BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

STEVEN NEAL,

Claimant,

vs.

MENARD, INC.,

Employer,

and

PRAETORIAN INSURANCE CO.,

Insurance Carrier,
Defendants.

File No. 5049640

ARBITRATION DECISION

Head Note Nos.: 1402.20, 1402.40, 1801.1, 1802

Claimant Steven Neal filed a petition in arbitration on April 6, 2016, alleging he sustained injuries to his right elbow, right arm, left wrist, left elbow, left arm, and body as a whole while working for the defendant, Menard, Inc. ("Menards"), naming Menards, Menards' insurer, Praetorian Insurance Company ("Praetorian"), and the Second Injury Fund of Iowa ("Fund") as the defendants. The Fund filed an answer on April 18, 2016. Menards and Praetorian filed an answer on May 4, 2016.

An arbitration hearing was held at the Iowa Workforce Center in Cedar Rapids, Iowa, on February 6, 2017. Prior to the hearing Neal settled his claim with the Fund. Attorney Paul McAndrew appeared on behalf of Neal. Neal appeared and testified. Attorney Charles Blades appeared on behalf of Menards and Praetorian. Exhibits 1 through 9, 11 through 15, 18 through 19, and A through N were admitted into the record. The record was left open through March 15, 2017, for the receipt of post-hearing briefs. At that time the record was closed.

Before the hearing the parties prepared a hearing report listing stipulations and issues to be decided. Menards and Praetorian waived all affirmative defenses.

STIPULATIONS

1. An employer-employee relationship existed between Menards and Neal at the time of the alleged injury.

2. Neal sustained an injury on December 10, 2013, which arose out of and in the course of his employment with Menards.

3. The alleged injury is a cause of temporary disability during a period of recovery.

4. If Menards and Praetorian are liable for the alleged injury, Neal is entitled to temporary benefits from February 26, 2015 through February 27, 2015.

5. Although entitlement to temporary benefits cannot be stipulated, Neal was off work from February 26, 2015 through February 27, 2015.

6. If the injury is found to be the cause of permanent disability, the disability is a scheduled member disability to Neal's left upper extremity.

7. The commencement date for permanent partial disability benefits, if any are awarded is November 4, 2015.

8. At the time of the hearing Neal's gross earnings were $250.63 per week, he was single and entitled to one exemption, and the parties believe his weekly rate is $182.23.

9. Although disputed, the medical providers would testify as to the reasonableness of their fees and/or treatment set forth in the listed expenses and the defendants are not offering contrary evidence.

10. Prior to the hearing Neal was paid forty weeks of compensation at the rate of $182.23 per week, for a total of $7,289.20 in permanent partial disability benefits.

11. Costs have been paid.

ISSUES

1. What is the nature of Neal's disability?

2. What is the extent of Neal's disability?

3. Is Neal entitled to temporary disability benefits from February 26, 2015 through February 27, 2015?

4. Is Neal entitled to payment of medical expenses?

5. Is Neal entitled to recover the cost of an independent medical evaluation?

6. Should costs be assessed to either party?

FINDINGS OF FACT

Neal lives in Iowa City and at the time of the hearing he was fifty-five. (Transcript, page 9) Neal graduated from high school in 1979 and he has not received any additional education. (Tr., p. 9) Neal attended special education throughout his schooling. (Tr., p. 29)

Menards hired Neal in 2013. (Exhibit 13, p. 4) On December 10, 2013, Neal was making "cutbacks," where he cut wood into smaller sizes for sale in the wood shed at work. (Tr., p. 12) Neal stopped what he was doing to assist a customer load wood onto a trailer. (Tr., p. 13) After he assisted the customer Neal walked back to his work area and tripped over a two-by-six-by-twenty-foot long board and fell. (Tr., p. 13) Neal testified "I went down, I put my arm out to break my fall, and I landed on my arm and my wrist." (Tr., p. 13) Neal reported he hit his left elbow on the board before his left forearm and wrist. (Tr., p. 14)

Neal reported his 2013 injury to his department manager, Steve Berres. (Tr., pp. 15-16) Neal filled out an incident report with the assistant manager, left Menards, and drove himself to the emergency room at Mercy Hospital. (Tr., pp. 16-17)

Kirk Gieswein, M.D., examined Neal at the hospital and documented Neal reported he had injured his left wrist. (Exhibit 1, p. 1) Hospital staff documented Neal reported he had a "previous fracture and surgery to this wrist in the past." (Ex. 1, p. 2) Dr. Gieswein diagnosed Neal with a fracture of the ulnar styloid, fitted him with a splint, and released him to work the next day with restrictions of right hand work only for two weeks. (Ex. 1, pp. 1, 4-7)

Neal testified after he received treatment he returned to Menards and told the assistant general manager, Brandon Butcher, and Berres about his elbow and pain in his wrist. (Tr., pp. 17-19) Berres sent Neal home for the day. (Tr., p. 19)

Neal testified in 2008 he fell and injured his left wrist while working for Wal-Mart. (Tr., pp. 9-10) Neal relayed he did not sustain a permanent impairment as a result of the injury and he denied having any limitations with his left arm that interfered with his ability to work. (Tr., pp. 10-11, 101)

Neal has a previous history of left elbow, hand, and wrist injuries. In February 2005, Neal tripped in his driveway and fell on his left knee and left elbow. (Ex. 2, p. 2) Neal sought treatment at the University of Iowa Hospitals and Clinics ("UIHC") in April 2005, complaining of knee pain, which had improved, and "significant discomfort in the left elbow as well as some mild discomfort in the left shoulder." (Ex. E, p. 2) Elbow x-rays revealed "a small fracture in the lateral aspect of the left radial head." (Ex. E, p. 3)

In March 2007 Neal again sought treatment at the UIHC after falling with an outstretched hand. (Ex. E, p. 5) A record from Mercy Hospital documents Neal was experiencing "[s]harp pain along left elbow, pain in left hand and tingling in the fingers." (Ex. E, p. 6) Neal testified at hearing he could not recall reporting he was experiencing sharp pain along his elbow. (Tr., pp. 72-73) Neal was later assessed with left medial epicondylitis. (Ex. E, p. 7) Neal's employer in 2007, Paul's Discount, completed a First Report of Injury or Illness form, documenting Neal experienced an injury at work to his left elbow and hand while lifting an empty pallet at work. (Ex. J, p. 1)

