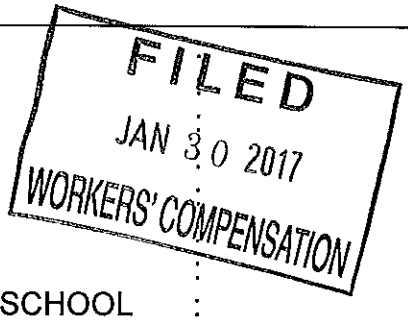
BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER



KATHALEEN BROWN,

Claimant,

vs.

CAMANCHE COMMUNITY SCHOOL DISTRICT,

Employer,

and

UNITED HEARTLAND,

Insurance Carrier,
Defendants.

File No. 5034722

ARBITRATION

DECISION

Head Note Nos.: 1108; 1803; 1801; 2500

STATEMENT OF THE CASE

Kathaleen Brown, claimant, filed a petition in arbitration seeking workers' compensation benefits against Camanche Community School District, employer, and United Heartland, insurer, for a work injury occurring on June 2, 2010.

Causation was originally decided in the arbitration decision issued on April 10, 2012, heard before the undersigned. The arbitration decision found, in relevant part, that claimant sustained a pulmonary injury as a result of mold exposure at her workplace.

The decision was appealed and upheld by the Commissioner, District Court and Court of Appeals. The claimant asserts she is now at maximum medical improvement (MMI) and seeks an industrial disability finding.

The present case was heard on October 11, 2016, in Des Moines, Iowa, and considered fully submitted on November 2, 2016, upon the simultaneous filing of briefs.

The record in this case includes claimant's exhibits 1-12, 14-18, 20, 23-32, Defendants exhibits A-E, claimant's testimony and the testimony of Katherine Sykora, daughter of the claimant.

ISSUES

1. Whether claimant's heart condition is related to the work injury of June 2, 2010;

2. Whether claimant is entitled to temporary or healing period benefits from June 30, 2010, through January 31, 2015.

3. Whether claimant is entitled to reimbursement of medical expenses in exhibit 12.

4. Whether claimant is permanently and totally disabled;

5. Whether claimant is an odd-lot employee;

6. What credit, if any, the defendants are entitled to.

STIPULATIONS:

The parties agree claimant has sustained a permanent injury. They disagree as to the extent of the injury and whether she is entitled to temporary benefits beyond that which she has already been paid.

At the time of her injury, claimant's gross earnings were 848.00 per week. At all relevant times, she was single and entitled to one exemption. Her weekly benefit rate is $515.06.

Prior to the hearing, claimant has been paid $96,969.71 in healing period benefits from June 2, 2010, through May 10, 2012, along with 100 weeks of permanent partial disability for a total of $29,845.77. (Ex. D, p. 1, Ex. E, p. 1)

FINDINGS OF FACT

Claimant Kathaleen Brown comes before the undersigned following a holding that she suffered a lung ailment as a result of exposure to mold in her workplace. Temporary benefits were awarded until such time as section 85.31 was fulfilled. Claimant has not returned to work, but instead argues she is at maximum medical improvement. She also asserts that because of the medications, she has developed heart problems.

Claimant seeks benefits for a total disability arising out of the lung condition and the heart condition.

The facts of the preceding Arbitration Decision are adopted and incorporated herein. Since the arbitration hearing of January 19, 2012, claimant has continued to

receive treatment for various ailments including, but not limited to, her pulmonary issues.

In April 2011, Jason Wittmer, a Des Moines pulmonologist, found no abnormal lung function and no airway obstruction. He opined that her shortness of breath complaints did not match up with her objective test results.

She began to treat with Joel Kline, M.D., at the University of Iowa Hospitals Pulmonary Clinic. Dr. Kline concluded that claimant had a pre-existing asthmatic condition that was substantially aggravated to environmental exposures at claimant's work place.

Following the hearing in January 2012, claimant continued to treat at the Huxley Family Medical Center with Allison Testroet, D.O. During one such visit, it was noted that claimant complained of hyperventilation. The 02 monitor read 100 percent continuously. (Ex. 1, p. 12) In the discussion notes, it read, "If [claimant] was distracted, she breathed normally with no hyperventilation." (Ex. 1, p. 12) She complained to Dr. Bruyntjens office that she had a very serious illness in December 18, 2012 and that x-rays were taken. (Ex. 2, p. 5) According to the Family Medicine records, on December 13, 2012, she had a slightly elevated temp of 101 degrees with nasal drainage but her lymph nodes were normal, her lungs were clear to auscultation, and her heart rate was normal. She was given antibiotics and released. (Ex. 1, p. 14)

Every few months, throughout 2012-2015, claimant was treated for sinus and bronchial infections. Her symptoms, consistently, were subjective fever, facial pain, nasal drainage, headaches, tooth aches, and cough. Testing confirmed that she had thick nasal drainage and lungs that were not clear to auscultation. Sometimes she had effusion in her ears and other times they were clear and normal. (See generally Exhibit 1)

Her "active problem" list from Family Medicine in Huxley included Coronary Artery Disease as far back as April 13, 2012. (Ex. 1, p. 1) This continued to be an "active problem" throughout 2012 and up through 2016.

