BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

MARK PRESSON, Claimant, vs. FREIBURGER CONCRETE & TOPSOIL, INC., Employer, and IOWA MUTUAL INSURANCE CO., Insurance Carrier, Defendants.	File No. 5049542 ARBITRATION DECISION Head Note Nos.: 1108, 1402.40, 1801

STATEMENT OF THE CASE

Claimant, Mark Presson, filed a petition in arbitration seeking workers' compensation benefits from Freiburger Concrete & Topsoil, Inc., employer, and Iowa Mutual Insurance Company, insurance carrier, both as defendants, as a result of a stipulated injury sustained on May 19, 2014. This matter came on for hearing before Deputy Workers' Compensation Commissioner Erica J. Fitch. The record in this case consists of: joint exhibits 1 through 11[1], 13 through 27[2], and 31 through 43; claimant's exhibits 1 and 3 through 12[3]; defendants' exhibits A through E; and the testimony of the claimant, Mary Presson, and Sylvia Reyes. The parties submitted post-hearing briefs.

ISSUES

The parties submitted the following issues for determination:

1. Whether claimant is entitled to temporary disability benefits from April 23, 2015, through August 24, 2015;

[1] Joint exhibit 12 is marked as withdrawn in the supplied joint exhibits table of contents and was not filed.

[2] Joint exhibits 28 through 30 were marked as withdrawn in the supplied joint exhibits table of contents and were not filed.

[3] Although noted in claimant's hearing exhibit table of contents, no claimant's exhibit 3 was offered into evidence. Claimant's exhibits as offered at hearing and filed via WCES skip from claimant's exhibit 2, page 24 to claimant's exhibit 4, page 26.

2. Whether the injury is a cause of permanent disability;
3. The extent of permanent disability, including whether claimant is permanently and totally disabled under an industrial disability analysis or the odd-lot doctrine;
4. The commencement date for permanent disability benefits, if awarded;
5. Whether claimant is entitled to penalty benefits under Iowa Code section 86.13 and, if so, how much; and
6. Specific taxation of costs.

The parties filed a hearing report at the commencement of the arbitration hearing. On the hearing report, the parties entered into various stipulations. All of those stipulations were accepted and are hereby incorporated into this arbitration decision and no factual or legal issues relative to the parties' stipulations will be raised or discussed in this decision. The parties are now bound by their stipulations.

FINDINGS OF FACT

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

Claimant was 41 years of age at the time of hearing. He attended high school until age 15, when he was expelled sophomore year for assault. That same year, claimant made a Drano bomb and placed it on a doorstep; he was charged with terrorism. After his expulsion from high school, claimant was sent to Eldora State Training School (Eldora). He remained in Eldora for 6 to 9 months, during which time he obtained his GED and participated in auto body coursework. (Claimant's testimony; JE10, p. 199) Claimant estimated he earned his GED in approximately 1993 or 1994. (CE1, p. 2; DEB, p. 3) Claimant married in 2006. The former spouses separated and began living apart in fall 2013; the two divorced effective December 31, 2014. (Claimant's testimony; Ms. Presson's testimony; CE1, p. 2; DEB, p. 3) The former spouses share two minor children. (Claimant's testimony)

Claimant has been convicted or pleaded guilty to charges involving alcohol, drug possession, and physical altercations, including domestic assault, aggravated battery, assault resulting in injury, sexual abuse, and disorderly conduct. (DEA, p. 2) In 2014, claimant lost his driver's license due to multiple operating while intoxicated charges. As of the date of hearing, his license was no longer suspended. Although he went to the Department of Motor Vehicles shortly prior to hearing, he became upset when he was advised he did not have the correct information and was forced to leave. (Claimant's testimony)

Claimant's work history consists of fast food and similar miscellaneous jobs prior to beginning concrete work in 1997. From 1997 to 2007, claimant worked at Diercks Ltd. At Diercks Ltd, claimant typically worked year-round. In 2007, claimant began work at defendant-employer. He performed concrete finishing work and became a

working foreman within one year of his hire. Defendant-employer performed concrete work seasonally, typically from March through November. During winter months, defendant-employer provided claimant with snow removal work. As of the date of his stipulated work injury, claimant earned $18.50 per hour. (Claimant's testimony; JE31, p. 437; CE1, p. 2; DEB, p. 3)

Claimant's medical history is positive for relevant headaches, substance abuse, and mental health symptoms.

In June 1998, claimant presented to his primary care physician, Michael Gimbel, M.D., with complaints of daily right-sided headaches. A brain CT yielded normal results. Dr. Gimbel instituted a medication regimen. (JE39, pp. 525, 527) Dr. Gimbel also recommended neurological evaluation. In July 1998, claimant returned to Dr. Gimbel in follow up. Dr. Gimbel noted claimant did not follow through with the recommended neurological evaluation and used Relafen on an as needed basis instead of daily, as recommended. Claimant reported some improvement in headaches, which were located primarily in the right-sided occipital and neck regions, with occasional radiation to the right shoulder and upper extremity. The headaches occurred once or twice daily, lasting 20 to 30 minutes. Dr. Gimbel assessed: headache of questionable etiology, with previous normal brain CT; and right posterolateral neck pain with episodic radiculopathy and paresthesias to the right upper extremity. Dr. Gimbel ordered a cervical MRI to rule out disc injury and herniation, prescribed daily Relafen, and directed claimant to follow through with the neurological evaluation. (JE1, p. 1) Claimant returned to Dr. Gimbel in August 1998 and reported significant improvement with only a few minor headaches. Dr. Gimbel opined claimant's MRI and brain CT were normal. He assessed headaches of a suspected musculoskeletal tension variety and situational anxiety; he again recommended neurological evaluation. (JE1, p. 2)

In May 2000, claimant was evaluated with a head CT following an assault. The results were negative. (JE39, p. 529)

At the referral of Dr. Gimbel, on September 15, 2002, claimant presented to board certified neurologist, Rodney Short, M.D., for evaluation of headaches. Claimant reported his headaches began in 1997, but were intermittent in nature, sometimes removed by a period of months. However, headaches had worsened over recent months, occurring daily or at least 2 to 3 times weekly. Claimant described the headaches as commencing about the right shoulder muscle, radiating up the neck and into the entire right side of the head. Accompanying symptoms could include swollen and burning sensations of the eye, watering of the eye, drooping of the eyelid, nasal discharge, and nausea. Claimant reported the pain as the worst he had ever experienced, lasting as long as 1 hour and 45 minutes. Following the headache, he experienced tightness of the neck and shoulder, as well as tingling of the right upper extremity. Following history and examination, Dr. Gimbel assessed mixed migraine/cluster headaches. He issued prescriptions for propranolol and Midrin. (JE3, pp. 44-45)

At the referral of his substance abuse counselor, on February 2, 2006, claimant presented to Ronee Aaron, D.O., for psychiatric evaluation to consider possible medical management for depression symptoms. Dr. Aaron assessed: depressive disorder, not otherwise specified, major depressive disorder versus dysthymia versus adjustment disorder, with depressed and anxious mood; antisocial personality disorder; and migraines versus cluster headaches. Dr. Aaron began a course of Lexapro. (JE4, pp. 81-82)

On July 21, 2007, claimant presented to the emergency room for a cluster headache and received a morphine injection. (JE2, pp. 3-4)

On August 8, 2007, claimant returned to Dr. Short for evaluation of cluster headaches. Dr. Short noted a history of right-sided headaches dating to 1997. Headaches were described as starting about the neck and radiating forward into the head, and lasting almost exactly two hours. Headaches occasionally were accompanied by nausea and vomiting. Symptoms also included some slight photophobia and phonophobia, as well as redness, drooping, and tearing of the right eye. Such headaches had occurred on a near-daily basis for the preceding two months and the headache sensation was described as feeling "as if a hammer is hitting his head." (JE3, p. 46) Following examination, Dr. Short assessed cluster headaches and began a course of medications to address preventative and symptomatic concerns. (JE3, p. 47) On September 10, 2007, claimant returned to Dr. Short in follow up of cluster headaches and reported some improvement. Dr. Short adjusted claimant's medication regimen. (JE3, p. 49)

On December 16, 2007, claimant presented to the emergency room for headache complaints. The provider noted a history of cluster headaches and complaints of right facial headache. Claimant received morphine and Vistaril injections. (JE2, pp. 5-6)

On October 23, 2008, claimant returned to Dr. Short. Dr. Short noted he had not examined claimant in nearly one year; claimant had lost health insurance and was unable to attend appointments or obtain his medications. Although claimant had seen improvement on his medication regimen, claimant reported headaches had returned and were occurring 2 to 4 times per week. The headaches were right-sided in nature and lasted almost exactly 2 hours. Following examination, Dr. Short assessed cluster headaches and reinstituted a treatment regimen. (JE3, p. 50)

On December 27, 2008, claimant presented to the emergency room with a cluster headache over the right eye. He received morphine and Vistaril injections. (JE2, pp. 7-9)

On January 14, 2009, claimant returned to Dr. Short and reported generally less intense cluster headaches. Dr. Short adjusted claimant's medication regimen. (JE3, p. 51)

On September 20, 2012, claimant presented to the emergency room and was examined by Steven Gorsch, M.D. Dr. Gorsch noted claimant began taking Percocet three years prior for cluster headaches. When Percocet later failed to relieve pain, claimant began taking methadone and OxyContin he purchased on the street. Claimant indicated he wanted treatment for addiction and to stop use of narcotics. (JE2, p. 10) Claimant testified he underwent a treatment program. (Claimant's testimony)

On May 19, 2014, claimant was working for defendant-employer, tasked with finishing concrete at a baseball park. During the course of his work, he was struck on the right side of the back of his head with a baseball. Claimant did not lose consciousness or fall to the ground, but experienced pain and swelling at the impact site. He became angry and his boss, Jay Freiburger, told him to go calm down. Claimant testified the crew left the jobsite shortly thereafter. (Claimant's testimony)

After dropping off coworkers, claimant went to pick up a pizza for his family. At evidentiary hearing, claimant testified he ran into an acquaintance at the pizza restaurant. He testified she was a nurse and told him to seek medical care. Claimant said she later informed him that he was not making sense and was slurring his words. (Claimant's testimony)

Following the injurious event, claimant continued to work for defendant-employer. Approximately one week later, claimant testified his symptoms worsened. He described crying at work, inability to sleep or eat, headaches, and his wife informed him he was not making sense and slurring his words. After what he described as a bad day at work, he chose to seek medical care. (Claimant's testimony)

At a deposition on August 18, 2016, claimant described immediate complaints of headache and swelling following the incident. (JE22, Depo. Tr. pp. 74-75) He testified the following week, his condition was “out of control,” with stuttering, yelling, and nonsensical speech. (JE22, Depo. Tr. p. 76)

At a deposition on February 10, 2017, claimant testified on the day of the accident, he suffered from a headache. Claimant did not report immediate complaints of slurred speech. (JE24, Depo. Tr. pp. 68-69) Rather, claimant testified the stuttering and slurring began approximately one week later, around the time he chose to seek medical attention. (JE24, Depo. Tr. pp. 16-17)

On May 28, 2014, claimant presented to the emergency room and was examined by Rick Garrels, M.D. Claimant reported being struck in the head by a thrown baseball one week prior and described symptoms of head pain and swelling, as well as vomiting. No loss of consciousness was reported. A head CT was undergone, yielding normal results. Dr. Garrels assessed concussion with no loss of consciousness and a scalp contusion. Medications were prescribed and claimant was advised to follow up with Michael Gimbel III, M.D. (JE2, pp. 13-15; JE5, p. 84)

Defendant-insurance carrier referred claimant to CorVel for medical case management services. Bridget McBride, RN, was assigned to provide these services, beginning June 6, 2014. (JE13, p. 224)

On June 10, 2014, claimant presented to Dr. Garrels at Genesis Occupational Health. Claimant indicated that during the first week after the incident, he had multiple daily episodes of severe headaches and vomiting. Since that time, claimant reported daily headaches, with accompanying vomiting upon exacerbation of bending over. Claimant also reported poor recollection of the events in the week following the incident, as well as personality changes such as angry outbursts and crying. Following examination, Dr. Garrels assessed post-concussive syndrome; headache; and depression. He performed a Toradol injection, ordered a brain MRI, referred to Dr. Kent for psychological evaluation, recommended attendance at a neurological evaluation with Dr. Short, ordered commencement of the LIFT therapy program, and issued prescriptions for Imitrex, Xanax, and sertraline. Claimant was removed from work pending further evaluation. (JE8, pp. 155-157)

On June 11, 2014, claimant underwent a brain MRI. Joseph Phelan, M.D. read the results as revealing minimal small white matter foci appearing punctate bilaterally with an otherwise normal exam. (JE5, p. 85)

On June 18, 2014, claimant commenced the LIFT therapy program, focusing on group occupational and speech therapy. (JE9, pp. 166-167)

Claimant returned to Dr. Garrels on June 19, 2014. Claimant reported continued emotional issues, including notable crying throughout the day. Dr. Garrels referred claimant to Gonchigari Narayana, M.D. for psychiatric complaints. He noted claimant had appointments scheduled with neurologist, Dr. Short, on July 3, 2014, and psychologist, Dr. Kent, on July 15, 2014. Dr. Garrels added topiramate to claimant's medication regimen and increased the sertraline dosage. Dr. Garrels also ordered continued participation in the LIFT program. (JE8, p. 159)

Ms. McBride issued her first case management report on June 25, 2014. Claimant's subjective medical status included: daily migraine pain lasting approximately 45 minutes to 2 hours; nausea and a feeling of "fluid" in the front of his head when bending forward; and an inability to control outbursts of anger. In terms of treatment, Ms. McBride encouraged claimant to: visit the emergency room for urgent care; attend the LIFT program for evaluation and treatment of post-concussive syndrome; continue medications per Dr. Garrels; and follow up with Dr. Narayana for medication management, Dr. Short for neurological care, and Dr. Kent for talk therapy. (JE13, p. 225)

On June 25, 2014, claimant returned to the emergency room and was evaluated by Jennifer Wilson, PA-C. Claimant reported a history of head injury, with intermittent severe right-sided headaches that could be accompanied by vomiting. Claimant reported personality changes, anger issues, and notable crying. (JE2, p. 16) Ms.

