BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

MATTHEW A. LAWSON, Claimant, vs. BENTON SAND & GRAVEL, INC., Employer, and UNITED FIRE & CASUALTY COMPANY, Insurance Carrier, Defendants.	:	File No. 5066379 A R B I T R A T I O N D E C I S I O N Head Note Nos.: 1803.1, 1803, 2502

STATEMENT OF THE CASE

Claimant, Matthew Lawson, filed a petition in arbitration seeking workers' compensation benefits against Benton Sand & Gravel, Inc., employer, and United Fire & Casualty Company, insurer, both as defendants for an accepted work injury date of November 21, 2014.

The case was heard on November 12, 2019, in Des Moines, Iowa. The case was considered fully submitted on December 3, 2019, upon the simultaneous filing of briefs.

The record consists of Joint Exhibits 1-4; Claimant's Exhibits 1-13; Defendants' Exhibits A-G, and the live testimony of claimant and Jim Snodgrass.

ISSUES

1. Whether claimant has sustained a scheduled member injury or a whole body injury;

2. The nature and extent of the disability;

3. Rate;

4. Whether claimant is entitled to a reimbursement of a second independent medical examination (IME);

5. Costs.

STIPULATIONS

The parties stipulate that Mr. Lawson sustained an injury that arose out of and in the course of his employment on November 21, 2014. The parties also stipulate that Mr. Lawson's injury is a cause of temporary disability during the period of recovery and that Mr. Lawson's injury is a cause of permanent disability. Should the claimant be awarded permanent benefits, the commencement date for permanent partial disability benefits is January 19, 2015.

Defendants waive all affirmative defenses. Other than the claimant's request for the reimbursement of a second IME, no other medical benefits are in dispute.

It is stipulated claimant's gross earnings at the time of his injury were $992.00 per week and that he was married.

Prior to the hearing, claimant was paid 22.571 weeks of compensation at the rate of $646.70. Defendants are entitled to a credit of that amount against any permanent disability award.

In addition, the parties agree that defendants have a right to an 85.34(4) credit due to overpayment of temporary benefits.

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

Mr. Lawson was a forty-eight (48) year old person at the time of the hearing. His educational background includes a high school diploma, a commercial driver's license and annual courses on trench safety, CPR, and first aid classes.

At all times material hereto, he was married with two biological children and four step-children. In 2014, claimant claimed two on his tax return, but at least one other minor child lived with him more than 50 percent of the time. He was responsible for the child's food and shelter. He did not pay child support for any of his children. His wife claimed the minor child on her tax return in 2014 due to the terms in the divorce decree.

Claimant's relevant past work experience is primarily in labor-intensive positions including general construction laborer and heavy duty equipment operator. (Claimant's Exhibit B-5) He began employment with Benton Sand & Gravel as a heavy equipment operator in April 2014.

Claimant's job duties with Benton require him to dig in and lay pipe. The pipe that Mr. Lawson works with weighs up to two hundred (200) pounds. Claimant primarily uses machinery to move the pipe; however, he also enlists co-workers to help him move the pipe without the use of machinery on occasion. Claimant's job requires him to crawl and bend, but 80 percent of his work days he spends seated. Since his injury, claimant has returned to his normal duties but has help when he needs it. He is earning more today than he did at the time of his injury.

On November 21, 2014, at approximately 9:00 a.m., claimant was working for Benton at Standard Distribution. The ground was frozen and the weather was cold. Claimant was outside trying to fit a cable under a pipe. He was braced on his left knee with his right leg behind him. A dump truck ran over claimant's leg, below the right knee and then again down the length of his leg to his right toes.

Claimant motioned for a co-worker, Ben Hutchinson, to come over. Mr. Hutchinson then called 9-1-1. Claimant was taken by ambulance to Allen Memorial Hospital's Emergency Department in Waterloo, Iowa. (JE 1-1)

Jeffrey Wilkins, D.O., examined claimant. Id. Claimant's chief complaint was pain in his right lower leg and foot. Id. Dr. Wilkins noted that claimant had wounds on both sides of his right knee. Id. X-rays showed acute, non-displaced fractures throughout the base of claimant's 2nd and 3rd metatarsals and a possible navicular fracture. (JE 1-2) A CT showed further injuries including fractures of the fibular head, fractures at the bases of his 1st, 2nd, and 3rd metatarsals, and a fracture of his tarsal navicular bone. (JE 1-3) Allen Memorial subsequently transferred claimant to the University of Iowa Hospitals and Clinics ("UIHC") in Iowa City, Iowa due to the navicular fracture. (JE 1-4)

On November 21, 2014, claimant underwent more imaging tests at UIHC under the care of Daniel Miller, M.D. (JE 2-1) Claimant also complained of ankle pain at UIHC. (JE 2-2) The scans showed that claimant had fractures of the medial cuneiform and the base of his 1st, 2nd, and 3rd metatarsals and a comminuted, impacted fracture of his proximal right fibula. (JE 2-2, 2-6) UIHC put a splint on claimant's right leg, instructed him to remain non-weight bearing on his right lower extremity, and prescribed Vicodin and ibuprofen for pain management. (JE 2-6; Tr. p. 44, 20-24) UIHC replaced the splint with a cast a few days later.