In the intervening time, claimant reported a couple of new mold exposures: first at a friend's house and then later at her church. (Ex 1, p. 101)

She was seen at Charles Bruyntjens, M.D., office for various complaints such as swelling and weakness in her legs, pain in her rib cage, wheezing and other chest discomfort. She saw Dr. Bruyntjens approximately every six months to follow up on her asthmatic condition. On October 14, 2013, she complained of chest heaviness and pain in the rib cage and diaphragm. (Ex. 2, p. 7) At rest, her oximetery was 97 percent. She had absent breath sounds in the right lower lung. (Ex. 2, p. 8) Dr. Bruyntjens increased her Xopenex to 1.25 from .63. (Ex. 2, p. 8) In 2014, her oximetry at rest was 96 percent and in 2015, it was 92 percent. (Ex. 2, p. 17) Normal is between 95 and 100.

A preliminary pulmonary function report conducted on November 5, 2014, indicated:

Spirometry		Pre	Ref	%Ref	Post	%Ref	%Chg
FVC	Liters	2.58	3.02	86	2.60	86	0
FEV1	Liters	1.9	2.32	82	2.02	87	6
FEV1/FVC	%	74	78		78		
FEF25-75%	L/sec	1.35	2.18	62	1.75	80	29
PEF	L/sec	5.47	5.91	93	5.32	90	-3
PIF	L/sec	1.16			3.11		168

Comments

BEST NIF -84. BD GIVEN FOR POST BD SPIRO, 3 ACTUATIONS ALBUTEROL OVER 3 BREATHS VIA SPACER, PULSE 90/90. NO CPX NOTED. INSP. AND EXP, LOOP ARE FROM SEPARATE EFFORTS. DLCO NOT READABLE, LACK OF VOLUME, PT COULDN'T CATCH HER BREATH. RAM/B

(Ex. 2, p. 13) The pulmonary function test from November 23, 2015, showed:

Spirometry		Ref	Pre Meas	Pre %Ref	Post Meas	Post %Ref	Post %Chg
FVC	Liters	2.64	2.47	93	2.28	87	-7
FEV1	Liters	2.15	1.85	86	1.8	84	-3
FEV1/FVC	%	83	75		79		
FEF25-75%	L/sec	2.33	1.45	62	1.7	73	17
PEF	L/sec	5.3	6.3	119	6.32	119	0
FET 100%	Sec		10.66		7.71		-28
FEF/FIF50		<1.00	6.2		3.77		-39

(Ex. 2, p. 23)

At the end of January 2014, she suffered a non work related fall. In February 2015, claimant believed she suffered a cracked rib when her grandson performed the Heimlich maneuver on her. (Ex. 1, p. 78) X-rays were negative for any traumatic injury. She suffered another fall on April 13, 2015. (Ex. 1, p. 93)

During her July 16, 2015, annual wellness examination, claimant presented with a fairly normal examination. Her lungs were clear. Her respirations were normal. She exhibited no tenderness in the extremities. Her lymph nodes were all normal. Neurologically, she had intact and normal reflexes, sensation and strength. (Ex. 1, p. 97) Her diagnoses included hypertension, anxiety, coronary atherosclerosis, depression. (Ex. 19, p. 97-98)

She was advised to adjust her lifestyle. (Ex. 1, p. 15)

Jason T. Rasmussen, M.D., examined claimant for her chest pain and abnormal stress test. (Ex. B, p. 1) "She thinks she had a stress test at Genesis in Davenport in 2012. She recalls the result was not clear. A coronary angiogram was performed in 2012 in Des Moines at Iowa Heart which she says was 'ok'." (Ex. B, p. 1)

Claimant is able to walk short distances only because of her lung disease. (Ex. B, p. 1)

Claimant presented to Mary Greeley hospital on November 2, 2015, with complaints of chest pain. (Ex. 15, p. 5) Historically, she reported developing intermittent chest discomfort as well as chest heaviness radiating to the neck, jaw, shoulder blades and right arm. (Ex. B, p. 1) Her lungs were clear and her heart exhibited regular rate and rhythm with no murmurs, rubs, or gallops. Her peripheral pulses were equal and symmetric. (Ex. B, p. 2)

> Description of chest discomfort is typical of cardiac pain. Her stress test is a false positive vs 3 vessel disease. We discussed that a coronary angiogram would give a definitive answer. We discussed the benefits/risks/alternatives to the procedure and she has agreed to proceed.
>
> Will plan for coronary angiography tomorrow.

(Ex. B, p. 3) The angiography showed severe coronary artery disease of the mid RCA noted with 2 DES stents. (Ex. 15, p. 17)

> RIGHT CORONARY ARTERY: The right coronary artery is a large, dominant vessel. The entire mid RCA is diseased and in the middle portion there is an irregular and slightly hazy area of most severe stenosis which is about 85% at its worst. The total length of stenosis in the mid RCA is about 34mm and is mildly calcified. The distal RCA has some moderate stenosis of about 30% just before the bifurcation of the RPDA and RPL branch. The RCA then gives off a large PDA and large set of RPLV branches. The RPDA has a focal area of mild 30% stenosis in it proximal segment. The RPL branch has an area of mild 20% stenosis in its proximal segment. Otherwise, these vessels are angiographically free of significant disease.

