BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

DANNY DAVIS, Claimant, vs. LARSON AND LARSON CONSTRUCTION, Employer, and BITCO GEN. INS. CORP., Insurance Carrier, Defendants.	FILED AUG 01 2016 WORKERS' COMPENSATION	File No. 5047088 ARBITRATION DECISION Head Note No.: 1803

STATEMENT OF THE CASE

Danny Davis, claimant, filed a petition in arbitration seeking workers' compensation benefits against Larson and Larson Construction, employer, and Bitco Gen. Ins. Corp., insurance carrier, both as defendants. This case arises out of an accepted work injury date of March 19, 2013.

The record consists of claimant's exhibits 1-13 except for Exhibit 10, pages 8-11 which were excluded based on timeliness, defendants exhibits A-N, and the testimony of the claimant. The hearing was held on May 6, 2016, in Des Moines, Iowa. The record was closed as of May 6, 2016, and the case was considered fully submitted on the same.

ISSUES

1. The extent of claimant's disability; and/or

2. Whether claimant is considered an odd-lot employee.

STIPULATIONS

The parties stipulate that the claimant sustained an injury on March 19, 2013. They further agree that the claimant's gross earnings were $913.00 per week and that he was married and entitled to two exemptions. Based on those foregoing figures, the claimant's benefit rate is $596.68.

Prior to the hearing, the claimant was paid 55 weeks of compensation at $596.68. Benefits, if any are awarded, should commence on December 6, 2013.

FINDINGS OF FACTS

At the time of the hearing, claimant was a 51 year old male. He dropped out of the 9th grade and began construction work. His primary past employment was heavy duty manual labor. He joined a labor union at the age of 18 and did union work for many years doing primarily construction work. From 2004 – 2008, he worked for his brother in a vinyl siding business. After his brother retired, the claimant attempted to continue on his own but due to bidding mistakes and other numbers related problems, he had to file bankruptcy. He returned to construction work through the union and began his position with Larson and Larson in approximately 2010.

His past medical history is significant for diabetes, weight gain, and arthritis. He was seen by Maria Mitchell, M.D., on December 11, 2012, a few months before his work-related injury with reports of pain in his upper extremities, hands, fingers, back, hips and legs.

> This is a 47-year-old who was seen on December 11 who comes to Medicare medication recheck. He is concerned about his 18-pound weight gain, no drive or ambition to do anything since he started medication for blood pressure. So he decided to quit that. The other concern is his weight gain and he feels that he must have some arthritis because his upper extremities, his hands and fingers, his back, hips, and legs hurt. There is history of degenerative arthritis in the family, and today we spent a good 25 minutes discussing the difference between degenerative and rheumatoid arthritis and why he has making of some rheumatoid arthritis like symptoms, and it by [sic] him being fatigue, slow in the morning symmetrical environment.

(Ex. A, p. 1)

While at work, claimant tripped and fell. He was seen at the Mercy Main ED on March 20, 2013, for "lumbar and right hip strain with muscle spasm." (Ex. 1, p. 1)

He followed up with Cocentra Medical Centers on March 20, 2013, reporting increased back pain. (Ex. 2, p. 1) He was seen by Judith L. Nayeri, D.O., who prescribed conservative treatment with medication, rest, and icing. (Ex. 2, p. 1)

On examination, his gait was normal and the range of motion in his right hip was normal. There was pain on palpation in the area of the trochanter. (Ex. 2, p. 3) Overall, the examination was positive with increased range of motion although subjectively, claimant complained of pain everywhere. (Ex. 2, p. 4) Dr. Nayeri continued claimant's medication and restrictions while ordering physical therapy. (Ex. 2, p. 4)

Initially claimant's condition improved. (Ex. C, p. 11) During physical therapy, it was noted he had guarded walking with a limp on the right. His range of motion was within normal limits but he was tender to palpation. (Ex. 2, p. 8)

He reported that he was feeling "much better" and that he was anxious to return to work. (Ex. C, p. 11) At the physical therapy appointment, claimant reported he could lift and carry at least 100 pounds occasionally without pain. (Ex. C, p. 11)

By his fourth visit to therapy, claimant reported being back to regular duty, having no problems. (Ex. C, p. 14) He was released from care. Claimant worked full duty for approximately two months from March 19, 2013 until May 2013.

