BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

BRENDA WILLIAMSON,

Claimant,

vs.

SCHALLER-CRESTLAND COMMUNITY SCHOOL DISTRICT,

Employer,

and

EMC INSURANCE COMPANIES,

Insurance Carrier,
Defendants.

FILED

JUN 20 2018

WORKERS COMPENSATION

File No. 5058117

ARBITRATION DECISION

Head Note Nos.: 1803

STATEMENT OF THE CASE

Brenda Williamson, claimant, filed a petition in arbitration seeking workers' compensation benefits from Schaller-Crestland Community School District and EMC Insurance Company.

The evidentiary record includes Joint Exhibits JE1 through JE6, Claimant's Exhibits 1 through 3, and Defendants' Exhibits A, B, and D through I. At hearing, claimant and Mike Williamson, claimant's husband, provided testimony.

The parties filed a hearing report at the commencement of the arbitration hearing. On the hearing report, the parties entered into various stipulations. All of those stipulations were accepted and are hereby incorporated into this arbitration decision and no factual or legal issues relative to the parties' stipulations will be raised or discussed in this decision. The parties are now bound by their stipulations.

The arbitration hearing occurred on January 8, 2018. The parties submitted post-hearing briefs on February 26, 2018, and the matter was considered fully submitted on that date.

ISSUES

The parties presented the following issues for resolution:

1. Whether the stipulated injury that occurred on November 23, 2015, includes the right knee and left shoulder.

2. The extent of industrial disability.

3. Whether claimant is entitled to alternate medical care consisting of medical care recommended in the independent medical evaluation (IME) report of Robin Sassman, M.D.

FINDINGS OF FACT

After a review of the evidence presented, I find as follows:

Claimant, Brenda Williamson, was 52 years old at the time of the hearing. (Tr. page 13) She completed a bachelor's degree in elementary education and obtained her first teaching job with the defendant employer in 1990, teaching elementary school. (Tr. p. 14) She continued to work for the defendant employer at the time of the hearing, teaching fourth and fifth grade. (Tr. p. 15)

Over the years, claimant has held a number of coaching positions with the defendant employer, most often coaching volleyball. As a volleyball coach, claimant was required to place and remove the volleyball standards, which are heavy poles that hold up the net. She also carried bags of volleyballs, ran various drills for the players and physically demonstrated various techniques. (Tr. p. 17)

In her capacity as an elementary teacher, claimant interacts with elementary students, which requires physical activity including bending, reaching out and reaching overhead, standing and walking.

In addition to being a teacher and a coach, claimant volunteered as an emergency medical technician (EMT) for 17 years for Sac County. She last worked as an EMT shortly after November 23, 2015, the date of the injury herein. (Tr. pp. 20-21) She let her EMT license lapse after ceasing to work in that capacity. (Tr. p. 21) Claimant has also been a church organist and helped her husband in his electrical business at job sites, where she was "just basically . . . an extra set of hands for him," climbing ladders, and handling equipment and tool boxes. (Tr. p. 22)

Claimant has demonstrated that she is motivated to work by her continued employment with the defendant employer.

THE INJURY

On November 23, 2015, while working for defendant employer, claimant was assisting a 5th grade student into the building who did not want to go in. The incident/altercation resulted in claimant falling to the floor and landing forcefully on her hands and knees on a tile floor. (Tr. p. 24) Claimant testified that she reported the injuries to her hands, shoulders and knees on the day of the incident. (Tr. pp. 24-25) She stated that the workers' compensation insurance carrier authorized an appointment for her with her family physician, Bernadette Gyano, M.D., in Sac City, although it took more than two weeks after the injury to do so. (Tr. pp. 25-26)

PRE-INJURY MEDICAL TREATMENT

Claimant agreed that she had problems with her bilateral knees and shoulders that pre-dated the work injury of November 23, 2015. (Tr. p. 27) However, she testified that her prior problems did not interfere with teaching, coaching, helping her husband in his electrical business or working as an EMT. (Tr. p. 28) But, the undersigned notes that claimant underwent a substantial amount of treatment, including surgeries that pre-dated the work injury, and required at least some time away from work.

Claimant testified that she married Mike Williamson in either 2012 or 2013. (Tr. p. 50) Therefore, it is understood by the undersigned that "Brenda Mentzer" who is referenced in the medical records, who shares the same birthdate with claimant, is the same person as the claimant, Brenda Williamson. (Exhibit JE1, p. 7)

The prior medical history of the bilateral knees and shoulders, is set out individually below.

