BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

MICHAEL ARMSTRONG, Claimant, vs. COLLIS, LLC/SSW HOLDING CO. INC., Employer, and SAFETY NATIONAL CASUALTY CORPORATION, Insurance Carrier, Defendants.	File No. 19006218.01 ARBITRATION DECISION Head Notes: 1402.40; 1803; 1803.1; 2601.10

STATEMENT OF THE CASE

Claimant Michael Armstrong filed a petition in arbitration seeking worker's compensation benefits against Collis, LLC/SSW Holding Company, Inc., employer, and Safety National Casualty Corporation, insurance carrier, for an accepted work injury date of June 4, 2019. The case came before the undersigned for an arbitration hearing on October 20, 2020. This case was scheduled to be an in-person hearing occurring in Davenport. However, due to the outbreak of a pandemic in Iowa, the Iowa Workers' Compensation Commissioner ordered all hearings to occur via video means, using CourtCall. Accordingly, this case proceeded to a live video hearing via CourtCall with all parties and the court reporter appearing remotely. The hearing proceeded without significant difficulties.

The parties filed a hearing report prior to the commencement of the hearing. On the hearing report, the parties entered into numerous stipulations. Those stipulations were accepted and no factual or legal issues relative to the parties' stipulations will be made or discussed. The parties are now bound by their stipulations.

The evidentiary record includes Joint Exhibits 1 through 6 and Claimant's Exhibits 1 through 7. Defendants did not submit any additional exhibits.

Claimant testified on his own behalf. Deborah Bianchi testified on behalf of defendants. The evidentiary record closed at the conclusion of the evidentiary hearing

on October 20, 2020. The parties submitted post-hearing briefs on December 4, 2020, and the case was considered fully submitted on that date.

ISSUES

1. Whether claimant's accepted work injury is limited to the shoulder or extends to the body as a whole;
2. The extent of claimant's permanent partial disability;
3. Payment of certain medical bills.

FINDINGS OF FACT

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

Claimant's testimony was consistent as compared to the evidentiary record, and his demeanor at the time of hearing gave the undersigned no reason to doubt his veracity. Claimant is found credible.

At the time of hearing, claimant was a 54-year old person. (Hearing Transcript, p. 18) He is married and lives with his wife in Clinton, Iowa. (Tr., p. 9) Claimant attended high school until the 12th grade, but did not graduate. (Tr., p. 10) He later obtained a GED. (Tr., p. 11) He has also taken some courses online, but does not have a college degree. He has received some on-the-job training involving truck-driving and "blueprints." (Tr., p. 11)

Claimant's prior work history mainly involves physical labor. From 1996 until 1998 claimant worked for Jetter Hauling, essentially as a general laborer. (Tr., pp. 15-16) At some point later claimant worked for Hy-Vee as a stocker, which required lifting heavy boxes. (Tr., p. 16) Claimant also worked for Pallet Recovery, which involved pulling pallets off a trailer and going through them to find the ones that were good. (Tr., p. 17) Claimant then spent some time in prison between 2005 and 2012. (Tr., pp. 18-19) When he was released, he went to work for Molded Fibers, where his job was again as a laborer, working on lines making egg crates. (Tr., p. 17) Claimant said that job was not as physical. He worked there until he started working for defendant employer.

At the time of hearing, Claimant had worked for defendant employer for almost 6 years, meaning he started there in 2015. (Tr., p. 12) Claimant testified that his job at Collis is much better than his prior job at Molded Fibers, and he is happy with his employer. (Tr., pp. 19-20) Prior to his injury, claimant worked as a general laborer in Building 2, which is essentially a glass plant. (Tr., pp. 12; 58) His job initially was to load and unload trucks, work in the warehouse, pick up scrap, and complete other tasks as requested. (Tr., p. 13) On the date of injury, June 4, 2019, claimant was making $13.87

per hour, and was a "Grade 7" employee. (Tr., pp. 52; 54-55; 60)[1] Claimant worked 40-hours per week, and did not work overtime. (Tr., pp. 15; 22)

