BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

MIGUELINA VARGAS, Claimant, vs. TYSON FOODS, INC., Employer, Self-Insured, Defendant.	FILED APR 12 2016 WORKERS' COMPENSATION	File Nos. 5049103, 5049104 5049105, 5049106 5049107, 5049108 5049109, 5049110 5049111, 5049112 ARBITRATION DECISION Head Note Nos.: 1100; 1801; 1805; 2500; 2800

STATEMENT OF THE CASE

Miguelina Vargas, claimant, filed petitions in arbitration seeking workers' compensation benefits against Tyson Foods, Inc., a self-insured employer, for alleged work injury dates of October 2, 2012, November 6, 2012, December 20, 2012, January 14, 2013, April 11, 2013, June 21, 2013, August 13, 2013, September 10, 2013, February 5, 2014, and July 23, 2014.

This case was heard on December 7, 2015, in Des Moines, Iowa. The case was considered fully submitted on January 2, 2016 upon the simultaneous filing briefs.

The record consists of joint exhibits A-Y, claimant's exhibits 1-9, and the testimony of the claimant.

ISSUES

File No. 5049103 (Date of injury October 2, 2012). Affected body parts: Upper body, neck, and left shoulder.

1. Whether claimant sustained an injury on October 2, 2012, which arose out of and in the course of her employment;

2. Whether claimant's alleged injury is a scheduled member injury or industrial in nature;

3. The extent of any permanent disability;

4. Whether claimant is entitled to medical benefits;

5. Whether defendant is entitled to a credit of previously paid benefits under an agreement for settlement.

File No. 5049104 (Date of injury November 6, 2012). Affected body part: Left arm.

1. Whether claimant sustained an injury on November 6, 2012, which arose out of and in the course of her employment;

2. Whether defendant had proper notice;

3. Whether claimant's alleged injury is a scheduled member injury or industrial in nature;

4. The extent of any permanent disability;

5. Whether defendant is entitled to a credit of previously paid benefits under an agreement for settlement.

File No. 5049105 (Date of injury December 20, 2012). Affected body part: Low back.

1. Whether claimant sustained an injury on December 20, 2012, which arose out of and in the course of her employment;

2. The extent of any permanent disability;

3. Whether defendant is entitled to a credit of previously paid benefits under an agreement for settlement.

File No. 5049106 (Date of injury January 14, 2013). Affected body parts: Bilateral hands.

1. Whether claimant sustained an injury on January 14, 2013, which arose out of and in the course of her employment;

2. The extent of any permanent disability;

3. The commencement date for permanent partial disability benefits;

4. Whether defendant had proper notice;

5. Whether defendant is entitled to a credit of previously paid benefits under an agreement for settlement.

File No. 5049107 (Date of injury April 11, 2013). Affected body parts: Bilateral elbows.

1. Whether claimant sustained an injury on April 11, 2013, which arose out of and in the course of her employment;

2. The extent of any permanent disability;

3. Whether defendant had timely notice;

4. Whether claimant is entitled to medical benefits;

5. Whether defendant is entitled to a credit of previously paid benefits under an agreement for settlement.

File No. 5049108 (Date of injury June 21, 2013). Affected body parts: Bilateral feet.

1. Whether claimant sustained an injury on June 21, 2013, which arose out of and in the course of her employment;

2. Whether claimant is entitled to temporary disability benefits;

3. The extent of any permanent disability;

4. Whether claimant is entitled to medical expenses;

5. Whether defendant is entitled to a credit of previously paid benefits under an agreement for settlement.

File No. 5049109 (Date of injury August 13, 2013). Affected body parts: Left hand.

1. Whether claimant sustained an injury on August 13, 2013, which arose out of and in the course of her employment;

2. The extent of any permanent disability;

3. Whether defendant had appropriate notice;

4. Whether defendant are entitled to a credit of previously paid benefits under an agreement for settlement.

File No. 5049110 (Date of injury September 10, 2013). Affected body parts: Left hand.

1. The extent of any permanent disability;

2. Whether defendant is entitled to a credit of previously paid benefits under an agreement for settlement.

File No. 5049111 (Date of injury February 5, 2014). Affected body parts: Left arm, left leg, low back.

1. Whether claimant sustained an injury to her left arm and low back on February 5, 2014, which arose out of and in the course of her employment;

2. Whether claimant's alleged injury is a scheduled member injury or industrial in nature;

3. The extent of any permanent disability;

4. Whether defendant is entitled to a credit of previously paid benefits under an agreement for settlement.

File No. 5049112 (Date of injury July 23, 2014). Affected body parts: Bilateral arms, mid and upper body.

1. Whether claimant sustained an injury on July 23, 2014, which arose out of and in the course of her employment.

2. Whether claimant sustained a permanent disability and if so,

3. The extent of any permanent disability;

4. Whether defendant is entitled to a credit of previously paid benefits under an agreement for settlement.

FINDINGS OF FACT

The parties entered into an agreement for settlement for her right shoulder injury on July 2, 2014. (Ex. O, p. 2) The settlement awarded claimant healing period benefits from June 28, 2011, through July 25, 2011, as well as 25 weeks of permanency (at 5 percent impairment). (Ex. O, p. 3)

On January 20, 2011, claimant consulted with Theophilus A. Oyelayo, M.D., regarding worsening pain in her right shoulder. She presented with a four-week history of right shoulder pain with forward and backward movement of the upper right extremity. (Ex. A, p. 1-2) She was advised to start a physical therapy program three times a week for two weeks along with over-the-counter Naprosyn 500 mg twice daily. Work restrictions of no lifting more than 35 pounds more than 33 percent of the day were imposed. (Ex. A, p. 2)

She followed up with Dr. Oyelayo on March 3, 2011, with reports that the symptoms had worsened even with physical therapy. (Note: the medical record refers to claimant as a male. That is in error). (Ex. A, p. 3) Dr. Oyelayo imposed a restriction

of no use of the upper right extremity along with additional therapy and use of Naprosyn. (Ex. A, p. 3)

After the March 17, 2011, visit Dr. Oyelayo ordered an MRI arthrogram. (Ex. A, p. 5) He continued claimant with her restrictions. The test showed that she had a subdeltoid and subacromial bursitis. (Ex. A, p. 9) Dr. Oyelayo referred claimant to an orthopaedic surgeon.

She was seen by Tuvi Mendel, M.D., on May 4, 2011. (Ex. B, p. 1) She registered a positive Neer and Hawkins with tenderness over the anterior tip of the acromion along with discomfort on testing of the supraspinatus. X-rays showed mild changes at the AC joint and Dr. Mendel concluded claimant was suffering a right shoulder rotator cuff tendinitis, impingement. (Ex. B, p. 1) Claimant received a cortisone injection and a prescription for physical therapy and light duty work. (Ex. B, p. 2) Claimant returned at the end of the month on May 27, 2011, with ongoing complaints of right shoulder pain. The injection provided little relief. Dr. Mendel offered a surgical exploration of the right shoulder. (Ex. B, p. 3) Claimant underwent surgical decompression on June 28, 2011. The results were mixed. Dr. Mendel was disappointed in claimant's lackadaisical approach to home therapy. (Ex. B, p. 7) Eight weeks out, claimant underwent another injection. (Ex. B, p. 7) She was encouraged to continue with home therapy in conjunction with the physical therapy.

By September 9, 2011, claimant returned with no significant improvement. Dr. Mendel expressed frustration over this.

> PHYSICAL EXAMINATION: On exam today she has good range of motion. She still needs to work on strength. She is still complaining of moderate discomfort and pain. She is currently on light duty. She is doing physical therapy 3 times a week, although she is not really doing as much at home as I would like for her to do. We reviewed the arthroscopic pictures again which reveal minimal changes.

(Ex. B, p. 8)

Just two days prior to this visit, claimant was seen at the University of Iowa Hospitals and Clinics (UIHC) for "chronic low back pain" problems. (Ex. C, p. 1) The medical records note that symptoms were present for "greater than 10 years" and that there was no inciting incident. (Ex. C, p. 1) There was no indication that an interpreter was used during this medical visit.