Left Knee

In February 2004, claimant reported a six month history of medial sided left knee pain with a locking episode, and persistent catching, and clicking. (Ex. JE1, p. 2, 13)

On February 23, 2004, claimant had medial meniscectomy surgery on her left knee, in which the surgeon, Steven Meyer, M.D., noted that "[v]ery little meniscal remnant was left." (Ex. JE3, p. 1)

On December 15, 2010, claimant reported that she ruptured her hamstring playing softball in May 2010, and fell to the ground, twisting her left knee and that she had continuing knee pain and instability. (Ex. JE1, p. 24) She was diagnosed with mild degenerative joint disease of the left knee with "probable partial anterior cruciate ligament rupture and potential meniscal pathology." (Ex. JE1, p. 25) An MRI was obtained on December 20, 2010, which showed a horizontal tear through the posterior horn of the medial meniscus. (Ex. JE2, p. 2)

On January 6, 2011, claimant underwent a second surgery with Dr. Meyer on her left knee involving a partial medial meniscectomy, partial synovectomy and debridement of hypertrophic synovitis. (Ex. JE3, p. 3) She was noted to have "Grade I to II and a couple small areas of Grade III chondromalacia" in the medial compartment. (Id.)

On February 23, 2011, Dr. Meyer stated that claimant had an excellent recovery from her knee arthroscopy. (JE1, p. 28)

On September 28, 2011, claimant was seen following a slip and fall in which she landed "directly onto her left knee." (Ex. JE1, p. 29) Dr. Meyer opined that claimant likely sustained a patellar contusion. (Id.) She was given an injection to address probable inflammation and an MRI was recommended. (Id.) The MRI showed "a large tear of the medial meniscus." (Ex. JE1, p. 30) Arthroscopic surgery was recommended.

On November 16, 2011, claimant had her third surgery on her left knee, which was a partial medial meniscectomy, with debridement of the chondral flap, performed by Dr. Meyer. (Ex. JE2, p. 3)

On September 12, 2012, claimant reported that "both knees and her left shoulder [were] causing her difficulty in engaging in her desired activities . . . ." (Ex. JE1, p. 31) An MRI of both knees was recommended and she was diagnosed with a left knee meniscal tear. (Ex. JE1, p. 37) Left knee arthroscopy was recommended.

On October 10, 2012, claimant underwent a fourth surgery with Dr. Meyer on her left knee, again due to a medial meniscus tear and involving a partial medial meniscectomy. (Ex. JE2, p. 4)

In December 2012, claimant had Orthovisc injections in her "moderately arthritic left knee." (Ex. JE1, p. 39)

On December 13, 2013, claimant fell "with a blow to her shoulder as well as scraping her knee." (Ex. JE1, p. 41) The assessment at that time was probable left knee degenerative joint disease and she received an injection. (Ex. JE1, p. 43)

On December 4, 2014, claimant noted that her arthritis was acting up and the ibuprofen was no longer working concerning "[b]oth shoulders and knees and ankles and small joints." (Ex. JE4, p. 9)

On May 19, 2015, claimant was diagnosed with degenerative arthritis in the left knee. (Ex. JE1, p. 63)

Right Knee

On September 12, 2012, claimant reported "multiple extremity complaints" with her primary complaint being "new onset of right knee pain of about 3 months' duration." (Ex. JE1, p. 31) It was noted that "both knees and her left shoulder [are] causing her difficulty in engaging in her desired activities . . . ." (Ex. JE1, p. 31) An MRI of both knees was recommended. She was diagnosed with right knee patellofemoral arthrosis and received an injection into the right knee. (Ex. JE1, p. 37)

On December 8, 2014, claimant noted that her arthritis was acting up and the ibuprofen was no longer working concerning "[b]oth shoulders and knees and ankles and small joints." (Ex. JE4, p. 9)

Left Shoulder

On October 4, 2000, claimant was seen by Dr. Meyer for pain in her left shoulder and both legs that began in September 1999. (Ex. JE1, pp. 1, 3) She had an MRI on her left shoulder on November 1, 2000, which indicated that she had a possible partial tear of the supraspinatus tendon. (Ex. JE2, p. 1)

On April 27, 2005, claimant was seen by Dr. Meyer for left shoulder pain, and she advised that her previous left shoulder pain had a good result with treatment of an

injection and physical therapy. (Ex. JE1, p. 14) She was diagnosed with left shoulder rotator cuff tendonitis and was prescribed physical therapy.

On October 3, 2007, claimant was seen by Dr. Meyer for "ongoing left shoulder pain that has been bothering her intermittently for several years." (Ex. JE1, p. 17) She reported increased pain as well as catching in her left shoulder with overhead activities and being unable to lift heavy objects above her head. (Id.) An arthrogram MRI was recommended. (Ex. JE1, p. 18) She was administered a second injection in her shoulder on January 30, 2008. (Ex. JE1, p. 19)

On May 28, 2008, claimant saw Dr. Meyer with continued left shoulder pain, which was described as "profound AC joint arthrosis." (Ex. JE1, p. 20) An AC joint resection arthroplasty was recommended. (Ex. JE1, pp. 21, 22)

On May 29, 2008, claimant underwent AC joint resection surgery with Dr. Meyer on her left shoulder. (Ex. JE3, p. 2) On July 30, 2008, she was released to return to full activities post-surgery. (Ex. JE1, p. 22)

On February 23, 2011, Dr. Meyer stated that claimant had an excellent recovery from her AC joint injection. (Ex. JE1, p. 28)

On September 12, 2012, claimant reported to Dr. Meyer that she had "multiple extremity complaints," including a concern that the left shoulder AC joint had become more symptomatic. (Ex. JE1, p. 31) It was noted that "both knees and her left shoulder [are] causing her difficulty in engaging in her desired activities . . . ." (Id.)