(Ex. 15, p. 23)

She returned for a followup visit on November 16, 2015, but had an unremarkable checkup. (Ex. 7, p. 1) Dr. Rasmussen could not say whether her cardiac issues, to the extent that they existed, were related to the corticosteroid usage. (Ex. B, p. 17)

Joel N. Kline, the director of the UI Asthma Center, performed an IME at the request of the claimant. (Ex. 4) He reviewed the following:

> At your request, I have reviewed the relevant medical records of your client, Kathaleen A. Brown. These records include reports of her care at Family Medicine-Huxley between October 2011 and September 2015; her treatment by Dr. Charles Bruyntjens between July 2011 and November 2014; a letter dated October 7, 2015 by Dr. Patrick Hartley related to his independent medical examination (IME) on 11/5/14 and the IME report; and a letter by Dr. Henry Hoffman dated 5/12/15.

(Ex. 4, p. 1)

Current condition:

Previous Asthma History

#exacerbations in the past six months: six

The last exacerbation occurred at the beginning of this month. Typical exacerbations consist of increased cough, wheeze, dyspnea, and chest tightness and usually last a week or more.

# of nighttime asthma episodes per month: 20 consisting of symptoms of dyspnea and chest tightness. All asthma exacerbations have required treatment with high-dose oral corticosteroids. Past medications tried and failed include multiple courses of oral steroids, multiple inhaled steroids and long-acting beta agonists, anti-cholinergics.

The patient is currently on prednisone 10mg bid; she has been off steroids for up to several months, but has mostly required either prednisone or methylprednisolone on a daily basis over the past several years.

Risks associated with chronic oral corticosteroid use include osteoporosis, coronary disease (she required angioplasty and stent placement 11/15 and now is on aspirin and Plavix), anxiety (on Lexapro), osteoporosis (she is on calcium and Vitamin D3), shingles (on valcyclovir) and weight control difficulty.

Control on chronic oral corticosteroids: poor.

Risk to patient from asthma long-term include frequent exacerbations, each of which carries risk of respiratory failure.

(Ex. 5, p. 2)

Objective:

BP 184/70 mmHg | Pulse 88 | Temp(Src) 36.6°C (97.9 °F) (Tympanic) | Resp 24 | Ht 1.57 m (5' 1.81") | Wt 75.5 kg (166lb 7.2 oz) | BMI 30.63 kg/m2 | SpO2 98%

General appearance: alert, cooperative, no distress, appears stated age

Head: Normocephalic, without obvious abnormality, sinuses nontender to percussion

Eyes: conjunctivae/corneas clear. PERRL, EOM's intact. Fundi benign

Throat: Lips, mucosa, and tongue normal. Teeth and gums normal. Oral pharynx moist without thrush

Neck: supple, symmetrical, trachea midline, no adenopathy, thyroid: not enlarged, symmetric, no tenderness/mass/nodules, no carotid bruit and no JVD

Lungs: Scattered end-expiratory wheezing, some of which clear with coughing

Heart: regular rate and rhythm, S1, S2 normal, no murmur, click, rub or gallop

Abdomen: soft, non-tender. Bowel sounds normal. No masses, no organomegaly

Extremities: extremities normal, atraumatic, no cyanosis; 1-2+ pretibial pitting edema.

Neurologic: Grossly normal.

(Ex. 5, p. 4)

On MMI:

I previously replied that 'Given her relatively recent discontinuation of prednisone, and her fluctuating symptomatology, Ms. Brown has not yet reached Maximal Medical Improvement.'

I would like to amend this opinion and now believe that she has reached MMI. Exactly what date to assign MMI is difficult. Dr. Hartley suggested that two years from her last work date would be reasonable,

placing MMI May 2012. It is my expert opinion, however, that MMI was not achieved at that time, since she was off of systemic corticosteroids for a time that included that date; she has required oral corticosteroids most of the time since January 2015. As noted above, at MMI 'further recovery or deterioration is not anticipated'. Based on this standard, I would assign MMI January 2015. Consistent with this, her FEV1 and FVC at today's visit (both pre- and post-bronchodilator) were lower than those measured in 2011 or 2014.

(Ex. 4, p. 2)

4. If MMI has been reached, the permanent impairment caused by the Injuries, as gauged by the AMA Guides, 5th Ed.

I determined impairment rating today according to The AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, hereinafter referred to as the 'Guides.' The methodology described in Section 5.5 'Asthma' of the Respiratory System chapter of the AMA Guides (pages 102 through 104, and tables 5-9 and 5-10), is used for assigning an impairment rating in asthma. This method assigns a score based on pulmonary function testing (post bronchodilator FEV1), reversibility of airflow obstruction, and the amount of medication (particularly inhaled or oral steroid) that the patient is currently taking.

Referencing the pulmonary function testing performed today, her post-bronchodilator FEV1 was 80% of predicted, which would correspond to a score of 0. Current medications, which include daily prednisone correspond to a score of 4. She has no significant reversibility on today's pulmonary function testing but does have a history of a positive methacholine challenge in 2011, and therefore a score of 1 is assigned for this factor. The total score is 5. Referencing table 5-10, the asthma score of 5 is noted to be a class 2 impairment. Table 5-10 of the Guides indicates a range of 10%-25% impairment of the whole person for a class 2 impairment due to asthma. As her asthma score of 5 is highest score in this class, I would assign a 25 % impairment of the whole person as a consequence of her asthma.

It is important to consider also that this patient has had a number of adverse effects that are highly associated with the long-term use of oral corticosteroids. She has developed coronary artery disease, requiring angioplasty and stent placement; she developed shingles and has post-herpetic neuropathy; she has osteopenia, diagnosed by a DEXA scan 7/15 putting her at increased risk for hip fracture; she has anxiety, and she has difficulty sleeping. These adverse affects are NOT considered in the above impairment rating, but may be considered by the court in determining appropriate levels of compensation.