Wilson informed claimant he was experiencing post-concussive symptoms and the personality changes may continue for some time. She prescribed a Medrol Dosepak and Flexeril for the headache, and noted claimant was scheduled for neurological evaluation as well as physical therapy and the LIFT program, designed to treat post brain injury. (JE2, pp. 18-19)

Claimant returned to Dr. Short on July 3, 2014, at the referral of Dr. Garrels. Dr. Short noted claimant was struck in the head with a baseball on May 19, 2014, at which time he felt some mild pain and was angry. There was no loss of consciousness or obvious deficits noted. Within a few days, severe right-sided headaches began, with a constant dull ache over the right side of the head and occasional right-sided tingling, as well as a daily excruciating headache lasting approximately 45 minutes. Additional symptoms included significant mood issues, difficulty sleeping, and stuttering. Dr. Short noted he last saw claimant in 2009 for cluster headaches; claimant reported being headache-free since that time. (JE3, p. 52) Following examination, Dr. Short assessed posttraumatic cluster headaches with a component of occipital neuralgia. Dr. Short performed an occipital nerve block and prescribed verapamil, amitriptyline, and sumatriptan nasal spray. He also ordered a course of speech therapy for speech disturbance and removed claimant from work pending follow up. (JE3, pp. 53-54)

On July 21, 2014, claimant presented to the emergency room with complaints of bilateral wrist and knee pain, onset two days prior, as well as post-concussive symptoms. At the time of evaluation, claimant was under arrest and accompanied by police, who transported claimant for evaluation due to his complaints. X-rays of the wrists were negative. Following x-rays and physical examination, claimant was discharged with the police. (JE2, pp. 20-23)

That same date, July 21, 2014, claimant's mother, Mary Presson, completed an application for order of involuntary hospitalization alleging claimant suffered from serious mental impairment. Ms. Presson indicated claimant was suicidal, angry, nervous, slurring words, and stuttering. She further indicated claimant would disappear for periods of time and had a history of drug use. (JE32, pp. 440-441) Maribeth Chase completed an affidavit in support of Ms. Presson's application. She described claimant as depressed and angry. Ms. Chase also noted claimant threatened suicide, would disappear for periods of time, and had a history of drug use. (JE32, p. 442) Ms. Presson also filed an accompanying application alleging a substance-related disorder; her application was again supported by an affidavit of Ms. Chase. (JE32, pp. 443-444)

Later that same date, July 21, 2014, claimant was brought to the emergency room due to applications for commitment for mental illness and substance abuse. (JE38, p. 519) Rickey Wilson, M.D. admitted claimant to the hospital with diagnoses of anxiety disorder, depression, suicidal risk, and substance abuse. (JE38, p. 521) On July 22, 2014, Dr. Wilson noted impressions including: depressive disorder not otherwise specified, cocaine abuse and alcohol abuse by history; recent head injury, possible post-concussion syndrome; and cluster headaches. (JE38, p. 523) On July

24, 2014, Dr. Wilson completed a physician's report regarding the commitment applications. Thereby, he opined claimant was mentally ill, with diagnoses of depression and post-concussive syndrome. He opined claimant was not capable of making responsible decisions and his insight was somewhat impaired. (JE32, p. 445) Dr. Wilson also opined claimant had a substance-related disorder, noting claimant's history of opiate abuse and recent cocaine use. (JE32, p. 447) Claimant was discharged from the hospital on July 26, 2014. Ghada Hamdan-Allen, M.D. noted chief complaints of depression, agitation, and substance use. (JE2, p. 27; JE38, p. 517) Claimant was discharged to follow up voluntarily on an outpatient basis. (JE38, p. 518)

On agreement of the parties involved, the magistrate in the commitment proceedings entered an order continuing hearing, as claimant voluntarily agreed to follow Dr. Wilson's treatment recommendations. The magistrate indicated the case would be dismissed on September 24, 2014, unless one of the parties made a request for hearing due to claimant's noncompliance. (JE32, p. 449) No hearing request was made, and the applications were dismissed as scheduled. (JE32, p. 456)

At the referral of Dr. Garrels, claimant underwent psychological evaluation with Phillip Kent, Psy.D. Dr. Kent interviewed and tested claimant on July 15, July 18, and July 28, 2014. He authored his evaluation report on July 28, 2014. (JE10, p. 198) Dr. Kent opined claimant did not present with symptoms of post-concussion syndrome, beyond headaches. He found claimant's memory intact, no signs of psychosis, and no complaints of neuropsychological problems aside from a short attention span. Dr. Kent opined claimant's attention difficulties were probably related to headaches; in light of claimant's history, he opined the attention problems did not appear new. (JE10, p. 200)

Dr. Kent described the findings of claimant's psychological testing. In review of claimant's Million Clinical Multiaxial Inventory-III (MCMI-III), Dr. Kent opined claimant displayed a tendency to respond in a manner likely to somewhat exaggerate his problems. He opined claimant's profile was suggestive of a person with an underlying mood disorder. He also opined claimant was experiencing high levels of anxiety, some depression, and likely some manic symptoms. Dr. Kent noted prominent dependent and antisocial traits. He opined claimant's interpersonal relationships were likely intense and chaotic, with claimant undoubtedly seen by others as somewhat negativistic and manipulative. In review of claimant's MMPI-2 testing, Dr. Kent opined claimant's responses suggested chronic problems with depression and alienation, as well as unusual thought patterns and a likely affective disorder. Results also indicated strong addictive tendencies in claimant. (JE10, p. 201)

Following multiple interviews and psychological testing, Dr. Kent noted the following suggested diagnoses: mood disorder, not otherwise specified; attention deficit/hyperactivity disorder, by history; alcohol abuse, by history; opiate abuse, by history; personality disorder, not otherwise specified, with prominent antisocial, dependent, and borderline traits; and history of concussion and headaches. (JE10, p. 201) Treatment recommendations included: continued participation in the LIFT

program; outpatient chemical dependency treatment; Alcoholics Anonymous; and care with psychiatrist, Dr. Narayana. (JE10, p. 200-201) Dr. Kent opined claimant did not appear to be a candidate for psychotherapy and did not recommend neuropsychological evaluation. (JE10, p. 201-202) Dr. Kent opined claimant's concussion symptoms would likely remit within the next 2 to 4 months. (JE10, p. 201)

On August 1, 2014, claimant returned to Dr. Short for evaluation. Dr. Short noted clear improvement in claimant's cluster headaches, down to approximately two headaches per week. Headaches were noted to respond well to sumatriptan nasal spray, with complete relief within 15 minutes. Claimant identified possible triggers of heat and/or sunlight. Dr. Short noted claimant's recent psychiatric hospitalization "because of apparent anger management issues." Following examination, Dr. Short assessed posttraumatic cluster headaches and left claimant's medication regimen intact. He released claimant to return to work part-time, 4 hours per day. (JE3, p. 55)

On August 12, 2014, LIFT program personnel recommended discharge from the program, but continued individual speech therapy. Claimant informed his case manager he desired to discontinue the LIFT program as it made him anxious. LIFT program staff noted poor attendance and commented claimant could have made increased progress with more frequent attendance and increased effort. (JE9, pp. 189-190)

At evidentiary hearing, claimant testified the LIFT program "scared" him, as the group included patients who were crying and could barely function. (Claimant's testimony)

On August 20, 2014, claimant presented to psychiatrist, Dr. Narayana. Following interview, Dr. Narayana diagnosed a mood disorder and traumatic brain injury and instituted a medication regimen. (JE11, p. 204)

On August 21, 2014, Ms. Presson again filed commitment applications alleging serious mental impairment and substance-related disorders. Ms. Presson represented claimant was unstable, incoherent, and paranoid. She noted claimant's history of drug use and indicated claimant had worsened to a degree he was out of control. (JE32, pp. 450-451, 453) Jen Wouters filed affidavits in support of Ms. Presson's applications. (JE32, pp. 452, 454)

That same date, August 21, 2014, claimant was transported to the hospital and examined by Christopher Posey, D.O. A history reveals claimant was brought in by EMS and police as a court committal after being found running down the street with a bat, claiming he found his wife having an affair and was fearful he would be attacked. Police described claimant as agitated and claimant was handcuffed. (JE2, p. 26) Following evaluation and lab studies, as well as receipt of court committal papers, claimant was admitted to the behavioral health department. (JE2, p. 28)

On August 22, 2014, claimant was discharged from Genesis Medical Center by Jeffrey Weyeneth, M.D. Dr. Weyeneth authored a physician's report opining claimant

did not meet the criteria for involuntary inpatient treatment and requested both applications be dropped. (JE32, p. 455) In his discharge records, Dr. Weyeneth noted claimant had been referred the day prior by the emergency department on mental health and substance abuse petitions filed by claimant's mother and friend. He noted claimant had previously been admitted for 5 days and discharged 3 weeks prior, following petitions. Following that admission, claimant had been advised to begin outpatient mental health and substance abuse treatment. While he had begun mental health treatment, he had yet to begin substance abuse treatment. (JE2, p. 24)

Dr. Weyeneth indicated it was unclear why the family refiled the petitions, as the petitions described a number of events that occurred prior to the first admission and his current drug screen was negative. Claimant's alcohol level was zero. Dr. Weyeneth described claimant as calm, pleasant, cooperative, and appropriate during his current admission, without evidence of acute mania or psychosis. He noted claimant had a history of head injury and tended to be irritable at times, but this condition was chronic in nature. Dr. Weyeneth noted diagnoses of: major depressive disorder, recurrent; history of cocaine abuse; history of alcohol abuse; and history of closed-head injury/traumatic brain injury. Dr. Weyeneth opined claimant did not meet the criteria for admission and discharged claimant to home under the previous treatment regimen of medications and outpatient treatment. He authored a letter to the court resulting in both petitions being dropped. (JE2, pp. 24-25)

On August 27, 2014, claimant presented to the emergency department for mental health evaluation. Celeste Nelson, ARNP, noted primary symptoms of dysphoric mood, hallucinations, and bizarre behavior. She noted claimant recently violated a protective order from his wife. Her history notes claimant was hit in the head by a "bat" in a May work injury. Claimant reported his behavior changed after the event and he cannot always remember what he has done. Claimant indicated when his stress level rose, he "hears voices and sees things." She noted claimant had been jailed several times since the head injury, including for violation of the protection order, but no incarcerations prior to the head injury. She noted claimant's wife had filed for divorce the prior week. Ms. Nelson indicated claimant recently began a course of care and medication with Dr. Narayana. (JE7, p. 90) Ms. Nelson assessed depression, stress, anxiety, and behavioral disturbance. She medically cleared claimant for further psychiatric evaluation. (JE7, p. 93) Claimant was admitted for psychiatric care. (JE7, pp. 94-95)

On September 1, 2014, Dr. Narayana discharged claimant from the psychiatric hospitalization under diagnoses including: bipolar disorder, not otherwise specified; history of traumatic event, brain injury; and moderate psychosocial stressors: divorce, recent trauma, and marital distress. (JE7, pp. 94-95) By history, Dr. Narayana noted this as claimant's first psychiatric hospitalization at Trinity Medical Center. Dr. Narayana noted claimant had been under his care since August 20, 2014, pursuant to a workers' compensation referral following being struck by a baseball, with negative neurological workup. Nevertheless, claimant had experienced anger, rage, distress,

inappropriate behavior toward family, and property damage. Claimant obtained significant relief with use of Tegretol. His wife recently requested a divorce and obtained a restraining order. According to his mother, claimant was found very disorganized and delusionally preoccupied, complaining about 30 people following him. Police took claimant into custody and after a brief period in jail, claimant had been brought in for psychiatric evaluation and treatment. (JE7, pp. 95, 97-98)