In December 2012, claimant was diagnosed by Dr. Meyer with left rotator cuff tendinopathy and impingement syndrome. She received an injection into her left shoulder. (Ex. JE1, p. 39)

On December 8, 2014, claimant noted that her arthritis was acting up and the ibuprofen was no longer working concerning "[b]oth shoulders and knees and ankles and small joints." (Ex. JE4, p. 9)

Right Shoulder

On April 8, 2013, claimant had an MRI of her right shoulder at the request of Dr. Myer, which showed "[e]xtensive tearing of the superior labrum with paralabral cyst" and "[r]otator cuff tendinopathy with no full-thickness rotator cuff tear." (Ex. JE2, p. 5)

On April 24, 2013, claimant was seen by Dr. Meyer following the MRI of her right shoulder complaining of continued, significant pain and limited function with stiffness and catching. Dr. Meyer described the MRI as showing a "SLAP lesion of the right shoulder with rotator cuff tendinopathy." (Ex. JE1, p. 40) She was referred by Dr. Meyer to Dr. Tom Jacobson for evaluation and probable arthroscopic surgery concerning the labral tear. (Id.)

On December 13, 2013, claimant fell "with a blow to her shoulder as well as scraping her knee." (Ex. JE1, p. 41) Claimant was "well known to Dr. Meyer," due to her "ongoing shoulder and knee pain." (Id.) The assessment at that time was probable right shoulder impingement syndrome and she received an injection in her right shoulder. (Ex. JE1, p. 43)

On February 10, 2014, claimant was seen by Benjamin Bissell, M.D. "at the request of Dr. Meyer for consultation regarding [her] chief complaint of right shoulder pain." (Ex. JE1, p. 44) Claimant was noted to have a "long history of right shoulder issues requiring intermittent injections and treatments," noting that and "[i]n December she fell on the ice and it got a lot worse after that." (Id.) the assessment at that time was "[r]ight shoulder SLAP tear, possible posterior labral tear, now with superimposed adhesive capsulitis since a fall in December." (Ex. JE1, p. 44) Dr. Bissell recommended surgery. (Ex. JE1, p. 44)

On March 3, 2014, claimant underwent surgery with Dr. Bissell involving an open biceps tenodesis, loose body removal, chondroplasty of the humeral head and glenoid, anterior and posterior, limited superior and anterior capsular release, gentle manipulation under anesthesia and subacromial decompression. (Ex. JE1, p. 45; Ex. JE5, p. 1)

On or about May 12, 2014, Dr. Bissell noted that claimant was initially doing well after surgery, but she developed increased stiffness and pain consistent with "adhesive capsulitis versus arthritic symptoms." (Ex. JE1, p. 45) She received another injection into her right shoulder. (Id.)

On June 26, 2014, claimant had another right shoulder MRI, which was ordered by Dr. Bissell that revealed: mild supraspinatus tendon degeneration/tendinopathy; joint effusion with fluid in the rotator cuff interval; fluid in the subacromial/subdeltoid bursa, suggesting bursitis; and, moderate acromioclavicular joint arthropathy. (Ex. JE5, p. 6)

On July 14, 2014, Dr. Bissell noted that claimant had been doing "great after surgery for about 2 months but since then, she has ongoing pain, which at this point is arthritis and adhesive capsulitis." (Ex. JE1, p. 51)

On August 25, 2014, claimant reported to Dr. Bissell that she had continuing right shoulder pain that was worse with activity and better with rest and ibuprofen. She was taking ibuprofen 2 or 3 times per day at that time. (Ex. JE1, p. 52)

On December 8, 2014, claimant noted that her arthritis was acting up and the ibuprofen was no longer working concerning "[b]oth shoulders and knees and ankles and small joints." (Ex. JE4, p. 9)

Also on or about December 8, 2014, claimant's right shoulder pain was described as "getting worse," with "pain all the time," and "popping and shifting." (Ex. JE1, p. 53) Dr. Bissell gave her prescriptions for Mobic and Percocet, and noted that claimant has grade 4 changes "so arthroplasty may be an option at some point but she is a little on

the young side," although "[w]e could consider arthroplasty if really needed." (Id.) She was also given an injection in the shoulder. (Ex. JE1, p. 57)

On December 12, 2014, claimant noted that the pain was getting to the point that it was no longer tolerable and she "would really like to consider shoulder replacement." (Ex. JE1, p. 59)

On January 22, 2015, claimant had another right shoulder MRI, at the request of Dr. Bissell, which showed: mild supraspinatus tendon degeneration/tendinopathy; small glenohumeral joint effusion; fluid in the subacromial/subdeltoid bursa; small osteochondral defect/grade 4 chondromalacia superior glenoid; and moderate acromioclavicular joint arthropathy. (Ex. JE5, p. 7)

On February 18, 2015, claimant had surgery on her right shoulder with Dr. Bissell, which he described as arthroscopy with chondroplasty/debridement, capsule release, and bursectomy. (Ex. JE3, p. 4)