Another injection was administered on October 17, 2011, and subsequent MRI arthrogram revealed new, mild superior rotator cuff tendinopathy and worsening subacromial bursitis. (Ex. B, p. 9) She returned to UIHC on November 11, 2011, with ongoing complaints. It was recommended she seek an orthopaedic consult. (Ex. C, p. 7)

Dr. Mendel placed claimant at maximum medical improvement (MMI) on December 5, 2011. (Ex. B, p. 11) At that time, claimant reported ongoing discomfort and pain in her right shoulder. Dr. Mendel felt she had full range of motion but somewhat decreased strength on the right. (Ex. B, p. 11)

On December 19, 2011, claimant was seen by Robert Gordon, M.D., for evaluation of her right shoulder. Dr. Gordon held off on any diagnosis until after an EMG was conducted. (Ex. D, p. 3) On January 12, 2012, she was seen by Gregory Clem, M.D., to review the EMG study which was within normal limits. Dr. Gordon modified claimant's medication and asked for her to return in three weeks. (Ex. D, p. 4)

On January 30, 2012, she returned to see Dr. Gordon. She complained of increased right shoulder pain. Dr. Gordon noted that he observed her in the lobby moving her right shoulder without "apprehension or difficulty." (Ex. D, p. 5) His testing revealed little in the way of objective signs of shoulder injury. She had diffuse tenderness to very light palpation and with some "coaxing" her range of motion was near normal limits. (Ex. D, p. 5) Based on the EMG results and his own testing, Dr. Gordon discharged claimant and determined she was at MMI. (Ex. D, p. 5, Ex. F)

> Based upon my evaluation of Ms. Vargas on 1/30/12, she was able to flex to 160 degrees, which is equal to 1% impairment of the upper extremity, extend to 40 degrees, which is equal to 1% impairment of the upper extremity, abduct to 180 degrees, which is equal to 0% impairment of the upper extremity, adduct to 50 degrees, which is equal to 0% impairment of the upper extremity, internally rotate to 80 degrees, which is equal to 0% impairment of the upper extremity, internally rotate to 80 degrees, which is equal to 0% impairment of the upper extremity, and externally rotate to 80 degrees, which is equal to 0% of the upper extremity.
>
> Therefore, based upon my evaluation with these aforementioned measurements, she will incur 2% impairment of the right upper extremity, as pursuant to the Guides to the Evaluation of Permanent Impairment, Fifth Edition, [sic] as published by the American Medical Association.

(Ex. D, p. 7)

On March 1, 2012, claimant was seen by Mederic Hall, M.D., for chronic right shoulder pain at the UIHC. (Ex. G, p. 1) The physical examination revealed pain with palpation over the biceps tendon and a positive Speed's test. Dr. Hall recommended a sonographically guided biceps tendon sheath injection. (Ex. G, p. 3) The injection took place but claimant did not feel like it was helpful. Dr. Hall refused to see claimant again as he does not treat workers' compensation cases. (Ex. G, p. 4)

She returned for follow up on March 2, 2012, to MOHA for continued complaints of right shoulder pain. (Ex. D, p. 8) She explained she was working with the knife

again. Dr. Gordon felt that her examination was entirely nonphysiological and that while she complained of diffuse tenderness, she was discharged without restriction. (Ex. D, p. 9)

On March 30, 2012, she was seen by David A. Bedell, M.D., at UIHC for a four-month history of left neck radiating shoulder pain as well as heel pain. (Ex. H, p. 5) Dr. Bedell diagnosed claimant as suffering myofascial pain in the neck along with plantar fasciitis. (Ex. H, p. 7) He encouraged her to continue to exercise at home and wear heel cups. (Ex. H, p. 12)

She continued to express right shoulder pain to the defendant employer's health staff. (Ex. 1, p. 1)

On September 24, 2012, claimant refused to sign and complete a vibration questionnaire, asserting that she was having pain. (Ex. 1, p. 1)

There were no more visits to MOHA until October 25, 2012, when she represented with a left shoulder complaint. (Ex. D, p. 10) She expressed that the left shoulder pain developed during treatment for her right shoulder due to overcompensation. (Ex. D, p. 10) Dr. Clem prescribed her Prevacid for an unstable stomach. (Ex. D, p. 10) It was noted that claimant was still on light duty with restrictions of no gripping, pinch, push/pull, or reaching above the left shoulder. (Ex. D, p. 10)

Claimant underwent an IME with Robert W. Milas on October 30, 2012. He diagnosed claimant as suffering a derangement of the right shoulder.

> Neurological examination reveals Cranial Nerves II to XII to be intact. Examination of the patient's strength reveals significant weakness of the right hand grasp. Grip strength is recorded at 25 pounds on the right and 60 pounds on the left after repetitive testing. It is to be noted that the patient is right handed. There are no pathological reflexes evident. The patient's gait is normal. The patient demonstrates limitation of abduction to 120 degrees in the right upper extremity and right shoulder flexion to 140 degrees of the right upper extremity. The patient's [sic] demonstrates difficulty repetitively attempting to raise her arm above shoulder level and has great difficulty manipulating even a two-pound object above the shoulder level with the right upper extremity.

(Ex. I, p. 2) He further opined:

> Utilizing the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, this patient would have a 30% permanent partial impairment of the right upper extremity for a 61-100% loss of grip strength in the right upper extremity as reflected in Table 16-34 Page 509. This would translate to an 18% permanent partial impairment of whole person.

> I do feel that the repetitive nature of the work at Tyson, namely the use of the "wizard knife" in repetitively slicing meat is the direct cause of her condition of ill being.

(Ex. I, p. 2)

Dr. Milas recommended she be placed in light duty capacity and have a 10 pound weight restriction as well as a prohibition of working above shoulder height. (Ex. I, p. 2)

On November 6, 2012, claimant returned to Dr. Clem with left shoulder pain in addition to left elbow pain. The examination was largely unremarkable. (Ex. D, p. 11)

> EXAMINATION: Blood pressure: 105/68. Pulse: 63 and regular. She is a pleasant, 40-year-old Hispanic female here with the interpreter. Communication is excellent. She is tender over the left shoulder, both anteriorly and posteriorly. Her rotator cuff strength is normal. Impingement testing revealed an equivocal empty can test. Internal rotation is normal.

(Ex. D, p. 11) After a subsequent visit on November 13, 2012, Dr. Clem provided Bandit splints to wear over the elbow and referred her to Dr. Mendel. (Ex. D, p. 12)

Dr. Mendel saw claimant on November 30, 2012, for an evaluation of the left shoulder. (Ex. B, p.12) She complained about ongoing right shoulder pain and left shoulder difficulties. "She feels that she is overcompensating for the right and that gradually increased her symptoms on the left. She denies any actual specific injury to her left shoulder." (Ex. B, p. 12) Dr. Mendel recommended conservative management. An arthrogram was performed which did not show any definite rotator cuff tear but there was a significant amount of contrast present in the subacromial-subdeltoid bursa and along the course of the supraspinatus which Dr. Mendel deemed to be iatrogenic. (Ex. B, p. 15) An EMG was ordered which did not reveal any significant findings as it related to the neck or shoulder but did show evidence of moderate to severe bilateral carpal tunnel. (Ex. B, p. 6; Ex. 9, p. 86)

On January 10, 2013, claimant was seen by Dr. Gordon for evaluation of lumbar pain arising out of the fall in the parking lot on December 20, 2012. (Ex. D, p. 13) The claimant did exhibit tenderness of the lower lumbar paraspinal musculature. She showed no gross motor weakness in the lower extremities and had bilateral negative straight leg raises. (Ex. D, p. 13) Dr. Gordon did not assign any additional restrictions above and beyond the left shoulder restrictions that were already in place. Diagnostic radiographs were ordered. (Ex. D, p. 12) She returned on January 17, 2013, reporting no improvement. (Ex. D, p. 15) Dr. Clem continued claimant on medications, provided a free orthopedic back support and ordered physical therapy. (Ex. D, p. 16)

She returned on January 29, 2013 where she was seen by Jeff Lee, M.D., for her back pain. (Ex. D, p. 16) She ambulated without difficulty and demonstrated full flexion, extension, right and left bending, and right and left rotations. (Ex. D, p. 17) She was tender to palpation in the area of the right sacroiliac joint. (Ex. D, p. 17) She was advised to return to the clinic if her condition worsened. She was also seen on the same day for her left shoulder pain. She was able to demonstrate full range of motion but had tenderness upon abduction, internal rotation and extension. There was tenderness to palpation in the area of the anterior deltoid. (Ex. D, p. 19) She exhibited decreased range of motion with left ear to left shoulder movement and had tenderness to palpation in the area of C7 – C6 as well as pain upon palpation at the left rhomboid. (Ex. D, p. 19) She was advised to follow up with physical therapy and an MRI was ordered. (Ex. D, p. 19)

The radiographs did not show any evidence of spinal stenosis, nerve impingement or other abnormalities. The MRI of the left scapula showed no abnormalities. (Ex. D, p. 20) On February 12, 2013, Dr. Lee determined the claimant was at MMI for her low back pain and her left upper extremity. She was returned to full duty work without restrictions. (Ex. D, p. 21)

She sought care again from Dr. Hall at UIHC on April 11, 2013, for bilateral shoulder pain. She brought radiographs which showed inflammation of the tendons but nothing significant.

> She was told that this shows inflammation of the tendons, but nothing else significant. She was given some tramadol for her pain, and that was it. She has been seen in physical therapy at various times in the past. She states this did not help her and she stopped about 2 months ago. She is not to continue with any sort of home exercise program. She has not had any focused therapy for her elbow pain. She did try a counterforce brace, which only increased her pain, so she stopped this.

(Ex. G, p. 6) Examination revealed positive impingement test and a positive Speed's test.

> Examination shows full range of motion of the cervical spine. Negative Spurling's exam. The patient's shoulder exam shows full range of motion, although she is somewhat hesitant proceeding above 90 degrees of flexion or abduction. She is diffusely sore about the shoulder. She has positive impingement test. Positive Speed's test. No significant pain at the AC joint. Her labral provocative maneuvers do reproduce some pain, but I am not convinced it is labral in origin, as it seems to be more from just the positioning of the test. No catching or clicking is noted. No instability is noted. Examination of the elbow shows pain over the lateral epicondyle. She has pain with resisted middle finger extension. No weakness noted that about the upper extremities.