He then had a re-emergence of the pain and was seen by Dr. Nayeri on May 14, 2013. (Ex. C, p. 16)

> He returns today with Ongoing [sic] and worsening pain in the right hip and says he has back pain but with further discussion it appears the back pain is actually from the hip. The pain is described as chronic, moderate and shooting. Pain Intensity Level: 7/10. The pain radiated to the right hip to low back. Associated symptoms: none. Denies paresthesias, sensory loss, numbness and weakness. Pain returned about 2 weeks ago, denies new injury, gradually getting worse, Xrays were neg except for OA and benign bone islands.

(Ex. C, p. 16)

On June 3, 2013, he began treatment with Daniel Miller for renewed right hip pain radiating into the low back. He had no observable gait abnormalities but he did have tenderness over the right paralumbar muscles and pain with palpation over the greater trochanter on the right. (Ex. 3, p. 1) An MRI was conducted on June 10, 2013, which showed multilevel spondylosis, greatest at L1-L2 and L2-L3 in the low back and mild right gluteus minimus and medius tendinosis in the right hip. (Ex. B, p. 5-6)

Dr. Miller referred claimant to Cassim Igram, M.D., who claimant saw on July 15, 2013. Dr. Igram assessed claimant with a back strain, complicated by obesity. There was no need for surgical intervention. (Ex. D, p. 20)

Claimant returned to Dr. Miller on July 22, 2013, with reports of constant pain. (Ex. 3, p. 5) Dr. Miller wrote "explained to pt that his pain is due to his spondylosis and not disc pathology" and ordered claimant a trial of physical therapy. (Ex. 3, p. 5) Dr. Miller found "no good explanation for pts persistent severe hip pain" but decided to make an ortho referral to "see if anything is being overlooked." (Ex. 3, p. 7)

On August 2, 2013, claimant was laid off of work.

On September 9, 2013, claimant was seen by Patrick M. Sullivan, M.D., an orthopaedic specialist. Dr. Sullivan noted that claimant walked with a moderate limp on the right. (Ex. E, p. 22) He concluded that claimant had some back related issue.

> PLAN: Whether or not there is a surgical solution to this, I do not know, but this is definitely of back origin. His hips are normal.
>
> I have suggested that he either get a second opinion from a spine doctor or that they consider further management with a pain management physician.

(Ex. E, p. 23)

On September 26, 2013, claimant saw Dr. Miller with the same complaints. (Ex. 3, p. 8) On examination, Dr. Miller did not find signs of antalgic gait, but there was tenderness in the right paralumbar muscle, pain with palpation over the greater trochanter and ¾ range of motion as opposed to the opposite hip. (Ex. 3, p. 8) Claimant was given pain medication and ordered to follow up with Dr. Pollack.

On November 14, 2013, claimant returned to Dr. Miller reporting that there was no change in his condition. His medical appointments with Dr. Pollack were complete as was his course of physical therapy. The physical examination netted the same results: stable gait, tenderness and pain with palpation on the right hip, and reduced range of motion. (Ex. 3, p. 11)

An FCE was conducted on December 2, 2013. The FCE was deemed to be valid and placed claimant in the medium to light heavy duty demand. (Ex. 3, p. 12)

> The client, Danny Davis, gave a maximum voluntary effort during this functional capacity evaluation. The pain questionnaires are negative for symptom magnification. Cogwheeling was noted during the manual strength testing but not the lifting evaluation. There were no extreme overt pain behaviors during this evaluation. The client's gait deficit was consistent throughout this test. Gait while walking forward is antalgic, with decreased weight bearing on the right side. The antalgic gait pattern that is present when the client walks forward is also present when walking backward and during heel and toe walking.