On November 26, 2014, claimant consulted with his family doctor, Kelly Schmidt, M.D., for his leg condition. (JE 3-1) Claimant stated that Vicodin had been controlling his pain and he denied worsening in swelling, loss of sensation and also denied any numbness or tingling. (JE 3-1) There is a notation that claimant had an active issue with lumbosacral back pain, but this was not the subject of treatment. (JE 3-1) Dr. Schmidt examined claimant, gave him standard wound care instructions, and refilled his Vicodin prescription. (JE 3-1)

On December 1, 2014, claimant visited UIHC for an examination. (JE 2-8) He complained about the weight of the cast, and the hospital put him in a fiberglass cast to reduce the weight. (JE 2-10) On December 4, 2014, the claimant's wife, an RN, called to report increased complaints of knee pain. (JE 2-11) UIHC returned the call on the same day, but the claimant's wife was unhappy the phone call was directed to the claimant and not to her. (JE 2-13) Mary Greve, PA-C, made contact with claimant's wife on December 12, 2014, regarding claimant's report of foot and knee pain. (JE 2-14) An appointment was made for follow up. (JE 2-14)

On December 16, 2014, claimant returned to UIHC for a follow-up appointment with Ms. Greve. (JE 2-15) During this visit, he complained of swelling in his right foot and ankle, numbness in his right knee, soreness and achiness in his right mid-foot, and clicking and popping in his right knee. (JE 2-15) In addition, claimant complained of left-sided hip and low back pain and soreness because he was putting all of his weight on his left side while on crutches. (JE 2-17) Claimant had full range of motion with the right knee, no effusion, scattered areas of numbness in the medial and lateral knee and some quad atrophy. (JE 2-17) His right foot exhibited modest swelling, resolving bruises, and tenderness around the fractures. (JE 2-17) Ms. Greve encouraged claimant to move around more often while remaining non-weight bearing on his right leg but noted that his progress appeared normal. (JE 2-17) She changed his pain medication from Vicodin to Percocet and encouraged him to take fewer pills per week. (JE 2-17) Ms. Greve also referred claimant to physical therapy for the lower extremity as well as the left-sided hip and low back pain. (JE 2-17) Claimant did not attend the physical therapy testifying that it was cancelled for some reason.

Phinit Phisitkul, M.D., at UIHC examined claimant on January 15, 2015. (JE 2-18) Claimant's primary complaints were severe pain at the bottom of his right foot as well as right knee numbness. (JE 2-18) During the examination, claimant reported tenderness on palpation at the fibular neck, normal motor exam, no nerve deficit of the peroneal nerve, and soft tissue swelling at the area of pain. (JE 2-18) Dr. Phisitkul felt that claimant's numbness would improve and that the knee injury would not need surgery. (JE 2-18) Dr. Phisitkul ordered CT scans, prescribed physical therapy and moved claimant to partial weight bearing in a boot. (JE 2-18) Dr. Phisitkul released claimant to return to work with the following restrictions: sedentary duty only; must wear a boot and use crutches; and no driving while wearing the boot. (JE 2-21)

Claimant's wife called on January 20, 2015, angry with the care that had been provided. (JE 2-22) She demanded a prescription for pain stronger than Percocet but admitted claimant had not been taking his Percocet. (JE 2-22) She reported that claimant's lower leg was purple and that due to his seated work, she worried he would develop a blood clot. (JE 2-22) She felt that he would be better off work; however, claimant's wife was advised that claimant should elevate his leg at work and move around to avoid such an occurrence. (JE 2-22) Claimant's wife was not satisfied with this and threatened to discontinue care with Dr. Phisitkul. (JE 2-22) On January 21, 2015, the case manager called to reiterate these complaints and forward photos to Dr. Phisitkul. (JE 2-23)

On January 22, 2015, claimant had a follow-up appointment with Dr. Phisitkul. (JE 2-24) Claimant reported right leg, right foot, and right ankle pain along with color changes. (JE 2-24-25) Claimant was not putting weight on his right foot due to the pain and kept his foot elevated on a chair at work. (JE 2-24) He maintained that he was pain free at home but not at work and questioned this. (JE 2-24) He had recently started physical therapy and attended a single session at the time of the visit. (JE 2-24) Claimant testified at hearing that he also began experiencing lower back pain when sitting upon his return to work, but this was not noted in the medical records. During the examination, his foot had normal movement and was normal in color and temperature. (JE 2-24) He had normal ankle and subtalar motion. (JE 2-24) He was tender to palpation on the plantar aspect of the mid-foot and forefoot and had diminished sensation around his forefoot, mainly in the plantar aspect. (JE 2-24) He was nontender around the ankle and toes and over the dorsal aspect of the foot. (JE 2-24) His knee exam was also normal. (JE 2-24) He was slightly tender around the proximal fibular head but otherwise exhibited normal knee range of motion, stability and strength. (JE 2-24) The scans showed normal healing and stable alignment. (JE 2-24)

Dr. Phisitkul was puzzled as to why claimant was hurting while at work but not at home, if he was properly elevated at both locations. (JE 2-24) Further, Dr. Phisitkul could not explain why claimant's pain was on the plantar aspect of the foot since the classic presentation was dorsal foot pain. (JE 2-24) Dr. Phisitkul maintained claimant's restriction of sedentary work only despite claimant's wife's demands to take claimant off work. (JE 2-24) Dr. Phisitkul also recommended that claimant start 25 percent weight bearing for two weeks and scheduled a follow-up appointment for the next month. (JE 2-24, 2-25)

On January 21, 2015, claimant began physical therapy at Waverly Health Center. (JE 4-1) Nathan Folkerts, DPT, met with claimant. (JE 4-1) Upon physical examination, Mr. Folkerts noticed that claimant had significant swelling throughout the upper portion of his right lower extremity and his right ankle. (JE 4-1) He also noted that claimant had a "significantly limited" range of motion in his right ankle and had an abnormal gait. (JE 4-1) There was also a note that claimant had a history of low back pain. (JE 4-1) By February 18, 2015, claimant had progressed to 50 percent weight bearing with a pain rating of 4-5 on a 10 scale. (JE 4-3) Mr. Folkerts again noted claimant's altered gait on February 4, 2015. (JE 4-2)