In April 2008, Neal returned to the UIHC, reporting he fell on an outstretched hand after tripping over a shopping cart while working for Wal-Mart. (Ex. E, pp. 8, 10) Neal received x-rays, and the reviewing radiologist listed an impression of a

comminuted distal radius fracture which involves the articular surface and ulnar styloid fracture, and an "additional small osseous fragment along the lateral articular surface of the base of the first metacarpal. Source of the small osseous density probably originates from the trapezium." (Ex. E, p. 8) When he received treatment Neal reported he had occasional discomfort in his wrist, but denied "any numbness or tingling in his fingers." (Ex. E, p. 14) Neal was placed at maximum medical improvement on February 16, 2009, and released without any permanent work restrictions. (Ex. E, pp. 19-20) Erika Lawler, M.D. an orthopedic surgeon at the UIHC, used the Guides to the Evaluation of Permanent Impairment (AMA Press, 5th Ed. 2001) ("AMA Guides"), and found Neal had sustained a five percent left upper extremity impairment, using Figures 16-28, 16-37, and Tables 16-2, and 16-3. (Ex. E, p. 20)

During subsequent treatment at the UIHC in February 2013, staff documented Neal denied experiencing pain, numbness, tingling, or weakness in his left arm, and reported pain in his right arm with numbness and tingling most of the time, and weakness most of the time. (Ex. E, p. 31) During cross-examination Neal testified at hearing that prior to December 2013, he never had problems with his right arm. (Tr., p. 76) Neal acknowledged that the problems he was having before his injury at Menards were with his left wrist. (Tr., p. 77)

On December 11, 2013, Neal was examined by Daniel Hogan, M.D., with Mercy Occupational Health. (Ex. 2, pp. 4-6) Dr. Hogan diagnosed Neal with an avulsion fracture and sprain of the left wrist, referred him for an orthopedic consultation, and found Neal could return to work on December 12, 2013, with restrictions of no gripping, twisting, fine manipulation, reaching out, pushing, pulling, or reaching above the shoulder with the left arm. (Ex. 2, pp. 4, 8)

Neal testified he returned to the emergency room the next day, complaining of pain. (Tr., pp. 20-21) The record reflects Neal returned to the hospital two days later on December 12, 2013, complaining of "increasing pain in his hand and wrist all way up his arm." (Ex. 1, p. 8) Dr. Gieswein noted there was considerable swelling in Neal's hand and tenderness throughout his wrist area. (Ex. 1, p. 8) Dr. Gieswein restricted Neal from working until he could be evaluated by orthopedics, fitted Neal with a padded splint, ordered Neal to elevate his arm above his heart for twenty-four hours, administered a Toradol injection, and switched his hydrocodone to hydromorphone. (Ex. 1, p. 8) Neal testified after he left the hospital he returned to Menards and told Butcher he was still having problems with his elbow and Butcher sent him home. (Tr., pp. 22-23)

On December 16, 2013, Neal returned to Dr. Hogan complaining of constant, sharp pain, "shooting up into elbow," and fingertip numbness. (Ex. 2, p. 10) Dr. Hogan ordered imaging of Neal's left elbow and the reviewing radiologist noted an impression of "[n]egative left elbow radiographs." (Ex. 2, p. 12) Dr. Hogan diagnosed Neal with an ulnar styloid fracture and sprain of the left wrist and continued Neal's restrictions. (Ex. 2, p. 13)

On December 28, 2013, Neal returned to the emergency room complaining of pain and swelling, and he was examined by Charles Huss, M.D. (Ex. 1, p. 11) Dr. Huss

documented "[r]epeat x-rays [were] negative for any fracture," but observed a "slight widening of the wrist," tissue swelling, and tenderness. (Ex. 1, p. 11) Dr. Huss documented he believed the condition could be an exacerbation of Neal's arthritic wrist, he fitted Neal with a thumb splint, and he prescribed naproxen. (Ex. 1, p. 11) Neal received a computerized tomography scan, and the reviewing radiologist listed an impression of "mild deformity of the distal radius representing remodeling from a remote injury and there is associated mild posttraumatic osteoarthritis involving the radial carpal joint space" with no acute wrist abnormality. (Ex. 1, p. 13) Dr. Huss restricted Neal from using his left arm until he attended an orthopedic consultation. (Ex. 1, p. 15)

On January 3, 2014, Neal attended an appointment with Meiying Kuo, M.D., an orthopedic surgeon. (Ex. 3, pp. 1-4) Dr. Kuo examined Neal, and noted after Neal's initial emergency room visit Neal "returned to the ER several days later with continued pain, radiating up the elbow and was transitioned to a different splint." (Ex. 3, p. 1) The medical record notes "pain all way up his arm," it does not expressly mention the elbow. (Ex. 1, p. 8) Dr. Kuo noted that Neal reported a prior left wrist fracture in 2008 with a close reduction. (Ex. 3, p. 1) Dr. Kuo noted that Neal's x-rays and computerized tomography scan

> demonstrate old ulnar styloid nonunion, with arthritic changes of the TM and radiocarpal joints. A large part of these findings likely represent changes as a result of his fracture in 2008. Prior to his injury, however, he did not have appreciable wrist pain but is now symptomatic. He likely sustained a sprain, contusion of the left wrist from this injury. At this time he has moderate digital wrist stiffness and I will initiate hand therapy to work on ROM, then gradually progressing to strengthening. I will transition him to a removable wrist splint for comfort. He should continue light duties with right-handed work only.