Claimant testified that he injured his right shoulder while working on June 4, 2019. (Tr., p. 21) He had been asked to throw away several boxes that mainly contained scrap glass. (Tr., p. 21) He asked for someone to assist him, but no one was available so he had to do it alone. He testified that it was about "20 boxes, 5 to 6 or 7 skids, couple of pink racks, mostly glass." (Tr., p. 21) He said all of it was pretty heavy. As he got toward the end, his right shoulder began to tighten up, but it did not hurt and he could still move it, so he did not think much of it at the time. (Tr., pp. 21-22) He finished his shift and went home, where he showered and laid down to relax. (Tr., p. 22) It was at this point his shoulder began throbbing, and claimant's wife brought him ibuprofen and ice. (Tr., pp. 22-23) The next morning, his shoulder hurt worse, so he reported the injury to his employer. (Tr., p. 23)

Claimant was eventually sent to Medical Associates on June 18, 2019. (Joint Exhibit 1, p. 1) At that time he reported pain that was "20 on a 0-to-10 scale." He was prescribed medications, given a sling, and referred to orthopedics. (Jt. Ex. 1, p. 1) He was also placed on work restrictions of no use of the right arm. (Jt. Ex. 1, p. 3)

Claimant saw Xerxes R. Colah, M.D., on June 19, 2019. (Jt. Ex. 2, p. 5) Dr. Colah noted claimant had no prior history of right shoulder pain or issues, but did have a prior left shoulder injury, which resulted in surgery. (Jt. Ex. 2, p. 5; see also Tr., pp. 31-32) On physical exam, Dr. Colah noted his examination was limited due to "marked guarding the shoulder and associated pain;" however, he was "able to coax the shoulder through almost a full range of motion." (Jt. Ex. 2, p. 6) X-rays performed that day showed severe osteoarthritis of the acromioclavicular joint, as well as subacromial bursitis of the right shoulder joint. (Jt. Ex. 2, p. 6) Dr. Colah recommended an injection, which was performed that day, and referred claimant for physical therapy. (Jt. Ex. 2, pp. 6-7)

Claimant returned to Dr. Colah on June 26, 2019. (Jt. Ex. 2, p. 10) While the injection had provided him with short-term relief, his pain had returned. He continued using his sling at that time, and "guards and grimaces with any attempts to even passively attempt to take the shoulder through a range of motion." (Jt. Ex. 2, p. 11) He had not yet started physical therapy, so Dr. Colah showed him some exercises to do in the meantime. (Jt. Ex. 2, p. 11) Dr. Colah noted he may consider an MRI if claimant's condition did not improve with physical therapy. (Jt. Ex. 2, p. 11)

Claimant next returned on July 3, 2019. (Jt. Ex. 2, p. 15) At that time he had only had one physical therapy session. He continued to wear a sling. Dr. Colah advised him

[1] Claimant initially testified he was making $14.27 per hour on the date of injury. (Tr., p. 14) On cross-examination, he was reminded that he received a raise after the date of injury, and was making $13.87 per hour on the date of injury. (Tr., p. 52) Claimant indicated he had forgotten about the raise and was not attempting to deceive anyone with his prior testimony. (Tr., p. 53) The undersigned has no reason to doubt this, and accepts that claimant forgot about the raise prior to being reminded on cross-examination.

to consider discontinuing the sling, as it might contribute further to his shoulder stiffness. (Jt. Ex. 2, p. 17) He was instructed to continue with physical therapy, and an MRI was ordered. (Jt. Ex. 2, p. 17) At his next follow-up on July 10, 2019, he continued to wear the sling and had been attending physical therapy. (Jt. Ex. 2, pp. 20-23)