(Ex. G, p. 7) Dr. Hall believed she suffered from myofascial pain and tendon overuse likely related to repetitive work activities. (Ex. G, p. 8)

On June 21, 2013, she underwent injections into her heels to alleviate pain. (Ex. H, p. 21) On July 19 2013, defendant formally denied claimant's plantar fasciitis as a work related injury. (Ex. R, p. 1)

On July 2, 2013, claimant presented to Dr. Clem reporting heel pain for the past four months. (Ex. D, p. 22) She had a normal gait with no limp but was tender over the medial and lateral calcaneal areas distally in the proximal plantar fascial area. She was diagnosed as suffering bilateral plantar fasciitis but it was noted to be non-work-related. (Ex. D, p. 22) Claimant felt that her foot pain was related to standing on her feet all day but Dr. Clem disagreed.

She continued to seek treatment from Dr. Clem for her plantar fasciitis. He gave her samples of Voltaren and a night splint for her foot. (Ex. D, p. 24)

On August 13, 2013, she complained of left wrist pain that occurred suddenly while she was tossing bits of fat. (Ex. 1, p. 4) On August 19, 2013, she reported improvement in her left wrist. (Ex. 1, p. 5) An equipment change took place and claimant reported an improvement in her pain. (Ex. 1, p. 6) On September 10, 2013, she renewed her complaints of left finger, hand, wrist and forearm pain. She attributed the pain to throwing off the scraps of product and her mesh glove. (Ex. 1, p. 6)

On September 9, 2013, claimant presented to Milton K. Smoot, M.D., an orthopaedic specialist, for her heel pain. (Ex. K, p. 1) He noted that this injury occurs commonly in sedentary individuals and could not state with specificity that the plantar fasciitis was work related. (Ex. K, p. 3) Conservative treatment did not provide more than 30 percent relief and claimant sought injection therapy options. (Ex. K, p. 7)

On October 21, 2013, she was seen for left index finger pain. Dr. Klein recommended buddy taping the middle finger to the index finger and gave her free samples of Relafen. She was performing regular duty tasks and he encouraged her to continue to do so. (Ex. D, p. 25)

On November 7, 2013, claimant returned to see Dr. Clem for the left index finger popping. He agreed to send her to the hand specialist at Steindler Clinic. (Ex. D, p. 27)

On November 27, 2013, claimant was seen at Steindler Orthopedic Center for pain in the left forearm, wrist, hand, and fingers. She attributed this to the mesh gloves she wore as part of her job. (Ex. L, p. 1) Her index finger rested in a slight swan-neck deformity posture but the claimant was able to easily open and close her fingers as well as make a full fist and fully extend without difficulty. (Ex. L, p. 3) Brian P.D. Wills, M.D., informed the claimant that her pain could be related to the posture of the digit and the fact that she has to repeatedly open and close her hand as part of her job. (Ex. L, p. 3)

He recommended splinting to improve the posture of the finger and was seen by the hand therapist to have a custom orthosis fabricated. (Ex. L, p. 3)

She was seen in follow-up on January 14, 2014 and reported a "significant improvement in the symptoms since the last visit." All the pain had resolved and there was no significant swan-neck positioning. (Ex. L, p. 4) She did not have any tenderness to palpation about her fingers, hand, wrist, forearm or elbow. A more permanent orthosis was measured for and ordered. Dr. Wills determined claimant was at MMI and released her. (Ex. L, p. 5)

On January 16, 2014, claimant underwent a diagnostic ultrasound of the right plantar fascia which showed severe right plantar fasciitis. (Ex. 4, p. 19) An injection was administered. A subsequent corticosteroid injection took place on March 19, 2014. (Ex. 4, p. 22)

On March 3, 2014, Dr. Smoot recommended claimant sit while at work for another three months. (Ex. K, p. 10)

On March 19, 2014, Dr. Hall performed a fasciotomy on the claimant's right foot to treat the fasciitis condition. (Ex. 4, p. 22) She was to be given a note to be off of work the following day and then no prolonged standing. (Ex. 4, p. 20) Claimant had the work restriction from Dr. Smoot from March 3, in place. However, Dr. Hall also wrote a medical excuse suggesting claimant needed to be off work for a minimum of two weeks and maybe up to six weeks due to the fact that she would need to be in a walking boot on the right foot. (Ex. 4, p. 34)

On April 2, 2014, she was seen by Dr. Hall again for the right heel pain. She had continued tenderness but Dr. Hall ordered physical therapy and recommended she continue with current work restrictions. (Ex. 4, p. 23)

On April 22, 2014, she presented at the UIHC for complaints regarding her shoulder. (Ex. H, p. 22) Dr. Bedell found her examination results were fairly unremarkable.

> Left strap muscles of neck are tense, she has decreased rotation to the right, pain with flexion and right lateral bending, Tinel's and Phalen's are positive, there is no noticeable thenar or hypothenar wasting, strengths in both hands are intact, sensation to light touch is intact. Shoulder has almost full range of motion with discomfort at extremes of flexion and abduction and slight decreased internal rotation.

(Ex. H, p. 23)

Claimant was seen on May 7, 2014 by George Phillips, M.D., who noted that she had been referred by Dr. Bedell. (Ex. M, p. 1) Claimant reported bilateral shoulder and neck pain. She had a visible spasm of the right trapezius and increased tenderness to palpation over the paraspinous musculature as well as with trapezius. She had full

range of motion of both shoulders but increased pain with impingement signs. (Ex. M, p. 2) He concluded that her neck muscle spasms were compensatory for her chronic shoulder pain. Dr. Phillips proceeded with steroid injections into both subacromial regions. (Ex. M, p. 3)

On May 15, 2014, Dr. Hall returned claimant to eight hour shifts but recommended alternating sit/stand postures at work. (Ex. 4, p. 24) She was working four hour shifts. The parties stipulated that the claimant was off work from March 19, 2014, through May 14, 2014. She was paid $1,116.00 for short-term disability during this period of time. (Hearing Report)

Dr. Bedell saw her again on June 12, 2014, for shoulder and hand pain. He prescribed a muscle relaxant. (Ex. H, p. 26)

On June 25, 2014, Dr. Hall wrote a medical note regarding work accommodations:

> Mrs. Vargas Alvino is cleared to return to 10 hour work days. Patient should have a chair available at all times at work. This simply means she should have a chair available at all times to be able to sit as needed. These restrictions are temporary for 3 months. If she needs to be seen after that for further restrictions she will need to be seen in the workman's compensation clinic. She will not be returning her [sic] for follow up on a scheduled basis to Dr. Hall.

(Ex. G, p. 9)

On August 7, 2014, claimant presented for two problems: left fingers, posterior thumb and index finger pain and sacral and left hip pain. (Ex. D, p. 27) She was given a wrist splint and placed on restricted work duties of no repeated firm gripping or pinching with the right hand, but no restrictions for the left. She was also restricted from repetitive twisting, bending, squatting, kneeling and no reaching above her shoulder due to back problems. (Ex. D, p. 28)

She was seen a week later and reported her pain at 9 out of 10. (Ex. D, p. 29) William H. Candler, D.O., examined the claimant and did not find objective signs of her complaints. She claimed to have fallen in the lunchroom on February 5, 2014, and had not gotten better.

> PHYSICAL EXAMINATION: The patient is alert an does not appear to be in acute distress in spite of her pain rating of 9/10. Pulse was 73. Blood pressure 109/80. Her lumbar sacral spine was palpated where she complains of pain. She states on her left lower lumbar/sacral area she has discomfort. There was no edema. There was no increased muscle turgor, and there were no muscle spasms noted. The patient complained of pain with extension of the back, but she did not elicit any notable pain

> behavior with flexion, side bending, or rotation of her lumbar spine. She has 5/5 strength in her lower extremities. Deep tendon reflexes were 2+ bilaterally. Extensor hallucis longus strength was 5/5 bilaterally. Straight leg testing was negative in the sitting and the supine position. He [sic] hip again was examined. She complained of some discomfort with left leg extension, but no appreciable discomfort in flexion, abduction, or adduction. She did complain of discomfort when her cranium was pressed in unison. She complained of back pain, and she complained of pain when her torso was rotated in unison.

(Ex. D, p. 29) Dr. Candler continued her Naprosyn, added Flexeril, and encouraged her to continue physical therapy and home exercises. He revised her work restrictions to be: "occasional lifting of up to 20 pounds and occasional bend, twist, and squat." (Ex. D, p. 30)

On August 20, 2014, Dr. Bedell wrote a note recommending a permanent work restriction:

> Miguelina needs to have a chair available at all times due to her plantar fasciitis. This need is valid for at least a year and probably permanent.

(Ex. H, p. 28) He believed that the plantar fasciitis was caused by her work:

> Miguelina has work [sic] at Tyson since 2006. She worked/s in the line 765. She was on her feet all day on hard concrete. In February of 2013 she developed bilateral plantar fascitis [sic]. She hadn't had any special activity or trauma outside of work. Plantar fasciitis is a problem of repeat microtrauma which can be cause be [sic] standing and walking for long periods of time on a hard surface. The most like [sic] cause of her plantar fascitis [sic] is her time she spent at work standing on the concrete floor.