(Ex. 3, p. 3) Dr. Kuo estimated Neal could return to work with limitations on January 17, 2015. (Ex. 3, p. 5)

Neal continued to complain of wrist pain with therapy. (Ex. 3, pp. 6-7) Dr. Kuo fitted him with a thumb spica splint and administered an injection. (Ex. 3, p. 7) During his appointment on February 28, 2014, Neal reported no improvement in his pain after the injection and that he was continuing to work with his right hand. (Ex. 3, p. 9) Dr. Kuo recommended "surgery for radiocarpal arthritis, first, followed by TM arthritis." (Ex. 3, p. 10) Dr. Kuo performed a left proximal row carpectomy, and posterior interosseous nerve excision on Neal on April 7, 2014. (Ex. 5, p. 1)

On April 16, 2014, Neal attended a follow-up appointment with Dr. Kuo noting his pain was manageable and that he had no numbness or tingling in his fingers and he was eager to return to work. (Ex. 3, p. 11) Dr. Kuo placed Neal's arm in a cast, ordered him to continue elevating his left arm and to engage in finger range of motion exercises, and noted he could return to work with right handed activities only. (Ex. 3, p. 12)

Neal continued to receive treatment from Dr. Kuo and during his appointment on June 6, 2014, he reported severe pain in his right elbow as a result of overuse. (Ex. 3,

p. 19) Dr. Kuo referred Neal for "hand therapy referral for right counterforce brace and stretching/strengthening program for right lateral epicondylitis," hand therapy for his left wrist, and restricted him from working. (Ex. 3, p. 20)

On July 3, 2014, Neal attended a follow-up appointment with Dr. Kuo complaining of left wrist pain, numbness and tingling on the back of the ulnar hand and dorsal small finger. (Ex. 3, p. 25) Dr. Kuo noted Neal had been fitted with a thermoplastic left wrist splint during his last appointment and had been fitted with a right wrist splint and counterforce brace for carpal tunnel and right tennis elbow. (Ex. 3, p. 25) Neal continued to take hydrocodone for pain, and Dr. Kuo assessed him with left wrist synovitis, left ulnar neuropathy, right lateral epicondylitis, and right carpal tunnel syndrome. (Ex. 3, p. 26) Dr. Kuo placed Neal in a left short arm cast, ordered electromyography of the left upper extremity, and noted he could return to work with a five pound restriction for both hands. (Ex. 3, p. 26)

Neal's electromyography was cancelled because he had not returned to Dr. Kuo to have his cast removed before the testing. (Ex. 3, p. 27) During his appointment on July 30, 2014, he continued to complain of wrist pain at night, and numbness of the left ring and small fingers. (Ex. 3, p. 27) Dr. Kuo noted Neal had left hand numbness prior to his surgery, but it had become more noticeable since his surgery. (Ex. 3, p. 27)

Neal underwent electromyography with Sunny Kim, M.D., on August 14, 2014. (Ex. 3, p. 30) Dr. Kim listed an impression of "severe axonal ulnar sensory motor neuropathy across the elbow segment with denervation" and "moderate-severe L median neuropathy across the wrist consistent with overlapping carpal tunnel syndrome." (Ex. 3, p. 30)

On August 27, 2014, Neal returned to Dr. Kuo reporting his wrist was about as painful as before his surgery. (Ex. 3, p. 33) Dr. Kuo documented Neal

> has resumed work with 0-5 lbs left handed activities, wearing his wrist splint. His left wrist remains painful and about as painful as prior to his surgery. He has more symptoms from left elbow pain just distal to the elbow radiating down his hand and has constant numbness of the dorsal ulnar hand and small finger/half of the ring. He does not recall injuring his elbow at the time of his fall last December but just remembers landing on left outstretched hand. He also does not recall the exact time when he noted numbness of his fingers but believes this was after surgery.

(Ex. 3, p. 33) Dr. Kuo assessed Neal with continued left wrist pain, severe left cubital tunnel syndrome, and electrodiagnostic evidence of left carpal tunnel syndrome. (Ex. 3, p. 34) Dr. Kuo documented she discussed the electromyography results with Neal, which "demonstrated severe left ulnar neuropathy localized at the elbow. (Ex. 3, p. 34) Dr. Kuo noted,

> I cannot definitively explain the onset of symptoms, relative to his injury back in December, since it was not noted at the time of his initial evaluation that the intrinsic atrophy was present. Additionally, I do not

> think the existing ulnar neuropathy is related to his surgery, since the site of compression is at his elbow. Even so, this is severe and warrants surgical decompression, with possible anterior transposition.

(Ex. 3, p. 34) Dr. Kuo continued Neal's restrictions and ordered him to resume therapy for his left wrist. (Ex. 3, p. 34)

Neal attended a follow-up appointment with Dr. Kuo on December 16, 2014, complaining of pain in his left wrist and left elbow pain radiating down his forearm into his hand, "mostly a tingling that he feels into his ring/small fingers." (Ex. 3, p. 36) Dr. Kuo documented Neal believed his elbow pain started at the time of his fall in December "when he believes he fell onto his left elbow." (Ex. 3, p. 36) Dr. Kuo discussed a wrist fusion with Neal, which he declined, and a left cubital tunnel release and possible anterior transposition with fascial sling, and continued his work restrictions. (Ex. 3, p. 37)

On January 5, 2015, Dr. Kuo sent a letter to Neal's attorney, following a telephone conversation, noting,

> [a]s we discussed, I first evaluated Mr. Neal on 1/3/2014 after he sustained a fall injuring his left upper extremity at Menards on 12/10/2013. He was seen by Mercy Occupational Health and underwent an xray of his left elbow on 12/16/2013, which was negative for a fracture. This was done as he was experiencing shooting pain up to his elbow. During his treatment, he did not manifest left ulnar neuropathic symptoms until about 2 months after his surgery, which was performed on 4/7/2014. He subsequently underwent nerve testing on 8/14/2014, demonstrating severe ulnar neuropathy across the elbow and is now advised to undergo left cubital tunnel release. We had discussed potential causation of his nerve symptoms. I suspect he may have had some underlying ulnar neuropathy prior to his injury, which may have been exacerbated by his injury. Therefore, I feel his work injury may have played a role in potentiating his current ulnar neuropathy.