Claimant returned to his family doctor, Dr. Schmidt, on January 26, 2015. (JE 3-2) Claimant complained of a burning pain in the sole of his right foot. (JE 3-2) Dr. Schmidt diagnosed claimant with neuralgia in his foot. (JE 3-2) Claimant reported, erroneously, that "in Iowa City, they told him there is nothing they could do for the neuralgia." (JE 3-2) Dr. Schmidt prescribed Gabapentin for Mr. Lawson's pain. (JE 3-3) It is noted that the back pain and right leg fracture resolved January 26, 2015. (JE 3-2) During the examination, claimant showed trace edema in the right lower extremity and was non-weight bearing on the right due to burning neuralgia in the sole of the right foot. The remainder of the claimant's right lower extremity examination was normal including the lack of any complaints of diffuse knee pain, low back pain, or hamstring issues. (JE

3-3) Dr. Schmidt noted that the neuralgia was so serious he could barely touch the sole of claimant's right foot without a significant pain response. (JE 3-4) As it related to the fractures, Dr. Schmidt wrote, "I was rather impressed with how well his foot was healing. Given the nature of the injury, I think things could be much worse. He had absolutely no soft tissue destruction, which I thought was excellent. I was happy to see that there was [sic] no open wounds on this foot. He is definitely going to have some arthritis, but the foot is going to heal and he is going to be able to use it. I told him to be patient and give it time to heal." (JE 3-4)

There was no report to Dr. Schmidt that claimant's pain was different at work as opposed to at home.

On February 19, 2015, claimant returned to UIHC for an appointment with Dr. Phisitkul. (JE 2-28) At this appointment, claimant reported he was 50 percent weight bearing on his right side with increased pain globally, including pain in his right ankle. (JE 2-28) Dr. Phisitkul performed a physical examination on Mr. Lawson and noted that claimant had diffuse tenderness in his right knee in multiple locations, including his hamstring tendons, joint line, femoral condyles, and patella. (JE 2-30) Despite the diffuse pain, claimant had no swelling in the knee, was stable to varus and valgus stress test, anterior and posterior drawer tests were negative, and there was no limitation of knee motion. (JE 2-3) For the foot, Dr. Phisitkul noted mild swelling and mild tenderness to the mid-foot area, but there was no limitation of passive range of motion at the ankle and subtalar joints and the plantar aspect of the foot was less sensitive compared to previous visit. (JE 2-30) Dr. Phisitkul believed that claimant was progressing well and recommended that he increase weight bearing in the boot. (JE 2-30)

Because of the discord between Dr. Phisitkul and claimant and his wife, Dr. Phisitkul discontinued treatment. (JE 2-31) In the medical note, Dr. Phisitkul wrote, "They were upset that the diagnosis and treatment of nerve pain was not made by us although we found that his physical examination was challenging due to irregularities in the pain manifestations. The diffuse pain on the knee examination today was an example of inconsistencies we encountered." (JE 2-31)

Claimant then began treatment with Timothy Gibbons, M.D., at the Mason City Clinic in Mason City, Iowa on March 31, 2015. (JE 5-1) Dr. Gibbons noted claimant's fibular and metatarsal fractures. (JE 5-2; 5-3) He recommended that claimant begin bearing weight on his right side and start to wean himself off of the use of crutches. (JE 5-3) Dr. Gibbons noted that claimant was only taking one Gabapentin 300mg on occasion in the morning. "On balance, he feels that he is getting better," Dr. Gibbons recorded. (JE 5-1)

X-rays of his knee were normal with some disuse osteopenia. (JE 5-2) The 1st MTP joint showed chronic arthropathy. (JE 5-2) On examination, claimant had a little tenderness to deep palpation in the forefoot but no swelling or effusion in the knee, no abnormal warmth, full range of motion and no swelling in the ankle or foot. (JE 5-2)

Dr. Gibbons did not believe further physical therapy was necessary. (JE 5-3) Dr. Gibbons limited claimant to alternating four hours of standing and four hours of walking per day, or continuous sitting. (JE 5-4) He also limited him to only occasional lifting and carry of 11 to 20 pounds, occasional bending, climbing, stooping, and operating foot controls and no pushing or pulling or lifting and carrying 21 to 100 pounds. (JE 5-4)

Dr. Gibbons met with claimant again on May 5, 2015. (JE 5-6) Claimant complained of numbness and dizziness due to increased consumption of Gabapentin. (JE 5-6) Dr. Gibbons performed a physical exam and observed that claimant was able to bear weight on his right side but exhibited decreased range of motion. (JE 5-6)

In a phone call with Dr. Gibbons' office on May 26, 2015, claimant reported numbness in the big and 2nd toe. (JE 5-8) He mentioned this to the work comp nurse who instructed him to contact Dr. Gibbons' office. There was no pain. Dr. Gibbons replied that numbness was a side effect of the crush injury claimant suffered and that it may resolve or may be permanent. (JE 5-8)

Claimant visited Clark and Associates in Waterloo, Iowa on May 14, 2015 to get set up with orthotics at the recommendation of Dr. Gibbons. (JE 6-1) On this date, claimant complained of low back pain which the orthotic specialist attributed to claimant's feet position. (JE 6-1) On June 3, 2015, claimant visited Clark and Associates for the delivery of his work shoe orthotics. (JE 6-3) Claimant reported immediate relief in his feet, knees, and lower back with the orthotics. (JE 6-3)

On June 16, 2015, claimant met with Dr. Gibbons again. (JE 5-9) He reported that he was performing his regular duties at work despite the doctor's restrictions. (JE 5-9) Claimant was upset that Benton was not adhering to Dr. Gibbons' restrictions. Claimant's wife was present and the medical note described them both as angry. (JE 5-10) Claimant was given restrictions of lifting and carrying 21 to 100 pounds only occasionally and pushing and pulling frequently. (JE 5-11) All other activities could be done continuously without restrictions. (JE 5-11)