Claimant had an MRI of the right shoulder on July 15, 2019. (Jt. Ex. 5, pp. 87-88) He returned to Dr. Colah on July 17, 2019, to discuss the results. (Jt. Ex. 2, p. 25) Dr. Colah's assessment after review of the MRI results was superior glenoid labrum lesion; arthritis of right acromioclavicular joint; and tendinitis of right rotator cuff. (Jt. Ex. 2, p. 27) Dr. Colah recommended a referral to a shoulder specialist. (Jt. Ex. 2, p. 28)

Claimant was referred to Abdullah Foad, M.D., who he saw on July 24, 2019. (Jt. Ex. 4, p. 49) Dr. Foad examined claimant and reviewed the MRI. (Jt. Ex. 4, p. 49) He noted that claimant exhibited significant pain behaviors. (Jt. Ex. 4, pp. 49-50) He recommended that claimant discontinue using the shoulder sling, as he believed that was causing further stiffness and pain. (Jt. Ex. 4, p. 50) He offered additional physical therapy, which claimant declined as he felt his prior physical therapy made his symptoms worse. Dr. Foad instead provided claimant with a home exercise program and a steroid injection. Claimant asked to be released from work restrictions, so Dr. Foad allowed him to return to full duty. (Jt. Ex. 4, pp. 50; 53)

Claimant returned to Dr. Foad on August 14, 2019. (Jt. Ex. 4, p. 54) The steroid injection did not help, and claimant was still demonstrating "significant pain behaviors," in which his subjective complaints far outweigh his objective findings. (Jt. Ex. 4, pp. 54-55) Dr. Foad noted that he was "reluctant" to offer surgery until claimant had a second opinion. (Jt. Ex. 4, p. 55)

Claimant was sent for a second opinion at University of Iowa Health Care, where he saw Matthew J. Bollier, M.D. (Jt. Ex. 6, p. 91) He saw Dr. Bollier on August 29, 2019, who noted claimant reported pain at a level 10 of 10. After his examination, Dr. Bollier's assessment was that the reported work incident was a significant factor in causing the current symptoms and need for treatment. (Jt. Ex. 6, p. 93) He noted that although the MRI was negative for structural tears, the work injury was a significant factor in causing the frozen shoulder and aggravating the AC joint osteoarthritis. Dr. Bollier opined that the "most reliable and quickest return to work treatment option" would be surgery. (Jt. Ex. 6, p. 93) He recommended right shoulder arthroscopic biceps tenotomy, open vs. arthroscopic distal clavicle excision, lysis of adhesions, manipulation, decompression, and possible repair. (Jt. Ex. 6, p. 94)

Claimant returned to see Dr. Foad on September 18, 2019. (Jt. Ex. 4, p. 58) Dr. Foad noted claimant said he had 10 of 10 pain all of the time and cannot move his shoulder. He noted very limited range of motion. Dr. Foad explained to claimant that "he may not be the best candidate [for surgery] and that there is a strong possibility that he may not get significant improvement with surgical intervention as he has significant pain issues that may be nonorganic." (Jt. Ex. 4, pp. 58-59) Claimant was insistent on wanting to proceed with surgery, so Dr. Foad agreed. (Jt. Ex. 4, p. 59)

Surgery took place on September 30, 2019. (Jt. Ex. 4, p. 62) The postoperative diagnosis was right shoulder acromioclavicular joint impingement with inferior directed bone spur causing mass effect; right shoulder anterior to posterior superior labral tear; and right shoulder complex tear of anterior-superior labrum. There was no evidence of adhesive capsulitis, and the rotator cuff was intact. (Jt. Ex. 4, p. 62) Dr. Foad noted that once claimant was under anesthesia, he had full passive range of motion with forward flexion and abduction, 90 degrees of external rotation and 85 degrees of internal rotation with his shoulder abducted 90 degrees. (Jt. Ex. 4, p. 63) He noted fluid range of motion during the entire examination under anesthesia, with normal blood pressure and heart rate. (Jt. Ex. 4, p. 63) Dr. Foad performed arthroscopic extensive glenohumeral joint debridement of superior labral tear, including biceps tenolysis, arthroscopic subacromial bursectomy and decompression, and arthroscopically assisted open distal clavicle excision. (Jt. Ex. 4, p. 62)