(Ex. 3, p. 38)

On January 28, 2015, the attorney for Menards and Praetorian sent Neal's attorney a letter advising the defendants were denying liability with respect to Neal's left ulnar neuropathy condition on the basis that the condition did not arise out of or in the course of his employment with Menards. (Ex. M, p. 1)

Neal underwent a left cubital tunnel release and anterior submuscular transposition on February 26, 2015. (Exs. 3, p. 39; 5, p. 10) During his appointment with Dr. Kuo on March 12, 2015, Neal reported he had experienced "no major change in the numbness along the back of his hand and the ring/small fingers" and he had returned to work with no left handed activities. (Ex. 3, p. 39)

In March 2015, Scott Neff, D.O., an orthopedic surgeon, performed a records review for Menards and Praetorian and provided an opinion on causation. (Ex. B, pp. 3-6) Dr. Neff noted the December 16, 2014, record with Dr. Kuo is the first reference he could find where Neal stated that he fell on his elbow. (Ex. B, p. 5) Dr. Neff agreed with Dr. Kuo that Neal had an ulnar entrapment at the elbow, and opined,

> there is nothing in the records which supports a direct causal relationship between the accident (falling on the left wrist) and cubital tunnel syndrome. Consequently, I cannot opine that the injury as described is associated with left cubital tunnel syndrome and therefore the treatment for left cubital tunnel syndrome is not related to the fall, with the person landing on the outstretched wrist. Mr. Neal has preexistent significant arthritis in the wrist. He had an old nonunion of the ulnar styloid fracture. The radiographs shortly after injury show preexistent arthritic disease and malunion of the distal radius. The arthritic changes in the wrist are the result of his previous injury, which occurred in approximately 2008, and in my opinion are not the direct result of the contusion or sprain that he had with this injury.

(Ex. B, p. 5)

On March 30, 2015, Dr. Kuo sent another letter to Neal's attorney, noting the last paragraph of her letter should be revised to "[w]e had discussed potential causation of his nerve symptoms. I suspect he may have had some underlying ulnar neuropathy prior to his injury, which probably was exacerbated by his injury. Therefore, I feel his work injury likely played a role in potentiating his current ulnar neuropathy." (Ex. 3, p. 42)

In May 2015, Neal experienced a heart attack and at the time of the hearing he was receiving Social Security Disability Insurance ("SSDI") benefits due to a heart condition. (Tr., pp. 64, 66) Neal testified that his ability to use his left arm was not part of the decision to award him benefits. (Tr., p. 65)

After his heart attack Neal was placed on a five pound lifting restriction and is restricted from standing more than four hours per day. (Tr., p. 67) Neal had also applied for SSDI in 2010, and part of his application included a left wrist injury and back injury while he was working for Wal-Mart. (Tr., pp. 87-88)

On June 3, 2015, Neal returned to Dr. Kuo reporting no noticeable improvement in his left hand sensation or strength. (Ex. 3, pp. 36-47) Dr. Kuo documented she discussed "the high likelihood he may not regain sensation or strength of his left hand," and she could not provide a permanent impairment rating until after a year from his most recent surgery. (Ex. 3, p. 47) Dr. Kuo imposed a five pound lifting restriction with the left hand. (Ex. 3, p. 48)

Neal returned to Dr. Kuo on November 4, 2015, for a follow-up appointment. (Exs. 3, p. 49; C, p. 1) Dr. Kuo examined Neal and noted "left intrinsic atrophy, with 4/5 weakness in ring/small finger FDP with instrinsics; diminished sensation dorsal ulnar

hand; sensation grossly wnl [*sic*] along left elbow scar; 2-pt left ring finger 7mm; absent 2-pt small finger." (Exs. 3, p. 49; C, p. 1) Dr. Kuo further documented Neal was unable to make a closed fist and "active left wrist flexion – 15 degrees/extension – 55 degrees/RD-10 degrees/UD-10 degrees; pronation-65 degrees/supination-70 degrees." (Exs. 3, p. 49; C, p. 1) Dr. Kuo placed Neal at maximum medical improvement and anticipated he would remain on a five to ten pound restriction with his left hand. (Exs. 3, p. 5; C, p. 2)

> On November 9, 2015, Dr. Kuo sent Menards's attorney a letter, opining,
>
> [u]sing the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, and based upon clinical measurements, he has a left wrist motion impairment of 16%, based on Figure 16-28 on page 467, Figure 16-31 on page 469, and Figure 16-37 on page 474 of the guide. This would translate to a 16% left upper extremity impairment.

(Exs. 4, p. 1; C, p. 3)

Richard Kreiter, M.D., an orthopedic surgeon, conducted an independent medical examination for Neal in December 2015. (Ex. 8) Dr. Kreiter examined Neal and reviewed his medical records. (Ex. 8, p. 1) Dr. Kreiter opined:

> [t]he diagnosis of the present left upper extremity condition, related to the 12/10/13 fall at Menards, and surgical outcomes, include: A) Post left proximal row carpectomy of the wrist with marked limited range of motion and chronic pain. B) Ulnar nerve contusion of the left elbow post cubital tunnel release and transposition of the nerve with marked ulnar nerve dysfunction, with intrinsic hand muscle atrophy, sensory loss, and grip weakness. C) Median nerve entrapment of the left wrist with hand numbness.

(Ex. 8, p. 1) Using the AMA Guides, Dr. Kreiter opined:

> [l]ooking at page 467, figure 16-28, wrist extension of 20 degrees equals a 7% upper extremity impairment. Flexion of 20 degrees equals an 18% upper extremity impairment. Page 469, figure 16-31, radial deviation of 5 degrees equals a 3% upper extremity impairment. Ulnar deviation of 0 degrees equals a 5% upper extremity impairment. Therefore, a 33% upper extremity impairment from loss of range of motion. Looking at page 492, table 16-15, sensory and/or motor deficits with the ulnar nerve above mid forearm, which is severe in this case, may well be a 25% upper extremity impairment due to the combined motor and sensory deficit. This contributes to the grip strength weakness of 15 kg as well. From the combined values chart, this would be a 50% upper extremity impairment, or a 30% whole person impairment from table 16-3.