5. If MMI has been reached, the work restrictions caused by the Injuries.

Based on her occupational asthma alone, Ms. Brown should avoid workplace exposures to environments that are significantly dusty or associated with fumes, vapors, smoke, or mold. Her long-term steroid use has given her proximal muscle weakness, and rising from the seated position is challenging for her. In addition, she can only tolerate limited contact with the public, given her susceptibility to common viral and other illnesses. Her fatigue and interrupted sleeping likewise reduce her energy level, making it unlikely that she could tolerate a full working day.

(Ex. 4, p. 2-3)

Dr. Bruyntjens wrote a note on a prescription pad that he agreed with the three page report of Dr. Kline. (Ex. 3)

Patrick G. Hartley, M.D., performed an IME at the request of the defendants. (Ex. A, p. 1)

Claimant reported to Dr. Hartley that the longest time that she has been relatively symptom-free has been 2-4 months at a time. (Ex. A, p. 8) This is consistent with the medical records. She continues to have significant issues despite no longer being exposed to the mold which caused the initial injury.

Claimant complained of several ailments from day-to-day exposures.

Ms. Brown reports that she has a number of symptoms when she is exposed to fumes or strong odors. She noted on her way to clinic today that traffic fumes entering her vehicle caused her to experience headache, shortness of breath, and lightheadedness and the car air conditioning system had to be turned to recirculate of air to limit this exposure. She reports that during the colder winter months, she wears a face mask when outside, and in general tends to avoid outside exposures during very cold weather or very hot/humid weather.

(Ex. A, p. 8)

She does note increased symptoms associated with exposure to nonspecific triggers such as strong colognes or perfumes, cigarette smoke or other smoke, gasoline, or vehicle exhaust, fertilizer, household chemicals, or burning leaves. She reports that she is very limited choice of cleaning chemicals which she can tolerate it when cleaning her home.

(Ex. A, p. 9)

On examination, claimant was in no acute distress and she had unlabored respiration. Her tympanic membranes were normal. A chest exam revealed symmetric chest expansion. She did have tenderness to palpation along the right coastal margin and in the right mid axilla. On auscultation, she exhibited symmetric breathing sounds with no wheezes, crackles or pleural rubs. Cardiac exam was normal.

Her lung test results were as follows:

> UIHC pulmonary function testing:
>
> Spirometry performed on the date of her IME revealed normal FEV1 and FVC without significant change post beta-agonist inhaled bronchodilator.
>
> FEV1 1.9 (82%), FVC 2.58 (86%), FEV1/FVC 74%. However, mid expiratory flows did significantly improve postbronchodilator; FEF 25-75% prebronchodilator was 1.35 (62%), and increased by 29% to 1.75 postbronchodilator.
>
> Of note, flow volume loop reveals significant inspiratory airflow limitation with flattening of the inspiratory loop suggesting a Possible [sic] variable extrathoracic airflow obstruction.

(Ex. A, p. 10)

Dr. Hartley diagnosed claimant with bronchial hyperactivity asthma and that her asthmas was partially attributable to her workplace exposure. (Ex. A, p. 11)

> It is my opinion, to a reasonable medical certainty, that Ms. Brown is at maximum medical improvement with regards to her asthma/bronchial hyperreactivity. Impairment is determined according to The AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, hereinafter referred to as the 'Guides'. The methodology described in Section 5.5 'Asthma' of the Respiratory System chapter of the AMA Guides (pages 102 through 104, and tables 5-9 and 5-10) is used for assigning an impairment rating in asthma. This method assigns a score based on pulmonary function testing (post bronchodilator FEV1), reversibility of airflow obstruction, and the amount of medication (particularly inhaled or oral steroid) that the patient is currently taking. Referencing the pulmonary function testing performed on the date of her IME (11/5/14), the post-bronchodilator FEV1 was 87% of predicted, which would assign a score of 0. Current medications, which includes a high potency inhaled steroid (ciclesonide), would correspond to a score of 3. She has no significant reversibility on recent pulmonary function testing but does have a history of a positive methacholine challenge in 2011, and therefore a score of 1 is assigned for this factor. The total score is 5. Referencing

table 5-10, the asthma score of 4 is noted to be a class 2 impairment. Table 5-10 of the Guides indicates a range of 10%-25% impairment of the whole person for a class 2 impairment due to asthma. As her asthma score is 4 (and 5 is the highest score in this class) I would assign a 20 % impairment of the whole person as a consequence of her asthma.

As I have noted in my review of the external records provided, I would disagree with the calculation of a preliminary impairment rating assigned by Dr. Kline in his letter to claimant's attorney on 9/9/11. Dr. Kline assigned a score of 1 for a postbronchodilator FEV1 of 83%. In my opinion an FEV1 of 83% is greater than the lower limit of normal and a score of 0 should have been assigned for this factor. He assigned a score of 1 for her methacholine challenge results, with which I would I [sic] agree. Dr. Kline assign a score of 3 for her asthma medication which, at the time, included an inhaled steroid and long-acting beta agonist. This would have resulted in a class 2 impairment (not a class 3 impairment as Dr. Kline had erroneously added the asthma scores).