While admitted, claimant did not experience any delusions or hallucinations. Dr. Narayana noted that despite claimant's explanations, it was possible he suffered some psychotic episodes. During the course of his hospitalization, claimant's medication regimen was adjusted. (JE7, p. 95) Claimant continued to demonstrate some intensity of emotion, volatile anger, irritability, lack of insight, and questionable judgment. Claimant's mother informed Dr. Narayana that during the event preceding his hospitalization, claimant became preoccupied with the idea that "30 little people [were] chasing him around the town" and he had accumulated a number of knives and even sought police assistance. While the events were "real" to claimant, his mother believed the events were delusions. (JE7, p. 96) On September 1, 2014, claimant was discharged from the hospital under a medication regimen and advised to follow up with Dr. Narayana. (JE7, pp. 95, 102)

Claimant presented to Dr. Narayana in follow up on September 18, 2014. Dr. Narayana adjusted claimant's medication regimen. (JE11, 206)

On September 25, 2014, Ms. Presson again filed an application for order of involuntary hospitalization alleging serious mental impairment. On this occasion, she did not file an accompanying application alleging substance-related disorder. Ms. Presson represented claimant was suicidal, depressed, and potentially using drugs. (JE32, pp. 457-458) Ms. Presson described claimant as "totally messed up" and in need of long-term care, not simply care for a few hours or days. (JE32, p. 458) The application was supported by affidavit of Jen Wouters. (JE32, p. 459)

On September 25, 2014, claimant was again transported to the emergency room under court committal. He was admitted to the behavioral health unit. (JE2, pp. 35-37) Dr. Weyeneth took a history, noting this as claimant's third commitment in 2 months. He noted claimant was only present on a mental health petition on this occasion, as opposed to an additional substance abuse petition. Dr. Weyeneth noted claimant posted suicidal thoughts online and continued to use alcohol and drugs. However, he found claimant lacked suicidal intention and rather, acted impulsively when upset. Claimant was admitted under diagnoses of: major depressive disorder, recurrent; alcohol dependence; and cocaine abuse. (JE2, pp. 37-38; JE6, pp. 86-88)

On September 30, 2014, Dr. Weyeneth completed a physician's report in the committal action. Thereby, he opined claimant was mentally ill, with a diagnosis of major depressive disorder. (JE32, p. 460) Dr. Weyeneth also opined claimant was stable and capable of continuing with outpatient treatment. (JE32, p. 461) The

commitment action was dismissed shortly thereafter on agreement of the parties, as claimant agreed to voluntarily participate in treatment. (JE32, p. 462)

On November 4, 2014, police transported claimant to the emergency department for mental health evaluation. That evening, claimant was at his mother's home when he claimed friends of his ex-wife were in the woods harassing him. Claimant filled glass bottles with gasoline, homemade Molotov cocktails, to throw at these individuals. Claimant's mother called the police. The officer-completed petition noted no individuals were present in the area. (JE7, pp. 120-121, 130) Emergency room providers assessed acute psychosis and methamphetamine use. (JE7, p. 125)

Claimant was admitted for psychiatric hospitalization and remained hospitalized until discharged on November 10, 2014. Dr. Narayana noted discharge diagnoses including: bipolar disorder, manic with psychotic features; polysubstance abuse, positive for methamphetamine; antisocial personality traits; and status post head injury and chronic headaches. Dr. Narayana described the pre-hospitalization event as claimant responding to active hallucination and expressing hostile remarks. He noted claimant was also recently released from jail and had been using amphetamines and cocaine. Claimant, however, denied drug use despite laboratory results. (JE7, pp. 130, 132) Dr. Narayana noted claimant's history of "minor" head injury at work, with no neurological sequelae and negative neurological workup. (JE7, p. 130)

During claimant's hospitalization, a counselor met with claimant's mother and aunt prior to a family session. The two expressed great concern regarding claimant's paranoia and unpredictable, dangerous behavior. They described incidents of claimant holding down his wife while stabbing the floor with a knife, as well as his insistence that he video recorded his wife's infidelity despite no such recording existing. Claimant's mother noted she had been informed that claimant had been using the drugs "shrimp and ice." During the family session, Dr. Narayana informed claimant and his family members that he was experiencing paranoia and delusions as a combined result of use of illegal drugs and severe bipolar disorder. Claimant was noted as making delusional statements during the session and he became angry when his mother attempted to identify his delusions. (JE7, p. 136)

Dr. Narayana also indicated claimant had a long-standing, life-long history of unaddressed mood disorder. (JE7, pp. 130, 132). He described claimant as "in denial" regarding this underlying mood disorder. (JE7, p. 131) Dr. Narayana described claimant as having been "cycling up and down" with the "consistent… mood problem of bipolar disorder." (JE7, p. 132) He noted claimant's risky behavior of drug abuse often led to inappropriate behavior, delusional thoughts, and active hallucinations. Dr. Narayana noted claimant had "dropped off" of treatment with Dr. Narayana and was noncompliant with medication, despite prior improvement. At the time of admission, claimant was agitated and insistent "nothing [was] wrong." After a course of treatment and medication, claimant was discharged under the continued care of Dr. Narayana. (JE7, p. 131)

Claimant's estranged wife obtained a no-contact order against claimant. Claimant admitted to violating the order on two or three occasions. He admitted to being arrested and jailed for 21 days after he approached her with money for school lunches. In November 2014, claimant was jailed for 90 days after going to her residence; he does not recall this event. The former couple's divorce was finalized in December 2014. Claimant was released from jail in February 2015, at which time he moved in with his mother at her residence in Carbon Cliff, Illinois. (Claimant's testimony)

On March 9, 2015, claimant returned to Dr. Short. Claimant reported he continued to experience cluster headaches 2 to 3 times per week, which were disabling, but relieved within 45 minutes with use of sumatriptan nasal spray. Dr. Short assessed episodic cluster headaches. He prescribed verapamil for cluster headache prevention, amitriptyline for sleep, sumatriptan nasal spray as needed, and Midrin for milder headaches. Dr. Short released claimant to work without restriction, with the noted exception that 2 to 3 days per week it would be expected that claimant may be unable to work for 45 minutes due to cluster headaches. (JE3, pp. 57-59)

Claimant returned to Dr. Narayana on March 25, 2015, who noted claimant had recently been released from jail after three months of incarceration. Dr. Narayana noted claimant had a long history of bipolar disorder, history of head injury, and had indulged in illicit drugs. He described claimant as volatile and lacking in insight/judgment, as claimant was prone to impulsive acting out. Dr. Narayana also noted claimant denied the source of his problem was underlying bipolarity. Claimant requested medication to aid his concentration, which Dr. Narayana denied and described as "obviously indirectly seeking amphetamines." Dr. Narayana prescribed a medication regimen. (JE11, pp. 207-208)

Ms. McBride referred claimant to Daniel Tranel, PhD, of the University of Iowa Hospitals and Clinics (UIHC) for neuropsychological assessment. Dr. Tranel noted he was asked to "help sort out the extent" to which claimant's personality issues may be concussion-related as opposed to attributable to preexisting factors/traits, as well as whether claimant had achieved maximum medical improvement (MMI) relative to the May 19, 2014 work injury. Dr. Tranel evaluated claimant on May 20, 2015 and issued his report on May 30, 2015. (JE14, p. 251) Dr. Tranel reviewed and summarized claimant's treatment records. (JE14, pp. 252-258) Dr. Tranel interviewed claimant and his mother. (JE14, pp. 258-261)

Dr. Tranel administered a number of clinical assessments. (JE14, pp. 261-262) In regard to symptom validity and effort, Dr. Tranel opined claimant's response profiles on non-cognitive measures of symptom validity were borderline to grossly abnormal; he opined this indicated claimant's self-reporting of symptoms could not be taken at face value. (JE14, p. 262) He found no overt signs of intentional reduction of effort, but noted the results may be a slight underestimate of claimant's cognitive capacity, as psychological and behavioral factors appeared to negatively impact claimant's effort.

(JE14, p. 263) Claimant's mother also completed a questionnaire describing her subjective views of claimant's pre- and post-injury personality and behavioral functioning. Dr. Tranel found her responses lacked validity "due to generalized minimization regarding premorbid functioning," as she described claimant as average to superlative in all measures, and "gross exaggeration regarding current functioning," as she rated nearly every measure at the worst level of functioning. (JE14, p. 265)

Dr. Tranel offered recommendations regarding claimant's care and treatment. He opined claimant would benefit from substance abuse treatment and recommended a community support program such as Alcoholics Anonymous or Narcotics Anonymous. He described such substance abuse care as the first priority. Thereafter, Dr. Tranel indicated claimant would likely benefit from treatment for sleep problems and a pain management program. No further neuropsychological treatment was recommended. (JE14, p. 267)

Dr. Tranel ultimately opined the neuropsychological evaluation indicated claimant possessed normal, intact cognitive functioning. Intellectual abilities were generally found to be in the average to high average range. All other cognitive abilities were intact, including learning, memory, attention, orientation, concentration, processing speed, speech, language, visuoperceptual and visuoconstructional abilities, executive functioning, and higher-order reasoning and problem solving. Dr. Tranel opined these findings supported the conclusion, to a reasonable degree of neuropsychological certainty, that claimant did not present with any permanent brain dysfunction or permanent neurological injury as a result of the work injury. He opined claimant suffered, at worst, an "uncomplicated concussion." (JE14, p. 266) Dr. Tranel opined claimant's behavioral and psychological adjustment issues appeared longstanding and were not attributable to the work injury. Dr. Tranel noted claimant's longstanding problems with drug and alcohol abuse, 2006 diagnosis of antisocial personality disorder, and diagnoses of adjustment and depressive disorder. (JE14, pp. 266-267) Dr. Tranel continued:

> The psychiatric difficulties he has experienced since the May 2014 accident may be seen as an aggravation of preexisting conditions due to pain (headaches), although this is difficult to establish with a reasonable degree of certainty due to open questions about drug abuse and contributions from psychosocial stress. In any event, any such aggravation would be seen as temporary. In short, there is no basis to expect that [claimant] suffered any permanent injury in the May 2014 accident.

(JE14, p. 266)

On May 21, 2015, claimant returned to Dr. Narayana. Dr. Narayana described claimant as poorly compliant with his suggested medication regimen, as he had

discontinued certain medication. Dr. Narayana issued prescriptions for a recommended medication regimen to treat diagnosed mood disorder. (JE11, pp. 209-210)

On June 15, 2015, claimant returned to Dr. Short. He reported continued intermittent headaches lasting up to one hour. While headaches had been occurring about 2 to 3 days weekly, over the last 12 days the headaches occurred daily. Dr. Short adjusted claimant's medication regimen and performed a right occipital nerve block. Dr. Short again released claimant to work without restriction, yet noted a caveat that headaches could prevent claimant from working for up to one hour daily. (JE3, pp. 60-62)

Claimant returned to Dr. Short on August 24, 2015. Dr. Short noted considerable improvement and decent control of headaches. He noted claimant had utilized the sumatriptan nasal spray on 4 or 5 occasions for cluster headaches, but none in recent weeks. He also noted claimant had used Midrin to treat mild headaches about once per week. Dr. Short assessed episodic cluster headaches and placed claimant at MMI without work restrictions. (JE3, pp. 63-64)

On August 25, 2015, claimant presented to Dr. Narayana and described himself as "back to my normal self." Claimant reported continued cluster headaches. Dr. Narayana provided claimant with information pertinent to a possible diagnosis of bipolar spectrum, which Dr. Narayana described as "prevalent all his life[,] more so with the family." (JE11, p. 211) Dr. Narayana noted claimant had been poorly complaint with medications, but issued prescriptions for a medical regimen to treat mood disorders. (JE11, pp. 211-212)

In 2016, claimant worked as a concrete finisher off and on for Christopher Reynolds, owner of CCS Construction. Claimant testified his return to concrete work was not successful and he would experience headaches, dizziness, and vomiting. (Claimant's testimony) He earned $12.00 per hour. (CE1, pp. 2, 19; DEB, p. 3)

Christopher Reynolds, the owner of CCS Construction, testified claimant was never an employee of CCS Construction, but did perform work for Mr. Reynolds personally on a couple of occasions. (JE42, Depo. Tr. p. 6) He explained he would call claimant on an as-needed basis in 2016, in the event he needed assistance with concrete finishing. Mr. Reynolds estimated claimant worked approximately one day per week, occurring on four occasions. On those occasions, Mr. Reynolds paid claimant cash. (JE42, Depo. Tr. pp. 7-8) Mr. Reynolds testified claimant did not meet his expectations for a concrete finisher and he would walk away mid-job. (JE42, Depo. Tr. pp. 13-14)