(Ex. 8, p. 1) Dr. Kreiter recommended a five pound lifting restriction with no strenuous or physical activity with the left wrist and hand, no repetitive activity, no heavy grasping,

and no vibratory tools. (Ex. 8, p. 1) Dr. Kreiter noted Neal's dexterity is "very limited." (Ex. 8, p. 1)

Dr. Neff conducted an independent medical examination of Neal on March 16, 2016. (Ex. B, p. 7) Dr. Neff reviewed Neal's medical records and examined him. (Ex. B, p. 7) During the examination Neal reported on December 10, 2013 he fell at work, landing on his wrist and elbow, which Dr. Neff noted was a different history than the history he provided to other examiners. (Ex. B, p. 8) Dr. Neff opined Neal did not experience a wrist or elbow injury as a result of his December 10, 2013 work injury "other than a contusion or a sprain." (Ex. B, p. 15) Dr. Neff noted Neal had a preexisting intraarticular fracture in 2008, and opined the December 2013 work injury did not "cause a material or substantial aggravation, acceleration, or lightening [*sic*] up of a preexistent or chronic condition" or a permanent impairment. (Ex. B, p. 15) Dr. Neff further opined the left cubital tunnel syndrome was not caused by or related to the December 2013 work injury. (Ex. B, p. 15)

Dr. Neff reported he agreed somewhat with Dr. Kreiter's diagnoses, noting Neal has had a left proximal row carpectomy of the wrist, but there is no evidence of an ulnar contusion at the elbow, and there is evidence of continued ulnar nerve dysfunction secondary to cubital tunnel release and transposition. (Ex. B, p. 16) Dr. Neff noted electromyography showed a median nerve entrapment of the left wrist and it was unclear why a carpal tunnel decompression had not been accomplished. (Ex. B, p. 16)

Neal testified he has experienced a wasting with his left hand he described "between my index finger and my thumb on my left hand." (Tr., p. 40) Neal reported he does not have normal grip strength in his left hand and relayed, "I don't have the motion to go down with my fingers, and these two fingers here are completely numb (indicating), and this whole side of my forearm to my elbow on my left hand – arm is numb." (Tr., p. 40) Neal clarified he has numbness in his left small and ring fingers that affects his ability to pick up objects. (Tr., p. 41) Neal described his grip with his left hand as eighty percent. (Tr., p. 42) Neal reported that because of his condition he drops things and tries to compensate by gripping with his grand finger, his index finger and his thumb. (Tr., p. 43) Neal reported the strength in his left hand is about twenty percent the strength in his right hand. (Tr., p. 44) Neal testified he cannot put weight on his elbow because of sharp pain, and putting anything against the bottom of his elbow hurts. (Tr., pp. 50-52) At hearing, I observed Neal's left elbow is swollen and larger than his right elbow. (Tr., p. 51)

Neal has not been returned to his duties in the wood shed at Menards. (Tr., p. 57) Neal testified he has constant pain in his left wrist through his forearm into his elbow and he has difficulty lifting heavy objects. (Tr., p. 15) Neal reported since his injury he has trouble assembling patio furniture at Menards because he has to hold the parts together with one hand and screw in the other hand. (Tr., p. 45)

Neal is working light duty where he mops the floor, uses a floor scrubber, cleans the registers and register belts, and picks up cardboard. (Tr., pp. 57-58) Recently Neal has been operating the cash registers. (Tr., p. 58) Neal uses his left hand to some extent to perform his duties at Menards, including changing the pad on the floor

scrubber. (Tr., p. 68) Neal reported he does not use his left hand very much at work. (Tr., p. 71) Neal relayed he cannot hold onto a nail with his left hand because he does not have strength. (Tr., p. 56)

Neal testified before his work injury he used to hunt deer and fish, but now he cannot pull back the trigger of his gun or balance the gun, or grip his fishing pole and operate the reel because of loss of feeling in his hand. (Tr., pp. 45-47) Neal used to enjoy water skiing, but he cannot tolerate having his arms extended to hold onto the rope due to pain, and he does not have the strength to hold onto the rope. (Tr., p. 48)

Neal testified it is difficult for him to operate a can opener and cook food in the oven and stove because he cannot grip or handle the weight of food. (Tr., pp. 49-50, 52) Neal testified he has dropped items he has taken off the shelf at work. (Tr., p. 50) Neal reported he drops furniture because of his gripping problem. (Tr., p. 53)

Neal relayed he used to mow a lawn with a self-propelled push mower and he cannot pull the self-propelled bar back. (Tr., p. 55) Neal also cannot use his weed eater because it takes two hands to hold it and pull the trigger. (Tr., pp. 55-56)

Neal testified he used to detail cars, but cannot use his left arm, and he is no longer able to perform car detailing. (Tr., pp. 54, 93) During his deposition in 2015 Neal testified he had completed about five detailing jobs in the past year. (Tr., p. 93) This testimony is inconsistent with Neal's testimony at hearing.

CONCLUSIONS OF LAW

I. Nature of the Injury

The parties have stipulated Neal sustained an injury arising out of and in the course of his employment with Menards on December 10, 2013. The parties disagree on the nature of the injury. Neal avers he sustained work-related injuries to his left wrist and elbow. Menards and Praetorian admit Neal sustained an injury to his left wrist, but deny he sustained an injury to his left elbow.

To receive workers' compensation benefits, an injured employee must prove, by a preponderance of the evidence, the employee's injuries arose out of and in the course of the employee's employment with the employer. 2800 Corp. v. Fernandez, 528 N.W.2d 124, 128 (Iowa 1995). An injury arises out of employment when a causal relationship exists between the employment and the injury. Quaker Oats v. Ciha, 552 N.W.2d 143, 151 (Iowa 1996). The injury must be a rational consequence of a hazard connected with the employment, and not merely incidental to the employment. Koehler Elec. v. Willis, 608 N.W.2d 1, 3 (Iowa 2000). The Iowa Supreme Court has held, an injury occurs "in the course of employment" when:

> it is within the period of employment at a place where the employee reasonably may be in performing his duties, and while he is fulfilling those duties or engaged in doing something incidental thereto. An injury in the course of employment embraces all injuries received while employed in

> furthering the employer's business and injuries received on the employer's premises, provided that the employee's presence must ordinarily be required at the place of the injury, or, if not so required, employee's departure from the usual place of employment must not amount to an abandonment of employment or be an act wholly foreign to his usual work. An employee does not cease to be in the course of his employment merely because he is not actually engaged in doing some specifically prescribed task, if, in the course of his employment, he does some act which he deems necessary for the benefit or interest of the employer.