In the meantime, Clark and Associates had made the orthotics for claimant's work boots at this time; however, he was still waiting for orthotics for his non-work shoes. (JE 7-1) Claimant informed Dr. Gibbons that his back pain had improved with the orthotics. (JE 7-1)

Claimant saw Dr. Gibbons again on August 6, 2015. (JE 5-12) He complained of numbness and tingling on this date, as well as popping in his right ankle. (JE 5-12; JE 7-5) Claimant also reported that he was back to his regular duties at work, and while it hurt a little bit, for the most part he was doing well. (JE 5-12) He exhibited a bit of pitting edema that was slightly greater than the contralateral side. (JE 5-12) Claimant was accompanied only by the case manager during this visit. (JE 5-12) Dr. Gibbons noted that Mr. Lawson had some edema but concluded that he could bear full weight on his right side. (JE 5-12) Dr. Gibbons noted that he had decreased range of motion in his

right ankle (5 degrees of dorsiflexion to 33 degrees of plantar flexion). (JE 7-1) On this date, Dr. Gibbons released claimant to full work duty with no restrictions. (JE 7-5)

On September 22, 2015, claimant called requesting pain medication. (JE 5-14) The nurse explained that Dr. Gibbons did not refill pain medication so far out from surgery and recommended use of over-the-counter analgesics. (JE 5-13) Claimant was unhappy with this response. The nurse recorded claimant's response as follows, "So I'm going to have to live with this pain? That's what two other doctors told me." (JE 5-14) In a follow-up conversation with the case manager, it was explained that claimant wanted the Gabapentin refilled but Dr. Gibbons' office would not agree to this. (JE 5-15) Claimant was instructed to seek the renewal from his prescribing physicians. (JE 5-15)

Claimant saw Dr. Schmidt again on October 7, 2015 for a follow-up evaluation of his right foot pain. (JE 3-5) Dr. Schmidt advised claimant that he would likely need to take Gabapentin or similar medication for the rest of his life in order to control his nerve pain. (JE 3-5) He renewed claimant's Gabapentin prescription for one year and recommended consultation with a podiatrist. (JE 3-5, 3-7) Dr. Schmidt noted that claimant was ambulating with a limp on his right foot. (JE 3-7) Dr. Schmidt also noted that claimant's ankle and forefoot had "significantly reduced range of motion." (JE 3-7) While there was a notation of lumbar pain, the right lower extremity was noted to have routine healing. (JE 3-6) There were no complaints of right lower extremity pain.

Dr. Gibbons met with claimant on November 10, 2015. Claimant complained of right knee pain and altered sensation in his right big toe. (JE 5-17) Dr. Gibbons noted "this is the first time I note him complaining about his knee and I do not think it has anything to do with the issues at hand today." (JE 5-17) The physical examination revealed a slight loss of height in the foot arch on the involved side versus the non-evolved side. (JE 5-17) Claimant had plantar flexion at the ankle to 40 degrees and dorsiflexion just to neutral. (JE 5-17) Dr. Gibbons noted that claimant had complaints of altered sensation in the superficial peroneal distribution on the medial side of his great toe which Dr. Gibbons found to be atypical. (JE 5-18) Claimant's plantar sensation was completely intact. (JE 5-18) He had good two-point discrimination in the areas that claimant reported subjective issues. (JE 5-18) Claimant was deemed to be at maximum medical improvement (MMI) and Dr. Gibbons released claimant from his care with no restrictions. (JE 5-18) When claimant reported good relief with Gabapentin, Dr. Gibbons noted that he found that reasonable and that claimant should continue care for that through his family physician. (JE 5-18) The knee issue went unaddressed.

Dr. Gibbons gave claimant a 12 percent lower extremity impairment rating—7 percent for mild ankle motion restriction and 5 percent for superficial peroneal nerve dysesthesia. (JE 5-18) On November 22, 2015, Dr. Gibbons changed this to a 9 percent lower extremity impairment rating due to a misapplication of a table. (JE 5-19) He gave claimant a 15 percent foot permanent impairment rating. (JE 5-19)

On February 25, 2016, claimant consulted with Dr. Gibbons for the right knee pain which was identified as new. (JE 5-21) Examination revealed point tenderness at

the posterior medial corner of the knee but no instability. (JE 5-21) Dr. Gibbons suspected a little fascial tear of the anterior lateral compartment. (JE 5-21) X-rays were normal, but due to claimant's complaints an MRI was ordered. (JE 5-21) The MRI revealed small joint effusion with no other abnormalities. (JE 5-23) In a medical visit on March 24, 2016, Dr. Gibbons reviewed the MRI with claimant and noted in the record that if there was an injury to the proximal medial facet of the tibia it would have been exposed on the MRI. (JE 5-24) Mentions of back pain were not present during this visit or the previous one, but Dr. Gibbons noted that claimant presented with an initial antalgic gait that dissipated the more he walked. (JE 5-25) Dr. Gibbons informed claimant that there was nothing structurally wrong and that the symptoms would abate with time. (JE 5-25)

On August 30, 2016, claimant visited Clark and Associates for a new pair of orthotics. (JE 6-5) Claimant reported numbness and tingling in the arch area and big toe of his right foot. (JE 6-5) He also complained about lower back pain. (JE 6-5) Claimant visited Clark and Associates for new orthotics on July 14, 2017 and August 6, 2018. (JE 6-6; 6-7)

In September of 2016, claimant was involved in a motor vehicle accident when a driver rear-ended him on the way home from work. (Defendants' Ex. C-12) He did not injure his right leg, right hip, or lower back in the accident. (Tr. p. 57, 10-13) When he was seen by Dr. Schmidt on October 17, 2016, there was a notation about neuralgia and neuritis of the right plantar foot, but no issues related to claimant's low back or right lower extremity other than in the past medical history portion. (JE 3-9, 3-10) Dr. Schmidt diagnosed claimant with strain of the distal levator scapulae attachment to the right upper medial scapula. (JE 3-10) In the assessment and order section, Dr. Schmidt did not include treatment for lumbago or right lower extremity pain but the neuralgia and neuritis were. (JE 3-12)