On September 9, 2016, claimant returned to Dr. Short. Claimant reported he resumed cement work 5 to 6 months prior and the associated bending over, heat, and physical tasks aggravated the right-sided headaches. Tylenol and Midrin would dull the pain; sumatriptan provided full relief within 15 to 20 minutes, but claimant only received 6 doses per month. While he had not missed work as a result of the headaches, he

only worked 15 to 20 hours per week and sometimes needed to take a break due to a headache. Following examination, Dr. Short assessed intractable episodic cluster headaches and opined the cluster headaches were interfering with claimant's ability to function. He opined claimant had failed or did not respond adequately to certain medications and occipital nerve blocks in the past. As a result, he prescribed atenolol and sumatriptan nasal spray. (JE3, pp. 65-66)

Dr. Short sat for deposition on September 19, 2016. Dr. Short testified he began treating claimant in September 2002, at which time he diagnosed cluster headaches. He described cluster headaches as a type of headache syndrome, meaning there is no underlying structural brain abnormality causing the headache. (JE23, Depo. Tr. pp. 6-7, 29-30) Dr. Short indicated cluster headaches are thought to be due to episodic overactivation of some of the pain fibers coming out of the base of the brain, with the cause of activation varying between individuals. (JE23, Depo. Tr. p. 30)

Dr. Short testified that on July 3, 2014, shortly after the work injury, he had diagnosed posttraumatic cluster headaches with a component of occipital neuralgia. (JE23, Depo. Tr. p. 10) Dr. Short placed claimant at MMI, without restrictions, on August 24, 2015. (JE23, Depo. Tr. p. 18) At that time, Dr. Short testified that claimant appeared to have returned to baseline for his cluster headache syndrome. (JE23, Depo. Tr. p. 29) However, claimant returned for evaluation on September 9, 2016. At that time, Dr. Short diagnosed episodic cluster headaches, intractable. Dr. Short testified the change in claimant's condition was likely attributable to his return to work. At deposition, Dr. Short opined claimant's condition was likely permanent in nature and likely to interfere with claimant's function to some extent. (JE23, Depo. Tr. pp. 21, 29) Dr. Short testified he believed claimant's work injury aggravated his preexisting condition. (JE23, Depo. Tr. pp. 25-26) In response to inquiry requesting explanation as to how an impact could trigger an aggravation of cluster headaches on one side of a patient's head, Dr. Short replied he lacked a "good explanation." He clarified that posttraumatic headaches occur fairly regularly, but experts lack a good understanding of the exact pathophysiological mechanism for the occurrence. (JE23, Depo. Tr. p. 27)

For four days in November 2016, claimant worked as a concrete finisher for Dave Chenworth, earning $14.00 per hour. (CE1, pp. 19-20)

On December 6, 2016, claimant returned to Dr. Garrels for follow up and impairment rating. Claimant reported continued intermittent, unpredictable headaches. Claimant reported he also became irritable and obsessive. Following examination, Dr. Garrels assessed: chronic cluster headache, not intractable; polysubstance abuse; major depressive disorder; and unspecified superficial injury of the scalp. (JE8, p. 163) Dr. Garrels placed claimant at MMI and released him to regular work duty. Utilizing the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, Chapter 13, Dr. Garrels opined claimant sustained 0 percent permanent impairment. Dr. Garrels based his opinion upon a lack of objective findings. (JE8, p. 164)

John "Jay" Freiburger, IX, sat for deposition on December 10, 2016. Mr. Freiburger co-owned defendant-employer with his father, John Freiburger, VIII. (JE41, Depo. Tr. p. 5) Mr. Freiburger indicated he hired claimant in 2011 as a concrete finisher and promoted claimant to foreman within a year. (JE41, Depo. Tr. p. 6) He described claimant as hardworking when present, but indicated claimant was not dependable. For approximately one year prior to the work injury, Mr. Freiburger indicated claimant's work was interrupted. He explained claimant was on prescription narcotics for headaches, but also had been using prescription narcotics that were not prescribed to claimant. Mr. Freiburger indicated he attempted to support claimant in ceasing use of these pills. (JE41, Depo. Tr. pp. 7-8) He estimated claimant missed two to four days per month pre-injury. (JE41, Depo. Tr. p. 35)

When claimant was released to work four hours per day following the work injury, Mr. Freiburger indicated claimant would not show up for work or left early. He described the situation as "same old" claimant, with claimant coming and going as he pleased. (JE41, Depo. Tr. p. 33) Mr. Freiburger indicated he was unable to rely on claimant for the approved four hours per day and as a result, he informed claimant his services were no longer needed. Mr. Freiburger did not believe claimant experienced headaches during this failed attempt to return to work. (JE41, Depo. Tr. p. 34)

Review of claimant's earnings from defendant-employer during the years 2009 through 2013 reveals earnings ranging from nearly $24,000.00 to nearly $33,000.00 annually. (JE31, pp. 437-438) In 2013, the year preceding the work injury, claimant earned $29,290.19 at defendant-employer, with an hourly rate of $18.50. (CE10, p. 40; JE31, pp. 437-438)

At the referral of his counsel, on December 15, 2016, claimant presented to neurosurgeon, Robert Milas, M.D., for evaluation. Dr. Milas performed a records review and interviewed claimant. Claimant reported he felt dazed and extreme pain following the work injury. He indicated he went to pick up a pizza and the individual waiting on him, who had some medical training, told him he was not making sense and should immediately seek medical treatment. Claimant reported dramatic personality changes following the work injury, with extreme irritability and difficulty concentrating. (JE15, p. 283) Dr. Milas reviewed claimant's June 11, 2014 head MRI and opined the study revealed numerous punctate-like matter lesions characteristic of axonal injury as a result of blunt head trauma. Following examination, Dr. Milas assessed post-concussion syndrome and cognitive impairment secondary to head injury. Utilizing the AMA Guides, Tables 13-6 and 13-8, Dr. Milas opined claimant suffered a Class I impairment related to mental status, warranting a permanent impairment of 14 percent whole person. He further opined claimant suffered a Class II impairment related to emotional and behavioral disorders, warranting a 29 percent whole person impairment. (JE15, p. 284) Thus, Dr. Milas opined claimant sustained a combined 39 percent whole person impairment. (JE15, p. 285) Dr. Milas opined the work injury of May 19, 2014 was the direct cause of claimant's "condition of ill being," specifically including

headaches, cognitive dysfunction, and behavioral dysfunction including loss of temper and substance abuse. He further indicated claimant's condition rendered him unemployable in his preinjury position and claimant was likely to "always" require some form of supervision of his lifestyle and living situation. (JE15, p. 285)

Dr. Milas authored an addendum to his report dated December 19, 2016, specifically addressing his review of Dr. Tranel's report. Dr. Milas clarified he did not "entirely" attribute claimant's substance abuse issues to the work injury. Rather, he felt strongly that claimant suffered a significant head injury which resulted in axonal shear injuries. He opined these injuries further reduced claimant's cognitive and executive function to a degree such that claimant was no longer able to function independently. He further opined the injuries worsened claimant's level of self-control and personal responsibility. Ultimately, Dr. Milas opined the work injury "significantly worsened" claimant's condition(s). (JE15, p. 286)

On January 16, 2017, defendants requested Dr. Garrels perform a records review. (JE36, pp. 511-513) Dr. Garrels subsequently reviewed and critiqued the opinion of Dr. Milas, notably stating Dr. Milas opined an axonal brain injury, while Dr. Garrels found no such injury on MRI. He opined claimant did not demonstrate imaging evidence or a clinical pattern supporting axonal injury. Dr. Garrels also opined claimant's neuropsychological testing did not support cognitive deficits. Rather, Dr. Garrels opined long-term substance abuse could profoundly impact the brain and result in emotional and behavioral disorders; he also opined claimant demonstrated psychiatric issues that bore no relationship to the work injury. Ultimately, Dr. Garrels opined claimant presented with a significant preexisting history, including chronic intermittent cluster headaches with essentially same symptom pattern currently as in the early 1990s, as well as substance abuse. Dr. Garrels opined the head injury temporarily resulted in a pattern of increased headaches, but the pattern had since returned to baseline. (JE8, p. 164)

Defendants referred claimant back to Dr. Tranel for neuropsychological reevaluation to assess his cognitive and emotional functioning secondary to the work injury. Claimant presented to Dr. Tranel on January 11, 2017, accompanied by his girlfriend, Sylvia Reyes. (JE14, p. 270) Dr. Tranel summarized claimant's work injury and subsequent treatment. (JE14, pp. 270-271)

During interview, claimant reported continued intermittent headaches, photophobia, phonophobia, and sleep disturbance. Claimant denied cognitive-behavioral changes or functional changes in the interim following his initial evaluation on May 20, 2015. Claimant and his girlfriend reported claimant had experienced more intense emotional difficulties and anger issues. He denied any recent hallucinations, delusions, or psychiatric hospitalizations. Claimant reported he ceased drinking alcohol two years prior and only occasionally smoked marijuana, primarily when stressed and/or suffering with a headache. (JE14, pp. 271-272) Claimant's girlfriend reported witnessing "extreme obsessiveness," with claimant "staring and zooming" in on a picture

for an hour in an attempt to locate an image within the broader image. She also reported he accused her of unfaithfulness and that she had observed claimant "break down" and cry. (JE14, p. 271)

Claimant underwent neuropsychological assessment. Dr. Tranel opined formal validity measure was within expected limits, but claimant's response style and endorsements suggested over-reporting of some types of symptoms. (JE14, p. 272) On questionnaires, claimant reported symptoms consistent with severe depression and moderate anxiety. In MMPI-2 testing, claimant reported depression and anxiety. Dr. Tranel opined claimant lacked confidence in his ability to cope with life demands and his resources were overwhelmed. Results indicated claimant tended to react to these elevated demands and stress with physical symptoms. Dr. Tranel opined claimant's profile also revealed: feelings of mistreatment, suspicion, and resentment; concern over the intentions of others; and likely difficulty with authority figures. (JE14, p. 273)

Dr. Tranel ultimately opined claimant's cognitive profile remained stable as compared to the May 2015 evaluation and claimant continued to have normal, intact cognitive functioning. Dr. Tranel opined he found no indication of cognitive impairment or brain damage as a result of the May 2014 work injury. He described the results of the current neuropsychological assessment as strong confirmation of his conclusion, citing now two extensive neuropsychological examinations yielding normal results. Dr. Tranel opined claimant's psychological condition was the "salient feature" in claimant's case and further opined claimant's depression and anxiety warranted immediate treatment. Dr. Tranel opined claimant's emotional distress served as "the major factor underlying his cognitive concerns." Additional factors such as occasional drug use and sleep disturbance were also described as undoubtedly playing a role in claimant's difficulties. Dr. Tranel concluded claimant did not experience ongoing, permanent problems related to the work injury of May 2014. (JE14, p. 274)

While mental health, pain management, and headache treatment was recommended to address claimant's condition, Dr. Tranel opined these recommendations were not related to the work injury. Dr. Tranel specifically cautioned against attempts to infer causal connection between the work injury and headache complaints on the basis of the existence of a preexisting headache condition and the minor nature of the work injury. Dr. Tranel also addressed Dr. Milas' impairment rating, stating: claimant's neuropsychological test results were entirely normal on two testing occasions; claimant did not have impairment in cognitive function; claimant did not have cognitive deficits that would prevent him from working at the same level as pre-injury; and claimant's conditions of depression and anxiety would not warrant impairment ratings, as claimant could be returned to premorbid levels of function with treatment. (JE14, pp. 274-275)

On February 1, 2017, claimant presented to Dr. Short. He reported improvement over the last few months, a fact he attributed to not working. Claimant reported experiencing mild headaches twice per week, self-treated with Tylenol; with over-

exertion, he felt right-sided headaches beginning at the back of his head. Claimant expressed concern cluster headaches would return upon resumption of work in the spring. Dr. Short noted claimant had been seen at UIHC and alternative treatments had been recommended, such as acupuncture. Dr. Short noted any recommendations for such care would need to come from him in order to be covered by workers' compensation. Following examination, Dr. Short assessed episodic cluster headache, not intractable. He suspected claimant's headaches would flare upon returning to work. Dr. Short opined further trials of preventative medicines were unlikely to be helpful, given past failures. He recommended occipital nerve blocks at three-month intervals throughout the spring and summer, with the first in March 2017. Dr. Short also indicated alternative treatments would be reasonable and indicated he would obtain the UIHC neuropsychology records in order to determine their recommendations. (JE3, p. 67-68)

From February 2017 through August 2017, claimant worked at J.L. Hardscape as a construction supervisor and earned $18.50 per hour. (Claimant's testimony; CE1, p. 3; DEB, p. 4; DED, pp. 4-6)

On March 8, 2017, claimant underwent the occipital nerve block recommended by Dr. Short to treat occipital neuralgia. (JE3, p. 72)