Farmers Elevator Co. v. Manning, 286 N.W.2d 174, 177 (Iowa 1979).

An injury to one part of the body can later cause an injury to another. Mortimer v. Fruehauf Corp., 502 N.W.2d 12, 16-17 (Iowa 1993) (holding a psychological condition can be caused or aggravated by a scheduled injury). The claimant bears the burden of proving the claimant's work-related injury is a proximate cause of the claimant's disability and need for medical care. Ayers v. D & N Fence Co., Inc., 731 N.W.2d 11, 17 (Iowa 2007); George A. Hormel & Co. v. Jordan, 569 N.W.2d 148, 153 (Iowa 1997). "In order for a cause to be proximate, it must be a 'substantial factor.'" Ayers, 731 N.W.2d at 17. A probability of causation must exist, a mere possibility of causation is insufficient. Frye v. Smith-Doyle Contractors, 569 N.W.2d 154, 156 (Iowa Ct. App. 1997).

The question of medical causation is "essentially within the domain of expert testimony." Cedar Rapids Cmty. Sch. Dist. v. Pease, 807 N.W.2d 839, 844-45 (Iowa 2011). The commissioner, as the trier of fact, must "weigh the evidence and measure the credibility of witnesses." Id. The trier of fact may accept or reject expert testimony, even if uncontroverted, in whole or in part. Frye, 569 N.W.2d at 156. When considering the weight of an expert opinion, the fact-finder may consider whether the examination occurred shortly after the claimant was injured, the compensation arrangement, the nature and extent of the examination, the expert's education, experience, training, and practice, and "all other factors which bear upon the weight and value" of the opinion. Rockwell Graphic Sys., Inc. v. Prince, 366 N.W.2d 187, 192 (Iowa 1985).

It is well-established in workers' compensation that "if a claimant has a preexisting condition or disability, aggravated, accelerated, worsened, or 'lighted up' by an injury which arose out of and in the course of employment resulting in a disability found to exist," the claimant is entitled to compensation. Iowa Dep't of Transp. v. Van Cannon, 459 N.W.2d 900, 904 (Iowa 1990). The Iowa Supreme Court has held,

> [a] disease which under any rational work is likely to progress so as to finally disable an employee does not become a "personal injury" under our Workmen's Compensation Act merely because it reaches a point of disablement while work for an employer is being pursued. It is only when there is a direct causal connection between exertion of the employment and the injury that a compensation award can be made. The question is whether the diseased condition was the cause, or whether the employment was a proximate contributing cause.

Musselman v. Cent. Tel. Co., 261 Iowa 352, 359-60, 154 N.W.2d 128, 132 (1967).

Neal asserts that he injured his left wrist and elbow when he tripped and fell at Menards on December 10, 2013. Menards contends Neal's testimony is not credible. When assessing witness credibility, the trier of fact "may consider whether the testimony is reasonable and consistent with other evidence, whether a witness has made inconsistent statements, the witness's appearance, conduct, memory and knowledge of the facts, and the witness's interest in the [matter]." State v. Frake, 450 N.W.2d 817, 819 (Iowa 1990).

The following exchange took place during Neal's direct testimony:

Q. What happened next?

A. There was a customer that came in to the board shed with a trailer, and I stopped what I was doing. That's your job, to stop what you're doing to help with the guests, and I ordered him what he needed. So I helped him load up his wood that he needed, so he went upstairs, grabbed the wood. He was sorting through it and handing me one up on his trailer. There was two-by-fours. There was four-by-fours, decking wood. It's all treated. Then I got all done. I headed out, and I went back to the table. I was doing cutbacks. And it was a treated two-by-six-by-twenty-foot-long board on the floor, and I stepped over it, and I tripped, and when I tripped I went down on – all the way down. My arm it [*sic*] the wood behind me.

Q. What arm?

A. My left arm. And I went down, I put my arm out to break my fall, and I landed on my arm and my wrist. So after that –

Q. Hold on a second. I'd like to interject. What part of your arm hit the pile of wood before –

A. My left elbow –

Q. Please, when Mr. Blades or I ask you a question, please let us finish it. Settle down, take your time, please. What part of your arm hit the pile of wood before your arm hit the ground?

A. Left elbow.

Q. What part of your arm hit the ground when your arm reached the ground?

A. My left arm.

Q. What part of your left arm hit the ground?

A. The forearm and my left wrist.

(Tr., pp. 12-14)

Neal's initial medical records do not document an injury to his elbow, or complaints that he hit his elbow. (Ex. 1, pp. 1-7) Dr. Hogan documented Neal complained of left elbow pain during his appointment on December 16, 2013. (Ex. 2, pp. 12-13) Dr. Hogan ordered imaging and the reviewing radiologist listed an impression of "[n]egative left elbow radiographs." (Ex. 2, p. 12)

During his deposition Neal testified his elbow pain "showed up later." (Tr., p. 79) During cross-examination at hearing, the attorney for Menards and Praetorian asked:

Q. Again, I'm looking at page 33. I highlighted it here. And you say, "Because it showed up later," and then I asked, "The elbow pain showed up later?" And then you said, "Yeah." Do you see that?

A. Yeah.

Q. And then I said, "How much later?" And you said what?

A. A month later.

Q. Probably a month later; right? Didn't you tell me that?

A. Yeah.

Q. So really all these things you testified to earlier about talking to people at Menards the day of the fall and in the days after, that couldn't have happened because you didn't know you had an elbow problem until a month after you fell. Does that make sense?