On May 19, 2015, claimant was diagnosed with degenerative arthritis right shoulder. (Ex. JE1, p. 63)

General Complaints

On May 9, 2003, claimant was seen for a rheumatologic consultation concerning a possible generalized arthritic process and was noted to have "a very complicated musculoskeletal history." (Ex. JE1, p. 7)

On September 12, 2012, claimant reported "multiple extremity complaints" to Leszek Marczewski, M.D. as part of a history and physical. (Ex. JE1, p. 31)

In January 2013, claimant was seen by Dr. Marczewski, to discuss arthritis and aching joints and medications for chronic conditions. (Ex. JE4, p. 1)

In May 2013, claimant complained of aching joints including her shoulders, hands and knees. (Ex. JE4, pp. 3, 5)

On December 8, 2014, claimant noted that her arthritis was acting up and the ibuprofen was no longer working concerning "[b]oth shoulders and knees and ankles and small joints." (Ex. JE4, p. 9)

On May 19, 2015, claimant was referred by Dr. Bissell to Robert Wisco, M.D. for assessment of her "multiple musculoskeletal problems and the possibility of having a generalized inflammatory arthritis." (Ex. JE1, p. 61) She was noted to have "an extraordinarily complicated musculoskeletal history." (Id.) She was diagnosed with degenerative arthritis in the left knee and right shoulder. (Ex. JE1, p. 63)

POST-INJURY MEDICAL TREATMENT

On December 11, 2015, claimant was seen by her primary care physician, Dr. Gyano, and she described her work injury that occurred on November 23, 2015.

(Ex. JE4, p. 12) She stated that she fell and hit both knees on the floor and twisted her right shoulder. (Ex. JE4, p. 12) The assessment was; left knee pain and right shoulder pain. (Ex. JE4, p. 13)

On January 27, 2016, claimant was seen by Dr. Meyer who had treated claimant extensively in the past for her knees and shoulders (Ex. JE1, p. 66) Claimant reported "functioning quite well until 11/23/15," the date of the work injury herein. (Id.) She reported landing "directly on both knees" and that "she twisted both knees as well," and that since that time she has had "significant anterior and medial joint line tenderness of both knees, left greater than right." (Ex. JE1, p. 66) Bilateral knee MRIs were recommended. (Ex. JE1, p. 68)

On January 21, 2016, claimant stated that she had multiple aching joints and her right knee gave out that morning, causing her to fall to the ground, landing "directly on both knees" and catching herself with her hands which "jolted" her body. (Ex. JE4, p. 14)

On February 24, 2016, claimant reported that the left knee continued to be "far more painful than the right," and she was falling "on a regular basis," but she "cannot describe why she falls, but says that her legs just give out on her, although she does not have any discernible weakness or radicular-type symptoms that would point to a neurologic etiology." (Ex. JE1, p. 69) Claimant was diagnosed with a possible left knee meniscal tear and chondromalacia patella and degenerative change in the right knee. (Ex. JE1, p. 70) She received an injection in the left knee.

On March 2, 2016, claimant was seen by Dr. Meyer for follow-up of her ongoing left knee and right shoulder pain along with achiness in her low back. (Ex. JE1, p. 72) Surgery for the left knee was recommended and she received an injection in the right shoulder. (Ex. JE1, p. 73)

On March 17, 2016, claimant had surgery with Dr. Meyer on the left knee, which was a partial medial meniscectomy of the meniscal remnant. (Ex. JE3, p. 5)

On April 26, 2016, Dr. Meyer referred claimant back to Dr. Bissell for consultation regarding her chief complaint of right shoulder pain. Dr. Bissell had done "2 prior right shoulder scopes on her," with the most recent on February 18, 2015. (Ex. JE1, p. 76) After the most recent surgery claimant "was doing really well and she was actually back to coaching high school volleyball doing overhead serves, spikes, etc., with no problems," full range of motion and strength and no pain. (Ex. JE1, p. 76) However, after the November 23, 2015 incident when "[s]he injured both her right knee and right shoulder," claimant "has had sudden onset of pain, weakness, [and] limited motion." (Id.)

On May 16, 2016, claimant was seen for follow-up noting that her shoulder pain was unchanged. (Ex. JE1, p. 79) Dr. Bissell stated that the November 2015 work injury caused the right shoulder to take "a large amount of force as she caught herself on it and jammed it hard." (Id.) He recommended right shoulder arthroscopy. (Ex. JE1, p. 80) The goal was to give claimant increased motion and decreased pain, "but she

understands that she has some underlying osteoarthritis that could give her ongoing recurrent symptoms in the future." (Ex. JE1, p. 80) Dr. Bissell stated

> She did have some underlying documented pre-existing degenerative changes, but she was doing very well prior to this incident with good motion and thus I do feel that the arthroscopy and lysis of adhesions and manipulation, debridement is related to the work injury. However, it could be postulated that if she needed a shoulder replacement in the future at some point that may potentially not be covered by workers comp.