At the referral of claimant's counsel, claimant presented to vocational expert, Kent Jayne, on March 29, 2017, for purposes of a vocational assessment. Mr. Jayne authored a vocational assessment dated July 13, 2017. As elements of his assessment, Mr. Jayne performed a medical records review and summarized select records. (JE34, pp. 469-473) He also noted claimant's work history and education. Mr. Jayne interviewed claimant regarding his care and complaints, as well as administered a number of questionnaires and checklists. (JE34, pp. 473-475) Mr. Jayne evaluated the results and described the testing as standardized instruments designed to evaluate residual vocational capacities. He described claimant's dexterity scores as rather dismal. (JE34, pp. 476-477, 480)

Mr. Jayne ultimately opined claimant's physical restrictions alone precluded his return to work as a concrete finisher. He further opined claimant's vocational test scores would preclude claimant from supervisory work, entry level clerical work, or bench assembly work. (JE34, p. 480) Mr. Jayne concluded claimant was precluded from participation in the competitive labor markets in Iowa and Illinois. He opined claimant's pre-injury abilities were no longer within his capacities at even a light or sedentary level due to extremely poor performances in fine motor coordination, finger/manual dexterity, name comparison, clerical perception, numerical ability, and nonverbal reasoning capacity. Mr. Jayne further opined it was unlikely vocational rehabilitation would be successful. (JE34, p. 487)

Mr. Reynolds, the owner of CCS Construction, sat for deposition on April 5, 2017. Mr. Reynolds further testified that approximately two weeks prior to deposition, he had

spoken to claimant in person, as claimant was working for JL Hardscape and was attempting to recruit Mr. Reynolds' employees. (JE42, Depo. Tr. pp. 9-10)

Claimant testified he was able to tolerate work at JL Hardscape for a few months. He indicated he was not a comparable worker to his preinjury self; he was unable to work full days. Claimant testified he reached a state where he was not sleeping or eating and he was acting out violently. Claimant indicated he was unsure if these symptoms were potentially due to stress and/or anxiety. Claimant testified he ultimately quit JL Hardscape. (Claimant's testimony)

Claimant's legal representation arranged for claimant to be evaluated by a team of providers in California. On October 16, 2017, claimant presented to board certified neurologist, Fernando Miranda, M.D. (JE 16, pp. 289, 297) Dr. Miranda noted claimant was struck in the head by a baseball on May 19, 2014. Claimant reported feeling disoriented and confused, with people indicating he was not "making any sense." (JE16, p. 297) Claimant's complaints included: anger issues; irritability; anxiety; memory difficulties; sleep problems; headaches, including whenever he is angry; dizziness and nausea upon looking downward; balance difficulties; paranoia; impulsive; forgetfulness; emotional expressions; and notable depression with headaches. (JE16, pp. 297-298) Dr. Miranda noted claimant had been admitted for mental health care on several occasions. He noted the admissions were due to people believing claimant was under the influence of drugs and further stated claimant was "[a]lways released because all blood and urine tests are negative." (JE16, p. 298)

Claimant underwent a 3T MRI of the brain, read by board certified radiologist, Murray Solomon, M.D. (JE17, p. 301; JE37, p. 514) Dr. Solomon opined the results revealed:

> T2 flair images reveal a few small foci of increased signal intensity within the supraventricular and periventricular frontal lobe white matter bilaterally as well as within the right cerebellar hemisphere in the region of the middle cerebellar peduncle. If there is no underlying history of migraine headaches or prior viral encephalitis, any or all of these white matter lesions could be posttraumatic in etiology.

(JE17, p. 308; JE37, p. 516)

Dr. Miranda reviewed the MRI results and opined it revealed posttraumatic white matter lesions. (JE16, p. 298) Dr. Miranda opined claimant's EEG was abnormal, with findings compatible with traumatic brain injury. (JE16, pp. 298-299) Following examination, Dr. Miranda opined claimant suffered a traumatic brain injury secondary to being struck in the head on May 19, 2014. Dr. Miranda opined claimant's MRI results revealed damage in regions of the brain consistent with the mechanism of being struck in the back of the head with a baseball. He opined claimant would continue to experience cognitive changes, but may receive some relief with a course of medications. (JE16, pp. 299-300)

At the referral of Dr. Miranda, claimant underwent neuropsychological examination on October 17 and October 18, 2017, with Edgar Angelone, Ph.D. Dr. Angelone noted claimant had been struck in the back of the head with a baseball on May 19, 2014 and since that time, had experienced a number of cognitive, physical, and emotional issues. Claimant reported immediate head pain after being struck and indicated when he stopped for pizza on the way home, another patron, who was a nurse, indicated claimant was slurring his words and should seek medical attention. Dr. Angelone identified the purpose of the examination as assessment of the extent to which these issues were related to the work injury. (JE18, p. 320) Dr. Angelone interviewed claimant, his girlfriend, and his mother. (JE18, pp. 320-323) He also performed a medical records review. (JE18, pp. 324-331)

Dr. Angelone administered a neuropsychological examination. (JE18, p. 331-337) Following evaluation, Dr. Angelone opined the neuropsychological examination revealed: mild to severe impairment of simple and complex forms of auditory and visual attention and concentration; impaired working memory; signs and symptoms of conversion insufficiency; diminished grip strength of the dominant left hand; mildly impaired simple motor function of the left hand; mildly impaired fine motor coordination; mild dynamic balance difficulties; mildly impaired memory studies; mild problems with central dysarthria and categorical fluency; average intellectual abilities with impaired working memory and processing speed; significant impairment of executive functions; and symptoms of Pseudo-Bulbar Affect. (JE18, pp. 338-339) Dr. Angelone indicated the examination revealed mild to moderate impairment in overall levels of functioning. He noted claimant also reported symptoms of anxiety, depression, personality changes, and distress “secondary to experiencing a traumatic event.” (JE18, p. 338)

Dr. Angelone ultimately opined he found clear, objective evidence that claimant suffered a traumatic brain injury in the work accident. He opined a diagnosis of mild traumatic brain injury was warranted. Dr. Angelone opined there was clear, objective evidence that claimant developed symptoms of post-concussion syndrome related to the traumatic brain injury. (JE18, pp. 338-339). He opined the traumatic brain injury and post-concussion syndrome were direct contributors to claimant’s current emotional state and were responsible for claimant’s depression symptoms and personality changes. Dr. Angelone opined a diagnosis of personality changes due to another medical condition (traumatic brain injury), combined type, with associated depression and anxiety was warranted. (JE18, p. 339) In terms of prognosis, Dr. Angelone opined claimant’s complex combination of cognitive, personality, and behavioral disturbances would be difficult to treat, particularly with a preexisting demonstration of personality maladjustment. Dr. Angelone opined that even with treatment, claimant’s chances of recovery were minimal. (JE18, p. 340)

In November 2017, claimant was hired at Sooner Concrete. He remained employed by Sooner at the time of hearing. (Claimant's testimony; Mr. Grchan’s testimony) Claimant earns $20.00 per hour. (CE1, p. 3; DEB, p. 4)

On February 23, 2018, claimant presented to Dr. Short for headache evaluation. Dr. Short noted a history of cluster headaches that were worsened after being struck in the head by a baseball, as well as development of a component of posttraumatic occipital neuralgia. Dr. Short opined claimant responded well to occipital nerve blocks, with the last done nearly one-year prior which yielded near complete relief for 4 to 5 months. Headaches returned late the previous summer, but improved over the winter months while not working. He also noted complete relief of severe headaches within 15 minutes of use of sumatriptan nasal spray; without use, headaches can incapacitate claimant for up to 4 hours. Claimant also reported relief with use of marijuana. He expressed concern regarding worsening headaches upon resumption of work in March or April, due to heat and physical exertion. Following examination, Dr. Short assessed: episodic cluster headaches; posttraumatic headaches; and occipital neuralgia. He recommended repeat right occipital nerve block and use of sumatriptan nasal spray. Dr. Short also indicated he would investigate referral to an Illinois-based physician who could prescribe medical marijuana, as he believed it was a reasonable treatment option. (JE3, p. 73)

Claimant's counsel authored correspondence to Dr. Short, inquiring if he recommended the medications mentioned by Dr. Miranda and further, if claimant would benefit from medical marijuana. In the event he believed medical marijuana was appropriate, counsel requested Dr. Short issue a referral to an Illinois-based physician. (JE35, pp. 509-510) Dr. Short replied he did not recommend the medications mentioned by Dr. Miranda. Dr. Short indicated the medications were not FDA approved for claimant's diagnosis and in his experience, did not provide much benefit in claimant's situation. He further highlighted claimant's resistance to medication use. Dr. Short did agree claimant might benefit from medical marijuana and issued a referral to Ramon Pla, M.D. (JE35, p. 510)

On April 19, 2018, claimant underwent a repeat right greater occipital nerve block with Dr. Short. Dr. Short recommended repeat block in 4 months' time. (JE3, pp. 75-76)

Defendants in the related personal injury lawsuit referred claimant for an independent medical examination with board certified neurologist, Michael Jacoby, M.D. Claimant presented to Dr. Jacoby on June 29, 2018. (JE19, pp. 368) Claimant described the injury on May 19, 2014 and symptoms he related to the event. (JE19, pp. 369-370) Dr. Jacoby reviewed and summarized provided medical records and relevant depositions. (JE19, pp. 371-375) Dr. Jacoby performed general and neurologic examinations. (JE19, pp. 370-371) He specifically took issue with references in the medical records to "concussion," stating the diagnosis was possible, but lacking in documentation of supportive symptoms. Dr. Jacoby also took exception to Dr. Milas' diagnoses of post-concussion syndrome and cognitive impairment secondary to head injury, citing to Dr. Tranel's neuropsychological testing demonstrating no traumatic brain injury and his own evaluation which failed to show cognitive impairment. Regardless of

whether or not claimant initially suffered a concussion, Dr. Jacoby opined claimant suffered no cognitive residual effects. Dr. Jacoby also disagreed with Dr. Milas' opinion that the July 2014 MRI showed features characteristic of axonal injury as a result of blunt head trauma; Dr. Jacoby opined the findings were nonspecific and not unique to the type of injury suffered by claimant on May 19, 2014. (JE19, p. 376)

Following records review, interview and examination, Dr. Jacoby addressed ongoing complaints which claimant related to the work injury. Dr. Jacoby noted claimant endorsed persistent headaches, including severe headaches two to three times weekly. Dr. Jacoby opined that while claimant may have experienced posttraumatic headache "at the time," he found it "unusual" that claimant would continue to have headaches four years' post-injury. (JE19, p. 375) He indicated posttraumatic headaches improve gradually over time, typically demonstrating notable improvement within three to six months and resolution by the one-year mark. Dr. Jacoby opined posttraumatic headaches are not cluster headaches, as had been diagnosed by one neurologist. Dr. Jacoby noted claimant's preexisting headache problems, beginning at least eight years prior to the work injury. The pre-injury care included a diagnosis of cluster headaches. He, therefore, opined claimant's ongoing headache complaints might be related to the long-standing headache issue. (JE19, p. 375-376) On this issue, Dr. Jacoby stated:

> I contend that he may have experienced some degree of post-trauma headache, but that headache is now resolved and any continued problems [claimant] has with headaches is related to the headache problems that he experienced long before such incident.