A. It's kind of confusing for me.

(Tr., p. 79) Neal testified that he might have been mistaken when he testified he had elbow pain a month later. (Tr., pp. 81-82) Neal's medical records document he was complaining of elbow pain within six days of his work injury. (Ex. 2, pp. 10-12)

Neal began treating with Dr. Kuo in January 2014, complaining of pain radiating up his elbow. (Ex. 3, p. 1) During his appointment with Dr. Kuo on August 27, 2014, Dr. Kuo documented she spoke with Neal regarding his elbow and she documented, "[h]e does not recall injuring his elbow at the time of his fall last December but just remembers landing on left outstretched hand." (Ex. 3, p. 33)

During the hearing I did not observe Neal engage in any furtive movements. His eye contact was appropriate. Neal has an obvious interest in this case. Neal is a poor historian and he could not recall specific information concerning treatment he received to his left upper extremity prior to his employment with Menards, and when he began experiencing elbow pain after his work injury. Neal did not initially identify his elbow as

hitting the wood pile. Through additional questioning by his attorney, Neal identified his elbow as hitting the wood pile. Neal's testimony regarding his elbow hitting the wood at hearing is inconsistent with his statement to Dr. Kuo on August 27, 2014. Neal has made other inconsistent statements, as reflected through this testimony regarding his ability to engage in car detailing. (Tr., p. 93) Neal's medical records do not support he reported he hit his elbow on the pile of wood when he fell. I do not find his testimony that he recalls hitting his elbow on the pile of wood credible.

Neal has a preexisting history of left wrist, arm, and elbow injuries from other falls that have occurred at home and work. Three orthopedic surgeons have given causation opinions regarding Neal's left elbow condition, Drs. Kuo, Neff, and Kreiter. Drs. Kuo and Kreiter opined Neal's left elbow condition is causally related to his work injury; Dr. Neff disagrees. I find the opinion of Dr. Neff to be the most persuasive regarding Neal's elbow condition.

Dr. Kuo is the orthopedic surgeon who treated Neal over the course of more than a year. (Ex. 3) During her appointment with Neal on August 27, 2014, Dr. Kuo documented Neal did not recall injuring his left elbow at the time of his fall, and recalled landing on a left outstretched hand. (Ex. 3, p. 33) Following electromyography, Dr. Kuo diagnosed Neal with severe ulnar neuropathy localized at the elbow, and noted,

> I cannot definitively explain the onset of symptoms, relative to his injury back in December, since it was not noted at the time of his initial evaluation that the intrinsic atrophy was present. Additionally, I do not think the existing ulnar neuropathy is related to his surgery, since the site of compression is at his elbow. Even so, this is severe and warrants surgical decompression, with possible anterior transposition.

(Ex. 3, p. 34) During Neal's appointment on December 16, 2014, Dr. Kuo documented Neal believed his elbow pain started at the time of his fall in December "when he believes he fell onto his left elbow." (Ex. 3, p. 36)

Neal requested a causation opinion from Dr. Kuo and she opined, "I suspect he may have had some underlying ulnar neuropathy prior to his injury, which may have been exacerbated by his injury. Therefore, I feel his work injury may have played a role in potentiating his current ulnar neuropathy." (Ex. 3, p. 38) She later revised her opinion, stating "I feel his work injury likely played a role in potentiating his current ulnar neuropathy." (Ex. 3, p. 42) Dr. Kuo did not explain what led her to revise her opinion. Dr. Kuo did not opine the work injury "aggravated, accelerated, worsened, or 'lighted up'" Neal's preexisting condition. Van Cannon, 459 N.W.2d at 904 (Iowa 1990). I do not find her opinion persuasive.

Dr. Neff opined the work injury did not cause Neal's elbow condition. Neal avers Dr. Neff did not fully examine him, his appointment was only fifteen minutes, and Dr. Neff was involved in a telephone conversation for the bulk of the appointment. Dr. Neff's report is thorough and discusses the treatment Neal received for his elbow at the UIHC and Mercy Hospital prior to the December 2013 work injury. (Ex. B) Dr. Neff's report records measurements and findings from his personal examination of Neal. Dr.

Neff noted Neal did not report hitting his elbow for months after the work injury and opined falling on an outstretched arm does not cause cubital tunnel syndrome.

Dr. Kreiter's opinion is not as detailed as Dr. Neff's opinion. (Ex. 8) Dr. Kreiter's opinion provides, in part,

> [h]e does admit that in 2008, he had a closed fracture of his left wrist, which was treated at the University of Iowa, with a closed reduction. There was no surgery done. The cast was removed after some 6 to 8 weeks. He had no problem, nor numbness in the extremity following that fracture, and no other treatment for a left upper extremity problem until he fell at Menards; this being on 12/10/13.

(Ex. 8, p. 3) Dr. Kreiter was not provided with a copy of Neal's treatment records at the UIHC. There is no discussion in his report of the treatment Neal received in 2005 after he fell on his left knee and left elbow, the treatment Neal received in 2007 after he fell with an outstretched hand and experienced sharp pain along the left elbow, pain in the left hand and tingling in the fingers. (Ex. E)

Dr. Kreiter's opinion also discusses Neal returning to the emergency room on December 12, 2013, "having increasing pain his hand and wrist, all the way up his arm to the elbow." (Ex. 8, p. 3) Neal's medical record does not discuss pain into the elbow; it documents "increasing pain in his hand and wrist all [the] way up his arm." (Ex. 1, p. 8)

"When an expert's opinion is based upon an incomplete history, the opinion is not necessarily binding on the [trier of fact]." Dunlavey v. Economy Fire & Cas. Co., 526 N.W.2d 845, 853 (Iowa 1995) (citing Bodish v. Fisher, Inc., 257 Iowa 521, 521-22, 133 N.W.2d 867, 870 (1965)). The trier of fact determines the weight of the opinion, "that may be affected by the completeness of the premise given the expert and other surrounding circumstances." Id. I do not find Dr. Kreiter's opinion as persuasive as Dr. Neff's opinion because it is based on an incomplete history.

Considering all of the evidence, including Neal's testimony, his medical records, and the expert opinions in this case, I do not find Neal has met his burden of proof that he sustained an injury to his left elbow arising out of and in the course of his employment with Menards on December 10, 2013. Given my finding that Neal has not met his burden of proof that he sustained an injury to his left elbow arising out of and in the course of his employment with Menards Neal is not entitled to temporary total disability benefits from February 26, 2015 through February 27, 2015, related to his surgery, or medical expenses totaling $1,655.44 related to the surgery.

II. Extent of Disability

Neal avers he sustained a fifty percent permanent impairment to his right upper extremity. Menards and Praetorian contend Neal has not sustained a permanent impairment, and if he has, the impairment is minor.