Claimant's first postoperative visit was October 2, 2019. (Jt. Ex. 4, p. 66) He started physical therapy on October 3, 2019. (Jt. Ex. 3, p. 37) When he returned to Dr. Foad on November 12, 2019, he continued to voice significant pain and limitations with activities of daily living. (Jt. Ex. 4, p. 74) He stated that he was better than he was before surgery, and attributed his slow progress to age. Dr. Foad noted difficulties and significant pain behaviors with attempts at range of motion. He again noted that the objective findings did not correlate with claimant's subjective complaints, and that he was progressing much slower than expected. He continued claimant's physical therapy. (Jt. Ex. 4, pp. 74-75)

At claimant's next follow-up visit on January 7, 2020, he continued to complain of sharp pain, and said his pain was about the same as it was prior to surgery. (Jt. Ex. 4, p. 79) Claimant's physical therapist was with him at the appointment, and noted that he was not making significant progress due to pain. Dr. Foad again noted that claimant's objective findings did not correlate with his subjective complaints, and showed claimant the arthroscopy pictures and reminded him that they were able to get full passive range of motion under anesthesia. (Jt. Ex. 4, p. 79) Dr. Foad noted that it was difficult to determine exactly where claimant's pain was coming from, so he offered a steroid injection into the glenohumeral joint for both diagnostic and therapeutic reasons. (Jt. Ex. 4, p. 79)

Following the injection, claimant continued with physical therapy, and at his next visit with Dr. Foad on January 28, 2020, he reported doing much better. (Jt. Ex. 4, p. 83) On physical examination, he had much improved range of motion, and fewer pain behaviors than he had in the past. Physical therapy records from the same time frame also indicate that claimant had significantly improved following the steroid injection. (Jt. Ex. 3, pp. 40-41) Dr. Foad placed claimant at maximum medical improvement (MMI) on that date, and released him to work with no restrictions. (Jt. Ex. 4, p. 83)

Dr. Foad provided an impairment rating on February 28, 2020. (Jt. Ex. 4, p. 86) Using the fifth edition of the AMA Guides to the Evaluation of Permanent Impairment,

Dr. Foad provided 5 percent of the right upper extremity for range of motion deficits, and 10 percent for the distal clavicle excision. Combined, he provided a rating of 9 percent of the whole person. (Jt. Ex. 4, p. 86) In reviewing the AMA Guides, I note that 9 percent of the whole person converts to 15 percent of the upper extremity. See AMA Guides to the Evaluation of Permanent Impairment, Table 16-3, p. 439.

Claimant returned to his regular work position with the same job duties and the same pay following his release. However, in March of 2020, when the pandemic began, claimant was laid off for a period of time. (Tr., p. 14) Deborah Bianchi testified at hearing on behalf of the employer. Ms. Bianchi is the human resources manager for Collis, the employer. (Tr., p. 56) Ms. Bianchi's testimony was consistent, and her demeanor at the time of hearing gave the undersigned no reason to doubt her veracity. Ms. Bianchi is found credible.

Ms. Bianchi has been the human resources manager at Collis for 30 years. (Tr., p. 57) She testified that at the time of claimant's injury, he was making $13.87 per hour. (Tr., p. 57) He was working as a Grade 7 general laborer in building 2, which is mainly a "glass plant." (Tr., pp. 57-58) In October of 2019, after the date of injury, all employees, including claimant, received a 40-cent wage increase. (Tr., p. 58) Due to the outbreak of the coronavirus pandemic, about 80 employees were laid off, including claimant. (Tr., p. 59) Claimant was on voluntary layoff from March 31, 2020, until July 19, 2020. (Tr., p. 59) When he was recalled to work, his position was resistance welder operator, which is a grade 6 position. (Tr., pp. 59-61) At the time of hearing, due to a decrease in sales, Collis no longer had any employees in the general labor position. (Tr., p. 59) If and when sales increase, claimant will have the opportunity to bid back into his prior position as general laborer. (Tr., pp. 59-60) At the time of hearing, claimant was making $13.90 per hour as a grade 6 employee. (Tr., p. 60)