(JE19, p. 376)

Dr. Jacoby also addressed causation with respect to claimant's other complaints. With respect to a complaint of balance difficulties, Dr. Jacoby opined the complaints were not related to the work injury. Rather, he opined claimant's examination was strongly suggestive of peripheral neuropathy, which he opined was much more likely to cause balance issues than a strike to the head. Dr. Jacoby described claimant's complaint he had difficulty holding up his head as unfounded, citing lack of reference in the medical records, good strength of neck musculature, and no neuro-anatomic explanation for the symptom. He opined claimant's complaint of stuttering speech was unfounded, citing minimal focus during medical care beyond subjective reports and lack of speech impediment during the course of IME evaluation. (JE19, p. 376) Dr. Jacoby ultimately opined he was unable to attribute functional impairment to the work injury of May 19, 2014. (JE19, p. 377)

Pursuant to the referral of Dr. Short, claimant presented to Ramon Pla, M.D., to establish care. Dr. Pla noted claimant's history of traumatic brain injury and post-concussion syndrome. Dr. Pla indicated claimant's depressive score was consistent with major depression, but claimant was unwilling to take an antidepressant. Claimant

expressed interest in medical marijuana. Dr. Pla indicated he would first review claimant's neurological records. (JE33, p. 463)

Defendants referred claimant back to Dr. Tranel for neuropsychological reevaluation on August 8, 2018. Following evaluation, Dr. Tranel authored a report dated August 27, 2018. Dr. Tranel noted interim persistent complaints of difficulties with attention, concentration, short term memory, and multitasking, as well as worsening mood, anxiety, and frustration. Claimant described instances of hypervigilance and heightened startle response. He also reported avoidance of public and leisure activities, citing a resultant headache. (JE14, p. 277) Claimant reported continued pulsating headaches and neck pain, with headaches often accompanied by nausea. He reported working concrete part-time for the last year and that his boss at Sooner Concrete was understanding and flexible regarding his condition. (JE14, p. 278) Dr. Tranel noted claimant had not pursued psychiatric consultation or psychotherapy as previously recommended, as the care was not covered by workers' compensation and claimant lacked insurance. (JE14, pp. 277-278) Claimant reported consuming a "few drinks" over the prior month. He also reported daily use of marijuana since October 2017 to address anxiety and pain complaints; Dr. Tranel noted claimant was in the process of obtaining a medical marijuana card. (JE14, p. 278)

Dr. Tranel administered a clinical assessment, during which claimant gave adequate effort. (JE14, pp. 278-279) Following review of results, Dr. Tranel opined the evaluation again revealed normal, intact cognitive functioning. Dr. Tranel opined claimant's intellectual abilities typically fell in the average to high average range. Additionally, he described claimant's other cognitive abilities as intact, including learning and memory, attention and orientation, concentration and processing speed, speech and language, visuoperceptual and visuoconstructional abilities, executive functioning, and higher-order reasoning and problem-solving. Dr. Tranel opined the findings again supported the conclusion that, to a reasonable degree of neuropsychological certainty, claimant did not have any permanent brain dysfunction or permanent neurological injury related to the May 19, 2014 incident. Dr. Tranel opined claimant presented with ongoing behavioral problems and psychological adjustment issues, but indicated the conditions appeared long-standing in nature and not attributable to the work injury. Dr. Tranel again opined the psychiatric difficulties experienced since the work injury may be seen as an aggravation of preexisting conditions due to headache pain; however, he cautioned this would be difficult to establish to a reasonable degree of certainty given open questions regarding drug use and contributions from psychosocial stress. Dr. Tranel offered care recommendations regarding claimant's condition and specifically recommended substance abuse care as the first priority. (JE14, p. 281)

At some point following Dr. Tranel's August 8, 2018, evaluation, Dr. Angelone authored an undated supplemental report. Dr. Angelone summarized a number of interim medical records he was provided for review, including the reports of Drs. Tranel and Jacoby. (JE18, pp. 347-351) Following review, Dr. Angelone critiqued the provided

records as incomplete and unreliable given what he deemed contraindications and errors. He opined Dr. Tranel's data was incomplete. Dr. Angelone critiqued Dr. Tranel's August 2018 opinion that claimant's cognition was intact, citing to "cognitive and emotional difficulties" noted in Dr. Tranel's own report. (JE18, p. 352) Dr. Angelone also opined Dr. Tranel failed to take microsmia and personality changes into effect when rendering his conclusions, both of which are seen in individuals with brain injury and damage of orbital frontal regions. (JE18, pp. 352-353) Given his concerns regarding Dr. Tranel's reports, Dr. Angelone opined Dr. Jacoby's opinions had "no objective evidence" of claimant's cognitive function, due to reliance on Dr. Tranel's findings. (JE18, p. 353)

Claimant underwent repeat right greater occipital nerve block with Dr. Short on August 22, 2018. Dr. Short planned for repeat injection in 3 months. (JE3, pp. 77-78)

On September 7, 2018, Dr. Pla noted claimant would be applying to the Illinois medical cannabis program on the bases of headaches and anxiety related to traumatic brain injury with post-concussive syndrome. (JE33, p. 466)

Defendants referred claimant to vocational case manager, Lana Sellner, for consideration of claimant's vocational outlook. She ultimately authored a vocational assessment report dated October 4, 2018. (JE20, p. 380) Ms. Sellner interviewed claimant and reviewed medical records and deposition transcripts. Her report provides detail of this review and discussion, focusing upon claimant's work restrictions, medical status, background, education, and work history. (JE20, pp. 380-383) Ms. Sellner opined claimant was capable of medium-heavy physical demand level work prior to his work injury. Utilizing the opinions of Drs. Tranel and Garrels, Ms. Sellner found no vocational impairment post-injury. (JE20, p. 384) Utilizing the opinion of Dr. Short, restricting claimant from bending, excessive physical work or heat, Ms. Sellner found claimant capable of working in a light to medium physical demand position. With respect to the opinions of Drs. Milas, Angelone and Miranda, opining claimant possessed cognitive impairments which prevented claimant from functioning independently, Ms. Sellner identified some possible accommodations which could benefit claimant, as she noted claimant had already been working part-time in his preinjury position. (JE20, p. 385) Ms. Sellner also identified positions available within claimant's labor market which comported with the restrictions of Dr. Short. (JE20, pp. 385-387) Finally, Ms. Sellner indicated claimant might benefit from registration with organizations such as IowaWorks, in the event he sought to engage in a job search. (JE20, p. 388)

Defendants in the personal injury action referred claimant to vocational specialist, Bruce Mailey, for evaluation of claimant's residual vocational potentials. Mr. Mailey authored a vocational evaluation report dated November 16, 2018. (JE21, p. 393) Mr. Mailey noted claimant's education and work history. (JE21, p. 396) He also noted claimant had a history, dating to his mid-teens, of anger management issues, alcohol and substance abuse issues, and a number of arrests for assault, underage drinking,

OWI, and drug possession. He opined these factors impacted claimant's vocational potentials. (JE21, p. 394) Mr. Mailey reviewed and summarized relevant medical factors. (JE21, pp. 394-396, 405) He concluded Drs. Garrels, Tranel, and Jacoby each opined claimant was capable of working full time without restrictions, which placed claimant in the heavy physical demand category of work. (JE21, p. 396) Following consideration of the opinions of Drs. Garrels, Tranel, and Jacoby, as well as claimant's education, training, experience, and transferrable skills, Mr. Mailey opined: claimant was capable of returning to his preinjury position; claimant was qualified for a number of other semi-skilled and unskilled occupations within his labor market; the qualified positions fell in the heavy, medium, light, and sedentary demand categories; and jobs "undoubtedly" existed in claimant's labor market. Utilizing the opinion of Dr. Short, Mr. Mailey opined: claimant was capable of returning to his preinjury position with accommodations; claimant was qualified for unskilled occupations within his labor market; and the qualified positions fell in the heavy, medium, light, and sedentary demand categories. (JE21, p. 400) Mr. Mailey identified a number of appropriate, available positions within claimant's vocational profile. (JE21, pp. 401-402) He ultimately opined claimant's labor market analysis reveal "approximately 0" percent loss of access to the labor market. (JE21, p. 403)

Dr. Milas authored a supplemental report dated December 20, 2018. Thereby, Dr. Milas reiterated his diagnoses of post-concussion syndrome and cognitive impairment secondary to head injury. He opined claimant's June 2014 brain MRI demonstrated numerous punctate white matter lesions which were characteristic of axonal shear injury as a result of blunt head trauma. He opined the EEG and P300 studies ordered by Dr. Miranda confirmed structural brain changes, which Dr. Milas opined were posttraumatic in origin. Dr. Milas further opined the October 2017 MRI again showed white matter lesions which the radiologist opined could be posttraumatic in nature. Dr. Milas opined his evaluation and the evaluations of the LIFT program revealed cognitive impairment. He opined claimant demonstrated many criteria associated with post-concussion syndrome and further, that claimant's symptoms rendered it "impossible for [claimant] to be gainfully employed in the future." (JE15, p. 287)

On January 9, 2019, Dr. Short preformed repeat greater occipital nerve block. He recommended repeat block in three months. Claimant reported experiencing two headaches per week, which improve somewhat with use of sumatriptan nasal spray. However, claimant reported the headaches resulted in difficulty working and resulted in missing a considerable amount of work. Dr. Short recommended a trial of Emgality. (JE3, pp. 79-80)

Dr. Short sat for a second deposition on January 31, 2019. Dr. Short again testified he began treating claimant in 2002 and initially diagnosed elements of migraine and cluster headaches. In retrospect, Dr. Short indicated he likely would have only diagnosed cluster headaches. He explained he may have thought the nausea symptom

represented a migrainous element, as most cluster headache patients do not complain of nausea. (JE26, Depo. Tr. pp. 9, 12) Dr. Short acknowledged claimant reported a history of right-sided facial fracture with persistent numbness over the right side of his face. Dr. Short opined it was possible for a facial fracture to cause axonal lesions; however, he did not know if that was the result in claimant's case. (JE26, Depo. Tr. pp. 9-10)

Dr. Short testified he continued to believe the work injury trauma aggravated claimant's preexisting condition. He also continued to recommend avoidance of bending, excess physical work, and heat, as claimant reported these activities aggravated his headaches. (JE26, Depo. Tr. pp. 54-55) Based upon his professional experience, Dr. Short opined it was likely claimant's cluster headache condition would continue indefinitely. He indicated that in his history of treating patients with headaches presumably triggered by head injuries, patients who do not improve within one year of the trauma do not improve. (JE26, Depo. Tr. p. 60)

Dr. Short testified cluster headaches can occur with or without trauma and most frequently, without trauma. He testified claimant's subsequent development of occipital neuralgia could be related to the cluster headaches or trauma. He was unable to opine with certainty which represented the cause of the occipital neuralgia. (JE26, Depo. Tr. p. 29)

On February 5, 2019, vocational specialist, Mr. Mailey, authored correspondence to defense counsel. Thereby, Mr. Mailey clarified his earlier report had "artificially inflated" the annual salaries of the positions of concrete finisher and supervisor of concrete finishers, as the earnings had been based on a 12-month, full-time schedule, whereas claimant had only worked seasonally. Mr. Mailey opined records regarding claimant's post-injury employment "completely disprove[d]" the assertion that claimant was not employable, as opined by Mr. Jayne and Dr. Milas. (CE4, p. 26)

On February 9, 2019, Dr. Pla completed a certification form identifying claimant as a qualifying patient for participation in the Illinois Medical Cannabis Pilot Program. He designated a debilitating medical condition of traumatic brain injury with post-concussion syndrome. (CE7, pp. 33-35)

In February 2019, claimant applied for Social Security Disability benefits. No decision had been rendered by the date of evidentiary hearing. (Claimant's testimony; CE1, p. 13)

Claimant continued to work at Sooner Concrete throughout 2018 and into the 2019 concrete season. (Claimant's testimony)

On April 4, 2019, Mark Grchan sat for deposition. Mr. Grchan is the owner of Sooner Concrete. (JE27, Depo. Tr. p. 3) Mr. Grchan hired claimant in November 2017, after he was recommended by an existing employee. Claimant worked for two days in 2017 and then returned during the 2018 season. (JE27, Depo. Tr. pp. 4-5) The work

season typically runs from April to November, with workers generally working 40 hours per week. (JE27, Depo. Tr. pp. 13, 26) Claimant was paid $20.00 per hour as an independent contractor and earned a total of $7,410.00 during 2018. (JE27, Depo. Tr. p. 12)

During the 2018 season, Mr. Grchan indicated claimant would begin working for the day, but after approximately four to five hours, claimant's face would turn red and he would indicate he did not feel well. (JE27, Depo. Tr. p. 7) Mr. Grchan testified claimant would generally complain of a headache and then appear as if he was sick to his stomach. (JE27, Depo. Tr. p. 14) At that time, Mr. Grchan would direct someone to drive claimant home. (JE27, Depo. Tr. p. 7) Mr. Grchan observed claimant vomit on one or two occasions. On many occasions, claimant informed Mr. Grchan he vomited after returning home. (JE27, Depo. Tr. p. 14) Mr. Grchan testified this series of events would occur on two-thirds of the days claimant worked. After such an incident, claimant typically would not work the following day. (JE27, Depo. Tr. p. 7) Mr. Grchan testified claimant's condition was worse with hot weather, but would improve following his occipital block injection. (JE27, Depo. Tr. p. 8)

Mr. Grchan testified claimant had returned to Sooner Concrete for the 2019 season. As of the date of his deposition, claimant had worked one day for four hours. (JE27, Depo. Tr. p. 17) Mr. Grchan testified claimant is a hard worker, when he is capable of working. (JE27, Depo. Tr. pp. 13-14) He described claimant as very knowledgeable, capable of setting to specifications and with correct dimensions and measurements. For these reasons, Mr. Grchan values claimant's input in concrete work. (JE27, Depo. Tr. pp. 9-10)

Claimant underwent a right greater occipital nerve block by Dr. Short on April 8, 2019. (CE6, pp. 29) In his procedure note, Dr. Short assessed right occipital neuralgia and posttraumatic headache. He recommended repeat nerve block in three months. Claimant reported experiencing poor energy "ever since his head injury." Dr. Short noted a California-based head injury specialist had recommended a stimulant medicine; he issued a prescription for Nuvigil. (CE6, p. 30)

