BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

DAVID IDDINGS,

Claimant,

vs.

TIMBERLINE DIVERSIFIED, INC.,

Employer,

and

FARM BUREAU PROPERTY & CASUALTY INSURANCE COMPANY,

Insurance Carrier,
Defendants.

FILED
MAY 23 2019
WORKERS' COMPENSATION

File No. 5060429

ARBITRATION

DECISION

Head Notes: 1802, 1803, 2206, 2700

STATEMENT OF THE CASE

David Iddings, claimant, filed a petition in arbitration seeking workers' compensation benefits from Timberline Diversified, Inc. and its insurer, Farm Bureau Property and Casualty Insurance Company as a result of an injury he sustained on October 30, 2015 that arose out of and in the course of his employment. This case was heard in Des Moines, Iowa and fully submitted on January 15, 2019. The evidence in this case consists of the testimony of claimant, Tara Morris, Joint Exhibits 1 - 4, Defendants' Exhibits A - C and Claimant's Exhibits 1 - 3. Both parties submitted briefs.

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 defendants agreed that they would pay the costs of the independent medical examination performed by Jacqueline Stoken, D.O. (Transcript page 7)

ISSUES

1. Whether the claimant will be entitled to a running award of healing period benefits after right knee replacement surgery.

2. The extent of claimant's permanent disability.

3. Commencement date of any permanent disability benefits.

4. Whether claimant is entitled to alternative medical care, including right knee replacement surgery.

5. Assessment of costs.

FINDINGS OF FACT

The deputy workers' compensation commissioner having heard the testimony and considered the evidence in the record finds that:

David Iddings, claimant was 59 years old at the time of the hearing. Claimant graduated from high school and went to college for a year and a half. Claimant did not obtain any post-secondary degrees or certifications. (Transcript page 11)

Claimant has worked all his adult life. Claimant has worked construction from 1978 through 2015. Claimant described his work as,

> A. Mostly drywall, finishing, hanging; attic blowing insulation, putting insulation in the walls; I've done some concrete work, some general construction; we've flipped houses. We've done pretty much top to bottom anything you can do on construction.

(Tr. p. 12) Claimant testified that from the time period of 1990 to 2015 ninety percent of his work has been drywall. (Tr. p. 12) Claimant testified that prior to October 30, 2015 he had never seen a physician for his knee. (Tr. pp. 12, 16) Claimant testified that he did see a doctor about his knee in 1976 after a wrestling injury to his ankle. (Tr. p. 19)

Claimant testified that shortly before his injury he was working with drywall. Claimant would use stilts to work the top level of the drywall. Claimant would try to split his time so about fifty percent was on stilts. (Tr. p. 13) When he was not on his stilts he would also need to be on his knees, crouch or sometimes lie down. (Tr. p. 14)

On October 30, 2015 claimant was at work and climbed down off some scaffolding. When he was on the ground he turned his leg, and his knee twisted and popped. (Tr. p. 16)

On January 4, 2016 Christopher Vincent, M.D. performed right knee surgery. (Tr. p. 17) In his deposition claimant said that Dr. Vincent found an old tear and new tear in his knee and both were repaired. (Ex. A, p. 20) Claimant said that after the surgery his knee would start to get better but would reach a point where it stopped getting better. Claimant did agree that after the surgery, especially after the cortisone shots his symptoms improved. (Tr. p. 38) Claimant told Dr. Stoken that right after the surgery his symptoms improved. (Exhibit 1, p. 1) Claimant testified that he had fluid

taken off his right knee on February 11, 2016 and had a corticosteroid injection. On April 11, 2016 claimant returned to Dr. Vincent because of effusion in his knee. (Tr. p. 19) Claimant had the fluid removed and another corticosteroid injection. (Tr. p. 20) On June 9, 2019 claimant saw Dr. Vincent for swelling of his knee. At that visit Dr. Vincent noted claimant had significant Grade IV chondral loss of the lateral compartments which was contributing to the large effusions. (Tr. p. 20) Claimant said that he was told he had arthritis but said that he was not told by Dr. Vincent that this condition was contributing to his swelling. (Tr. p. 20) Claimant had the fluid taken off his knee and another corticosteroid injection. (Tr. p. 21) Claimant returned to Dr. Vincent on June 16, 2016 and was given an Orthovisc injection for the primary osteoarthritis of the right knee. (Tr. p. 21) Claimant received Orthovisc injections on June 23, 2016 and July 14, 2016. (Tr. p. 22)

On August 25, 2016 claimant saw Dr. Vincent and had a large knee effusion. Claimant was informed that Dr. Vincent had no other treatment options and that he had reached maximum medical improvement (MMI).