Work Restrictions: Dr. Kline in a letter to claimant's attorney on 11/14/11 recommended that 'As a direct result of her occupational asthma, Ms. Brown should avoid workplace exposures to environments that are significantly dusty or associated with fumes, vapors, smoke or mold.' These recommendations are reasonable for any patient with persistent asthma who is symptomatic with exposure to nonspecific irritants, in my opinion should be considered permanent restrictions.

(Ex. A, p. 12)

Claimant's past work history includes work in a preschool child care center. She worked in an upholstery shop for four years making auto and airplane seats. She transitioned into substitute teaching which led to a full time job as a fourth grade elementary schoolteacher until May 25, 2010.

Dr. Hartley was asked to update his opinion and did so on October 7, 2015.

As I noted in my IME report, it is my opinion, to a reasonable medical certainty, that Ms. Brown is at maximum medical improvement (MMI). I would a assign [sic] the date of MMI as being 2 years following her separation from the work place. This recommendation is consistent with the American Thoracic Society (ATS) guidelines published in 1993 regarding assessment of disability/impairment in patients with asthma (Am Rev Respir Dis 1993; 147; 1056-1061), which states that: 'Assessment of long-term impairment/disability should be carried out 2 years after removal from exposure, when improvement has been shown to plateau'. The

methodology used to determine asthma-related impairment recommended in the AMA Guides to the Evaluation of Permanent Impairment, is based on these ATS 1993 guidelines. According to your February 2015 letter, it would appear that Ms. Brown last worked in the elementary school in May 2010, which would place her at MMI in May 2012.

Of the list of symptoms in questions #2 of your February 2015 letter, it is my opinion that the following symptoms cannot with reasonable medical certainty be attributed to her asthma and work-related exposures: fatigue, forgetfulness, short attention span, inability to make decisions, difficulty sleeping (unless directly attributable to nocturnal shortness of breath, which can be asthma related), elevated blood pressure, elevated pulse rate, headaches, and swelling of her hands and feet. Depending on whether she was experiencing a symptomatic exacerbation of asthma, she may have chest or rib cage soreness. Redness and dryness of the eyes may occasionally be attributable to work-related allergy or decreased humidity in the work setting.

It is my opinion that Ms. Brown is not precluded from working in any specific work environment or setting. In fact, I would encourage Ms. Brown, and all patients with asthma, to work. There are, however, some work environments that are more challenging for patients with asthma due to the presence of inhaled irritants and sensitizers/allergens that may result in an exacerbation of asthma symptoms. I have, in my IME report, agreed with Dr. Kline's restriction that 'Ms. Brown should avoid workplace exposures to environments that are significantly dusty or associated with fumes, vapors, smoke or mold', which I have stated are reasonable recommendations for any patient with persistent asthma who is symptomatic with exposure to nonspecific irritants. However, this would not preclude her from working in the majority of work places, including office settings, which in my opinion are not 'significantly dusty or associated with fumes, vapors, smoke or mold'.

Ms. Brown may have some limitation in performing outdoor activities, particularly if she may be exposed to irritant chemicals (lawn care chemicals, chlorine in swimming pools), or dust (e.g. during harvest time), if these trigger her airway symptoms. However, she should be encouraged to participate in outdoor activities and exercise as tolerated.

Vocal cord dysfunction may, albeit infrequently, arise as a consequence of work-related exposures, more typically to inhaled irritant exposures than allergens. If present, it may be a significant contributing factor, or even the sole cause of patient's episodic shortness of breath. As you are aware, Ms. Brown did subsequently undergo a thorough evaluation for vocal cord dysfunction at UIHC in May 2015, where she was

> evaluated by Dr. Henry Hoffman, and by Speech Pathology. No vocal cord dysfunction was identified on evaluation.

(Ex. A, p. 20-21)

A subsequent conference call was held between the defendant's counsel and Dr. Hartley in response to the possible long-term effects of claimant's corticosteroid usage. On March 17, 2016, Dr. Hartley wrote:

> I have reviewed the most recent clinical notes from Ms. Brown's followup assessment by Dr. Joel Kline, UIHC Pulmonary Clinic on 2/19/16. Dr. Kline observed that she is currently on long-term oral steroids and has had 'a number of adverse effects that may be directly linked to her long-term use of oral corticosteroids,' including coronary artery disease, shingles and post-herpetic neuropathy, anxiety, and difficulty sleeping. I cannot state to a reasonable medical certainty that her long-term use of oral steroids was a substantial contributing factor to her coronary artery disease, herpes zoster infection (shingles) and postherpetic neuralgia, anxiety disorder or difficulty sleeping. While recognizing that long-term oral steroids may cause or contribute to significant adverse effects, I cannot state to a reasonable medical certainty that in Ms. Brown's situation, that this is the case with regard to the medical issues cited above. For example, review of her medical records indicates that she was diagnosed with shingles in October 211, at a time when she was not on long-term oral steroids.
>
> Of note, Mr. [sic] Brown's pulmonary function tests (PFTs), over time, have been in the low normal or borderline abnormal range, while she reports significant symptoms which she attributes to her asthma. Her reported limitation appears disproportionate to the objective measurements of airflow obstruction by PFT. Ms. Brown believes herself to be 'disabled' and incapable of returning to the work force. I will not opine on whether she is a disabled or not, as disability is an administrative and legal term, rather than a medical one. In general, patients who develop asthma in association with workplace exposures, usually have improvement (though not always complete resolution) of their asthma symptoms following removal from the inciting work exposure situation. Ms. Brown's continued symptoms in the non-work setting despite, relatively normal pulmonary function testing, is somewhat unusual. Nonetheless, I acknowledge that 30-50% of patients with occupational asthma do continue to have symptoms, following removal from the work setting, though typically with demonstrable airflow obstruction on objective testing.
>
> I would encourage Ms. Brown (as I do with all patients with asthma) and her treating providers to seek opportunities to return her to gainful