(Ex. 5, p. 1)

Claimant had diminished abilities in completing material handling activities as well as sitting, standing, walking, stair/ladder climbing, kneeling, squatting and forward bending. (Ex. 5, p. 2) The therapist/examiner concluded that claimant should not squat but he could perform the following duties:

2. The client is able to safely perform the following activities on the job:
   - Waist to floor lifting – 55 lbs., occasionally
   - Waist to crown lifting – 35 lbs., occasionally
   - Carrying – 35 lbs., occasionally
   - Sitting/standing/walking – Frequently with positional changes as required
   - Kneeling – Occasionally, with use of mechanical support for transitional movements
   - Bending - Occasionally

(Ex. 5, p. 2)

On December 5, 2013, claimant saw Dr. Miller after the FCE complaining of increased pain. Dr. Miller determined claimant was at maximum medical improvement (MMI) and discharged him from care. (Ex. 3, p. 12) Dr. Miller then assessed claimant with a 2 percent impairment rating. (Ex. G, p. 29) Dr. Miller wrote a revised letter after learning of the pre 2013 symptoms:

> I have reviewed the records you sent me. I particularly paid attention to Dr. Mitchell's note dated December 11, 2012. This is 3 months prior to when Mr. Davis first presented to me.
>
> At that visit, Mr. Davis mentioned concern about arthritis as he had pain in his hands, fingers, back, hips and legs. There is a family history of degenerative arthritis. Dr. Mitchell was concerned about possible rheumatoid arthritis and was going to order lab work to further evaluate. I do not see any report on the report of that work-up. In fact, the next note I see from Dr. Mitchell is dated June 10, 2013.
>
> In reviewing my records, a note from Dr. Sullivan who evaluated Mr. Davis for hip pained [sic], opined that the pain Mr. Davis is experiencing is from his back and not the hip. A lumbar MRI revealed that Mr. Davis has advanced degenerative changes.
>
> At the time that I placed Mr. Davis at MMI and discharged him, I believed that the work injury exacerbated his degenerative back disease. I ordered a FCE which showed that Mr. Davis did have restrictions due to his condition.

> In reviewing the records you provided me, it appears that Mr. Davis' back and hip complaints started prior to the alleged work injury of March 19, 2013. He no doubt has arthritis and degeneration in his back which was not caused by and was present prior to the alleged work injury.
>
> In light of this new information, I can not [sic] say with medical certainty that Mr. Davis' alleged work injury caused or was a material factor in causing or materially aggravating Mr. Davis' low back and hip condition.
>
> I also can not [sic] with medical certainty that the limitations found in the FCE are causally related to his alleged work incident.

(Ex. G, p. 30) Dr. Miller further opined on May 4, 2015, that as spondylosis is often progressive, it was of no surprise that claimant's FCE in 2015 showed more significant restrictions than the one in 2013. (Ex. G, p. 33)

> There is a discrepancy between the two FCEs. As spondylosis often is progressive, it is not surprising that the FCE from January 2015 shows worsening movement and strength, etc. from the 2013 FCE, and that category of work that Mr. Davis was able to do was more to a light physical demand. Again, I believe that this is related to his chronic spondylosis and not related to the alleged work injury March 10, 2013.

(Ex. G, p. 33)

He was seen on April 28, 2014, for an IME with Anandeep Kumar, M.D. (Ex. 6, p. 4) Claimant reported that he had difficulty with certain tasks:

> Currently he reports that due to the above pain symptoms, he is somewhat limited with lifting and carrying more than 30 pounds, sitting an hour each time with breaks. No significant problem otherwise with carrying, standing, and moving about. No significant problems reported otherwise with moving about. Walking and sitting in an 8-hour work day is difficult due to his back pain symptoms. Similar limitations with stooping, climbing, kneeling, and crawling. No problems reported with handling objects, hearing, speaking, traveling, and work environment.