Claimant testified his knee was not returned to his pre-injury function. (Tr. p. 21) Claimant testified that whenever Dr. Vincent would drain the fluid off his knee the fluid would return in three days to a week. (Tr. p. 23)

Claimant returned to Dr. Vincent on March 16, 2017. Claimant said that his knee condition had not changed or improved between visits. (Tr. p. 24) Claimant had the fluid removed and another corticosteroid injection. (Tr. p. 24) Dr. Vincent ordered a functional capacity examination (FCE).

In October 2017 claimant popped his knee again and his knee swelled. Claimant saw Dr. Vincent on October 20, 2017 and had fluid drained. Claimant was told at that visit he would need a knee replacement. (Tr. p. 25)

Claimant returned to work with Timberline Diversified after his knee surgery in January 2016. Claimant testified that his father owns Timberline Diversified and that another company would not hire him. (Tr. p. 27) Claimant is unable to use stilts at work. He is able to use scaffolds but has a coworker move them around rather than doing it himself. (Tr. p. 28) Due to pain, claimant avoids doing low work now and has other coworkers perform the low work he used to perform. (Tr. p. 30) Claimant said that he can perform about fifty percent of the work he could do before his injury. (Tr. p. 32)

Claimant said that he would like his knee to get better and that as a knee replacement is his only option he wants that surgery. (Tr. p. 33)

Tara Morris testified at the hearing. Ms. Morris has worked with the claimant for about six years. (Tr. p. 50) Ms. Morris said that before the injury claimant could do everything at work including climbing ladders, carry everything, drive, do the mudding, hang drywall and work on stilts. (Tr. p.52) Since the injury Ms. Morris testified that their

roles have reversed and claimant needs help doing the hard work. (Tr. p. 53) Ms. Morris testified that since his work accident she has not seen claimant walk normally or do as much work as he used to do. (Tr. p. 56)

Claimant was seen by Matthew Doty, M.D. at the Pella Regional Health Center Occupational Medicine on November 3, 2015 for his right knee injury of October 30, 2015. Dr. Doty noted that x-rays showed degenerative changes of the right knee. The x-rays read by Alison Smith, D.O. showed,

1. Multi-compartmental degenerative changes without evidence of fracture.

2. Suprapatellar effusion, moderate in volume.

(JE. 3, p. 76) Dr. Doty assessed claimant with, "Right knee sprain." (JE 3, p. 73) Dr. Doty ordered an MRI. On November 10, 2015 Dr. Smith interpreted the MRI. Dr. Smith's impression was,

1. Complex tears of the medial and lateral menisci as described above.

2. Prepatellar swelling.

3. Degenerative change.

4. Joint effusion.

(JE. 3, p. 79) On November 11, 2015 Dr. Doty reviewed the MRI. Doty wrote the MRI showed complex tears of the medial and lateral menisci and degenerative changes and effusion. (JE. 3, p. 81) Dr. Doty referred claimant for orthopedic evaluation and returned claimant to modified work duty as of November 15, 2015. (JE. 3, p. 82) Dr. Doty saw claimant on February 16, 2018 when claimant stepped off a truck and hurt his right knee on February 13, 2018. Dr. Doty referred claimant to Dr. Vincent. (JE. 3, pp. 83, 86)

Claimant was seen by Dr. Vincent on November 19, 2015 for claimant's October 30, 2015 right knee injury. Dr. Vincent's assessment was,

> The patient is a 56-year-old male whose history, exam, radiographs and magnetic resonance imaging are all suggestive of chronic lateral compartment osteoarthritis with a degenerative tear of the lateral meniscus and a new acute medial meniscus tear. He states prior to this injury he was not having any knee pain, swelling or catching and locking. Since the twisting event, he has had a large knee effusion that has been persistent, painful catching in the medial aspect of the knee, and his physical exam findings are all suggestive of a symptomatic medial meniscus tear.