(Ex. JE1, p. 80)

On June 22, 2016, claimant underwent right shoulder surgery with Dr. Bissell, involving "arthroscopy, extensive debridement including bursectomy, mild labral debridement, [and] capsule release." (Ex. JE3, p. 6)

On August 1, 2016, claimant was seen by Dr. Bissell in follow-up to the right shoulder surgery on June 22, 2016. Claimant reported her pain had improved considerably and her strength was returning as well. (Ex. JE1, p. 84) She was returned to full duty, but she was also told that "if she overdoes it with activity she may have some mild discomfort but should notice continued improvement of symptoms over the next couple of weeks." (Ex. JE1, p. 85)

On November 2, 2016, claimant complained of ongoing right shoulder pain and left knee pain, which she stated never stopped hurting following the November 23, 2015 work incident. (Ex. JE4, pp. 17, 18) She was referred to Thomas Greenwald, M.D. and an MRI of the right shoulder was recommended. (Ex. JE4, p. 17)

On November 8, 2016, the MRI of the right shoulder was conducted and showed glenohumeral joint osteoarthritis, and mild subacromial bursitis.

On December 7, 2016, claimant was seen by Dr. Greenwald for a second opinion. (Ex. JE6, p. 1) Claimant reported being frustrated that "she has pain each and every day." (Id.) She was aware that she was too young for shoulder replacement. Arthroscopic surgery was recommended. (Id.)

On January 4, 2017, claimant underwent a second post-injury surgery on her right shoulder with Dr. Greenwald involving "[r]ight shoulder arthroscopy with (extensive) debridement chondromalacia /DJD/labral tear," and "bursoscopy with subacromial decompression." (Ex. JE6, p. 4)

On January 24, 2017, Dr. Greenwald noted that claimant had "a little bit of similar type discomfort to the left shoulder, but it is mild at this point," and he was "hopeful that it will improve with her rotator cuff stretching and strengthening program." (Ex. JE6, p. 7) Claimant was also noted to have bilateral knee degenerative joint disease. (Id.)

On February 17, 2017, and again on February 28, 2017, Dr. Meyer indicated that claimant sustained two percent impairment to the left lower extremity, while referencing

Table 17-33 and the Fifth Edition of the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment. (Ex. JE1, pp. 87, 88)

On June 1, 2017, claimant stated that she was "a little 'achy in the morning, but I can work my way through that.'" (Ex. JE6, p. 9) She was released to return to all of her normal activities, by Dr. Greenwald, but it was also recommended that she participate in an at-home stretching and strengthening program. (Id.)

On June 8, 2017, Dr. Greenwald, a treating physician, provided handwritten notes in response to a letter from the insurance carrier asking for a rating concerning the right shoulder work injury. (Ex. JE6, p. 10) He indicated that claimant reached MMI on June 1, 2017 when she was released to return to work without restrictions, and that she sustained 16 percent impairment to the upper extremity based on loss of range of motion and loss of strength, which he converted to 10 percent of the whole person. Dr. Greenwald referenced various figures and tables for assessment of the loss of range of motion and strength and conversion from upper extremity to the whole person. Although not specifically stated, these appear to be consistent with the AMA Guides, Fifth Edition. (Ex. JE6, p. 10)

On September 11, 2017, claimant returned to Dr. Meyer with complaints of right knee and left shoulder pain. Claimant was diagnosed with right knee patellar tendinitis and "AC arthrosis remnant AC joint status post AC joint resection and arthroplasty." (Ex. JE1, p. 89) She received an injection in the AC joint.

On October 30, 2017, Dr. Meyer, opined that the left knee and right shoulder treatments that he and Dr. Greenwald provided were due to the November 23, 2015 work injury and that the left knee and right shoulder have reached MMI and no restrictions are needed. Regarding the right knee and left shoulder, Dr. Meyer opined that the only medical treatment related to the November 23, 2015 work injury, would have been the initial evaluation and the treatment thereafter for a period of three (3) months. Dr. Meyer opined that none of the current condition of the right knee and left shoulder are related to the work injury. (Ex. JE1, p. 94)

On November 28, 2017, Terry Davis, M.D., a forensic psychiatrist, issued a report following a psychiatric evaluation of claimant at the request of defense counsel. (Ex. G) Dr. Davis referred claimant to, Rosanna Jones-Thurman, Ph.D., of Thurman Psychological LLC for part of the evaluation. (Ex. G, p. 7) The role of Dr. Jones-Thurman was "to help determine diagnostic impressions and treatment planning." (Ex. H, p. 1) Dr. Davis stated that claimant showed evidence of a somatic symptom disorder and her records indicated a history of persistent depressive disorder and anxious distress. (Ex. G, p. 13) However, he opined that neither of those conditions were "caused, aggravated, or exacerbated by her 11-23-15 work accident or injury" and further, that she had no mental illness or other condition that was caused, aggravated or exacerbated by the work injury, temporarily or permanently. (Id.)