On July 18, 2019, Mr. Jayne authored an addendum to his vocational report. Thereby, he noted review of additional documentation and provided comment. (JE34, pp. 497-504) Mr. Jayne devoted attention to critiquing Mr. Mailey's report. (JE34, pp. 504-507) He also opined the job postings detailed by Ms. Sellner did not comport with claimant's test results. (JE34, pp. 507-508)

On August 15, 2019, Dr. Short performed a repeat right occipital nerve block for indications of occipital neuralgia and cluster headaches. Claimant reported improvement in daily headaches with injections, but no impact upon exertional headaches. Dr. Short noted the trial of Nuvigil was discontinued due to lack of benefit. (CE6, pp. 31-32)

Ms. Sellner authored an addendum vocational report dated August 19, 2019. Ms. Sellner reviewed additional records and noted that to her knowledge, no medical provider had altered claimant's restrictions from a physical or cognitive standpoint. She highlighted that no medical provider had restricted claimant's work hours. (JE40, p. 532) Accordingly, she provided an updated list of viable positions within claimant's restrictions. (JE40, pp. 532-536) She opined claimant continued to be employable, as demonstrated by claimant's current employment in his preinjury occupation despite self-limiting hours. (JE40, p. 536)

Mr. Jayne reviewed Ms. Sellner's report of August 19, 2019 and authored a responsive letter dated September 19, 2019. Thereby, Mr. Jayne noted claimant's employer documented claimant capable of working only one day per week during the summer due to symptoms of headaches, vomiting, and heat reaction. He opined such work was "not competitive employment" and should claimant no longer work at Sooner Concrete, claimant would not be employable. (CE5, p. 27) Mr. Jayne also opined claimant was not capable of performing any of the occupations proposed by Ms. Sellner in her report, based upon Mr. Jayne's findings regarding claimant's residual vocational capacities. (CE5, pp. 27-28)

On September 18, 2019, Mark Woods, M.D., completed a certification form identifying claimant as a qualifying patient for participation in the Illinois Medical Cannabis Pilot Program. (CE8, pp. 36, 38) He designated debilitating medical conditions of chronic pain and traumatic brain injury with post-concussion syndrome. Dr. Woods noted claimant suffered a head injury in 2014 when struck by a baseball and two weeks later, developed neurologic changes. He noted claimant suffered migraine headaches, was unable to concentrate, and experienced decreased cognition. Dr. Woods also noted cannabis was "helpful." (CE8, p. 37) The Illinois Department of Public Health approved claimant for provisional access, lasting 90 days, to a medical cannabis dispensary pending further review of his application. (CE9, p. 39)

Claimant believes the medical marijuana is helpful to his conditions. He described himself as more focused than he had been in five years and denied negative outbursts. (Claimant's testimony)

On October 9, 2019, Ms. Sellner authored a response to Mr. Jayne's most recent vocational opinion. Thereby, Ms. Sellner noted Mr. Jayne opined claimant was unemployable if not accommodated by Sooner Concrete and had expressly disagreed with potential job positions Ms. Sellner previously identified. Ms. Sellner reviewed Dr. Short's restrictions of avoidance of excess physical work, bending, and heat. Thereafter, she opined claimant's work at Sooner Concrete fell outside those restrictions, which likely explained why claimant was unable to work full-time and required accommodation. Ms. Sellner noted she had identified positions that fell in the light to low-heavy physical demand categories. She concluded claimant remained employable on a full-time basis, provided he work within the restrictions imposed by Dr.

Short. Ms. Sellner opined many positions existed in the labor market which did not requiring working in excessive heat, bending, and excessive physical work. (DEE)

Claimant claims the following injurious conditions are causally related to the work injury of May 19, 2014: cluster headaches; "some rage and anger;" occasional stuttering; short-term memory loss; difficulty reading, sleeping, and concentrating; reduced attention span; anxiety; and the feeling of heaviness and swelling of his head. (CE1, p. 4) Cluster headaches occur when performing physical work, bending over, or when in the heat; occasionally, vomiting accompanies the headaches. (CE1, pp. 5-7) Claimant admits he experienced cluster headaches prior to the work injury, but believes those headaches had resolved. (CE1, p. 6) Claimant indicated he did not miss work due to headaches prior to the work injury. (CE1, p. 5)

Post-injury, claimant testified he experiences difficulty with reading comprehension and retention, impacted memory, and withdrawn behavior. Claimant also testified he will lose his temper if situations do not go as he anticipated. He testified to experiencing two cluster headaches in the month prior to hearing, both of which began at work. (Claimant's testimony)

Claimant testified he continues to work at Sooner Concrete as a concrete finisher. He described his boss, Mr. Grchan, as lenient. Claimant testified he is able to work for a while, but then he develops a headache and begins vomiting. Claimant testified he is sometimes able to work two or three days in a row, but is often lucky to average one day per week. He explained he started off the 2019 season well, but once the weather became hot and humid, his hours decreased significantly due to symptoms. (Claimant's testimony)

Claimant testified he has not attempted to obtain a sedentary, less physical job. He spoke with an employee at Save-A-Lot regarding a stocker position, but the discussion did not bear fruit. This is the only specific position claimant inquired of which fell outside the concrete industry. (Claimant's testimony)

Ricardo Ramirez, self-described close friend of claimant, sat for deposition. (CE11, Depo. Tr. p. 10) He testified claimant never complained of headaches or physical pain prior to May 19, 2014. (CE11, Depo. Tr. p. 11) He admitted he has observed claimant in a "handful" of fights over the years. (CE11, Depo. Tr. p. 12) In response to inquiry regarding whether he knew of any history of claimant's anxiety or depression, Mr. Ramirez replied, "none in any way, shape or form." (CE11, Depo. Tr. p. 11) Mr. Ramirez indicated he observed claimant use marijuana in high school. (CE11, Depo. Tr. p. 11) Otherwise, he believed claimant sought out illegal substances after the work injury, not before. (CE11, Depo. Tr. p. 12)

Mr. Ramirez testified that a couple weeks after the work injury, claimant's demeanor and behavior started to go "awry." (CE11, Depo. Tr. p. 13) Mr. Ramirez testified claimant was different after this point, looked past people, was unfocused, complained about lack of sleep, jumped between topics, was emotional and tearful, and

spoke of horrible headaches. (CE11, Depo. Tr. pp. 13-14, 16) He testified claimant was "erratic" and "spiraled." (CE11, Depo. Tr. p. 12) Mr. Ramirez testified claimant became erratic, accused Mr. Ramirez of sleeping with claimant's wife and also broke into a neighbor's garage. He said claimant was no longer "all there" and even scared Mr. Ramirez. (CE11, Depo. Tr. p. 16)

Mr. Ramirez testified claimant was "emotionally distraught" about the breakup of his marriage. Following the work injury, claimant could not grasp what was occurring in his life and still believed he could "fix" the situation, but behaved irrationally. (CE11, Depo. Tr. p. 21) Mr. Ramirez was not aware, however, that claimant and his wife were living separately before the incident. (CE11, Depo. Tr. pp. 42-43) Mr. Ramirez testified claimant began to drink heavily and use drugs, worrying his family. (CE11, Depo. Tr. p. 15) Claimant would disappear for days, causing friends and family to search for him. (CE11, Depo. Tr. p. 17) He testified claimant spoke of suicide and hurting others; this, as well as his arrests, led to the petitions for involuntary commitment. (CE11, Depo. Tr. p. 29)

Claimant's mother, Mary Presson, testified at evidentiary hearing. She moved from Iowa to Carbon Cliff, Illinois in April 2014. Prior to her move to Illinois, she testified she saw her son often and the two were close. She admitted she saw her son less often following her move; however, after his release from jail in February 2015, claimant moved into her residence. Ms. Presson testified she sought to involuntarily commit her son because others told her she needed to do so to get him off the streets. She testified he suffered from delusions and hallucinations. She became fearful for her son. (Ms. Presson's testimony)

Ms. Presson testified claimant has changed significantly; he becomes obsessed and fixated on silly things, cannot tolerate loud noises, is anxious in crowds, cannot stay focused, and forgets conversations and events. She testified he becomes upset if he forgets things. Ms. Presson testified claimant vomits frequently. For a time, claimant seemingly vomited in the driveway every time he left the house to go to work. She testified the vomiting is not always related to going to work, as he also vomited before going to doctor's appointments. She questioned whether the vomiting was related to anxiety. Ms. Presson testified claimant experienced severe headaches prior to the work injury, but indicated claimant now stays in a dark room and she will not see him for days. Ms. Presson expressed optimism regarding claimant's medical marijuana treatment; she indicated claimant has become more talkative and his facial expressions are more animated. (Ms. Presson's testimony)

Ms. Presson believes claimant has only worked a limited number of days since the work injury. Ms. Presson works full time, 7:30 a.m. to 4:00 p.m., Monday through Friday. However, she believes claimant is in his room the majority of the time and she would be aware if he left for work based upon the nature in which she keeps her home and the presence of his work clothes. (Ms. Presson's testimony)

Ms. Presson was visibly distraught during her testimony. Ms. Presson was visibly emotional and appeared significantly troubled by her role in claimant's legal issues. Beyond her emotional involvement, Ms. Presson appeared genuine and credible in her testimony. Her desire to help her son is clear; however, Ms. Presson is either unaware of certain elements of claimant's life and/or she wishes to downplay his undesirable actions. I, therefore, find Ms. Presson to be a credible witness; however, the probative value of her testimony is quite limited.

Sylvia Reyes testified at evidentiary hearing. Ms. Reyes has dated claimant since March 2015; the two previously dated in the early 2000s. Between the end of their relationship in 2005 and recommencement in 2015, Ms. Reyes did not interact with claimant. Ms. Reyes testified claimant has memory and trust issues, as she will tell him about plans she may have and he will deny she ever informed him of her plans. She also testified claimant is paranoid, as he believes she will be unfaithful and others are targeting him. Ms. Reyes testified claimant becomes frustrated and overwhelmed by paperwork, is triggered by sound, has a hard time concentrating and focusing, sometimes searches for words, and is anxious about leaving the home. She also expressed hope regarding claimant's improvement with use of medical marijuana, as claimant is now calmer, more focused, and more talkative. (Ms. Reyes' testimony)

Ms. Reyes' testimony was direct, forthcoming, and consistent with the evidentiary record. Her demeanor was excellent and gave the undersigned no reason to doubt her veracity. Ms. Reyes is found credible.

At the time of evidentiary hearing, claimant was clearly and visibly irritated. Claimant's heightened irritation resulted in him losing his composure on multiple occasions; a fact claimant acknowledged at evidentiary hearing. Claimant's reactions at hearing were erratic, swinging from anger to tearful. His emotional variation made it difficult for the undersigned to assess claimant's credibility. While he did not obviously demonstrate the typical indicators of an intention to deceive, claimant was not forthcoming and at times unresponsive to questioning. This unresponsiveness could be attributable to memory-impairing issues such as potential brain injury, mental health conditions, passage of time, after-effects of substance abuse, or deception. Claimant's demeanor and presentation at hearing quite simply did not assist the undersigned in determining whether claimant is a credible witness.

As a result, I was forced to rely upon the evidentiary record as a whole in order to determine if claimant is a credible witness and historian. Following review of the entirety of the records, I conclude he is not. The evidentiary record is replete with examples of incomplete or unsubstantiated statements regarding claimant's medical, legal, and psychiatric histories. For instance, claimant initially did not mention any reports of stuttering or slurred speech until after passage of approximately one week following the work injury. However, by the time of his evaluation by Dr. Milas in December 2016, claimant's reported history of symptoms immediately post-injury included a statement that an acquaintance he saw at the pizza restaurant the night of

his injury informed him he required medical attention and had been slurring his words. This history was repeated to the evaluating providers in California. Claimant also testified to this series of events at hearing, but had not done so in his prior depositions. Review of the records also revealed claimant regularly downplayed his history of and any culpability for his pre-injury legal issues, including numerous arrests and expulsion. Similarly, claimant downplayed his history with mental health issues and substance abuse. Furthermore, claimant lays responsibility for his divorce upon his behavior post-injury, despite the couple separating and living apart several months before the incident. This pattern of downplaying negative personal history, while upselling post-injury symptomatology, leads the undersigned to doubt claimant's veracity and ultimately find he is not a credible witness or historian.

CONCLUSIONS OF LAW

The first issue for determination is whether claimant is entitled to temporary disability benefits from April 23, 2015 through August 24, 2015.

The party who would suffer loss if an issue were not established ordinarily has the burden of proving that issue by a preponderance of the evidence. Iowa R. App. P. 6.904(3)(e).

