claimant's cervical pain had spiked to 7/10 on an analog scale. (Jt. Ex. 1, p. 2) Claimant continued to report neck symptoms on May 27, 2011. (Jt. Ex. 3, p.148) The increase in his neck pain pre-dated his employment at Ferguson.

Previously, the undersigned stressed the impairment rating Dr. Delbridge provided to claimant for his 2009 motor vehicle accident. Dr. Delbridge opined claimant

had a 10 percent impairment to the neck as a result of that accident. Claimant **did not report** an injury to his neck as a result of his May 1, 2012 incident. (Ex. 6, pp. 21-22) Claimant alleges he sustained a neck injury on August 5, 2014 when he tripped or jumped over a box. (Ex. 12, pp. 30-31) However, records for Ferguson indicated claimant reported he landed flat on his back. (Ex. 12, pp. 30-31) Claimant reported only injuries to his back and hip. (Ex. 12, p. 29)

Claimant did not report any neck symptoms until August 19, 2014. Prior to that date, claimant reported his back was doing well when questioned by his supervisor, Nick Crawford. It was only when Mr. Crawford approached claimant about his productivity within the plant that claimant stated: "My productivity was suffering because of my injury." (Tr., p. 123)

Because claimant mentioned his back was symptomatic, Mr. Crawford completed an accident report on August 19, 2014. (Ex, 12, p. 32) Claimant refused medical treatment. (Ex. 12, p. 30; Tr., pp. 123-124) Ferguson provided several options for medical care.

Claimant did present to the emergency room on August 24, 2014 for medical care with complaints of left-sided neck pain. (Jt. Ex. 8, pp. 256-257) Claimant reported he had slept incorrectly on his neck two days prior to his visit to the emergency department. He also reported he did not have any history of prior chronic neck or back pain. That was totally fictitious. The hospital treating physician diagnosed cervicalgia, multi-level cervical spondylosis, central C3-4 disc herniation with right paracentral C4 osteophyte, stenosis of C3-4 neuroforamen, and status post anterior cervical discectomy and fusion at C5-6. (Jt. Ex. 8, p. 275) Claimant requested a leave of absence via FMLA due to a non-work related health condition in order for him to go to the hospital from August 24, 2014 through August 26, 2014. (Ex. 13, p. 34) The FMLA leave was approved. (Tr., p. 168)

During day one of the arbitration hearing, claimant could not recall whether he had told the emergency room personnel, "Patient presents to ED with complaints of left-sided neck pain that started Friday a.m." (Tr., pp. 109-110)

During day two of the arbitration hearing, claimant attempted to explain away his left-sided neck pain of two days' duration. Claimant testified:

> Q. What is with the stiff neck, sleeping on it wrong? Do you remember, was that occurring then too, or what do you recall about that?
>
> A. I was only using that as an example of how I was feeling when I was talking to a nurse, because it felt as though it does when a person sleep [*sic*] on your arm or you sleep on your hand and your fingers tingle when you wake up and you've got to shake your hand to get your

> circulation back. So I was only stating that as an example of how my pain felt to me in my neck.

(Tr., pp. 148-149)

Claimant's second explanation still fails to approach the fact he reported the onset of his neck pain only several days prior to visiting the emergency room. Claimant's explanation was not credible.

Management officials terminated claimant on November 3, 2015. (Tr., p. 176) Claimant's last day of work was on November 2, 2015. He did not sustain any injuries to his neck on that day.

Claimant sought treatment from Dr. Koos on December 22, 2015. However, there was no mention of any neck problems. (Jt. Ex. 3, pp. 190-191) It was not until claimant sought additional narcotic pain medication from Dr. Baridon in April of 2016 that claimant began complaining of neck, shoulder, and back pain again.

Claimant did not complain of neck symptoms again until October 2016 when he reported the onset of new symptoms. Claimant reported pain equaling 10/10 on an analog scale. (Jt. Ex. 2, p. 117) Claimant denied any injury. (Jt. Ex. 2, p. 117) Claimant was admitted to Covenant Medical Center. A cervical MRI was taken. Test results demonstrated degenerative disc disease, a left-sided disc protrusion at C6-7 on the left, and an unchanged C3-4 moderate central disc protrusion. (Jt. Ex. 2, pp. 126-127)

It is the determination of the undersigned deputy workers' compensation commissioner; claimant did not injure his neck on August 5, 2014. Claimant suffers from a long history of cervical problems. He had a discectomy in 2010. There was residual pain stemming from the surgery. Claimant also injured his neck at home by sleeping incorrectly which in turn, affected his neck. As of September 6, 2014, claimant had reported to the medical providers at the Veterans Affairs Outpatient Clinic, he had 0/10 symptoms throughout all areas of his body. (Jt. Ex. 2, pp. 62-63) Moreover, claimant's own nurse practitioner, Melissa Oltmann, ARNP, released claimant to return to work without restrictions on September 9, 2014. The evidence establishes claimant did not complain of neck symptoms until October of 2016. There was an unexplained event. The event occurred approximately 11 months after claimant was terminated. It is impossible to relate the event to claimant's employment at Ferguson.

Because claimant has failed to prove by a preponderance of the evidence that his neck symptoms were caused or materially aggravated by his employment at Ferguson, claimant is not entitled to any workers' compensation benefits for the alleged injury dates of May 1, 2012; August 5, 2014; or November 3, 2015.

The final issue is the matter of costs. Iowa Code section 86.40 states:

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

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

Costs. Costs taxed by the workers' compensation commissioner or a deputy commissioner shall be (1) attendance of a certified shorthand reporter or presence of mechanical means at hearings and evidential depositions, (2) transcription costs when appropriate, (3) costs of service of the original notice and subpoenas, (4) witness fees and expenses as provided by Iowa Code sections 622.69 and 622.72, (5) the costs of doctors' and practitioners' deposition testimony, provided that said costs do not exceed the amounts provided by Iowa Code sections 622.69 and 622.72, (6) the reasonable costs of obtaining no more than two doctors' or practitioners' reports, (7) filing fees when appropriate, (8) costs of persons reviewing health service disputes. Costs of service of notice and subpoenas shall be paid initially to the serving person or agency by the party utilizing the service. Expenses and fees of witnesses or of obtaining doctors' or practitioners' reports initially shall be paid to the witnesses, doctors or practitioners by the party on whose behalf the witness is called or by whom the report is requested. Witness fees shall be paid in accordance with Iowa Code section 622.74. Proof of payment of any cost shall be filed with the workers' compensation commissioner before it is taxed. The party initially paying the expense shall be reimbursed by the party taxed with the cost. If the expense is unpaid, it shall be paid by the party taxed with the cost. Costs are to be assessed at the discretion of the deputy commissioner or workers' compensation commissioner hearing the case unless otherwise required by the rules of civil procedure governing discovery. This rule is intended to implement Iowa Code section 86.40.

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

It is the determination of the undersigned each party shall bear his/its/their own costs to litigate these claims.

ORDER

THEREFORE, IT IS ORDERED:

In File Number 5056336, claimant takes nothing from these proceedings.

In File Number 5056337, claimant takes nothing from these proceedings.

In File Number 5056338, claimant takes nothing from these proceedings.

Each party shall bear his/its/their own costs to litigate these claims.

Defendants shall file all reports as required by law.

Signed and filed this 23rd day of August, 2018.

Michelle A. McGovern

MICHELLE A. MCGOVERN
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.