(Ex. 6, p. 3) His physical examination was fairly unremarkable:

> Mild paraspinal tenderness on bilateral aspects of the upper neck back and lower back with slef [sic] induced myofascial restrictions. Cervical, thoracic, and lumbar spine palpation is otherwise within normal limits. Range of motion of her cervical and lumbar spine have well preserved forward flexion, extension, side bending, and lateral rotation. Mild palpatory tenderness noted in the posterior sacroiliac and PSIS area

> bilaterally. SLR is within normal limits. DTRs 2+ and symmetrical. Extremities are otherwise neurovascularly intact.

(Ex. 6, p. 3)

Dr. Kumar concluded that claimant needed better care but that claimant was more likely in the sedentary to light duty category of work. (Ex. 6, p. 4)

> [T]hat his diagnosis has been mainly low back pain related and hip pain related. He has been somewhat undertreated, underdiagnosed, and would need to be readdressed by primary care physician versus occupational and recommended ongoing followup with Dr. Maria Mitchell, his primary care physician, for addressing pain management and possible evaluation by Pain Management for adequate management of his pain symptoms and to enable him to facilitate him to become more functional as he is really young and otherwise healthy. He would benefit from a structured Outpatient Rehabilitation Therapy Program focusing on stretching, strengthening, range of motion, flexibility, core strengthening exercises, lumbar stabilization program with work occupational rehabilitation to maximize his functional abilities and capacities and Iowa Vocational Rehabilitation Services for work occupational rehabilitation rather than pursuit of disability as he is fairly young and otherwise healthy. If his symptoms are better controlled and musculoskeletal reconditioning therapist done, I think that based on his functional abilities, he should be able to pursue a sedentary to light duty-type of occupation based on the Department of Labor guidelines once his pain symptoms are better controlled and musculoskeletal reconditioning therapist have been completed.

(Ex. 6, p. 4)

On June 15, 2014, claimant was seen by Thomas A. Carlstrom, M.D., for an IME. During the examination, claimant appeared to be uncomfortable both sitting and standing. He walked carefully and had restricted range of motion on all planes. (Ex. 7, p. 1) Dr. Carlstrom agreed with Dr. Sullivan and Dr. Igram that claimant's radiographic reports were unremarkable. Dr. Carlstrom diagnosed claimant with chronic myofascial low back and hip pain and recommended a 15 percent impairment rating. (Ex. 7, p.2) He did not agree with the FCE reports but instead suggested more stringent restrictions.

> I would recommend a maximal lifting restriction of 25 pounds, and repetitive restriction of 15 pounds. He should also not work below his waist or above the shoulders. Again, I consider these restrictions to be permanent.

(Ex. 7, p. 2)

Claimant was seen by Ronnie Hawkins, M.D., for back pain and neck pain along with hypertension and hyperlipidemia. (Ex. H, p. 35) He was prescribed Hydrocodone for pain and referred to Iowa Ortho for evaluation and treatment of neck pain. There was no note of any reduced range of motion in the back. (Ex. H, p. 36) In a subsequent visit to Dr. Hawkins on December 3, 2014, it was noted that claimant's chronic pain existed for six years. (Ex. H, p. 39)

Another FCE was performed on January 22, 2015. This FCE placed claimant in the light duty and the restrictions were similar to those imposed by Dr. Carlstrom back in June of 2014. (Ex. 8, p. 1)

> Based on results obtained the client is able to perform light, physical demand category work with occasional short carrying at waist height at 20 lbs. The client lifted 20 lbs. from floor to waist. The client lifted 15 lbs. to shoulder height and overhead. The client right/left carried 10 lbs. Push and pull strengths were measured at 107 lbs. and 109 lbs. respectively.
>
> Non-material handling testing indicates the client demonstrates an occasional tolerance for sitting, standing, walking, squatting, and elevated work. Forward bending, kneeling, stair climbing, and ladder climbing were performed on a rare basis. He is unable to crouch or crawl.
>
> Musculoskeletal exam results indicate bilateral upper and lower extremity active range of motion (AROM) is within normal limits except for his bilateral hip AROM and left knee flexion AROM. AROM for the trunk was decreased throughout. The client demonstrated decreased strength with his bilateral hips and right knee during manual muscle testing. An inflammatory response to exercise was noted for the low back and right hip.