About one to two weeks later, claimant began experiencing symptoms from the accident, including right arm pain, right shoulder pain, and numbness and tingling in his index and middle fingers. (Def. Ex. C-12; JE 9-3) Dr. Schmidt referred claimant for an MRI and to the pain clinic. (JE 3-15) He sought care at St. Luke's Hospital in Cedar Rapids, Iowa. (Def. Ex. C-12) MRI scans showed that he had a herniated disc at C6-7 to the right. (JE 9-4) On May 11, 2017, claimant underwent surgery. (JE 9-9) The only ongoing issue he has from the September 2016 accident is numbness in one of his fingers. (Def. Ex. C-13)

On October 11, 2016, claimant received a right knee corticosteroid injection from Dr. Gibbons for pain that claimant described as migratory moving from laterally to medially. (JE 5-27) The injection provided him with some pain relief. (JE 5-30) In a December 4, 2016, letter, Dr. Gibbons agreed that the November 21, 2014, injury was a substantial contributing factor to claimant's ongoing knee symptomology but that no further treatment was necessary. (JE 5-28)

On March 21, 2017, Mary L. Hlavin, M.D., saw claimant at the request of Ashar Afzal, M.D., for the right arm, right shoulder and index and middle finger complaints. (JE 9-3) The crush injury was mentioned in connection with the Gabapentin claimant took for the foot pain. (JE 9-3) During the examination, he was hypo-to areflexic except for a 1+ knee jerk. (JE 9-3) He exhibited normal gait. (JE 9-3) In the problem list from Dr. Hlavin's records, the crush injury issues were all marked as resolved but for the neuralgia and neuritis of the right plantar foot. (JE 9-7) During the pre-operative exam conducted prior to the anterior cervical spine fusion, there was no mention of any low back, right knee or hip pain. (JE 9-11) Claimant reported not taking Gabapentin often and only for the right lower extremity arising out of the right foot crush injury. (JE 9-11)

On October 3, 2017, claimant returned with complaints of knee pain. (JE 5-29) He described the pain as an ache that would intensify with "awkward positions in extreme valgus type of maneuvers" which prevented him from walking on it until "the thing seems to work its way out." (JE 5-29) The knee pain was identified as predominantly anterior with no antalgic gait. (JE 5-29) Dr. Gibbons administered claimant another right knee corticosteroid injection. (JE 5-29) The second injection did not provide him with any pain relief. (JE 5-30)

On November 24, 2017, claimant was seen by Heidi L. Prose, ARNP, at UnityPoint to establish care regarding his Gabapentin use. (JE 10-1) He complained of persistent pain, and numbness/burning/tingling sensation in the plantar and medial foot. (JE 10-1) He denied any other concerns. (JE 10-1) NP Prose refilled the prescription and instructed claimant to return in six months. (JE 10-1)

On February 27, 2018, Dr. Gibbons gave claimant a third right knee corticosteroid injection noting that there was no obvious swelling or effusion in claimant's knee and that while there was a fascial tear in the right leg, claimant's tenderness was more proximal medial. (JE 5-31) Dr. Gibbons told claimant that there was little treatment for the condition. (JE 5-31) Claimant did not return to Dr. Gibbons for further injections.

Claimant returned to NP Prose on December 15, 2018, for a refill of his Gabapentin prescription. (JE 10-3) Claimant also reported problems in the right knee "stressed due to walking differently" due to his crush injury. (JE 10-3)

In an October 3, 2019, letter, Dr. Gibbons agreed that the 2014 work injury was not a substantial factor in directly causing or materially aggravating a pre-existing condition resulting in claimant's hip and back complaints. (JE 5-33) Dr. Gibbons believed that claimant's injuries were limited to his right leg and did not involve any hip or low back pain. (JE 5-33) He agreed that claimant can continue to use Gabapentin to assist with right foot pain as well as an orthotic but that no other further care was necessary arising from the 2014 work injury. (JE 5-44)

From October 25, 2016 to January 17, 2017, claimant visited Cameron Hayward, DC, at the Vanderloo Chiropractic Clinic in Waterloo, Iowa. (JE 8:1) Dr. Hayward noted

that claimant suffered from degenerative disc disease in the L3-L4 region. (JE 8-1) There was no mention of any crush injury that impacted claimant's back complaint on the initial visit. (JE 8-1) After the initial visit, the chiropractic treatment turned to claimant's right arm, shoulder, and right neck pain. (JE 8-2) On January 17, 2017, the area of concern was noted to be the inside of the right leg, low back, and right foot due to a construction accident in addition to the right arm and hand complaints. (JE 8-18,19) Claimant was marked as suffering a 64 percent crippled disability. (JE 8-22) On January 24, 2017, the complaint for the inside right knee was described as three on a ten-scale, intermittent, and affecting activities throughout the day only slightly. (JE 8-24)

Claimant testified he suffers weakness in his right knee, burning pain in the bottom of his right foot, pain in the area of his foot where his toes meet his foot along with right hip and low back pain. He testified he feels a stabbing tightness in his lower back and a poking pain in his right hip. Claimant reports that he limps when he walks. He manages his pain by taking Gabapentin and Advil daily. In addition, he continues to use orthotics. He would like to continue to receive full body adjustments from Dr. Vanderloo's clinic in order to control his right hip and low back pain.