> Magnetic resonance imaging interpretation: Magnetic resonance imaging demonstrates a large intra-articular knee effusion. There is advanced osteoarthritis of the lateral compartment. The cruciate ligaments are intact. There is a complex tear of the medial meniscus in the posterior mid body. The lateral compartment also demonstrates disruption and what appears to be a complete radial tear in the posterior horn of the lateral meniscus. Large knee effusion. Remaining osseous and soft tissues are unremarkable.

(JE. 2, pp. 18, 19) Dr. Vincent recommended right knee arthroscopy with partial medial and lateral meniscectomy. (JE. 2, p. 19) Dr. Vincent wrote that this was "Work Comp" and provided temporary restrictions to claimant. (JE. 2, p. 20) On January 4, 2016 Dr. Vincent performed surgery. His postoperative diagnosis was,

1. Right medial meniscus tear.

2. Right lateral meniscus.

3. Right osteoarthritis of the lateral compartment.

FINDINGS:

1. Exam under anesthesia demonstrates a stable ligamentous exam and no significant malalignment.

2. Arthroscopy of the patellofemoral joint demonstrated normal articular cartilage of the patella. There was grade II to III diffuse chondromalacia of the patellar trochlea. Medial and lateral gutters were normal without loose body. Medial compartment demonstrated grade I chondromalacia of the medial compartment articular cartilage. There was degenerative horizontal cleavage tear in the mid body extending to the posterior horns of the medial meniscus.

3. ACL and PCL are intact.

4. The lateral compartment demonstrated grade 4 kissing lesions in the posterior half of the tibial plateau and significant chondral loss of the femoral condyle.

5. There was significant degenerative tearing of the lateral meniscus with radial component and horizontal degenerative component.

(JE. 2, p. 21) Dr. Vincent allowed claimant sit down work only with an anticipated return to full duty in six weeks. (JE. 2, p. 23) On February 11, 2016 Dr. Vincent noted claimant had a large right knee effusion and he provided an aspiration and corticosteroid injection. (JE. 2, p. 26) Claimant was returned to work with no restrictions on February 11, 2016. (JE. 2, p. 29) On April 11, 2016 Dr. Vincent saw

claimant with a large effusion on his knee. He noted that the effusion was limiting full recovery. Dr. Vincent provided a corticosteroid injection and aspiration on that date. (JE. 2, p. 31) On June 9, 2016 claimant returned to Dr. Vincent with a large effusion of his right knee. Dr. Vincent wrote,

> This is a 57-year-old male approximately 5 months status post RIGHT knee arthroscopy with arthroscopic partial medial and lateral meniscectomies. He received an aspiration and cortisone injection 2 months ago that provided about 2-3 weeks of relief. His swelling has returned and he continues to have a large, tense knee effusion limiting his full recovery. He has significant grade 4 chondral loss of the lateral compartment which is contributing to the persistent large effusions. Because he did not receive relief of his effusions with a corticosteroid injection, I discussed a series of aspirations and viscosupplementation injections, specifically a 4 injection series of Orthovisc coupled with aspirations. This is my current recommendation.
>
> The patient is a candidate for viscosupplementation for the treatment of symptomatic chondral loss of the affected knee. I discussed the risks, benefits, and alternatives, and the patient wishes to proceed. We will obtain preauthorization for the injection and I will see the patient back to administer the first aspiration/injection.

(JE. 2, p. 35) On June 16, 2016 claimant received his first Orthovisc injection and an aspiration of the right knee. (JE. 2, p. 39) This was considered to be "Work Comp" according to a form filled out by Dr. Vincent. (JE. 2, p. 40)

On June 23, 2016 claimant had his second Orthovisc injection. The assessment was "Primary osteoarthritis of right knee." (JE. 2, p. 42) This was considered to be "Work Comp" according to a form filled out by Dr. Vincent. (JE. 2, p. 42) On July 7, 2016 claimant had a third Orthovisc injection. (JE. 2, p. 45) This was considered to be "Work Comp" according to a form filled out by Dr. Vincent. (JE. 2, p. 46) On July 14, 2016 claimant had a fourth Orthovisc injection. Claimant has not had any pain relief from the Orthovisc injections. (JE. 2, p. 48) This was considered to be "Work Comp" according to a form filled out by Dr. Vincent. (JE. 2, p. 49)

On August 25, 2016 Dr. Vincent examined claimant and wrote,

> Patient has had corticosteroid injections and viscosupplementation but continues to have a large knee effusion and functional limitations due to pain and stiffness and swelling in the knee joint. At the time of arthroscopy he was found to have grade 4 chondral loss of the medial compartment which is likely the cause of his continued functional symptoms and limitations.