(Ex. 8, p. 10)

Dr. Carlstrom was deposed on September 17, 2014. (Ex. M, p. 138) He conceded that there were no objective signs of claimant's radicular pain. (Dep, p. 18) He was unaware of claimant's prior low back complaints but stated that those would not have been important. What was meaningful to Dr. Carlstrom was that claimant returned to work full duty without restrictions prior to the fall and after could not work at the same level. (Dep. p. 12-13)

Claimant was seen by Lynn M. Nelson, M.D., at the request of the defendants. Dr. Nelson concluded as follows:

> My opinions, with a reasonable degree of medical certainty, are as follows:
>
> 1. Mr. Davis' lumbar MRI scan from IOC of 6/12/13 demonstrated multilevel spondylosis, greatest at L1-2 and L2-3. These degenerative changes obviously predated the 3/19/13 injury. The

patient may have sustained a temporary aggravation of his underlying degenerative changes in the 3/19/13 incident. If so, the aggravation resolved by 4/4/13. Given that several days after his reported work injury of 3/19/13 Mr. Davis indeed returned to his regular job for several weeks, I cannot relate Mr. Davis' persistent pain complaints to the 3/19/13 incident.

2. Utilizing The AMA Guidelines to the Evaluation of Permanent Partial Impairment, Fifth Edition, [sic] a permanent partial impairment rating of zero percent is indicated as complaints and findings are most consistent with a DRE Lumbar Category I impairment (Table 15-3, page 384).

3. Mr. Davis' FCE was valid. Therefore, I believe the following are appropriate permanent work restrictions:

   a. Maximum lift of 55 pounds on an occasional basis.

   b. Frequent positional changes in regards to sitting, standing and walking.

   c. Kneeling, bending and twisting be limited to an occasional basis.

(Ex. E, p. 27)

In a February 3, 2015 vocational assessment performed by Shannon Ford and René Haigh. Claimant reported low back and right hip pain that burned and throbbed. (Ex. J, p. 58) The pain affected every aspect of his daily life from sleeping to household chores. (Ex. J, p. 58) He also complained of neck pain and headaches. At this time, he was still a member of the union. (Ex. J, p. 59) Based on the restrictions of Dr. Miller and Dr. Carlstrom, claimant's employability fell at the light to select medium strength physical demand category. (Ex. J, p. 66) Recommended jobs included janitor, assembler, gate guard, clerk, and light delivery work. (Ex. J, p. 67)

Claimant left the union. He testified that he did it because he was not at 100 percent.

He returned to Dr. Hawkins on May 19, 2015, for follow up of neck and back pain. As with his previous visits to Dr. Hawkins, the neck pain was the primary focus of the visit. There were no notes regarding pain on examination on the low back pain. (Ex. H, p. 41) During a July 15, 2015, visit, Dr. Hawkins documented the following examination finding:

> MUSCULOSKELETAL: Gait and station are within normal limits. The digits and nails are normal without clubbing or cyanosis. Joints, bones, and muscles are normal on inspection and palpation. His range of motion

> is within normal limits. Patient's stability is normal. Muscle strength and tone is normal. The spine has normal alignment and range of motion.