employment, albeit with accommodations for her medical restrictions to limit or avoid precipitating exposures. Since some of her symptoms may be related to fatigue and muscle weakness, perhaps associated with her steroids or other unrelated factors, rather than pulmonary airflow obstruction, participation in a pulmonary rehabilitation/exercise program may be helpful in determining the extent to which she can tolerate physical activity, or even being outside her home situation, that could further inform a decision regarding 'disability'.

(Ex. A, p. 22-23)

Dr. Kline disagreed with Dr. Hartley.

I have reviewed Dr. Hartley's report regarding my opinions on the nature and extent of Kay Brown's disability.

The adverse effects of chronic use of systemic corticosteroids are well known and well documented. For example, mood disturbances, insomnia, and anxiety are common, with severe reactions in 6% of steroid users and mild-to-moderate in about 28% of patients. (TP Warrington and JM Bostwick, Psychiatric Adverse Effects of Corticosteroids, May Clinic Proceedings 81:1361-67, 2006) Cardiovascular side effects including atherosclerosis, the major cause of coronary artery disease, are likely due to the development of dyslipidemia and hypertension in patients using corticosteroids (DE Sholter and PW Armstrong, Adverse effects of corticosteroids on the cardiovascular system, Canadian Journal of Cardiology 16:505-511, 200), and there is an excess cardiovascular mortality in steroid-treated patients (SR Maxwell, RJ Moots, and MJ Kendall, Corticosteroids: Do they Damage the Cardiovascular system? Postgraduate Medical Journal 70:863-870, 1994). And finally, the immunosuppressive effects of oral corticosteroids have been shown to significantly increased the risk of herpes zoster (SC Hu et al, Immunosuppressive medication use and risk of herpes zoster in patients with systemic lupus erythematosus: a nationwide case control study Journal of the American Academy of Dermatology, 2016 Mar 3. pii: S0190-9622(16)00070-0. doi: 10.1016/j.jaad.2015.12.059).

In summary, it is my opinion to a reasonable degree of medical certainty that Ms. Brown has suffered significant adverse effects of chronic corticosteroid usage. In addition, it is my opinion, also to a reasonable degree of medical certainty, that she has continued to have symptomatic asthma even following avoidance of the initial inciting exposures. As Dr. Hartley pointed out, '30-50% of patients with occupational asthma do continue to have symptoms, following removal from the work setting.'

(Ex. 17)

Dr. Hartley followed that letter up with another one on July 22, 2016, wherein he wrote:

> I have reviewed the most recent clinical notes from Dr. Joel Kline on 2/19/16. There is medical literature which indicates that there may be increased risk of coronary artery disease associated with long-term use of oral corticosteroids. However, I cannot state to a reasonable degree of medical certainty that Ms. Brown's use of oral steroids was a substantial contributing factor to her coronary artery disease. There are other potential causes for coronary disease, and it is unclear whether other contributing or causative factors have been fully addressed.
>
> The issue of post-herpetic neuropathy was addressed in my letter to your office dated 3/17/16.
>
> With respect to Brown's reported anxiety disorder and difficulty sleeping, I cannot state within a reasonable degree of medical certainty that Ms. Brown's use of oral steroids was a substantial contributing factor. There are multiple references in the medical record to depression and anxiety dating back to 2002. She has been prescribed a number of medications over the years for mental health including Zoloft, Xanax and Lexapro.
>
> In my letter of 3/17/16, I did note that 30 to 50% of patients with occupational asthma do continue to have symptoms following removal from the work setting. However, in the majority of cases where there are continuing symptoms following removal from the work setting, it is accompanied by demonstrable airflow obstruction on objective testing. Ms. Brown's PFT's have been in the low normal or borderline abnormal range. Her pulmonary function testing would be more typical in a patient with mild asthma, would not be expected to need treatment with long-term systemic steroids. Her reported ongoing symptoms appear significantly disproportionate to the objective measurements of airflow obstruction.

(Ex. A, p. 24)

Dr. Hartley continued to be concerned about claimant's long-term corticosteroid usage considering the lack of objective measurement of airflow obstruction. (Ex. A, p. 25) Dr. Hartley is an well-known expert in lung diseases. He has written dozens of articles and taught a multitude of classes on lung disease, respiratory illnesses, and other pneumonic issues. (Ex. A) Dr. Kline is a well-known expert on asthma and has written articles and taught classes on the topic of asthma in the workplace as well as treatment and prevention. (Ex. 9)

At the request of claimant's counsel, Allison Testroet, D.O., wrote the following:

> I received your fax today regarding Kathaleen Brown 12/18/1952 and two questions you ask. "High risk medication" is in reference to needing prednisone on a regular basis to treat her respiratory symptoms. It is considered high risk because it can lead to severe health conditions including osteoporosis, adrenal gland insufficiency, and diabetes just to name a few. She will need to be monitored for these conditions as long as she is on prednisone. Chronic sinusitis has been as a result of exposure to environmental allergens and irritants on the job. Same cause as her asthma.