(Ex. H, p. 29)

On August 21, 2014, she was seen for right hand neuropraxia. (Ex. D, p. 31) Dr. Clem continued her on the night splint and started neuroglide activity in therapy. He continued her restrictions for the right hand. (Ex. D, p. 31)

On August 29, 2014, she returned for follow up of her back pain. Dr. Clem ordered x-rays. (Ex. D, p. 32) The x-rays showed, "no evidence of fractures...." (Ex. D, p. 33) Dr. Clem ordered an MRI which demonstrated no evidence of fractures, mild degenerative changes of the disc and facet seen within the lumbar spine at mainly L2, L3 and L5-S1.

On September 15, 2014, claimant was back to see Dr. Clem for treatment of her right hand issues. She reported "a little bit of residual numbness" and Dr. Clem marked

the issue as virtually resolved. He believed she should be at MMI at the end of her therapy. (Ex. D, p. 34) She did not want to return to the Whizard knife job because she attributed the job to many of her physical issues. (Ex. D, p. 34)

On October 2, 2014, she returned to Dr. Clem regarding complaints of bilateral hand numbness, wrist and forearm pain, and bilateral elbow pain. (Ex. D, p. 37) Bilateral EMGs were ordered. (Ex. D, p. 37) The EMGs showed bilateral carpal tunnel syndrome (CTS) was moderate to severe. (Ex. D, p. 39)

Claimant was referred to Michael Dolphin, D.O., for an orthopedic consult for her low back and left-sided buttock pain. (Ex. N, p. 1) She rated the pain as 8 on a 10 scale. She was able to ambulate about the room without difficulty. Her gait was normal. She had full range of motion in the upper extremities along with no joint instability or tenderness. She also exhibited full range of motion at the hips, knees and ankles along with equal and normal strength and sensation. (Ex. N, p. 2) Dr. Dolphin did not find any abnormalities in either her imaging studies or physical examination and did not believe that her present symptoms were related to a February fall. He posited they may be more related to an altered gait status post a right foot surgery. However, he returned her to work without restrictions and discharged her. (Ex. N, p. 2)

On October 10, 2014, she returned to Dr. Clem for neck pain. He encouraged her to do physical therapy at home. (Ex. D, p. 40)

On October 21, 2014, claimant was seen by Dr. Wills for her bilateral carpal tunnel symptoms and left lateral epicondylitis. (Ex. L, p. 7) Dr. Wills recommended an injection to separate which symptoms were coming from the carpal tunnel versus other etiologies. (Ex. L, p. 10) The claimant agreed to the injection but experienced little relief. (Ex. L, p. 12) Her lack of response to the injection worried Dr. Wills but he agreed to the surgery given the claimant's desires:

> I went over my findings, treatment options, and recommendations in detail. I had a very long discussion with her and her case manager about her symptoms today. The findings involving her elbow pain today seems to be more consistent with the myofascial and bilateral upper extremity pain than they do with lateral epicondylitis. I reassured her that her x-rays of the left elbow were benign and that I anticipate that her symptoms involving the elbows should get better with time. I would not recommend any further treatment at this time. If she continues to have symptoms involving the elbows, I would recommend she be reevaluated by occupational medicine as it may be that these are related to the myofascial pain that she has in the neck and upper arms.
>
> With regard to her carpal tunnel syndrome, I explained to her that I was not encouraged by the fact that she did not have any significant improvement or response in terms of the numbness and tingling following the orbital tunnel injection. I explained to her that I am less optimistic

> about surgery given that she has had no improvement then I would be if she had had improvement following the injection. I explained to her that there was a significant chance that she may not find any significant relief or improvement following surgery. Despite understanding this, she feels that her symptoms are quite bothersome and is willing to undergo surgery in the hopes that it will improve her symptoms.

(Ex. L, p. 14)

On November 26, 2014, claimant was seen for complaints of neck pain. She reported home exercises were not helpful. Dr. Candler ordered a course of physical therapy and a trial of Skelaxin, a muscle relaxer. (Ex. D, p. 41) She returned on December 11, 2014, with pain complaints in her bilateral trapezius and neck. Her pain rating was a 9 out of 10 on a 10 scale. The physical examination was not consistent with her subjective complaints. Dr. Clem continued claimant on physical therapy, discontinued the Skelaxin but continued with the Naprosyn. (Ex. D, p. 42)

Surgery for claimant's right carpal tunnel symptoms occurred on December 19, 2014. (Ex. L, p. 16)

On December 23, 2014, after her carpal tunnel release, she was seen by Dr. Clem for right trapezius and neck pain. Physical therapy was continued and there was some hope that the immobility of the right upper extremity would aid in healing of the shoulder. (Ex. D, p. 44)

On December 30, 2014, claimant was seen in follow-up after her right carpal tunnel release. Her pain rating went from 9 out of 10 to 3 out of 10. She mentioned improvement in sensation but had continued pain in both elbows, more on the left than the right. (Ex. L, p. 18)

She was seen a month later for left lateral elbow pain, probable mild lateral epicondylitis. (Ex. D, p. 46) Dr. Candler encouraged her to continue with physical therapy to increase her range of motion. (Ex. D, p. 46)

On January 30, 2015, she was seen for follow up of neck pain. Again her examination was not consistent with her subjective complaints. (Ex. D, p. 47)

> There was no anatomical abnormality noted. There was no edema or mass noted in the cervical musculature. Her neck had full range of motion with discomfort only in extrusion. Spurling's test elicited some bilateral neck pain and upper trapezius pain, but no pain radiating in her arms. Upper extremity deep tendon reflexes were 2+ bilaterally. Patient had excellent grip strength bilaterally including the hand, for which she just had her carpal tunnel release. Upper extremity: Sensation was grossly intact in all dermatomes in the upper extremity. She had excellent 2-point discrimination with 2 pounds 6 mm apart in the radial and ulnar side of the

> DIPs of all fingers in the left hand, but she did have decreased sensation in the right hand (the hand just had the carpal tunnel release). She had good upper extremity strength.

(Ex. D, p. 47)

Claimant was given a prescription for gentle range of motion physical therapy and instructed to follow the care instructions of Dr. Wills. (Ex. D, p. 47)

On February 12, 2015, she returned for follow up of neck pain, left radicular type symptoms and bilateral elbow pain. (Ex. D, p. 51) Dr. Clem noted that she was on light duty trimming combo and sirloin but that her neck pain was largely resolved. He deemed her to be at MMI. (Ex. D, p. 51)

On February 26, 2015, she reported bilateral leg pain and swelling. She referred to no specific injury at work although there was a time in which she straightened her right leg, she felt a pop. She sits and stands at her work station. (Ex. D, p 55) Dr. Candler did not consider the bilateral leg pain and swelling a work condition and encouraged her to seek treatment from a private physician.

Claimant was seen on March 10, 2015 in follow-up to her December 19, 2014 right carpal tunnel release. Her pain rating was mildly increased from 3 to 4 on a 10 scale. (Ex. L, p. 20) She did note that her numbness and tingling in the right hand was continuing to improve. (Ex. L, p. 20) On March 27, 2015, they went ahead with the left carpal tunnel release. (Ex. L, p. 22)

> She returned to Dr. Bedell on March18, 2015, for multiple pain complaints.
>
> Today, she describes pain on the Left side of her neck, extending from the base of the skull and running down the lateral edge of the trapezius muscle.
>
> She also has complaints of bilateral elbow and knee pain. Her elbows are painful on the lateral and medial aspects of the joints, but not the dorsal surface. Her knees are most painful on the medial inferior aspect of the joint R>L. She has noticed swelling in both knees.
>
> She also complains of bilateral ankle swelling and pain.