(Ex. H, p. 44)

He was seen by Mercy Neurosurgery for evaluation of neck pain and headaches on August 26, 2015. He reported at that time that he had severe low back and neck pain but that his "biggest concern is posterior neck pain and headaches...the pain in his neck and head is far worse than any extremity symptoms." (Ex. I, p. 45) In the pain diagram filled out by the claimant, the neck and arms were shaded but not the low back and hip. (Ex. I, p. 49)

René Haigh then wrote claimant on February 19, 2016, to recommend various jobs that the claimant could apply for. (Ex. J, p. 69) These jobs included cleaners and dishwashers, medical screeners, forklift operator, bellman, delivery specialists. (Ex. J, p. 70-81)

Claimant also underwent a mental status and IQ Consultation report with Cal J. Seda, Ph.D. on February 24, 2016. (Ex. 9, p. 1) Based on a series of tests, it was determined claimant was best suited for construction and tangible tasks and would benefit from routine and repetition. (Ex. 9, p. 2)

Finally, claimant was seen by Phil Davis, M.S., a vocational specialist. (Ex. 10) Mr. Davis concluded that based on the restrictions set forth by all the medical providers and Dr. Carlstrom as well as the FCE, claimant could not return to his past employment activities.

The FCE restrictions adopted by Dr. Carlstrom placed claimant in the light to sedentary work category. (Ex. 10, p. 5)

> Light – 20 pounds maximum lifting with frequent lift/carry up to 10 pounds. A job is light if less lifting is involved but significant walking/standing is done or if done mostly sitting, but requires push/pull on arm or leg controls.

(Ex. 10, p. 5) Mr. Davis concluded that 90-100 percent of the labor market was outside of claimant's current medical condition and mental capabilities. He took issue with the jobs that René Haigh had selected, asserting many were outside of claimant's lifting restrictions. Mr. Davis based part of his decision on the social security determination that claimant was disabled. Claimant's initial Social Security Disability (SSD) application was denied but upon rehearing, claimant's entire health picture was considered:

> 3. The claimant has the following severe impairments: degenerative disc disease including facet joint osteoarthropathy – particularly on the left at C6-C7 and C7-T1, significant foraminal encroachment, facet spur

> formation, synovial cyst, carpal tunnel syndrome, and obesity (20 CFR 404.1520(c)).

(Ex. 13, p. 9)

To the extent that claimant is asserting headaches and neck pain associated with the work injury, no expert witness testimony supports these claims. Dr. Kuhlein and Dr. Miller specifically reject the causation as it pertains to the headaches and neck pain.

On April 6, 2016, claimant's employability and/or access to the labor market was again assessed taking into account the vocational report, social security disability decision and Dr. Seda's report. (Ex. J, p 83) René Haigh affirmed the previous opinion.

> When analyzing Mr. Davis's work history, skills, and functional abilities, and through providing job leads for Mr. Davis as referenced above, this consultant continues to opine the labor market does yield employment alternatives for Mr. Davis. It is this consultant's opinion that Mr. Davis does have the work history, educational background, and residual functional capacity to obtain and maintain employment in the labor market in occupations classified in the LIGHT to LIGHT HEAVY physical demand levels as reflected in jobs identified for Mr. Davis in the initial vocational assessment completed 2/3/2015, 10 job leads developed for Mr. Davis and sent to him via his attorney 2/27/2015, and 10 job leads developed and submitted to Mr. Davis 2/19/2016.

(Ex. J, p. 88)

Claimant has made no applications for employment since the end of his unemployment eligibility. Currently claimant claims he is not able to stand or sit for any period of time due to his hip and back pain. He no longer walks, boats, hunts, bikes, or motorcycles. His day consists of eating, visiting with his brother, doing housework and/or yardwork, along with running a few errands.