Farid Manshadi, M.D., from the Physical Medicine and Rehabilitation Associates of Northeast Iowa was retained to conduct an IME on Mr. Lawson. (Cl. Ex. 1-1) Dr. Manshadi is a doctor of medicine (M.D.) and a physiatrist. (Cl. Ex. 1-1) He examined claimant on January 6, 2016 and reviewed his medical records, including his UIHC records and his records from Allen Memorial Hospital, Mason City Clinic, and Waverly Health Center Outpatient Physical Therapy. (Cl. Ex. 1-1) He issued his report on February 1, 2016. Dr. Manshadi used the American Medical Association's Guides to the Evaluation of Permanent Impairment, 5th Edition, to assign his impairment ratings. (Cl. Ex. 1-4). Dr. Manshadi reported that claimant had reduced right ankle range of motion. (Cl. Ex. 1-4) Dr. Manshadi assigned claimant a right foot impairment rating of 24 percent. (Cl. Ex. 1-4) He assigned claimant a 5 percent impairment of the right lower extremity. (Cl. Ex. 1-4) Further, Dr. Manshadi's report stated that claimant has an abnormal gait that will cause arthritic changes in his right ankle. (Cl. Ex. 1-4)

Dr. Manshadi also opined that claimant's right foot pain would get worse and his right knee would become weaker. Finally, Dr. Manshadi opined that claimant might suffer from right hip and low back weakness in the future as a result of the November 21, 2014 accident. (Cl. Ex. 1-4) Dr. Manshadi recommended that claimant avoid prolonged standing, walking, and slippery and uneven surfaces. (Cl. Ex. 1-4) He stated that claimant should be allowed to sit, stand, and walk as necessary. (Cl. Ex. 1-4)

Claimant was sent for a second IME with Mark Taylor, M.D., on April 8, 2019. (Cl. Ex. 3-9) Dr. Taylor is a doctor of medicine (M.D.), holds a Master's Degree in Public Health (M.P.H.), is a Certified Independent Medical Examiner (CIME), and is a Fellow of the American College of Occupational and Environmental Medicine. (Cl. Ex. 3-18) Dr. Taylor examined claimant for approximately 1–1.5 hours. (Tr. p. 66, 16-19) He also reviewed the entirety of claimant's medical records, including his records with Allen Memorial Hospital, UIHC, Mason City Clinic, Waverly Health Center, Vanderloo

Chiropractic, CorVel Corporation, Physical Medicine and Rehabilitation Associates of Northeast Iowa, and St. Luke's. (Cl. Ex. 3-9) Dr. Taylor issued his report on May 2, 2019. (Cl. Ex. 3-9) He diagnosed claimant with a proximal fibular fracture and multiple mid-foot fractures, persistent right knee arthralgia, right hip arthralgia, localized right low back pain, and persistent right lower extremity paresthesias. (Cl. Ex. 3-16) Dr. Taylor concluded that prior to claimant's November 21, 2014 accident, he was not experiencing right lower extremity pain, right hip pain, or low back pain. (Cl. Ex. 3-16) Dr. Taylor thus concluded that claimant's right lower extremity injuries were directly and causally related to the November 21, 2014 incident. (Cl. Ex. 3-16) Dr. Taylor recommended a date of MMI of October 11, 2016—the same date that he received his first corticosteroid injection from Dr. Gibbons. (Cl. Ex. 3-18)

Dr. Taylor further concluded that it was more likely than not that claimant's lower extremity issues contributed to his right hip and lower back pain because after some time had passed after the injury, claimant noted the gradual onset of the hip and back pain. (Cl. Ex. 3-16) Dr. Taylor stated that claimant's reports of back and hip pain were consistent with a sequela type issue, or an issue that arises as the consequence of a previous injury. (Cl. Ex. 3-16) He recommended claimant see a physiatrist for his hip and back pain. (Cl. Ex. 3-18) He also recommended that claimant seek an orthopedic evaluation if his right foot, ankle, and/or knee symptoms worsened. (Cl. Ex. 3-18) He stated that claimant should alternate sitting, standing, and walking as needed, exercise caution on slippery and uneven surfaces, climb stairs on an occasional basis, and climb ladders rarely. (Cl. Ex. 3-19) He recommended that claimant continue to use orthotics. (Cl. Ex. 3-19) Dr. Taylor used the American Medical Association's Guides to the Evaluation of Permanent Impairment, 5th Edition, to assign impairment ratings to claimant. (Cl. Ex. 3-18) He assigned a 21 percent right lower extremity impairment to claimant and a 10 percent whole person impairment. (Cl. Ex. 3-18)

Defendants retained Jeffrey Westpheling, M.D. to conduct an IME on claimant. Dr. Westpheling met with claimant on September 12, 2019, and issued his report on October 8, 2019. (Def. Ex. A-4) Dr. Westpheling has an M.D., a Master of Public Health degree (M.P.H.), and is board certified in occupational and environmental medicine. (Def. Ex. A-8) Dr. Westpheling met with claimant for approximately ten minutes. (Tr. p. 66, 6-11) He also reviewed claimant's prior medical records from Allen Memorial Hospital, UIHC, Mason City Clinic, and Vanderloo Chiropractic. (Def. Ex. A-4) His report stated that claimant reported numbness and tingling around his right knee, a burning sensation in his right foot, and intermittent pain in his dorsal metatarsals and right ankle. (Def. Ex. A-6) In addition, he noted that claimant complained of right low back pain and right hip pain. (Def. Ex. A-6) Dr. Westpheling assessed claimant as having multiple closed right foot fractures, a closed fracture of the right fibula, and altered sensation in his foot, which he concluded was caused by the November 21, 2014 accident. (Def. Ex. A-7)

Dr. Westpheling opined that claimant's right low back and hip pain was not causally related to the November 21, 2014 accident due to a lack of a temporal relationship between the accident and the hip and back pain. (Def. Ex. A-7) Lastly, Dr.