(Ex. H, p. 30-31)

Dr. Bedell included fibromyalgia as a possible diagnosis. (Ex. H, p 37)

On March 19, 2015, defendant employer denied that claimant's bilateral leg and knee pain was work related based on the February 26, 2015 medical record of Dr. Candler. (Ex. R, p. 2)

On April 16, 2015, she reported bilateral elbow pain and neck pain. Dr. Clem would not address her neck pain. He prescribed Voltaren gel and ordered her to return for a follow up. (Ex. D, p. 58)

On April 29, 2015, she was seen by Dr. Bedell with complaints of elbow pain, neck pain, bilateral knee pain with swelling and crepitus so severe that "at times she isn't able to get up from the toilet." (Ex. H, p. 38) She reported standing at work most of the time. (Ex. H, p. 38) Her examination results were normal and Dr. Bedell suggested that she obtain a sports medicine consult. (Ex. H, p. 40) She did follow up with the sports consult and received an intra-articular steroid injection which provided about a month of relief. (Ex. H, p. 41)

On April 30, 2015, claimant returned for bilateral elbow pain. She felt the Voltaren gel helped a bit. It was noted that she had been "placed out of the plant because she had been on light duty for 270 days." (Ex. D, p. 59) Dr. Clem gave her two different elbow supports and refilled her Voltaren gel. (Ex. D, p. 59)

On the same day she was seen by Dr. Wills and follow-up to both carpal tunnel release surgeries. He found that she was doing well enough to advance to work hardening during physical therapy. (Ex. L, p. 22)

On May 7, 2015, she was seen for follow up regarding her elbow pain. She was still tender over both lateral and medial epicondylar areas but was deemed to be at MMI with no impairment. (Ex. D, p. 60)

On May 14, 2015, she reported severe neck pain. On examination, she had tenderness over both trapezii, levator scapular areas, and interscapular areas along with mild muscle spasms and tightness. Dr. Clem ordered a trial of TENS unit as well as therapy. (Ex. D, p. 61) She was doing regular work. (Ex. D, p. 64) Because of ongoing problems, an MRI was ordered of her cervical spine. (Ex. D, p. 66) The MRI showed mild degeneration. (Ex. D, p. 67) On May 17, 2015, claimant was seen by Dr. Bedell for her bilateral leg, shoulder, and neck pain. He recommended she wear her splints nightly, encouraged her to do stretches, and continued her prescriptions. (Ex. 5, p. 47)

On June 11, 2015, she consulted with Dr. Wills regarding pain in the elbows, upper arms, and neck. He felt that it might be helpful if she was seen by spine specialist. In regards to her bilateral carpal tunnel release, he encouraged her to continue home therapy exercises and recommended she returned back in three months. (Ex. L, p. 24)

On September 2, 2015, she returned to Dr. Bedell for complaints of back pain, knee pain, leg swelling, along with a myriad of other complaints. (Ex. H, p. 41) Her MRI showed only mild degenerative changes. (Ex. H, p. 43)

She returned to Dr. Wills on September 15, 2015. She rated her pain at a 3 on a 10 scale and did not have any numbness or tingling during the day and only some numbness and tingling in the fingers at night. (Ex. L, p. 26) Dr. Wills anticipated that she would be at maximum medical improvement at her next appointment in four months. He encouraged her to continue with her work hardening program and home exercises. (Ex. L, pp. 27-28)

She underwent another IME with Dr. Milas on October 16, 2015. (Ex. I, p. 4) He diagnosed her as suffering "ligamentous injury of the cervical and thoracic spine."

> Utilizing the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, this patient would most properly fit under a DRE Cervical Category II, impairment of the whole person, which would have an 8% permanent partial impairment of the whole person as reflected in Table 15-5, Page 392. Similarly, the patient would fit under a DRE Thoracic Category II, impairment of the whole person, which would have an 8% permanent partial impairment of the whole person, as reflected in Table 15-4, Page 389. The patient has no evidence of neurological deficit at this time and MRI scans of the cervical and thoracic spine show no significant pathology other than mild disc changes. If one chose to add the individual impairments this would amount to a total of a 16% permanent partial impairment of the whole person. If one chose to use the combined values chart, this would amount to a 15% permanent partial impairment of the whole person.
>
> I do feel that the repetitive nature of work at the patient's place of employment is the direct cause of her condition of ill being.

(Ex. I, p 4) He wrote a letter of clarification on October 22, 2015:

> At the time of my examination, the patient demonstrated normal function of the upper extremities and her diagnosis of epichondylitis on November 6, 2012, resolved. Hence there is no impairment rating for that. Also, the patient's complaints of low back pain from December 20, 2012, resolved. With an MRI scan of the lumbar spine reported as showing no significant pathology.
>
> On January 14, 2013, the patient had complaints of bilateral hand pain and on April 11, 2013, the patient complained of bilateral elbow pain associated with the use of a Viz knife at her place of employment. The patient did undergo a right carpal tunnel release and was treated for bilateral epichondylitis. These two conditions resolved with no further complaints voiced by the patient at her appointment in my office.

On June 21, 2013, the patient had a bilateral plantar fasciitis treated with a fasciotomy and on my examination on October 16, 2015; the patient's gait is normal.

On August 13, 2013, the patient complained of left hand pain.

On September 10, 2013, complained of the left index finger and hand pain. These apparently resolved and were not brought to my attention on the examination carried out on October 16, 2015.

Her low back, left thigh, sacrum and hand pain described on February 6, 2014, following a fall in the cafeteria also apparently resolved.

The patient complained of bilateral hand, wrists, forearms and elbow pain on July 23, 2014. My examination found no evidence of dysfunction of those anatomical areas.

I could go on further lengthening this report to an unacceptable number of pages, but on my examination on October 16, 2015, the patient's only complaints were those of cervical and thoracic spine pain. The function of all four extremities was within normal limits. The patient's strength and deep tendon reflexes were symmetrical.

I reviewed a report of an MRI of the left shoulder dated December 7, 2012; there is no evidence of a rotator cuff tear and no evidence of a labral tear.

The patient had plantar fasciitis and was treated for this with no residual noted on my examination and no change noted in her gait.

While this individual has a huge number of claims reported at her work site there is no evidence of dysfunction to any system except the cervical and thoracic spine and this is felt to reflect ligamentous changes secondary to repetitive motion.

(Ex. I, pp. 5-6)

On November 3, 2015, claimant was seen by Dr. Milas again. It appeared that this was for a third IME. (Ex. I, p. 7) Dr. Milas noted that claimant was a poor historian. On examination, she showed mild limitation of the cervical spine and thoracic spine but demonstrated excellent movement of her elbows and no antalgic gait. She had some tenderness to palpation in the mid thoracic spine and a moderate muscle spasm in the mid thoracic region. (Ex. I, p. 8)

Her diagnosis remained "ligamentous injury of the cervical and thoracic spine." (Ex. I, p. 8)

Utilizing the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, this patient would most properly fit under a DRE Cervical Category II impairment of the whole person, which would have an 8% permanent partial impairment of the whole person as reflected in Table 15-5, Page 392. Similarly, the patient would fit under a DRE Thoracic Category II Impairment of the whole person, which would have an 8% permanent partial impairment of the whole person as reflected in Table 15-4, Page 389. The patient would have a 5% permanent partial impairment of each upper extremity for complaints of pain and paresthesia in the upper extremities with normal sensation and motor strength. This would amount to a total of a 10% permanent partial impairment of the upper extremities, which would translate to a 6% permanent partial impairment of the whole person. If one chose to add the individual impairments, this would amount to a 22% permanent partial impairment of the whole person. If one chose to use the combined values chart, this would amount to a 20% permanent partial impairment of the whole person.

(Ex. I, p. 8) He attributed these injuries to her repetitive work. (Ex. I, p. 9)

On November 12, 2015, she returned with multiple complaints.

She also has a fairly long history of chronic waxing and waning lateral epicondylitis which has been bilateral. This seems to be exacerbated by pulling, lifting or pushing with her forearm. Repetitive motion makes it much worse. It will be much better after having time off of work.

Additionally she has chronic low back pain for which I saw her in March of 2012 for the first time. She reportedly fell in the parking lot at work and this was the origin of the pain. She has consistently related it exacerbation to activities that she does at work at Tyson. She hasn't been complaining as regularly about the low back pain recently, not that it has gone away, but that it has been relatively stable. She does not have bowel or urine incontinence, saddle anesthesia, radiculopathy or peripheral neuropathy.

Recently she's been complaining more of neck and shoulder pain. She's been evaluated by the occupational health physicians for Tyson. She brought in MRI of her neck and thoracic back which showed mild cervical disc disease but no neural foraminal impingement and minimal disc bulging in the thoracic spine but otherwise completely normal. She does have some right-sided rhomboid/scapular bursa pain that is fairly localized. Using her right arm or shoulder exacerbates his [sic] pain. She is interested in an injection if this will help.

> Finally, she has a history of right shoulder subacromial impingement and underwent a decompression and June of 2011. This does not truly relieve her symptoms and then had a couple steroid injections without significant relief after the surgery.

(Ex. H, p. 46)

Due to right scapulohumeral bursitis, claimant was injected on November 20, 2015. (Ex. H, p. 45)

A deposition of Dr. Bedell was conducted on November 24, 2015. (Ex. 5) He concluded she had a multitude of problems and that her chronic history worsened after her falls. (Ex. 5, p. 48) He affirmed his opinion letter in which he checked off that he believed that there was a causal relationship between claimant's work activities and her bilateral carpal tunnel syndrome, bilateral epicondylitis, low back, and bilateral plantar fasciitis. (Ex. 3)

As to the bilateral carpal tunnel syndrome, he believed that she had permanent, mild persistent neuropathy causing pain and numbness in both of her hands. He recommended she wear wrist splints while working or avoid repeated wrist flexion and extension. (Ex. 4) He believed that her bilateral epicondylitis would resolve between 6 to 24 months if given adequate rest. He recommended to avoid repeated extension and flexion of the elbow, no lifting over 15 pounds and no repeat pulling over 15 pounds. (Ex. 4)

He attributed her low back pain to her falls at work on December 20, 2012 and February 5, 2014. And recommended she engage proper lifting mechanics and avoid repeated bending and lifting over 40 pounds. (Ex. 4)

Her bilateral plantar fasciitis was permanent and she should have the option of sitting to take her weight off her feet. (Ex. 4) Most of Dr. Bedell's conclusions rested heavily upon the claimant's personal history and report of pain and discomfort.