(Ex. 6, p. 1)

A vocational assessment was issued for the claimant wherein Kent Jayne reiterates his opinion that claimant is not employable, based on Dr. Kline's opinions. (Ex. 1)

> Dr. Kline notes further that Ms. Brown's 'long term steroid use has given her potential muscle weakness, and rising from the seated position is challenging for her. In addition she can only tolerate limited contact with the public, given her susceptibility to common viral and other illnesses. Her fatigue and interrupted sleeping likewise reduce her energy level, making it unlikely that she could tolerate a full working day.'

(Ex. 10, p. 2)

Katherine A. Sykora testified on behalf of her mother. She described claimant as physically frail, often incapable of even leaving her house. She does not garden, has difficulty walking due to unsteadiness on her feet. It is hard for her to be in an unstable, unfamiliar environment. Even someone who has a strong perfume can adversely affect her mother, according to Ms. Sykora. Claimant walks slowly, in part due to her breathing issues but also to her instability. Ms. Sykora also testified that while claimant is capable of driving, getting out of her car and exposing herself to different environments is potentially hazardous.

Claimant herself presents as a near shut-in, arguing that any environmental exposures outside her home are potentially hazardous.

CONCLUSIONS OF LAW

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

The claimant has the burden of proving by a preponderance of the evidence that the alleged injury actually occurred and that it both arose out of and in the course of the employment. Quaker Oats Co. v. Ciha, 552 N.W.2d 143 (Iowa 1996); Miedema v. Dial

Corp., 551 N.W.2d 309 (Iowa 1996). The words "arising out of" referred to the cause or source of the injury. The words "in the course of" refer to the time, place, and circumstances of the injury. 2800 Corp. v. Fernandez, 528 N.W.2d 124 (Iowa 1995). An injury arises out of the employment when a causal relationship exists between the injury and the employment. Miedema, 551 N.W.2d 309. The injury must be a rational consequence of a hazard connected with the employment and not merely incidental to the employment. Koehler Electric v. Wills, 608 N.W.2d 1 (Iowa 2000); Miedema, 551 N.W.2d 309. An injury occurs "in the course of" employment when it happens within a period of employment at a place where the employee reasonably may be when performing employment duties and while the employee is fulfilling those duties or doing an activity incidental to them. Ciha, 552 N.W.2d 143.

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

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

Claimant attributes many of her current issues to her long-term use of prednisone including, but not limited to her heart condition, her unsteadiness, her falls, her physical weakness, blurred vision, mental depression, mood changes. There is hardly a negative side effect to prednisone that claimant does not lay claim to.

Claimant is seriously deconditioned from her lack of physical activity. One of her physicians urged her to aggressively change her lifestyle, advice with claimant has not taken and would argue that she is physically incapable of taking. Her invalid-type lifestyle likely contributes to her constellation of symptoms.

Dr. Kline, a pulmonologist, and a family practice doctor, Dr. Testero, both opine that a known side effect to prednisone is atherosclerosis. Both Dr. Kline and Dr. Testero opinions are largely conclusory. Dr. Kline does not acknowledge that claimant suffered ailments like shingles before her steroid intake. Dr. Testero's opinion is that if the claimant suffers from a condition that is a known complication of prednisone, then it must be the prednisone.

Claimant had coronary artery disease part of her "active problems" as far back as 2012. Dr. Kline's opinions that claimant began a daily maintenance dose of steroids in 2015 which led to the late winter 2015 heart problems do not take into consideration her previous issues and diagnoses.

Neither Dr. Kline nor Dr. Testero's opinion is intellectually or medically rigorous. The sole heart specialist rendering an opinion in this case cannot provide a definitive conclusion that the heart condition is related to the steroid usage. Dr. Rasmussen's angiography revealed that the entire mid RCA is diseased with severe stenosis and calcification. Dr. Rasmussen's opinion is adopted rather than the other two lesser qualified medical professionals whose opinions are vague and conclusory.

Based on that finding, the medical expenses in the past that the claimant has incurred as a result of her heart condition, or any other condition unrelated to the pulmonary condition that was previously found to be causally related to the work injury in the April 2012 arbitration decision.

The next issue is the extent of claimant's disability. Claimant argues that she is permanently disabled, or, in the alternative, an odd-lot employee.

In Guyton v. Irving Jensen Co., 373 N.W.2d 101 (Iowa 1985), the Iowa court formally adopted the "odd-lot doctrine." Under that doctrine a worker becomes an odd- lot employee when an injury makes the worker incapable of obtaining employment in any well-known branch of the labor market. An odd-lot worker is thus totally disabled if the only services the worker can perform are "so limited in quality, dependability, or quantity that a reasonably stable market for them does not exist." Id., at 105.

Under the odd-lot doctrine, the burden of persuasion on the issue of industrial disability always remains with the worker. Nevertheless, when a worker makes a prima facie case of total disability by producing substantial evidence that the worker is not employable in the competitive labor market, the burden to produce evidence showing availability of suitable employment shifts to the employer. If the employer fails to produce such evidence and the trier of facts finds the worker does fall in the odd-lot category, the worker is entitled to a finding of total disability. Guyton, 373 N.W.2d at 106. Factors to be considered in determining whether a worker is an odd-lot employee include the worker's reasonable but unsuccessful effort to find steady employment, vocational or other expert evidence demonstrating suitable work is not available for the worker, the extent of the worker's physical impairment, intelligence, education, age,

training, and potential for retraining. No factor is necessarily dispositive on the issue. Second Injury Fund of Iowa v. Nelson, 544 N.W.2d 258 (Iowa 1995). Even under the odd-lot doctrine, the trier of fact is free to determine the weight and credibility of evidence in determining whether the worker's burden of persuasion has been carried, and only in an exceptional case would evidence be sufficiently strong as to compel a finding of total disability as a matter of law. Guyton, 373 N.W.2d at 106.