Permanent partial disabilities are divided into scheduled and unscheduled losses. Iowa Code § 85.34(2). If the claimant's injury is listed in the specific losses found in Iowa Code section 85.34(2)(a)-(t), the injury is a scheduled injury and is compensated by the number of weeks provided for the injury in the statute. Second Injury Fund v. Bergeson, 526 N.W.2d 543, 547 (Iowa 1995). "The compensation allowed for a scheduled injury 'is definitely fixed according to the loss of use of the particular member.'" Id. (quoting Graves v. Eagle Iron Works, 331 N.W.2d 116, 118 (Iowa 1983)). If the claimant's injury is not listed in the specific losses in the statute, compensation is paid in relation to 500 weeks as the disability bears to the body as a whole. Id.; Iowa Code § 85.34(2)(u). "Functional disability is used to determine a specific scheduled disability; industrial disability is used to determine an unscheduled injury." Bergeson, 526 N.W.2d at 547.

The Iowa Supreme Court has held that a permanent injury to the wrist is a scheduled loss to the arm. Holstein Elec. v. Breyfogle, 756 N.W.2d 812, 816 (Iowa 2008) (finding a permanent injury to the wrist is compensated as a loss of an arm as opposed to a loss of a hand). The schedule provides a maximum award of 250 weeks of compensation for loss of an arm. Id. at 815; Iowa Code § 85.34(2)(m).

Dr. Kuo opined Neal sustained a sixteen percent permanent impairment to his left upper extremity as a result of his work injury to his left wrist. (Exs. 4, p. 1; C, p. 3) She did not provide a permanent impairment rating with respect to his left elbow. (Exs. 4, p. 1; C, p. 3) Dr. Neff found Neal did not sustain a permanent impairment to his wrist. (Ex. B, p. 15) Dr. Kreiter found Neal sustained a permanent impairment to his left upper extremity of seven percent for wrist extension, and eighteen percent for flexion, for a total of twenty-five percent. (Ex. 8, p. 1) As discussed above, I do not find Dr. Kreiter's opinion persuasive because it is based on an inaccurate history.

With respect to the wrist, I find Dr. Kuo's opinion more persuasive than Dr. Neff's opinion. Dr. Neff opined Neal "did not have a wrist or elbow injury as a result of his fall on 12/10/2013 other than a contusion or a sprain," finding Neal had long-standing, chronic, preexisting, post-traumatic arthritis. (Ex. B, p. 15) The record reflects that Neal was performing his duties without accommodations for his wrist prior to his work injury. Neal has not returned to his prior position with Menards and has a permanent lifting restriction of ten pounds with respect to his left upper extremity. Dr. Kuo assigned an impairment rating of sixteen percent for the left upper extremity. Considering all of the evidence, including lay testimony and the expert opinions, I find Neal has sustained a twenty percent impairment to his left upper extremity as a result of his work injury.

III. Independent Medical Examination

Neal seeks to recover the $700.00 cost of Dr. Kreiter's independent medical examination and report. (Ex. 9) Menards and Praetorian aver Neal is not entitled to recover the cost of the independent medical examination because Dr. Kreiter's bill is not itemized.

After receiving an injury, the employee, if requested by the employer is required to submit to examination at a reasonable time and place, as often as reasonably

requested to a physician, without cost to the employee. Iowa Code § 85.39. If an evaluation of permanent disability has been made by a physician retained by the employer and the employee believes the evaluation is too low, the employee "shall, upon application to the employer and its insurance carrier, be reimbursed by the employer the reasonable fee for a subsequent examination by a physician of the employee's own choosing." Id. Dr. Kreiter's examination occurred after Dr. Kuo issued her impairment rating, in compliance with the statute.

In the case of Des Moines Area Regional Transit Authority v. Young, the Iowa Supreme Court held:

> [w]e conclude section 85.39 is the sole method for reimbursement of an examination by a physician of the employee's choosing and that the expense of the examination is not included in the cost of a report. Further, even if the examination and report were considered to be a single, indivisible fee, the commissioner erred in taxing it as a cost under administrative rule 876-4.33 because the section 86.40 discretion to tax costs is expressly limited by Iowa Code section 85.39.

867 N.W.2d 839, 846-47 (Iowa 2015). Dr. Kreiter's bill is not itemized. Under Young, Neal is not entitled to recover the $700.00 cost of Dr. Kreiter's exam and report. Id.

IV. Costs

Neal seeks to recover the $100.00 filing fee. Rule 876 IAC 4.33(6), provides

> [c]osts taxed by the workers' compensation commissioner or a deputy commissioner shall be (1) attendance of a certified shorthand reporter or presence of mechanical means at hearings and evidential depositions, (2) transcription costs when appropriate, (3) costs of service of the original notice and subpoenas, (4) witness fees and expenses as provided by Iowa Code sections 622.69 and 622.72, (5) the costs of doctors' and practitioners' deposition testimony, provided that said costs do not exceed the amounts provided by Iowa Code sections 622.69 and 622.72, (6) the reasonable costs of obtaining no more than two doctors' or practitioners' reports, (7) filing fees when appropriate, (8) costs of persons reviewing health service disputes.

Under the express wording of the rule, Neal is entitled to recover the $100.00 filing fee.

ORDER

IT IS THEREFORE ORDERED, that:

Defendants shall pay the claimant fifty (50) weeks of permanent partial disability benefits, at the rate of one hundred eighty-two and 23/00 dollars ($182.23), commencing on November 4, 2015.

Defendants shall take a credit for all benefits previously paid.

Defendants shall pay accrued benefits in a lump sum, with interest on all accrued benefits pursuant to Iowa Code section 85.30.

Defendants are assessed the one hundred and 00/00 dollar ($100.00) filing fee.

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

Signed and filed this 25th day of May, 2017.

HEATHER L. PALMER
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

Copies to:

Paul J. McAndrew, Jr.
Attorney at Law
2771 Oakdale Blvd., Ste. 6
Coralville, IA 52241-2781
paulm@paulmcandrew.com

Charles A. Blades
Attorney at Law
PO Box 36
Cedar Rapids, IA 52406-0036
cblades@scheldruplaw.com

HLP/srs

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.