Westpheling assessed Mr. Lawson with a 13 percent right foot impairment using the American Medical Association's Guides to the Evaluation of Permanent Impairment, 5th Edition. (Def. Ex. A-7)

On January 18, 2017, Lance Vanderloo, DC, Mr. Lawson's chiropractor, signed off on a letter from Mr. Carter Stevens, Mr. Lawson's former attorney. (Cl. Ex. 2-7) Dr. Vanderloo's letter states that Mr. Lawson was experiencing gait derangement from his November 21, 2014 injury. (Cl. Ex. 2-8) The letter also opined that due to his gait derangement, Mr. Lawson had right hip issues and would have back issues without continued adjustments. (Cl. Ex. 2-8)

ARGUMENT

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 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).

Claimant asserts his right lower extremity injury has extended to his low back and hip. There is sparse evidence in the record to support this. The first complaint of low back pain was on December 16, 2014, and claimant attributed it to all the weight being transferred to the left leg due to being non-weight bearing on the right. Complaints regarding the low back pain and altered gait appeared in January and February 2015 during claimant's physical therapy sessions. Claimant also made a complaint to Dr. Phisitkul regarding his low back in January which claimant said was due to being sedentary at work. In mid-June 2015, claimant obtained orthotics and reported

immediate relief in his low back. No new complaints of low back pain were made until August 2016 at a meeting with the orthotic staff. He went to see Dr. Vanderloo on October 25, 2016, but the complaints to the chiropractor were for right inner leg issues. The low back pain was not brought up again until January 17, 2017. At that time, Dr. Vanderloo, or his staff, marked claimant as suffering a 64 percent crippled disability and suffering from degenerative disc disease. However, a week later on January 24, 2017, the complaint for the inside right knee was described as three on a ten scale, intermittent, and affecting activities throughout the day only slightly. There was no mention of back and hip pain in that visit. Dr. Vanderloo's records are hard to read, but gait derangement did not appear in the treatment records. Dr. Vanderloo mentioned gait derangement in his later opinion letter written at the request of the claimant.

During claimant's pre-surgery physical in 2017, there was no notation of current back or hip pain whereas the neuralgia of the right foot was mentioned. While claimant returned to Dr. Gibbons for complaints of the "new" knee pain, claimant either walked normally or with a resolving antalgic gait.

While there were sporadic complaints of low back and hip pain and antalgic gait, there were also significant gaps in the record of such complaints including the times that claimant was seen by the chiropractor. These gaps in the medical records and the inconsistent complaints of pain and discomfort in the low back and hip regions were not addressed by either Dr. Manshadi or Dr. Taylor. In the January 2016, IME, Dr. Manshadi only mentioned that possibly claimant's right hip and low back involvement could not be ruled out entirely. Claimant asks the undersigned to rely on Dr. Vanderloo, as Dr. Vanderloo treated claimant on nine different occasions from October 25, 2016, until January 17, 2017. "Dr. Vanderloo was therefore able to see Mr. Lawson on various dates over a period of time and able to more fully evaluate Mr. Lawson's condition." (Cl Brief, p. 22) Yet it was only during the January 17, 2017, visit where back pain appeared on the pain drawing. During the first visit and the last visit, claimant's main issue was his lower right extremity.

In this case, the doctor who spent the longest time treating and evaluating claimant was Dr. Gibbons. Dr. Gibbons, who provided exhaustive care, including administering palliative injections for a subjective pain in claimant's right knee that Dr. Gibbons couldn't explain, opined that the low back and right hip complaints were not related to the 2014 crush injury. Dr. Gibbons did not re-examine claimant in 2018, but he reviewed the entirety of claimant's updated medical records and the IME of Dr. Taylor. Dr. Gibbons' treatment and opinions are relied upon, as they were more closely aligned with claimant's contemporaneous complaints of appearing and disappearing back pain and hip pain. It is found claimant did not prove by a preponderance of the evidence that claimant sustained a back and hip injury arising out of the work incident of November 21, 2014.

Where an injury is limited to scheduled member the loss is measured functionally, not industrially. Graves v. Eagle Iron Works, 331 N.W.2d 116 (Iowa 1983).

The courts have repeatedly stated that for those injuries limited to the schedules in Iowa Code section 85.34(2)(a-t), this agency must only consider the functional loss of the particular scheduled member involved and not the other factors which constitute an "industrial disability." Iowa Supreme Court decisions over the years have repeatedly cited favorably the following language in the 84-year-old case of Soukup v. Shores Co., 222 Iowa 272, 277; 268 N.W. 598, 601 (1936):

> The legislature has definitely fixed the amount of compensation that shall be paid for specific injuries . . . and that, regardless of the education or qualifications or nature of the particular individual, or of his inability . . . to engage in employment . . . the compensation payable . . . is limited to the amount therein fixed.

Our court has even specifically upheld the constitutionality of the scheduled member compensation scheme. Gilleland v. Armstrong Rubber Co., 524 N.W.2d 404 (Iowa 1994). Permanent partial disabilities are classified as either scheduled or unscheduled. A specific scheduled disability is evaluated by the functional method; the industrial method is used to evaluate an unscheduled disability. Graves, 331 N.W.2d 116; Simbro v. DeLong's Sportswear 332 N.W.2d 886, 887 (Iowa 1983); Martin v. Skelly Oil Co., 252 Iowa 128, 133, 106 N.W.2d 95, 98 (1960).

When the result of an injury is loss to a scheduled member, the compensation payable is limited to that set forth in the appropriate subdivision of Code section 85.34(2). Barton v. Nevada Poultry Co., 253 Iowa 285, 110 N.W.2d 660 (1961). "Loss of use" of a member is equivalent to "loss" of the member. Moses v. National Union C. M. Co., 194 Iowa 819, 184 N.W. 746 (1921). Pursuant to Iowa Code section 85.34(2)(u) the workers' compensation commissioner may equitably prorate compensation payable in those cases wherein the loss is something less than that provided for in the schedule. Blizek v. Eagle Signal Co., 164 N.W.2d 84 (Iowa 1969).