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).

A personal injury contemplated by the workers' compensation law means an injury, the impairment of health or a disease resulting from an injury which comes about, not through the natural building up and tearing down of the human body, but because of trauma. The injury must be something that acts extraneously to the natural processes of nature and thereby impairs the health, interrupts or otherwise destroys or damages a part or all of the body. Although many injuries have a traumatic onset, there is no requirement for a special incident or an unusual occurrence. Injuries which result from cumulative trauma are compensable. Increased disability from a prior injury, even if brought about by further work, does not constitute a new injury, however. St. Luke's Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); Ellingson v. Fleetguard, Inc., 599 N.W.2d 440 (Iowa 1999); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995); McKeever Custom Cabinets v. Smith, 379 N.W.2d 368 (Iowa 1985). An occupational disease covered by chapter 85A is specifically excluded from the definition of personal injury. Iowa Code section 85.61(4) (b); Iowa Code section 85A.8; Iowa Code section 85A.14.

While a claimant is not entitled to compensation for the results of a preexisting injury or disease, its mere existence at the time of a subsequent injury is not a defense.

Rose v. John Deere Ottumwa Works, 247 Iowa 900, 76 N.W.2d 756 (1956). If the claimant had a preexisting condition or disability that is materially aggravated, accelerated, worsened or lighted up so that it results in disability, claimant is entitled to recover. Nicks v. Davenport Produce Co., 254 Iowa 130, 115 N.W.2d 812 (1962); Yeager v. Firestone Tire & Rubber Co., 253 Iowa 369, 112 N.W.2d 299 (1961).

File No. 5049103 (Date of injury October 2, 2012). Affected body parts: Upper body, neck, and left shoulder.

Claimant asserts she sustained repetitive use injuries to her upper body, neck, and left shoulder as a result of an "accident" date of October 2, 2012. Claimant signed a "Statement of Injury/Illness" on this date which reported pain in the left upper extremity from using her left hand to move and cut the fat off loins. (Ex. Y, p. 1) Claimant was then seen by Dr. Clem on October 25, 2012, with complaints of left shoulder symptoms. Dr. Clem diagnosed claimant's left shoulder problems as secondary to the right shoulder due to compensation. She began physical therapy on the left shoulder on October 26, 2012. (Ex. 3, p.12-14)

She reiterated her belief that her left shoulder pain was not due to a new injury to Dr. Mendel. Dr. Mendel recorded in his notes on November 30, 2012, "[s]he feels that she is overcompensating for the right and that gradually increased her symptoms on the left. She denies any specific injury to her left shoulder." (Ex. B, p. 12)

The objective tests did not show any signs of injury. Dr. Gordon did not assign any additional restrictions above and beyond the left shoulder restrictions that were already in place when she saw him in January 2013. Ultimately she was returned to duty without restrictions on February 12, 2013. She consulted with Dr. Hall on April 11, 2013, for bilateral shoulder pain. Dr. Hall concluded she suffered from myosfascial pain and tendon overuse likely related to repetitive work activities. She did not receive treatment for the left shoulder again until April 2014.

Dr. Milas, an independent medical examiner, did not give any rating for the shoulder on November 3, 2015, because of the normal range and function. She did receive an injection to her right shoulder on November 20, 2015.

While Dr. Bedell did treat the claimant for shoulder complaints, he did not provide a causal opinion. The causal opinion as it relates to the left shoulder include Dr. Clem who found the left shoulder pain to be sequelae to the right shoulder injury that was part of an accepted and settled claim. The claimant argues that Dr. Milas provided an expert opinion on the causation between claimant's left shoulder pain and work, but Dr. Milas' reports only provide causation on the right shoulder, cervical and thoracic spine issues, and bilateral carpal tunnel. He does state that the impairment to the left shoulder would be difficult to rate, but does not provide an opinion statement about causation as to the left shoulder. (Ex. I, p. 8-9)

Thus, the claimant's left shoulder pain was not a condition of overcompensation and does not arise out of a November 2, 2012, injury, but rather is sequalae of the right shoulder injury. However, there is no opinion as to any impairment to the left shoulder. Dr. Milas did not provide a rating. During her October 16, 2015, examination, all four extremities were within normal limits. Her strength and deep tendon reflexes were symmetrical.

Therefore there is no finding of permanency as it relates to the left shoulder injury.

The claimant also claims upper body and neck injuries. She was seen by Dr. Bedell beginning on March 30, 2012, for a four-month history of left neck pain radiating into her shoulder. The November 30, 2012, EMG did not result in an abnormal finding related to the neck. She did not have further complaints of neck pain until May 7, 2014.

Dr. Milas concluded in his multiple reports that the ligamentous injury to claimant's neck and thoracic region was the result of repetitive injury. Dr. Phillips concluded that the claimant's neck muscle spasms were compensatory for her chronic shoulder pain. (Ex. M, p. 3) By February 2015, she reported a decline in neck symptoms and Dr. Clem noted that her neck pain was largely resolved. However, she continued to treat for neck pain throughout 2015.

Dr. Milas' October 16, 2015 note states that claimant described her neck and thoracic pain as progressively worsening after her right shoulder surgery. She denied any specific traumatic injury. The radiographs showed nothing more than mild, degenerative disc changes.

Claimant's report and Dr. Milas' historical account more accurately match that of Dr. Phillips' conclusion that claimant's neck and muscle spasms relate to her chronic shoulder pain and not a new, traumatic injury.

It is found as to File No. 5049103 that claimant's left shoulder, upper body, and neck injuries are sequalae or symptomatology arising out of claimant's right shoulder injury of 2011.

Claimant has not met her burden of proof that the left shoulder, upper body, and neck injuries were related to an October 2, 2012, work injury. The remaining issues as to medical bills are rendered moot by the finding of no causation. These would be more appropriately addressed in a review-reopening.

File No. 5049104 (Date of injury November 6, 2012). Affected body part: Left arm.

This claim arises out of an alleged work injury occurring on November 6, 2012 to claimant's left upper extremity.

In claimant's brief for File No. 5049104, she initially identifies that it is the left elbow pain which is the basis for this claim but in the argument section refers to Dr. Milas' causation opinions on bilateral upper extremity injuries. Dr. Milas' broad conclusions are difficult to apply to the ten discrete injuries claimant has asserted she has suffered.

Claimant first reported mild left elbow pain on November 6, 2012, during a visit with Dr. Clem. Dr. Clem provided Bandit splints for the claimant and referred her to Dr. Mendel. Dr. Mendel ordered an EMG which showed evidence of mild to severe bilateral carpal tunnel. She continued to have left elbow pain. A subsequent EMG was performed in 2014 which again showed bilateral CTS. She underwent carpal tunnel release on December 19, 2014, on the right and then again on March 27, 2015 for the left.

Dr. Clem found claimant to be at MMI for bilateral elbow pain on February 2, 2015. She continued to report pain symptomatology. Dr. Milas found claimant sustained a work related injury to her bilateral upper extremities as a result of repetitive work. He gave claimant an impairment rating of 5 percent for each upper extremity. However, it appears from the "impression" line that Dr. Milas was attributing the impairment to the claimant's bilateral carpal tunnel injuries.

During Dr. Bedell's deposition, he testified that claimant had sustained a bilateral epicondyle condition arising out of repetitive work duties. (See also Ex. 4, to Dr. Bedell's deposition). Claimant filed a bilateral elbow claim under File No. 5049107 with a date of injury of April 11, 2013.

It appears, although it is not expressly stated by Dr. Bedell, that his opinions relate to claimant's bilateral elbow claim. Claimant's initial complaints regarding left elbow were in conjunction with the left shoulder and neck pain. Dr. Clem surmised that those complaints were related to left shoulder overcompensation injury, or, more precisely, sequaela of the right shoulder. Therefore there is no opinion evidence to connect the left elbow injury to a November 6, 2012, injury date. Assuming arguendo that there was opinion evidence on causation, Dr. Milas determined that the November 6, 2012, diagnosis of epicondylitis was resolved as of October 22, 2015, and no impairment should be given for said injury. (Ex. I, p. 5)

The claimant has not met her burden to show that the left elbow pain arose out of and in the course of an injury on November 6, 2012. It appears that this 2012 left elbow pain was more likely related to the left shoulder. The bilateral elbow condition is addressed under File No. 5049107.

The other remaining issues are moot based on the causation finding.

File No. 5049105 (Date of injury December 20, 2012). Affected body part: Low back.

Claimant asserts she fell in the parking lot at work while walking out to her car at the end of a shift. She reported that she fell backward, injuring her low back. (Ex. Y, p. 2) Claimant testified she went to the company nurse; however, there is not a record of this visit in the Tyson Medical Record Reports. (Ex. 1, p. 1-2) Her first recorded medical visit took place on January 10, 2013, with Dr. Gordon. Dr. Gordon diagnosed her as sustaining a lumbar contusion. She was seen by Dr. Lee on January 29, 2013, and her examination was largely normal except for tenderness to palpation in the area of the right sacroiliac joint. On February 12, 2013, Dr. Lee found that claimant's contusion had resolved and she was returned to full duty work without restrictions. (Ex. D, p. 21)

Medical bills were paid and there was no lost time at work.