Claimant attended an independent medical evaluation (IME) with Richard L. Kreiter, M.D., on June 3, 2020. (Claimant's Exhibit 1, p. 1) At the time of the IME, claimant was still on layoff, and was not working. (Cl. Ex. 1, p. 4) Claimant told Dr. Kreiter that he still experienced shoulder stiffness in the mornings, and had difficulty sleeping on the right side. He continued to perform his home exercise program and stretching exercises. (Cl. Ex. 1, p. 4) He continued to have weakness and had trouble lifting on the right side and throwing. (Cl. Ex. 1, p. 4) He noted a dull ache most of the time in the shoulder, which could go up to "almost a 10/10" with vigorous activity. He was not able to perform any overhead work.

On physical examination, Dr. Kreiter noted some tenderness around the lateral clavicle and subacromial area of his right shoulder. (Cl. Ex. 1, p. 4) He noted some deficits in range of motion, but good strength. Dr. Kreiter's impression was "adhesive capsulitis of the right shoulder, post-resection lateral clavicle, labral debridement and biceps tenodesis, partial cuff tear, mild anterior instability with chronic pain/weakness." (Cl. Ex. 1, p. 4)

Dr. Kreiter provided an impairment rating. (Cl. Ex. 1, p. 1) Dr. Kreiter assigned 13 percent upper extremity impairment secondary to decreased range of motion; 10 percent related to the clavicle resection; and 6 percent related to what Dr. Kreiter opined was an occult pattern of instability. The total combined impairment, then, was 27 percent of the upper extremity, which converts to 16 percent of the whole person. (Cl. Ex. 1, p. 1) Dr. Kreiter also recommended permanent restrictions of very limited, if any, overhead work; no throwing; lifting with the right arm to the side primarily and not lifting with the arm away from the body; lifting two-handed with the arms to the side from floor to bench up to 35 pounds; and avoiding excessive pulling with the right arm such as starting a power mower or chain saw. (Cl. Ex. 1, p. 1) With respect to future medical treatment, Dr. Kreiter did not believe any additional surgery was needed but noted that anti-inflammatory medications and occasional injections may be needed. (Cl. Ex. 1, p. 2)

There are two main differences between the impairment ratings provided by Dr. Foad and Dr. Kreiter. The first relates to range of motion. At the time of Dr. Foad's last examination on January 28, 2020, claimant demonstrated active forward flexion to 134 degrees, active abduction to 130 degrees, full extension, and 75/85 degrees of internal/external rotation. (Jt. Ex. 4, pp. 83, 86) This is consistent with the physical therapy records, which had been showing improvement. (Jt. Ex. 3, pp. 39-41) However, at Dr. Kreiter's examination about 4 months later, his range of motion was quite diminished. Forward flexion was 110 degrees, abduction to 90 degrees, and 40/45 degrees of internal/external rotation. (Cl. Ex. 1., p. 4)

There is no explanation for the decrease in claimant's range of motion between the two examinations. It is noted throughout Dr. Foad's records that claimant consistently exhibited pain behaviors that did not correlate with the objective findings. Dr. Foad was also able to obtain full passive range of motion with normal blood pressure and heart rate during the examination under anesthesia. Further, Dr. Foad found no evidence of adhesive capsulitis during surgery, contrary to Dr. Kreiter's diagnosis. There was no contraction of the rotator interval, and the rotator cuff was intact - again, contrary to Dr. Kreiter's diagnosis.