On November 30, 2017, Robin Sassman, M.D., of Medix, issued a report following an (IME) conducted at the request of claimant's attorney. (Ex. 2) Dr. Sassman, after reviewing claimant's medical history and conducting a physical

examination, stated that claimant "has a long history of left knee surgeries, left shoulder surgeries and right shoulder surgeries," and she "clearly had symptoms in these areas prior to the injury in question." (Ex. 2, p. 14) However, claimant told Dr. Sassman that before the work injury, she did not have any pain in her knees "unless she overdid it," and that she could "do most everything she wanted to do." (Id.) Also, concerning her shoulder, claimant reported feeling "really good" and having "no limitations prior to this injury." (Id.) Dr. Sassman concluded that the November 23, 2015 injury "was a substantial aggravating factor in the surgeries to the right shoulder and the left knee." (Id.) In addition, Dr. Sassman opined that "based on the limited information" available to her, the November 23, 2015 injury "was at least an aggravating factor" concerning her left shoulder and right knee. (Id.)

Concerning future medical care, Dr. Sassman opined that claimant would likely need right shoulder and left knee replacement "at some point in the future." (Id.) She recommended an MRI for the left shoulder and the right knee. Dr. Sassman stated that absent the treatment that she has recommended, she would place claimant at maximum medical improvement (MMI) "11 months after the date of her most recent surgery, which would be December 4, 2017." (Ex. 2, p. 15)

Dr. Sassman assigned 4 percent impairment to the whole person regarding the left shoulder based on Tables 16-40, 16-43 and 16-46 of the AMA Guides. She assigned 7 percent impairment to the whole person for the right shoulder based on the same tables from the AMA Guides. Dr. Sassman found no ratable impairment for the right knee, but assigned 9 percent to the left lower extremity, which she converted to 4 percent of the whole person for the left knee relying on Tables 17-2, 17-31, and 17-33 of the AMA Guides. Using the combined values chart Dr. Sassman arrived at a "total of 13% whole person impairment for the injury that occurred on November 23, 2015." (Id.)

Dr. Sassman assigned restrictions of limiting "lifting, pushing, pulling and carrying to 20 pounds occasionally from floor to waist and 10 pounds occasionally from waist to shoulder," no lifting, pushing, pulling or carrying over shoulder height, use of vibratory or power tools, kneeling or crawling. (Ex. 2, p. 16) However, she did not distinguish between the left or right knee or shoulder concerning the application of the restrictions. Also, there is no particular discussion about claimant's physical abilities related to the assignment of the restrictions.

On or about December 23, 2017, Ian Crabb, M.D., issued a report following a medical records review. (Ex. I, p. 3) The report references claimant's pre-November 23, 2015 physical condition and multiple surgeries on her left knee and right shoulder, but the specific records referred to by Dr. Crabb, appear to only relate to treatment that occurred post-November 23, 2015. (Ex. I) Dr. Crabb opined that the work injury did "not necessitate a total knee replacement, nor did it accelerate or light up her underlying condition in a way that it speeds the necessity for total knee replacement." (Ex. I, p. 4) He further stated that concerning the left knee, claimant "does not need a total knee replacement as related to her accident of 11/23/2015." (Id.) Concerning the right shoulder, Dr. Crabb opined that "[t]here is no indication that the fall caused any acceleration of her underlying progressive degenerative condition. At the very most, she suffered a transient exacerbation of her condition." (Ex. I, p. 5) He

further stated that claimant will need no further medical treatment for her right shoulder due to the work incident. (Id.) Concerning the left shoulder and right knee, Dr. Crabb stated that "the medical record does not suggest that either of these joints was injured in any meaningful way at the time of her fall on 11/23/2015." (Ex. I, p. 5)

Concerning the left knee and right shoulder, Dr. Sassman and Dr. Meyer agree that claimant sustained injuries thereto as a result of the November 23, 2015 work injury. Dr. Crabb found no causal connection, however, this is not an issue for the undersigned to determine based on the parties' stipulations in the Hearing Report.

The causation issue in this case lies with the right knee and left shoulder. Dr. Sassman opined that "based on the limited information" available, the November 23, 2015 injury "was at least an aggravating factor" concerning her right knee and left shoulder. (Ex. 2, p. 14) Dr. Meyer stated that concerning the right knee and left shoulder that the only medical treatment related to the November 23, 2015 work injury, would have been the initial evaluation and treatment thereafter for a period of three (3) months, and that none of the current condition of the right knee and left shoulder are related to the work injury. (Ex. JE1, p. 94) Dr. Crabb opined concerning the right knee and left shoulder that "the medical record does not suggest either of these joints was injured in any meaningful way at the time of her fall on 11/23/2015." (Ex. I, p. 5)

I note that Dr. Sassman's opinion is based on what she herself described as limited information. Concerning the opinion of Dr. Crabb, I give it less weight because he did not have the opportunity to physically examine and speak with claimant. I accept the opinion of Dr. Meyer, the treating physician, who had multiple opportunities to see, evaluate and treat claimant both before and after the work injury regarding her long history of knee and shoulder problems. I therefore find that the November 23, 2015 work injury was a temporary exacerbation of the underlying condition of her right knee and left shoulder and that the period of treatment for 3 months post injury was related to the work injury, but that claimant did not sustain any permanent impairment from the work injury regarding the right knee and left shoulder.