Claimant did not appear to have more back complaints until 2014. Claimant asserts she sustained a second fall in the cafeteria on February 5, 2014, either injuring her back or aggravating a prior condition.

Dr. Bedell and Dr. Milas both concluded that claimant's low back pain was associated with falls on December 20, 2012, and February 5, 2014. However, Dr. Milas noted that the claimant's complaints of low back pain from December 20, 2012, had resolved. (Ex. I, p. 5)

It is found that claimant sustained a low back contusion as a result of a fall on December 20, 2012. It should be noted that Tyson asserts that the injury took place on December 21, 2012. Based on the claimant's testimony and the incident report, the injury date is determined to be December 20, 2012. (Ex. Y, p. 2)

Because it is an injury to the low back, claimant seeks an industrial award. While there is evidence that claimant sustained an injury, she was treated and released within two months of the incident. She returned to work without restrictions. She had full range of motion in her back. She did not receive any additional treatment for her low back until August 17, 2014. At that time, she sustained another fall on February 5, 2014.

It is determined that claimant sustained a back injury which resulted in a temporary insult that eventually resolved without permanency at or around February 2013. Defendants are not entitled to any credit.

File No. 5049106 (Date of injury January 14, 2013). Affected body parts: Bilateral hands.

Claimant testified she began to feel pain and numbness in her hands on or around January 14, 2013. She reported this to her supervisor. EMG testing on January 14, 2013, revealed that she suffered bilateral carpal tunnel syndrome, left equal to right, moderate to severe. There is a second upper extremity petition claimant filed

claiming upper extremity injuries including, but not limited to, her wrists contained in File No. 5049112. File No. 5049112 is an accepted claim.

An injury to the wrists is considered an arm rather than hand injury. Miranda v. IBP/Tyson Foods, Inc. File No. 5008521 (Appeal 2005); Holstein Elec. v. Breyfogle, 756 N.W.2d 812 (Iowa 2008). There appears to be no hand injuries arising out of a work related incident on January 14, 2013. The numbness and pain in her hands were symptoms of her bilateral carpal tunnel syndrome, a claim which the defendant has accepted.

The manifestation date of claimant's bilateral carpal tunnel syndrome is "the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person." Meyer v. IBP, Inc., 710 N.W.2d 213, 221 (Iowa 2006).

It became apparent to the claimant on or about January 14, 2013, when she reported the injury to her employer.

Thus the manifestation date of claimant's bilateral carpal tunnel syndrome is January 14, 2013. This is an accepted injury, however, even if it were not, there is sufficient evidence in the record to support a finding that the bilateral CTS is work related. Dr. Bedell and Dr. Milas concluded that claimant's bilateral carpal tunnel syndrome was related to her repetitive work. She has worked the same job, trimming fat with a Whizard knife, for approximately seven years. This job requires constant use of her hands and arms to hold, twist, pull and toss.

Claimant underwent bilateral carpal tunnel syndrome release on her right side on December 19, 2014, and March 27, 2015. She has not been released from Dr. Wills' care as it relates to her bilateral CTS and permanency is not ripe for determination according to the defendant.

Iowa Code section 85.34(1) provides:

> Healing Period. If an employee has suffered a personal injury causing permanent partial disability for which compensation is payable as provided in subsection 2 of this section, the employer shall pay to the employee compensation for a healing period, as provided in section 85.37, beginning on the first day of disability after the injury, and until the employee has returned to work or it is medically indicated that significant improvement from the injury is not anticipated or until the employee is medically capable of returning to employment substantially similar to the employment in which the employee was engaged at the time of injury, whichever occurs first.

Claimant has returned to the same job she worked prior to and at the time of her injury. Section 85.34(2) legally obligates an employer to begin paying weekly compensation for permanent partial disability at the point in time when the healing

period ends. The weekly compensation for permanent partial disability continues to be payable weekly thereafter until the employer's liability is fully satisfied. Late payments accrue interest.

According to the medical records, claimant returned to regular work on or about May 14, 2015. (Ex. D, p. 64) Dr. Milas assessed a 5 percent impairment rating for each upper extremity for complaints of pain and paresthesia. He noted she did have normal sensation and motor strength in the upper extremities.

The extent of the claimant's entitlement to permanent disability benefits is determined by one of two methods: industrial or scheduled member. In the case of scheduled member injuries, a party can seek a claim under 85.34(2)(s). Claimant did not plead an 85.34(2)(s) and therefore it is not considered.

If it is found that the permanent physical impairment is limited to a body member specifically listed in schedules set forth in one of the subsections to Iowa Code section 85.34(2), the disability is considered a scheduled-member disability and is compensated based on the degree of functional impairment shown to exist. Loss of the use of a scheduled member is equivalent to the loss of that member. Moses v. National Union C.M. Co., 194 Iowa 819, 822, 184 N.W. 746, 747 (1921). A scheduled-member disability is compensable based on the percentage of functional loss. Iowa Code section 85.34(2) (1999).

Based on Dr. Milas' impairment ratings, claimant's loss of function due to pain and numbness is 5 percent for each wrist. Therefore, claimant's functional impairment is found to be 5 percent loss to each wrist for a total of 12.5 weeks each.

Claimant also seeks reimbursement for an office visit with Dr. Bedell on April 29, 2015. (See medical bills attached to File No. 5049112) Dr. Bedell is claimant's family physician. He is not an authorized treating physician. Therefore entitlement to reimbursement of this medical bill is examined according to Bell Bros. Heating v. Gwinn, 779 N.W.2d 193 (Iowa 2010). The Supreme Court requires a finding that the unauthorized medical care provides a more favorable medical outcome than would likely have been achieved by the care authorized by the employer. Claimant has advanced no argument in this regard.

Claimant is still under the care of Dr. Wills. The sole office visit Dr. Bedell proferred encouraged her to follow up with Dr. Wills. Dr. Bedell's office visit did not provide a more favorable outcome than her visits with Dr. Wills. Therefore entitlement to the medical bill of Dr. Bedell is denied.

File No. 5049107 (Date of Injury April 11, 2013). Affected body parts: Bilateral elbows.

Claimant has alleged a bilateral elbow injury arising out of a "repetitive trauma accident" on April 11, 2013. Claimant was seen by Dr. Hall on April 11, 2014, for

bilateral shoulder complaints upon referral by Dr. Bedell. While she was there, she complained of bilateral elbow pain. Dr. Hall believed that she was suffering myofascial pain and tendon overuse likely related to her work activities. She was prescribed physical therapy specifically for the tennis elbow.

A medical bill for this medical visit was submitted to defendant employer and denied on May 15, 2013. (Ex. 8, p. 60)

Claimant was seen by Dr. Clem in October 2, 2014, complaining of bilateral hand numbness, wrist, forearm and bilateral elbow pain. She was then referred to Dr. Wills for treatment of her bilateral CTS and bilateral epicondylitis. Dr. Wills concluded that her elbow pain was consistent with myofascial pain and bilateral upper extremity pain rather than lateral epicondylitis. X-rays did not reveal any damage and he believed that she would get better with time. This is consistent with the opinion of Dr. Hall and Dr. Milas.

She continued to complain of pain and discomfort regarding her bilateral elbow pain in 2015 to Dr. Clem and Dr. Bedell. Dr. Bedell agreed via a form opinion that there was a causal connection between claimant's condition of bilateral elbow pain and her work activities.

Based on the opinions of Dr. Hall, Dr. Milas, Dr. Bedell and Dr. Wills, it is found that claimant's bilateral elbow pain arose out of and in the course of her employment. Specifically, the injuries were caused by claimant's repetitive work.

Defendant asserts a lack of timely notice defense.

Iowa Code section 85.23 requires an employee to give notice of the occurrence of an injury to the employer within 90 days from the date of the occurrence, unless the employer has actual knowledge of the occurrence of the injury.

The purpose of the 90-day notice or actual knowledge requirement is to give the employer an opportunity to timely investigate the facts surrounding the injury. The actual knowledge alternative to notice is met when the employer, as a reasonably conscientious manager, is alerted to the possibility of a potential compensation claim through information which makes the employer aware that the injury occurred and that it may be work related. Dillinger v. City of Sioux City, 368 N.W.2d 176 (Iowa 1985); Robinson v. Department of Transp., 296 N.W.2d 809 (Iowa 1980).

The time period both for giving notice and filing a claim does not begin to run until the claimant as a reasonable person, should recognize the nature, seriousness, and probable compensable character of the injury. The reasonableness of claimant's conduct is to be judged in light of claimant's education and intelligence. Claimant must know enough about the condition or incident to realize that it is work connected and serious. Claimant's realization that the injurious condition will have a permanent adverse impact on employability is sufficient to meet the serious requirement. Positive

medical information is unnecessary if information from any source gives notice of the condition's probable compensability. Herrera v. IBP, Inc., 633 N.W.2d 284 (Iowa 2001); Orr v. Lewis Cent. Sch. Dist., 298 N.W.2d 256 (Iowa 1980); Robinson v. Department of Transp., 296 N.W.2d 809 (Iowa 1980).