CONCLUSIONS OF LAW

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

The claimant has the burden of proving by a preponderance of the evidence that the alleged injury actually occurred and that it both arose out of and in the course of the employment. Quaker Oats Co. v. Ciha, 552 N.W.2d 143 (Iowa 1996); Miedema v. Dial Corp., 551 N.W.2d 309 (Iowa 1996). The words "arising out of" referred to the cause or source of the injury. The words "in the course of" refer to the time, place, and circumstances of the injury. 2800 Corp. v. Fernandez, 528 N.W.2d 124 (Iowa 1995). An injury arises out of the employment when a causal relationship exists between the injury and the employment. Miedema, 551 N.W.2d 309. The injury must be a rational consequence of a hazard connected with the employment and not merely incidental to

the employment. Koehler Electric v. Wills, 608 N.W.2d 1 (Iowa 2000); Miedema, 551 N.W.2d 309. An injury occurs "in the course of" employment when it happens within a period of employment at a place where the employee reasonably may be when performing employment duties and while the employee is fulfilling those duties or doing an activity incidental to them. Ciha, 552 N.W.2d 143.

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

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

A personal injury contemplated by the workers' compensation law means an injury, the impairment of health or a disease resulting from an injury which comes about, not through the natural building up and tearing down of the human body, but because of trauma. The injury must be something that acts extraneously to the natural processes of nature and thereby impairs the health, interrupts or otherwise destroys or damages a part or all of the body. Although many injuries have a traumatic onset, there is no requirement for a special incident or an unusual occurrence. Injuries which result from cumulative trauma are compensable. Increased disability from a prior injury, even if brought about by further work, does not constitute a new injury, however. St. Luke's Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); Ellingson v. Fleetguard, Inc., 599 N.W.2d 440 (Iowa 1999); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995); McKeever Custom Cabinets v. Smith, 379 N.W.2d 368 (Iowa 1985). An occupational disease covered by chapter 85A is specifically excluded from the definition of personal injury. Iowa Code section 85.61(4) (b); Iowa Code section 85A.8; Iowa Code section 85A.14.

Since claimant has an impairment to the body as a whole, an industrial disability has been sustained. Industrial disability was defined in Diederich v. Tri-City R. Co., 219 Iowa 587, 258 N.W. 899 (1935) as follows: "It is therefore plain that the legislature intended the term 'disability' to mean 'industrial disability' or loss of earning capacity and not a mere 'functional disability' to be computed in the terms of percentages of the total physical and mental ability of a normal man."

Functional impairment is an element to be considered in determining industrial disability which is the reduction of earning capacity, but consideration must also be given to the injured employee's age, education, qualifications, experience, motivation, loss of earnings, severity and situs of the injury, work restrictions, inability to engage in employment for which the employee is fitted and the employer's offer of work or failure to so offer. McSpadden v. Big Ben Coal Co., 288 N.W.2d 181 (Iowa 1980); Olson v. Goodyear Service Stores, 255 Iowa 1112, 125 N.W.2d 251 (1963); Barton v. Nevada Poultry Co., 253 Iowa 285, 110 N.W.2d 660 (1961).

Compensation for permanent partial disability shall begin at the termination of the healing period. Compensation shall be paid in relation to 500 weeks as the disability bears to the body as a whole. Section 85.34.

The defendants argue that claimant was returned to work without restrictions on March 19, 2013. He worked without restrictions for two months. He then returned for medical care. In the late winter of 2014, claimant began to complain of neck pain. At some point, his neck pain and headaches overshadowed his back pain. He reported to his doctor that the neck pain was the primary concern "far worse than any extremity symptoms." (Ex. I, p. 45)

The 2014 change in condition is important because there are two competing FCEs. The first in 2013 placed the following restrictions on claimant.