Concerning permanent impairment to the stipulated body parts of the left knee and right shoulder, Dr. Greenwald, a treating physician, opined that claimant sustained 10 percent of the whole person, due to the right shoulder injury. (Ex. JE6, p. 10) Dr. Meyer assigned a 2 percent impairment to the left lower extremity for the knee. (Ex. JE1, pp. 87, 88) Dr. Sassman assigned 7 percent impairment to the whole person for the right shoulder and 9 percent to the left lower extremity based on the AMA Guides. The undersigned, relying on Table 17-3, p. 527, of the AMA Guides, finds that the lower extremity rating of Dr. Sassman of 9 percent converts to 4 percent of the whole person. Relying on the combined values chart of the AMA Guides, p. 604, I find that 7 percent whole person plus 4 percent whole person equals 11 percent permanent impairment to the whole person.

I accept the impairment rating assigned by Dr. Sassman as the most recent assessment of claimant's functional loss. I therefore find that claimant has sustained 11 percent whole person functional impairment due to the November 23, 2015 work injury, which involve the left knee and right shoulder.

Dr. Meyer, the treating physician, who has treated claimant both before and after the work injury over a period of many years, and to whom claimant was "well known" due to her "ongoing shoulder and knee pain," stated that claimant did not require any permanent restrictions for her left knee and right shoulder injuries. (Ex. JE1, pp. 41, 94) Dr. Sassman recommended restrictions, which were not specific to the left knee and right shoulder and did not include any discussion or rationale for the assignment of the restrictions. I am unable to distinguish within Dr. Sassman's opinion, which if any of the proposed restrictions are specifically related to the left knee and right shoulder. I find that the opinion of the treating physician, Dr. Meyer, that claimant does not require restrictions for the left knee and right shoulder due to the November 23, 2015 work injury to be the most reliable and persuasive.

Claimant remains employed as a teacher, but no longer coaches and no longer works as an EMT. She stated that she no longer does any gardening or repair/painting work around the home. She stated that outside work such as mending fence, mowing and other activities "are difficult or not happening at all." (Tr. p. 46) Claimant initially testified that the injuries have made her sad and that the emotional impact has kept her from working as an EMT and a coach, but also stated that the primary reason for not engaging in those activities is because of her physical limitations. (Tr. p. 47) However, I note that no treating physician has advised her to avoid those activities.

Concerning the extent of claimant's industrial disability, I note that her age, her functional impairment, and the length of her healing period, would tend to support a higher percentage of industrial disability. However, her education, her earnings before and after the work injury, her lack of permanent work restrictions and her motivation to maintain employment would tend to support a lower percentage of industrial disability. In view of these factors and considering all other appropriate factors for the assessment of industrial disability, I find that claimant has sustained 20 percent industrial disability as a result of the November 23, 2015 work injury. Twenty (20) percent industrial disability is 100 weeks of benefits.

Claimant seeks the right shoulder and left knee replacement that Dr. Sassman mentions in her IME report as alternative medical care. However, I note that Dr. Sassman states only that claimant will likely need a right shoulder and left knee replacement "at some point in the future." (Ex. 2, p. 14) This is not seen by the undersigned as a statement for specific treatment to be done at the present time, but rather a statement of a potential treatment at some point in the future. I find that at the present time, claimant has not shown that the treatment that defendants are presently providing is unreasonable.

CONCLUSIONS OF LAW

The initial disputed issue in this case is the extent of industrial disability.

The first sub-issue is whether the left shoulder and right knee are included in the assessment of industrial disability.

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).

When an expert opinion is based upon an incomplete history, the opinion is not necessarily binding upon the commissioner. The commissioner as trier of fact has the duty to determine the credibility of the witnesses and to weigh the evidence, together with the other disclosed facts and circumstances, and then to accept or reject the opinion. Dunlavey v. Economy Fire & Casualty Co., 526 N.W.2d 845 (Iowa 1995).

I have found above based on the opinion of Dr. Meyer, the treating physician, for the reasons there stated that the November 23, 2015, work injury was the cause of a temporary exacerbation of the right knee and left shoulder for a period of 3 months post injury, which did not result in any permanent impairment.

Therefore, the assessment of industrial disability is limited to the left knee and right shoulder, which constitutes a body as a whole injury.

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, 593; 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. However, consideration must also be given to the injured worker's medical condition before the injury, immediately after the injury and presently; the situs of the injury, its severity, and the length of healing period; the work experience of the injured worker prior to the injury, after the injury, and potential for rehabilitation; the injured workers' qualifications intellectually, emotionally and physically; the worker's earning before and after the injury; the willingness of the employer to re-employ the injured worker after the injury; the worker's age, education, and motivation; and, finally the inability because of the injury to engage in employment for which the worker is best fitted. Thilges v. Snap-On Tools Corp., 528 N.W.2d 614, 616 (Iowa 1995); 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).