Evidence considered in assessing the loss of use of a particular scheduled member may entail more than a medical rating pursuant to standardized guides for evaluating permanent impairment. A claimant's testimony and demonstration of difficulties incurred in using the injured member and medical evidence regarding general loss of use may be considered in determining the actual loss of use compensable. Soukup, 222 Iowa 272, 268 N.W. 598. Consideration is not given to what effect the scheduled loss has on claimant's earning capacity. The scheduled loss system created by the legislature is presumed to include compensation for reduced capacity to labor and to earn. Schell v. Central Engineering Co., 232 Iowa 421, 4 N.W.2d 339 (1942).

The right of a worker to receive compensation for injuries sustained which arose out of and in the course of employment is statutory. The statute conferring this right can also fix the amount of compensation to be paid for different specific injuries, and the employee is not entitled to compensation except as provided by statute. Soukup, 222 Iowa 272, 268 N.W. 598.

Claimant testified that he has weakness in his right knee, significant pain in his foot, and pain in the region were his toes and foot meet. He is back to work at the same position, doing the same work as he did prior to the injury. He does seek out assistance from his co-workers when necessary. He has no official restrictions from Dr. Gibbons and has asked for no accommodations from defendant employer. Dr. Taylor assessed claimant with a 21 percent lower extremity rating and Dr. Manshadi assigned a 24 percent rating. Claimant argues that Dr. Taylor's opinions should be followed due to his lengthy report, his hour and a half examination of claimant, and his review of the medical records.

Dr. Gibbons assigned a 15 percent impairment rating to the right lower extremity. Claimant argues that Dr. Gibbons' opinion is less reliable because Dr. Gibbons did not fully appreciate claimant's ankle instability and loss of range of motion. However, since August 2015, the claimant's primary complaints have been his right knee and foot neuralgia. Even during his appointments with Dr. Vanderloo, whom claimant urges the undersigned to rely upon due to the extensive treatment in 2016 and 2017, there was no mention of right ankle pain. In the January 17, 2017, pain drawing, there were no markings at the ankle. Again, relying primarily on Dr. Gibbons, it is deemed that claimant has sustained a 15 percent functional loss.

The next issue is that of rate. Claimant asserts he is entitled to five exemptions. The dispute rests on whether claimant's minor child can be counted. In 2014, the minor child was claimed on the mother's tax return due to the terms of the divorce decree. Claimant claimed only two children as dependents and not three on his 2014 tax returns. (DE E) Claimant testified without rebuttal that the minor child spent more than 50 percent of her time in claimant's home, provided the child with food and clothing, and that claimant did not receive child support for the minor child.

There is no specific code statute to determine the meaning of dependents; however, the Iowa Worker's Compensation Commission has long held that the manner in which a claimant files his taxes creates a rebuttable presumption of his tax status. Echols v. Elite Staffing et al., No. 5047498, 2016 WL 5348927, at *17 (Iowa Workers' Comp. Comm'n Sept. 21, 2016). This Commission has also reasoned that "where support is provided it is inferred that the person is entitled to the dependency exemption unless contrary evidence rebuts this inference." Walker v. IBP, Inc., No. 1240597, 2002 WL 32125376, at *5 (Iowa Workers' Comp. Comm'n Jan. 4, 2002). Further, "[t]he Iowa Supreme Court has instructed that the definition and application of the law to determine who is a dependent should not be restricted severely." Cain v. Homes of Oakridge et al., No. 503836, 2013 WL 5300572, at *19 (Iowa Workers' Comp. Comm'n Sept. 18, 2013) (citing Murphy v. Franklin County, 145 N.W.2d 465, 468 (Iowa 1966).) "If a contribution is made to the ordinary comforts and conveniences which are reasonably appropriate to parties in their station in life, it should be considered as support and the recipient regarded as a dependent." Murphy, 145 N.W.2d at 468.

The Iowa Court of Appeals has relied on Iowa Code § 85.42 where "In the case of a deceased employee, a step-child is conclusively presumed to be a dependent

where the deceased employee 'actually provided the principal support for such child or children.'" Moffett v Collision Center, Inc., File No. 6-156/05-0699 (Iowa Ct. App, May 10, 2006) (quoting Iowa Code § 85.42). Based on the aforementioned facts, it is determined claimant provides the principal support for the minor child and is therefore entitled to five exemptions. The claimant's weekly benefit rate is $655.71.

The parties have stipulated to defendants' right to an 85.34(5) credit. Defendants overpaid temporary benefits. Claimant is entitled to 33 weeks of compensation (220 weeks x 15%).

Claimant wishes for the second IME with Dr. Taylor to be taxed as a cost. Iowa Code section 86.40 states:

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

In this case, the claimant's arguments did not prevail. Costs are not awarded to the claimant. Instead, the parties shall be responsible for their own costs. The cost of the transcript shall be borne equally by both parties.

ORDER

That defendants are to pay unto claimant thirty-three (33) weeks of permanent partial disability benefits at the rate of six hundred fifty-five and 71/100 dollars ($655.71) per week from January 19, 2015.

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 pursuant to the agreement and stipulations of the parties acknowledging that defendants have a right to an 85.34(4) credit due to overpayment of temporary benefits.

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

Defendants shall pay accrued weekly benefits in a lump sum together with interest at the rate of ten percent for all weekly benefits payable and not paid when due which accrued before July 1, 2017, and all interest on past due weekly compensation benefits accruing on or after July 1, 2017, shall be payable at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two percent. See Gamble v. AG Leader Technology File No. 5054686 (App. Apr. 24, 2018).

That each party shall pay their own costs and that the cost of the transcript shall be borne equally between the parties.

Signed and filed this 21st day of February, 2020.

JENNIFER S. GERRISH-LAMPE
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served, as follows:

Cory Abbas (via WCES)
Jenna Green (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.