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

On March 9, 2015, Dr. Short specifically released claimant to return to work, without restrictions. Dr. Short also, however, noted a caveat that it would be expected that claimant may be unable to work for 45 minutes due to cluster headaches. Defendants allege this date serves as the end of claimant's entitlement to temporary disability benefits, as it marked the date claimant was determined medically capable of returning to substantially similar work as that performed at the time of the injury. Defendants paid claimant temporary disability benefits through April 22, 2015. Claimant contends his period of temporary disability benefits should continue until Dr. Short placed claimant at MMI on August 24, 2015, interpreting Dr. Short's caveat as continued work restrictions.

Following Dr. Short's release on March 9, 2015, claimant did not immediately return to work. The language of Dr. Short's March 9, 2015 report is, admittedly, somewhat ambiguous in that he acknowledged scenarios when claimant would be unable to work. However, Dr. Short specifically released claimant to return to work without restrictions. He did not restrict with specificity claimant's hours or working conditions. Rather, he stated he would expect claimant would be unable to work during periods that were based solely upon claimant's subjective reports and that may or may

not come to fruition. Dr. Short ultimately placed claimant at MMI on August 24, 2015. During the intervening period, claimant was also seen by Dr. Tranel, who opined there was no basis to expect claimant sustained permanent disability as a result of the work injury.

The caveat stated by Dr. Short did not place regular, verifiable limitations upon claimant's hours, working conditions, or activities; thus, I find it did not preclude claimant from returning to substantially similar employment. When this subjective caveat is coupled with claimant's lack of credibility, I find it would be inappropriate to extend claimant's entitlement to temporary disability benefits based upon a caveat which extended claimant control over when he did or did not work, simply by claiming a subjective headache. It is determined claimant has failed to establish entitlement to temporary disability benefits from April 23, 2015 through August 24, 2015.

The next issue for determination is whether the injury is a cause of permanent disability.

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).

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, 76 N.W.2d 756 (1956). If 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, 115 N.W.2d 812 (1962); Yeager v. Firestone Tire & Rubber Co., 253 Iowa 369, 112 N.W.2d 299 (1961).

Claimant alleges a number of conditions of ill-being are causally related to the work injury of May 19, 2014. Such conditions have included, but are not limited to: cluster headaches; rage and anger; occasional stuttering; short-term memory loss; difficulty reading, sleeping, and concentrating; decreased attention span; anxiety; a sensation of heaviness or swelling of his head; challenges with comprehension and retention; withdrawn behavior; and loss of temper. By argument and post-hearing brief, claimant has combined these complaints generally into the diagnoses of traumatic brain injury, including a permanent aggravation of cluster headaches, and post-concussive syndrome. Defendants argue claimant has failed to prove the work injury was a cause of permanent disability, as claimant's complaints should be classified as preexisting of a chronic and severe nature.

Given the complexity of claimant's alleged work-related injuries, the opinions rendered by medical, psychological, and psychiatric providers are of paramount importance. The claims in this matter ultimately come down to a battle of these experts.

Claimant relies heavily upon the opinions of Drs. Short, Milas, Miranda, and Angelone. Upon review of the entirety of the evidentiary record, I find these opinions insufficient to meet claimant's burden on causation, in large part based upon inaccurate or incomplete histories. Expert opinions are probative and convincing only if based upon accurate and complete information.

Dr. Short opined the work injury aggravated claimant's preexisting headache condition and he suffered from posttraumatic occipital neuralgia. However, Dr. Short's opinions are based in significant part upon claimant's stated pre-injury history and subjective reports of worsened symptomatology and triggering post-injury. At the time claimant returned to Dr. Short in July 2014, claimant reported he was headache free for a period of years preceding the work injury; the record, however, denotes claimant suffered with continued headaches which he self-treated with illegal prescription drugs. It is unclear if Dr. Short possessed a full understanding of claimant's pre-injury head injuries and/or substance abuse. Dr. Short imposed permanent restrictions tied to headache triggers, but these triggers are identified solely via claimant's self-report. Dr. Short acknowledged cluster headaches may occur with or without trauma and, most frequently, without trauma. He was also unable to opine with a reasonable degree of certainty whether the cause of occipital neuralgia was cluster headaches themselves or trauma. Due to questions regarding the accuracy of history and reliance upon claimant's subjective complaints, I award Dr. Short's opinions little weight.

Dr. Milas diagnosed post-concussion syndrome and cognitive impairment secondary to head injury. In his report of injury to Dr. Milas, claimant reported immediate development of stuttering and slurred speech. He stated these symptoms were noted the evening of the work injury by a person he encountered at the pizza restaurant. This report is inconsistent with the contemporaneous medical records. Dr. Milas also noted lesions characteristic of axonal injury as a result of blunt head trauma; however, it is unclear whether Dr. Milas was aware of claimant's prior head injuries. Additionally, Dr. Milas diagnosed cognitive impairment based upon his own methodology and with contrary findings to Drs. Tranel and Jacoby. Furthermore, I am

troubled by Dr. Milas' opinion that claimant's work injury was a direct cause of claimant's conditions, specifically including headaches, cognitive dysfunction, and behavioral dysfunction, specifically including loss of temper and substance abuse. Given claimant's significant and long-standing history of headaches, mental health concerns, physical altercations, and substance abuse, Dr. Milas' cursory statement fails to adequately explain how the ongoing conditions were directly a result of the work injury. Due to inaccuracies in history and lack of adequate explanation distinguishing claimant's pre- and post-injury conditions, I decline to award weight to the opinions of Dr. Milas.

At the referral of legal counsel, claimant traveled to California and was examined by Drs. Miranda and Angelone on a one-time basis. Dr. Miranda's history is quite short and contains inaccuracies, such as to imply that immediately post-injury claimant was disoriented, confused, and not making sense; these complaints are inconsistent with the contemporaneous records. Further, Dr. Miranda noted claimant's prior mental health admissions, but seemingly dismissed this factor as due to false allegations that claimant was under the influence, when claimant's testing was always negative which resulted in his discharge. This characterization is patently false, as claimant was admitted on multiple occasions due to mental health conditions beyond substance abuse and claimant's medical records denote positive drug screens on multiple occasions. Given the inaccuracies in and truncated nature of Dr. Miranda's stated history, it is unclear if he possessed sufficient historical knowledge to conclude claimant's 3T MRI results showed posttraumatic white matter lesions and that these lesions were attributable to the work injury. Dr. Angelone's history notes claimant suffered immediate head pain and that a patron at the pizza restaurant that evening indicated claimant was slurring his words. As discussed *supra*, this history is not noted in contemporaneous records. Dr. Angelone also noted claimant reported symptoms of anxiety, depression, personality changes, and distress secondary to the traumatic injury. However, the extent of Dr. Angelone's knowledge of claimant's preexisting mental health conditions and concurrent marital stressors and substance abuse, is unclear. Due to these inconsistencies and questions regarding the completeness of histories, I am unable to award weight to Dr. Angelone's opinion that claimant suffered with personality changes due to traumatic brain injury, with associated depression and anxiety.

The evidentiary record contains numerous medical opinions contradicting the opinions relied upon by claimant.

Shortly following the injury, Dr. Kent found intact memory, no signs of psychosis, and no neurological problems aside from a short attention span, which he attributed to longstanding headaches. He assessed: mood disorder; ADHD; alcohol and opiate abuse by history; personality disorder with prominent antisocial, dependent, and borderline traits; and history of concussion and headaches. He predicted any concussion symptoms were likely to remit within two to four months.

Treating psychiatrist, Dr. Narayana assessed: bipolar disorder, manic with psychotic features; polysubstance abuse; antisocial personality traits; and status post head injury. He opined claimant's drug use and severe bipolar disorder resulted in

paranoia and delusions. Dr. Narayana opined claimant presented with a life-long history of unaddressed mood disorder.

Dr. Tranel performed three neuropsychological assessments, each of which revealed normal, intact cognitive function, including memory, attention, concentration, speech, and executive functioning. Dr. Tranel found no evidence of permanent brain dysfunction, neurological injury, cognitive impairment, or brain damage attributable to the work injury. He specifically cautioned against an inference of causal connection between the work injury and claimant's headaches, due to preexisting headaches and the minor nature of the work injury. Dr. Tranel opined claimant suffered, at worst, an uncomplicated concussion. Dr. Tranel opined claimant's psychological condition served as the major factor underlying claimant's cognitive concerns. He opined claimant's behavioral and psychological adjustment issues appeared longstanding and were not attributable to the work injury. Dr. Tranel opined these conditions may have been aggravated due to headache pain, but he was unable to so opine to a reasonable degree of certainty due to issues of drug use and psychosocial stress. Even if an aggravation had occurred, Dr. Tranel described it as temporary, with depression and anxiety returning to premorbid levels, and found no basis for permanent injury as a result of the work injury.

Treating physician, Dr. Garrels, assessed: chronic cluster headaches, not intractable; polysubstance abuse; major depressive disorder; and superficial injury of the scalp. Dr. Garrels opined he did not find evidence of axonal brain injury as opined by Dr. Milas. He also opined claimant's psychiatric issues bore no relationship to the work injury and further, that long-term substance abuse could impact the brain and result in emotional and behavioral disorders. Dr. Garrels opined claimant presented with significant preexisting history, including chronic intermittent cluster headaches with essentially the same symptom pattern and substance abuse. He opined the head injury temporarily increased claimant's headaches, but they returned to baseline. Dr. Garrels released claimant to regular duty, without impairment based upon a lack of objective findings.

Dr. Jacoby opined it was possible claimant suffered a concussion as a result of the work injury, but found the documentation of supportive symptoms lacking. He opined claimant's MRI findings were nonspecific and not unique to the type of injury claimant suffered. Dr. Jacoby found no cognitive impairment or permanent impairment. He opined it was possible claimant had posttraumatic headaches for a time post-injury, but such headaches had resolved. Dr. Jacoby opined that posttraumatic headaches are not the same as cluster headaches. He ultimately opined that any continued headache issues were attributable to claimant's long-standing headache problems. Dr. Jacoby dismissed claimant's complaints of inability to hold up his head and stuttering as unfounded, given the minimal focus of care beyond subjective reports and lack of observation during evaluation.

Ultimately, it is claimant's burden to prove by a preponderance of the evidence that the work injury was a cause of permanent impairment. Following review of the entirety of the record, I find claimant has not met that burden. Claimant was not a

credible witness or historian, leading the undersigned to question the accuracy of reports relied upon by the experts in this case. After such consideration and on weight of the evidence, claimant fell short of establishing his injury resulted in permanent disability. Claimant's claims are plausible, but mere plausibility is insufficient. While it may be tempting to point to the work injury as a "turning point" in claimant's condition, correlation does not imply causation. It is also too simplistic and an example of the post hoc fallacy to state to a requisite certainty that because these events and worsened conditions happened temporally following the work injury that they are the result of the work injury.

As claimant has failed to meet his burden of proving the work injury was a cause of permanent disability, consideration of the issues of extent of permanent disability, commencement date for permanent disability benefits, and any penalty benefits due on permanency benefits is unnecessary, as moot.

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

Claimant argues he is entitled to penalty benefits based upon an underpayment on weekly benefit rate. On the hearing report, the parties stipulated that at the time of the work injury, claimant's gross earnings were $845.00 and claimant was married and entitled to 4 exemptions. The proper rate of compensation is therefore, $562.45. Any weekly indemnity benefits paid should have been paid at this rate of compensation. Claimant alleges temporary total disability benefits were paid at a lower rate; however, the hearing report does not contain a stipulation as to temporary disability benefits paid and indemnity logs are not in evidence. As a result, I am unable to determine if claimant's temporary total disability benefits were underpaid and no penalty benefits can be awarded absent this determination.

The final issue for determination is a specific taxation of costs pursuant to Iowa Code section 86.40 and rule 876 IAC 4.33. Claimant requests taxation of a significant number of costs, as found in Claimant's Exhibit 12. Claimant failed to prevail on any issue presented for determination at hearing, and as such, taxation of costs against defendants is unwarranted.

ORDER

THEREFORE, IT IS ORDERED:

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

Claimant shall take nothing from these proceedings.

Defendants shall receive credit for benefits paid.

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

Costs are taxed to claimant pursuant to 876 IAC 4.33.

Signed and filed this 17TH day of March, 2021.

ERICA J. FITCH
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served as follows:

Jerry Soper (via WCES)

Peter Thill (via WCES)

Edward Rose (via WCES)

Right to Appeal: This decision shall become final unless you or another interested party appeals within 20 days from the date above, pursuant to rule 876-4.27 (17A, 86) of the Iowa Administrative Code. The notice of appeal must be filed via Workers' Compensation Electronic System (WCES) unless the filing party has been granted permission by the Division of Workers' Compensation to file documents in paper form. If such permission has been granted, the notice of appeal must be filed at the following address: Workers' Compensation Commissioner, Iowa Division of Workers' Compensation, 150 Des Moines Street, Des Moines, Iowa 50309-1836. The notice of appeal must be received by the Division of Workers' Compensation within 20 days from the date of the decision. The appeal period will be extended to the next business day if the last day to appeal falls on a weekend or legal holiday.