There are no weighting guidelines that indicate how each of the factors is to be considered. Neither does a rating of functional impairment directly correlate to a degree of industrial disability to the body as a whole. In other words, there are no formulae which can be applied and then added up to determine the degree of industrial disability. It therefore becomes necessary for the deputy or commissioner to draw upon prior experience as well as general and specialized knowledge to make the finding with regard to degree of industrial disability. See Christensen v. Hagen, Inc., Vol. 1 No. 3 Industrial Commissioner Decisions, 529 (App. March 26, 1985); Peterson v. Truck Haven Cafe, Inc., Vol. 1 No. 3 Industrial Commissioner Decisions, 654 (App. February 28, 1985).

Assessments of industrial disability involve a viewing of loss of earning capacity in terms of the injured workers' present ability to earn in the competitive labor market without regard to any accommodation furnished by one's present employer. Quaker Oats Co. v. Ciha, 552 N.W.2d 143, 158 (Iowa 1996); Thilges v. Snap-On Tools Corp., 528 N.W.2d 614 (Iowa 1995).

As stated above and for the reasons there given, I have determined that claimant has sustained 20 percent industrial disability.

The parties stipulated to the commencement of the permanency benefits in the event the injury involved the left knee only of March 30, 2017. (Hearing Report, p. 1) However, I have found permanency exists in the right shoulder as well and therefore, the scheduled member knee claim merges into the industrial shoulder claim. The parties have stipulated that in the event the injury includes permanency for the shoulder, that the proper commencement date is June 1, 2017. (Hearing Report, p. 1)

The final issue is claimant's request for alternate medical care consisting of knee and shoulder replacement as recommended by Dr. Sassman.

The employer shall furnish reasonable surgical, medical, dental, osteopathic, chiropractic, podiatric, physical rehabilitation, nursing, ambulance and hospital services and supplies for all conditions compensable under the workers' compensation law. The employer shall also allow reasonable and necessary transportation expenses incurred for those services. The employer has the right to choose the provider of care, except where the employer has denied liability for the injury. Section 85.27. Holbert v. Townsend Engineering Co., Thirty-second Biennial Report of the Industrial Commissioner 78 (Review-Reopening October 16, 1975).

By challenging the employer's choice of treatment – and seeking alternate care – claimant assumes the burden of proving the authorized care is unreasonable. See Iowa R. App. P 14(f)(5); Bell Bros. Heating v. Gwinn, 779 N.W.2d 193, 209 (Iowa 2010); Long v. Roberts Dairy Co., 528 N.W.2d 122 (Iowa 1995). Determining what care is reasonable under the statute is a question of fact. Long v. Roberts Dairy Co., 528 N.W.2d 122 (Iowa 1995). The employer's obligation turns on the question of reasonable necessity, not desirability. Id.; Harned v. Farmland Foods, Inc., 331 N.W.2d 98 (Iowa 1983).

An application for alternate medical care is not automatically sustained because claimant is dissatisfied with the care he or she has been receiving. Mere dissatisfaction with the medical care is not ample grounds for granting an application for alternate medical care. Rather, the claimant must show that the care was not offered promptly, was not reasonably suited to treat the injury, or that the care was unduly inconvenient for the claimant. Long v. Roberts Dairy Co., 528 N.W.2d 122 (Iowa 1995).

An employer's right to select the provider of medical treatment to an injured worker does not include the right to determine how an injured worker should be diagnosed, evaluated, treated, or other matters of professional medical judgment. Assmann v. Blue Star Foods, File No. 866389 (Declaratory Ruling, May 19, 1988).

I have found above that Dr. Sassman's mention of shoulder and knee replacement in her IME report merely relate to the probability that such treatment may be needed "at some point in the future." (Ex. 2, p. 14) There is no current recommendation for joint replacement. Based on the present status of the evidence, claimant has failed to carry her burden of proof that she is entitled to alternate medical care at this time.

Assessment of costs is a discretionary function of this agency. Iowa Code section 86.40. Costs are to be assessed at the discretion of the deputy commissioner or workers' compensation commissioner hearing the case. 876 IAC 4.33. In my discretion I assess costs against defendants in the amount of $100.00, representing the filing fee.

ORDER

THEREFORE, IT IS ORDERED:

Defendants shall pay claimant industrial disability benefits of one hundred (100) weeks, beginning on the stipulated commencement date of June 1, 2017 until all benefits are paid in full.

Defendants shall be entitled to credit for all weekly benefits paid to date. The parties have stipulated that defendants are entitled to a credit of fifty-five (55) weeks.

All weekly benefits shall be paid at the stipulated rate of eight hundred twelve and 98/100 dollars ($812.98) per week.

Defendants shall pay accrued weekly benefits in a lump sum together with interest at the rate of ten (10) percent for all weekly benefits payable and not paid when due which accrued before July 1, 2017, and all interest on past due weekly compensation benefits accruing on or after July 1, 2017, shall be payable at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two (2) percent. See Gamble v. AG Leader Technology File No. 5054686 (App. Apr. 24, 2018).

Defendant shall pay costs of one hundred and 00/100 dollars ($100.00).

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

Signed and filed this 20th day of June, 2018.

TOBY J. GORDON
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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TJG/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.