2. The client is able to safely perform the following activities on the job:

    - Waist to floor lifting – 55 lbs., occasionally
    - Waist to crown lifting – 35 lbs., occasionally
    - Carrying – 35 lbs., occasionally
    - Sitting/standing/walking – Frequently with positional changes as required
    - Kneeling – Occasionally, with use of mechanical support for transitional movements
    - Bending - Occasionally

(Ex. 5, p. 2)

> The 2015 FCE placed claimant in the light to sedentary work category.
>
> Based on results obtained the client is able to perform light, physical demand category work with occasional short carrying at waist height at 20 lbs. The client lifted 20 lbs. from floor to waist. The client lifted 15 lbs. to shoulder height and overhead. The client right/left carried 10 lbs. Push and pull strengths were measured at 107 lbs. and 109 lbs. respectively.
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> Non-material handling testing indicates the client demonstrates an occasional tolerance for sitting, standing, walking, squatting, and elevated work. Forward bending, kneeling, stair climbing, and ladder climbing were performed on a rare basis. He is unable to crouch or crawl.
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> Musculoskeletal exam results indicate bilateral upper and lower extremity active range of motion (AROM) is within normal limits except for his bilateral hip AROM and left knee flexion AROM. AROM for the trunk was decreased throughout. The client demonstrated decreased strength with his bilateral hips and right knee during manual muscle testing. An inflammatory response to exercise was noted for the low back and right hip.

(Ex. 8, p. 10)

Dr. Miller who treated claimant during 2013 explained that the difference in the FCEs could be attributed to the spondylosis which is progressive. Dr. Miller's assessment is more consistent with the claimant's entire medical picture. Just a few months prior to his work-related injury, claimant was reporting serious back pain due to his arthritis. Further, it was after claimant stopped working that his condition exacerbated and worsened. This fact pattern matches more closely with Dr. Miller's opinions than it does with Dr. Carlstrom.

Dr. Carlstrom was unaware of claimant's prior back problems (although he did state in his deposition that knowledge of prior back problems would not alter his opinion) and he was unaware that the claimant returned to work for two months without restrictions. While claimant was awarded SSD benefits, it was for claimant's entire constellation of health issues including his painful neck and headaches.

However, Dr. Carlstrom is correct that claimant was working full duty without restrictions prior to the work injury and that following the injury, he had significant pain in the back and right hip. The orthopaedist, Dr. Sullivan, believed that there was nothing wrong with claimant's hips and that all the pain stemmed from the back.

It is determined that based on all of the evidence, claimant sustained a permanent aggravation of his spondylosis. The 2013 FCE is determined to be the most

accurate representation of claimant's work-related injuries. His worsening condition following his lay-off and unemployment is more likely attributable to his spondylosis.

Claimant has a 9th grade education and his intellectual capacity is not well-suited for office jobs. His prior work history is primarily construction but his 2013 FCE physical restrictions would allow him to undertake some non-skilled or low skilled positions such as driving, delivery services, gate guard, factory work such as material handling of lower weights and forklift driving.

As such, it is based on the 2013 FCE along with claimant's lack of education, work history, motivation to return to work, and experience that it is found claimant has sustained a 50 percent industrial disability.

Because it is determined that claimant could have returned to some employment following his injury, the odd-lot claim is not appropriate.

ORDER

THEREFORE, it is ordered:

That defendants are to pay unto claimant two hundred fifty (250) weeks of permanent partial disability benefits at the rate of five hundred ninety-six and 68/100 dollars ($596.68) per week from December 6, 2013.

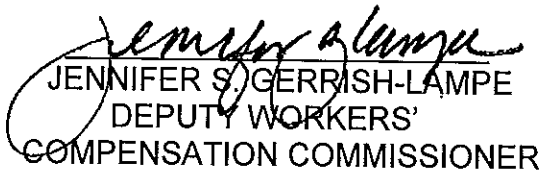
That defendants shall pay accrued weekly benefits in a lump sum.

That defendants shall pay interest on unpaid weekly benefits awarded herein as set forth in Iowa Code section 85.30.

That defendants are to be given credit for benefits previously paid.

That defendants shall pay the costs of this matter pursuant to rule 876 IAC 4.33.

Signed and filed this 1st day of August, 2016.



JENNIFER S. GERRISH-LAMPE
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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