The second difference in the impairment ratings comes from Dr. Kreiter's addition of 6 percent impairment related to "symptomatic shoulder instability patterns." (Cl. Ex. 1, p. 1) Dr. Kreiter cited to page 505, table 16-26 of the AMA Guides for this portion of the rating. I note, however, that the Guides specifically state that "[s]houlder instability, recurrent subluxation, or dislocation *must be adequately documented* through a complete medical history, physical examination, and radiographic findings." (AMA Guides, p. 504) (emphasis in original). It further states that an individual's "complaint of feeling or fearing that a joint is 'popping' or 'going out of place' without adequate clinical findings is not a basis for permanent impairment rating." Id. The only test Dr. Kreiter noted with respect to instability is the apprehension test, which he stated did not cause claimant's shoulder to dislocate, but gave him the feeling that something was about to "go out." (Cl. Ex. 1, p. 1) The Guides specifically state that feeling or fear alone is not enough for permanent impairment without adequate clinical findings. Given that there

are no medical records that indicate claimant had any instability issues, or had prior dislocations, Dr. Kreiter's additional 6 percent is not supported.

Given these findings, claimant's testimony, and the remainder of the medical evidence in the record, I find Dr. Foad's rating to be the most convincing. He was the treating surgeon who actually inspected claimant's shoulder intraoperatively and is familiar with claimant's injury, treatment, and recovery. Dr. Foad examined claimant several times over the course of his treatment, while Dr. Kreiter examined him once for the purposes of litigation. Having found Dr. Foad's rating most convincing, I find that claimant has sustained 15 percent permanent partial disability to the right shoulder.

CONCLUSIONS OF LAW

As an initial matter, it should be noted that claimant's petition alleged injuries to his back, neck, right shoulder, and right arm. Defendants admitted the right shoulder injury, but denied the other body parts. Claimant presented no evidence at hearing regarding his alleged back, neck, or right arm injuries, and appears to have conceded that his only compensable injury was to his right shoulder. As such, I find that claimant sustained an injury to his right shoulder arising out of and in the course of his employment on June 4, 2019, for which defendants have accepted liability.

The next issue to determine is whether claimant's shoulder injury resulted in permanent disability to be compensated as a scheduled member pursuant to Iowa Code section 85.34(2)(n), or to the body as a whole, compensated pursuant to section 85.34(2)(v). Again, claimant appears to have conceded this issue, as it was not addressed in his post-hearing brief. 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). Claimant did not meet his burden to prove that his shoulder injury should be compensated under Iowa Code section 85.34(2)(v).

Additionally, as defendants correctly point out, the Iowa Workers' Compensation Commissioner has recently addressed what constitutes a shoulder under the 2017 amendments to section 85.34(2). See Deng v. Farmland Foods, Inc., File No. 5061883 (App. Sept. 29, 2020) and Chavez v. MS Technology, LLC, File No. 5066270 (App. Sept. 30, 2020). In Deng, the main issue was whether a rotator cuff injury – specifically the infraspinatus - should be compensated as a shoulder under section 85.34(2)(n), or as a whole body injury under section 85.34(2)(v). The Commissioner ultimately determined that "shoulder" under section 85.34(2)(n) is not limited to the glenohumeral joint. The Commissioner also rejected the argument that whatever is proximal to the joint should be treated as an unscheduled injury under section 85.34(2)(v). Rather, the Commissioner held that given the entwinement of the glenohumeral joint and the muscles that make up the rotator cuff and the importance of the rotator cuff to the function of the joint, the muscles of the rotator cuff are included within the definition of "shoulder" under section 85.34(2)(n). Thus, the claimant's injury in Deng was compensated as a shoulder under section 85.34(2)(n).