> He states he is unable to do his normal job duties. I am obtaining a functional capacity evaluation of the patient to determine the need for permanent work restrictions and we will see him back after. At that point we will likely place him at MMI and make permanent work restrictions depending on the results of the functional capacity evaluation. I do not believe there are any other treatments that can be done to improve his function as a result of the work injury.

(JE. 2, p. 51) Dr. Vincent still indicated this was "Work Comp" on a form he filled out on August 25, 2016. (JE. 2, p. 53)

On March 16, 2017 Dr. Vincent wrote,

> This is a 57-year-old male approximately 14 months status post RIGHT knee arthroscopy with arthroscopic partial medial and lateral meniscectomies. Patient has had corticosteroid injections and viscosupplementation but continues to have a large knee effusion and functional limitations due to pain and stiffness and swelling in the knee joint. At the time of arthroscopy he was found to have grade 4 chondral loss of the medial compartment which is likely the cause of his continued functional symptoms and limitations. After my evaluation of the patient today, reviewing the patient's data, exam, interviewing the patient and discussing treatment options, the patient has elected to proceed with a corticosteroid injection to reduce inflammation and pain. I discussed the risks, benefits, and alternatives to injection and the patient gave informed consent to proceed.
>
> He states he is unable to do his normal job duties. I am obtaining a functional capacity evaluation of the patient to determine the need for permanent work restrictions and we will see him back after. At that point we will likely place him at MMI and make permanent work restrictions depending on the results of the functional capacity evaluation. I do not believe there are any other treatments that can be done to improve his function as a result of the work injury.

(JE, 2, p. 55) Dr. Vincent indicated this was "Work Comp" on a form he filled out on March 16, 2017. (JE. 2, p. 57)

On March 28, 2017 an FCE was performed. The results were considered valid. (JE. 1, p. 1) The FCE recommended the following restrictions,

1. Unable to perform 2 hand occasional lift 16" to waist >50#, waist to shoulder >45#, shoulder to overhead >35#.

2. Unable to perform 2 hand occasional carry >45# x 25ft carrying distance.

3. Unable to perform repetitive squatting, repetitive kneeling, crawling, and stair climbing on the RLE.

4. Unable to perform ladder climbing, standing and walking greater than the occasional category of work on RLE.

5. Unable to perform 2-hand occasional pushing >34 pounds of force and 2-hand occasional pulling > 22 pounds of force x 25ft.

(JE 1, p. 1)

On April 6, 2017 Dr. Vincent reviewed the FCE. Dr. Vincent adopted the restrictions regarding claimant's knee and stated that the lifting restrictions were not related to his knee injury. Dr. Vincent recommended claimant avoid repetitive squatting, kneeling, climbing and crawling due to his knee dysfunction. Dr. Vincent said claimant was at MMI and he had no additional treatment and released claimant from routine care. (JE. 2, p. 59) On October 19, 2017 claimant saw Dr. Vincent and claimant was provided a knee aspiration and a corticosteroid injection. (JE. 2, p. 64) Dr. Vincent indicated this was "Work Comp" on a form he filled out on October 19, 2017. (JE. 2, p. 65)

On July 27, 2017 Dr. Vincent provided a rating for the claimant's right knee injury. Dr. Vincent noted that under the AMA Guides up to a 10 percent lower extremity rating could be given for the procedure on claimant's knee, but considering the slight loss of lateral flexion he thought a 4 percent rating to the lower extremity was fair. (Ex. B, p. 36) On October 2, 2017 defendants notified claimant that he was going to be paid ten weeks of permanent partial disability based upon Dr. Vincent's rating. (Ex. 2, p. 13)

On March 19, 2018 claimant saw Dr. Vincent due to knee pain and swelling. Dr. Vincent stated that based upon his interview with claimant and review of new x-rays, Dr. Vincent believed claimant's ongoing symptoms are a result of claimant's osteoarthritis, which was pre-existing to his work injury. (JE. 2, p. 67) Dr. Vincent and claimant agreed at that visit to proceed with a total knee replacement. (JE. 2, p. 68)