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

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

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

The vocational expert opines claimant cannot work due to the restrictions and opinions of Dr. Kline.

Dr. Kline's opinions indicate that "based on her occupational asthma alone, Ms. Brown should avoid workplace exposures to environments that are significantly dusty or associated with fumes, vapors, smoke, or mold." Dr. Hartley agrees with this as does Dr. Bruyntjens. Her day-to-day complaints include a cough, shortness of breath, and nasal drainage.

Dr. Kline opines that other ailments associated with claimant's long-time steroid use is responsible for her inability to return to the workplace. These other ailments, such as the proximal muscle weakness, susceptibility to common viral and other illnesses, her fatigue and interrupted sleeping, are the conditions that contribute to claimant's belief she cannot tolerate a full working day. Dr. Hartley's opinions in this matter are given more weight because they are based on claimant's long condition rather than unassociated ailments.

Claimant did not carry her burden to prove that the other ailments such as the muscle weakness, fatigue and interrupted sleeping were related to the work injury. Her SSD application was also based on a wide constellation of issues in 2012, similar to those that she now claims are the result of long-term corticosteroid usage.

Claimant's past work history includes work in a preschool and/or child care center, an upholstery shop, and teaching. It is unlikely, given claimant's pulmonary condition, that she could work in a factory due to the fumes, vapors, and smoke. A preschool or child care center or even a daycare does not pose the same environmental risks. Claimant has the skill and education necessary to work in an office such as brokerage house, law firm, or insurance company.

While claimant's pulmonary condition does eliminate a great portion of the labor market, there are positions claimant could work with her pulmonary condition. The other conditions that may limit claimant's employability are not related to her work injury and are not part of consideration herein.

Because it is found that there are commonly known branches of the labor market that claimant could work, the odd-lot doctrine is not applicable.

Claimant is an older person with a bachelor's education. She has worked primarily as a school teacher in the relevant past. She is unmotivated to return to work and has not looked for any work primarily based on her own belief she is incapable of working. She has the skills, training, education, and experience to do office work, teaching and/or child care. However, she is reluctant to leave her house due to fear of negative exposures in non-controlled environments outside of her personal residence.

It is found that claimant has sustained a 85 percent industrial disability due to her pulmonary injury. Claimant has a significant sensitivity to fumes, odors, and vapors.

Permanent benefits commence when healing period ends.

Section 85.34(1) provides that healing period benefits are payable to an injured worker who has suffered permanent partial disability until (1) the worker has returned to work; (2) the worker is medically capable of returning to substantially similar employment; or (3) the worker has achieved maximum medical recovery. The healing period can be considered the period during which there is a reasonable expectation of improvement of the disabling condition. See Armstrong Tire & Rubber Co. v. Kubli, Iowa App 312 N.W.2d 60 (1981). Healing period benefits can be interrupted or intermittent. Teel v. McCord, 394 N.W.2d 405 (Iowa 1986).

Claimant cannot return to substantially similar employment and therefore the question of the commencement date of permanent benefits rests on the date on which the claimant reached MMI.

Dr. Kline imposed work restrictions on November 14, 2011 that remain in effect today, however, he determined that her MMI date was January 2015 given that was the date that further recovery or deterioration was not anticipated. Dr. Hartley set claimant's MMI date as two years from her last work date which would be May 2012.

Treatment alone does not extend the healing period unless it is likely that the treatment would decrease the extent of permanent disability. *See Pitzer v. Rowley Interstate*, 507 N.W.2d 389, 392 (Iowa 1993). When significant improvement is not anticipated, the claimant has reached MMI.

There is little medical evidence that the treatment provided to the claimant past even November 14, 2011, was expected to improve her condition. Instead, the medical records show that claimant received palliative or maintenance care. She exhibited a waxing and waning of asthma and/or bronchial-related symptoms that were treated with various medications including, but not limited to, prednisone. Dr. Kline wrote that "she has no significant reversibility on today's pulmonary function testing" since 2011. Dr. Hartley agreed.

Claimant was found to be not at MMI as of the hearing in January 2012. Dr. Kline's records show that claimant was off systemic corticosteroids for some time in 2012 and that it was not until January 2015 that she required oral usage on a regular basis. Based on Dr. Kline's testimony and claimant's medical usage, it is determined that her MMI date, when significant improvement was no longer anticipated, would be January 31, 2015.

Defendants would be entitled to a credit against the permanent benefits awarded for payments made beginning February 1, 2015.

ORDER

THEREFORE, it is ordered:

That defendants are to pay unto claimant four hundred twenty-five (425) weeks of permanent partial disability benefits at the rate of five hundred fifteen and 06/100 dollars ($515.06) per week from January 31, 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 against permanent benefits awarded for benefits previously paid beginning on February 1, 2015.

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

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

Signed and filed this 30th day of January, 2017.

JENNIFER S. GERRISH-LAMPE
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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