In Chavez, the claimant had injuries involving her rotator cuff, as well as a labral tear and subacromial decompression. Similar to Deng, the Commissioner found that the labrum is closely interconnected both in location and function to the glenohumeral joint. See Second Injury Fund of Iowa v. Nelson, 544 N.W.2d 258, 270 (Iowa 1995), as amended on denial of reh'g (Feb. 14, 1996) (quoting Lauhoff Grain Co., 395 N.W.2d at 839). In fact, like the rotator cuff, the labrum is not only extremely close in proximity to the glenohumeral joint (if not wholly contained within the joint space), but it is crucial to the proper functioning of the joint. As such the claimant's labral tear was compensated as a shoulder under section 85.34(2)(n). With respect to the subacromial decompression, the Commissioner determined that based on the medical definition of "acromion," it both forms part of the shoulder socket and protects the glenoid cavity. Therefore, the acromion is closely entwined with the glenohumeral joint both in location and function. As such, any disability resulting from a subacromial decompression should be compensated as a shoulder under section 85.34(2)(n).

In this case, claimant's injury involved acromioclavicular joint impingement with an inferior directed bone spur causing mass effect, right shoulder anterior to posterior superior labral tear, and right shoulder complex tear of anterior-superior labrum. There was no evidence of adhesive capsulitis, and the rotator cuff was intact. (Jt. Ex. 4, p. 62) Dr. Foad performed arthroscopic extensive glenohumeral joint debridement of superior labral tear, including biceps tenolysis, arthroscopic subacromial bursectomy and decompression, and arthroscopically assisted open distal clavicle excision. (Jt. Ex. 4, p. 62) Based on the Commissioner's decisions in Deng and Chavez, his injuries must be compensated as a shoulder pursuant to Iowa Code section 85.34(2)(n).

The next issue to determine is the extent of claimant's permanent partial disability under Iowa Code section 85.34(2)(n). Claimant argues that Dr. Kreiter's 27 percent impairment rating is more accurate, while defendants argue that Dr. Foad's 15 percent rating is entitled to greater weight.

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).

After consideration of the impairment ratings, claimant's testimony, and the remainder of the evidence in the record, I found Dr. Foad's rating to be the most convincing. He was the treating surgeon who actually inspected claimant's shoulder intraoperatively and is familiar with claimant's injury, treatment, and recovery. Dr. Foad examined claimant several times over the course of his treatment, while Dr. Kreiter examined him once for the purposes of litigation. Additionally, portions of Dr. Kreiter's rating related to range of motion and instability are not supported by the record. Having found Dr. Foad's rating most convincing, I found that claimant has sustained 15 percent permanent partial disability to the right shoulder.

Pursuant to section 85.34(2)(n), the shoulder is compensated based on 400 weeks of benefits. Therefore, claimant is entitled to a proportional award equivalent to 15 percent of 400 weeks, which is 60 weeks of permanent partial disability benefits. Iowa Code section 85.34(2)(n). Benefits commence on the stipulated date of January 28, 2020.

The only remaining issue to note involves medical bills that were unpaid at the time of hearing. (Cl. Ex. 4, pp. 9-12) Defendants' counsel indicated at hearing that the medical bills were under review, and bills for authorized care would be paid. (Tr., pp. 5-6) To the extent any medical bills for authorized, causally connected treatment remain unpaid, defendants are responsible for payment.

ORDER

THEREFORE, IT IS ORDERED:

Defendants shall pay claimant sixty (60) weeks of benefits at the stipulated rate of three hundred seventy-nine and 98/100 dollars ($379.98), commencing on January 28, 2020.

Defendants shall be entitled to a credit for all permanent partial disability benefits previously paid.

Defendants shall pay accrued weekly benefits in a lump sum together with interest 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.

Defendants are responsible for payment of all authorized, causally connected medical care.

Defendants shall file subsequent reports of injury (SROI) as required by this agency pursuant to rules 876 IAC 3.1(2) and 876 IAC 11.7.

Signed and filed this ___18th_____ day of August, 2021.

JESSICA L. CLEEREMAN
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served, as follows:

M. Leanne Tyler (via WCES)

Timothy Clausen (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.