On August 31, 2018 Dr. Vincent wrote claimant's attorney. Dr. Vincent wrote that prior to October 30, 2015 claimant's knee was asymptomatic with regard to right knee pain. Dr. Vincent noted that claimant has not returned to pre-injury level of functioning nor did the surgery resolve all of the claimant's pain as a result of his injury. (JE. 2, p. 70)

On October 8, 2018 Dr. Stoken issued an independent medical examination (IME). Dr. Stoken's impression was,

1. Remoted history of back surgery.

2. Status post work injury October 30, 2015 with medial and lateral meniscal tear of the right knee.

3. Status post right knee arthroscopy with arthroscopic partial medial and lateral meniscectomies on 1/4/2016 done by Dr. Christopher Vincent. Postoperative diagnosis is right medial meniscus tear. Right lateral meniscus. Right osteoarthritis of the lateral compartment.

4. Chronic pain of the right knee, left knee, left hip and back.

(Ex. 1, p. 8) Dr. Stoken found that the claimant's symptoms were causally related to his October 30, 2015 work injury and the work injury lighted up the underlying osteoarthritis. (Ex. 1, p. 9) Dr. Stoken provided a 10 percent lower extremity rating for claimant's right knee. (Ex. 1, p. 9) Dr. Stoken recommended restrictions of avoiding kneeling, crawling, stooping and bending of the right knee. Claimant should also avoid prolonged standing and walking and walking on uneven ground. (Ex. 1, p. 9)

Dr. Stoken agreed with Dr. Vincent that a total knee replacement was the only treatment option. (Ex. 1, p. 10)

On October 25, 2018, Dr. Vincent wrote to defendants' attorney. Dr. Vincent said claimant received treatment for a right knee injury. Claimant had a medial meniscus tear and also had advanced osteoarthritis of the lateral compartment at that time. As to the claimant's pain, Dr. Vincent commented that pain is subjective and only the claimant can know the level of his pain. (JE. 2, p. 71) Dr. Vincent wrote that the claimant's osteoarthritis pre-dated his work injury. Dr. Vincent stated claimant's medial meniscus did not accelerate the need for a total knee replacement. Dr. Vincent could not causally link the development and progression of the lateral compartment osteoarthritis to a meniscus injury of the medial compartment. (JE. 2, p. 71) Dr. Vincent stated that claimant's need for a total knee replacement is not due to his October 30, 2015 injury. (JE. 2, p. 72)

CONCLUSIONS OF LAW

CAUSATION AND ALTERNATE CARE FOR THE OSTEOARTHROSIS OF THE RIGHT KNEE

The defendants admit claimant had an injury to the right medial meniscus on October 30, 2015. Defendants deny that this injury accelerated the claimant's right knee osteoarthritis. Defendants assert that claimant is entitled to 8.8 weeks of permanent partial disability, and the defendants have paid 10 weeks of benefits, so claimant is not entitled to any additional indemnity benefits.

Claimant asserts that the work injury of October 30, 2015 injured the right medial meniscus and also his knee has not regained his prior function. And that his current need for a right total knee replacement is causally related to his admitted work injury of October 30, 2015. Claimant requests additional medical care, including a total knee replacement and a running award of healing period benefits when he has the knee replacement surgery.

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)

A treating physician's testimony is not entitled to greater weight as a matter of law than that of a physician who later examines claimant in anticipation of litigation. Weight to be given to testimony of physician is a fact issue to be decided by the workers' compensation commissioner in light of the record the parties develop. In this regard, both parties may develop facts as to the physician's employment in connection with litigation, if so; the physician's examination at a later date and not when the injuries were fresh; his arrangement as to compensation, the extent and nature of the physician's examination; the physician's education, experience, training, and practice; and all other factors which bear upon the weight and value of the physician's testimony. Both parties may bring all this information to the attention of the fact finder as either supporting or weakening the physician's testimony and opinion. All factors go to the value of the physician's testimony as a matter of fact not as a matter of law. Rockwell Graphic Systems, Inc. v. Prince, 366 N.W.2d 187, 192 (Iowa 1985).

Claimant is not required to prove his current knee condition was caused solely by his work, or that none of it was the result of natural degenerative processes. He is only required to show that those natural degenerative processes were accelerated, speeded up or aggravated by his work activities, and that his work was at least a substantial cause, not necessarily the only or the primary cause, of his current knee condition. The claimant has not shown that his condition was permanently accelerated by work activities.

There are two expert opinions concerning causation of the osteoarthritis of claimant's right knee and whether the need for knee replacement surgery is causally related to the October 30, 2015 work injury.

Dr. Stoken has opined that the work injury of October 30, 2015 lit up his pre-existing osteoarthritis condition. I do not find her opinion as to causation to be convincing. Compared to the detailed opinion of Dr. Vincent, Dr. Stoken's opinion lacks analysis. Dr. Stoken is not an orthopedic surgeon. Dr. Stoken had a one-time evaluation with claimant.

Dr. Vincent's opinions as to the claimant's knee condition are convincing as to whether the claimant's work injury of October 30, 2015 aggravated the lateral osteoarthritis.

Dr. Vincent provided detailed and consistent explanation concerning the osteoarthritis and why he did not believe the work injury accelerated claimant's right knee osteoarthritis. Dr. Vincent is an orthopedic surgeon who performed the arthroscopy on claimant's right knee.

Claimant has failed to prove by a preponderance of the evidence that the claimant's lateral osteoarthritis was accelerated or lit-up by his work injury. Claimant's request for alternate care of knee replacement surgery and a running period of healing period benefits is denied.

EXTENT OF IMPAIRMENT

Under the Iowa Workers' Compensation Act, permanent partial disability is compensated either for a loss or loss of use of a scheduled member under Iowa Code section 85.34(2)(a)-(t) or for loss of earning capacity under section 85.34(2)(u). The extent of scheduled member disability benefits to which an injured worker is entitled is determined by using the functional method. Functional disability is "limited to the loss of the physiological capacity of the body or body part." Mortimer v. Fruehauf Corp., 502 N.W.2d 12, 15 (Iowa 1993); Sherman v. Pella Corp., 576 N.W.2d 312 (Iowa 1998). The fact finder must consider both medical and lay evidence relating to the extent of the functional loss in determining permanent disability resulting from an injury to a scheduled member. Terwilliger v. Snap-On Tools Corp., 529 N.W.2d 267, 272-273 (Iowa 1995); Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417, 420 (Iowa 1994).

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

The courts have repeatedly stated that for those injuries limited to the schedules in Iowa Code section 85.34(2)(a-t), this agency must only consider the functional loss of the particular scheduled member involved and not the other factors which constitute an "industrial disability." Iowa Supreme Court decisions over the years have repeatedly

cited favorably the following language in the 83-year-old case of Soukup v. Shores Co., 222 Iowa 272, 277; 268 N.W. 598, 601 (1936):

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

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

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

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

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

It is the functional ability that must be assessed in this case. Both Dr. Vincent and Dr. Stoken stated that the AMA Guides 5th Edition allow up to a 10 percent

impairment rating for the claimant's injury and surgery. Dr. Vincent reduced the rating to 4 percent based upon his opinion that the AMA Guides overestimates the extent of loss for claimant's type of injury.

I find the convincing evidence is that clamant has a 10 percent lower extremity rating. I base this finding on the functional limitations of claimant's knee due to his October 30, 2015 work injury. Dr. Vincent provided significant restrictions on claimant based upon the October 30, 2015 injury. Dr. Stoken provided similar restrictions. I consider the credible testimony of claimant and Ms. Morris as to the claimant's ability to use his right leg. Claimant is entitled to 22 weeks of permanent partial disability commencing April 6, 2017.

I also award claimant the filing fee of $100.00 using my discretion under 876 IAC 4.33.

ORDER

Defendants shall pay claimant twenty-two (22) weeks of permanent partial disability benefits at the weekly rate of three hundred sixty-six and 84/100 dollars ($366.84) commencing April 6, 2017.

Defendants shall have credit for the ten (10) weeks of permanent partial indemnity benefits previously paid.

Defendants shall pay claimant costs in the amount of one hundred dollars ($100.00).

Defendants shall pay all past due amounts in a lump sum.

The parties are bound by their stipulations.

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

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

Signed and filed this 23rd day of May, 2019.

JAMES F. ELLIOTT
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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JFE/sam

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.