Defendant had notice that claimant believed she had suffered a work injury when claimant filled out a statement of injury and illness on October 2. There were medical visits with Dr. Clem pertaining to her upper extremities. She had an IME with Dr. Milas in the fall of 2012 which mentioned bilateral extremities. She later submitted treatment bills from the UIHC. At that time, a reasonable employer would have or should have recognized that the claimant was asserting a medical condition was caused by work activity.

Defendant has failed to show that they were not alerted to the possibility of a potential compensation claim by the employee within 90 days of the incident.

Defendant had notice that claimant believed she had suffered a work injury by the submission of the treatment bill from the UIHC. A reasonable employer would investigate the underlying basis.

Turning to the issue of permanency, claimant presented two contradictory opinions. Her treating doctor, Dr. Bedell, opined she should have work restrictions of no lifting over 15 pounds and no repeated pulling over 15 pounds. (Ex. 4 to Deposition of Dr. Bedell). He testified in his deposition that if she was able to rest her elbows, the condition should resolve. This was consistent with Dr. Halls' original opinion.

Dr. Milas is claimant's independent medical examiner. He wrote on October 22, 2015, that claimant demonstrated normal function of the upper extremities and her diagnosis of epichondylitis on November 6, 2012. He further stated that, "[O]n April 11, 2013, the patient complained of bilateral elbow pain associated with the use of a Viz knife at her place of employment. The patient...was treated for bilateral epichondylitis. These...conditions resolved with no further complaints voiced by the patient at her appointment in my office." (Ex. I, p. 5) The relevant examination took place on October 16, 2015.

During claimant's deposition taken one month later, she stated that she still had problems with swelling in her bilateral elbows. She testified at hearing that her elbows remain painful and that she uses a pain cream and braces for both elbows which were prescribed by Dr. Clem.

It appears that claimant's elbow pain waxes and wanes, but she continues to use prescriptions such as the pain cream and the braces to do her work. This was unchallenged. Therefore, it is determined that claimant has sustained a permanent injury. The commencement date of permanent benefits would be April 12, 2013.

Claimant agrees in her brief that the impairment rating given by Dr. Milas was for both her bilateral CTS and her bilateral upper extremity pain.

Section 85.36(9)(c) reads as follows:

> c. In computing the compensation to be paid to any employee who, before the accident for which the employee claims compensation, was disabled and drawing compensation under the provisions of this chapter, the compensation for each subsequent injury shall be apportioned according to the proportion of disability caused by the respective injuries which the employee shall have suffered.

In Mycogen Seeds v. Larry Sands, 686 N.W.2d 457 (Iowa 2004), the Iowa Supreme Court required three threshold elements to exist before apportionment can be applied: the employee 1) has missed work because of a work-related injury, 2) is receiving or is entitled to receive weekly disability benefits for the injury, and 3) suffers another work-related injury.

In this particular case, the claimant has not missed work, nor is she receiving or entitled to receive weekly benefits.

However, a finding of additional functional impairment is inappropriate given that Dr. Milas' impairment rating encompassed the entirety of claimant's upper extremity. No additional disability is awarded.

Claimant also seeks reimbursement of medical bills for the April 11, 2013 medical visit to Dr. Bedell which resulted in a MRI review and an injection. Under the Bell Bros. Heating v. Gwinn case, there is no evidence that the Dr. Bedell visit was more beneficial to the claimant than the care and treatment of authorized treating physicians such as Dr. Wills who provided injections on more than one occasion.

File No. 5049108 (Date of injury June 21, 2013). Affected body parts: Bilateral feet.

Claimant seeks compensation for bilateral plantar fasciitis which she asserts was caused by standing on her feet on hard concrete. She testified that for the past seven years, she has trimmed fat while standing on a concrete floor. On June 21, 2013, claimant filled out a statement of injury/illness asserting that standing at work in the cold had led to shooting pain up her legs and a pulsating pain in her feet. She sought treatment from her family doctor on the same day. Dr. Bedell injected claimant in her heels to alleviate the pain.

She next presented to Dr. Clem, the company doctor, for heel pain which she stated went back four months. She was diagnosed with bilateral plantar fasciitis. She believed her heel pain was work related but Dr. Clem disagreed and the defendant employer denied the claim on July 19, 2013.

On September 9, 2013, she was seen by Dr. Smoot via a referral of Dr. Bedell, who noted that plantar fasciitis was common with sedentary individuals. On January 16, 2014, claimant underwent diagnostic ultrasound which revealed severe right plantar fasciitis. She underwent more injection therapy. Dr. Smoot recommended claimant be allowed to sit at work.

Claimant was provided a stool and allowed to sit and stand as needed.

Dr. Bedell concluded that based on claimant's years of standing on concrete she developed bilateral plantar fasciitis, greater on the right than the left. Dr. Hall and Dr. Clem both agreed that this was a condition that could occur regardless of work conditions, however, Dr. Hall did not rule out work conditions.

Therefore, Dr. Bedell's opinions are adopted in this matter. Claimant did stand on concrete for her eight hour shifts for the past seven years. Standing on concrete was a physical demand of the job. (Ex. W)

It is found that claimant's bilateral foot plantar fasciitis arose out of and in the course of her work duties.

The next issue is one of permanency. While claimant maintains she suffers a great deal of pain from her bilateral foot condition, during her October 16, 2015, examination with Dr. Milas, he noted that she had ordinary gait. Her treatment was noted to have "no residual". (Ex. I, p. 6) Therefore there is no permanency.

Claimant was off work from March 19, 2014, through May 15, 2014, and would be entitled to temporary benefits during this time. Defendant is entitled to a credit from the short-term disability.

Claimant also seeks medical expenses in the amount of $2,470.31 for treatment with Dr. Smoot, Dr. Bedell, and Dr. Hall as well as six sessions of physical therapy. As no other care was being provided, this unauthorized medical care for a denied claim was more beneficial than what the defendant had proffered. Therefore, claimant is entitled to reimbursement for the medical expenses.

File No. 5049109 (Date of injury August 13, 2013) and File No. 5049110 (Date of injury September 10, 2013). Affected body parts: Left hand.

Claimant alleges a left hand injury arising out of an August 13, 2013 date of loss and/or September 10, 2013 date of loss. Claimant does not assert any traumatic injury on either date but rather the onset of pain and discomfort arising out of her repetitive work tasks.

The defendant accepted File No. 5049109 but asserts that File No. 5049110 relates to the same scheduled member for the same injury. The undersigned agrees with defendant.

Claimant's brief indicates that the August 13, 2013 injury pertains to left wrist pain. Left wrist pain was pled as an injury in File No. 5049106 for the bilateral wrists. As noted previously, a wrist injury is considered part of the arm. Claimant acknowledges that her left wrist pain is part and parcel of her overall bilateral upper extremity complaint. There is no separate finding of liability and permanency for File No. 5049109. It is duplicative and the claimant shall take nothing from this claim.

As it relates to File No. 5049110, claimant asserted an injury to the left index finger and hand on September 10, 2013. She was using a mesh glove on her left hand. She presented to the company nurse with complaints of pain to her left fingers, hand, wrist and forearm. On November 1, 2013, she was seen by Dr. Clem for index finger pain over the DIP and PIP with associated popping. She was eventually referred to Dr. Wills at Steindler Orthopaedic who diagnosed claimant with a mild swan neck deformity of the left index finger. This claim was accepted.

Claimant seeks a finding of permanency. Dr. Wills treated claimant with a splint and an orthotic. On March 3, 2014, Dr. Wills wrote that claimant reached MMI on January 19, 2014, and that she had no permanent impairment to the injury of the left index finger. He did encourage claimant to wear a wrap or similar material or a silver ring orthosis as needed at work for comfort. Similarly, Dr. Milas concluded she had no dysfunction to her bilateral hands as of his October 16, 2015, examination.

Therefore it is determined that claimant sustained a work related injury resulting in a left index finger and hand injury. That injury resolved with the treatment of a splint and use of an orthotic. She was examined a few months before hearing and found to have no dysfunction.

Therefore claimant shall take nothing from File No. 5049110.

File No. 5049111 (Date of injury February 5, 2014). Affected body parts: Left arm, left leg, low back.

Claimant testified that she slipped and fell in the cafeteria at work and struck her left hip. Pain increased to the point where she needed medical attention. She testified that the pain was so severe that she could not walk and was sent for an MRI. An MRI was taken on August 29, 2014, after a visit with Dr. Clem. It is unclear when it was that claimant was in such severe pain that she could not walk. In the summer of 2014, the only debilitating injury with corresponding work restrictions that was affecting her ability to work was a bilateral plantar fasciitis issue.

In fact, on June 25, 2014, Dr. Hall cleared claimant to return to work for 10 hour days with the restriction that she be allowed to sit as needed.

She presented on August 7, 2014, for left hip pain and was given a work restriction of no reaching above her shoulder due to back problems. A week later she was seen by Dr. Candler where the lunchroom fall on February 5, 2014, was first

recorded in the medical records. Dr. Candler noted that claimant's examination was positive for Waddell signs. He prescribed her Naprosyn, Flexeril, and physical therapy. He also advised her to start a home exercise program.

The MRI ordered by Dr. Clem did not reveal any abnormalities. She was referred to Dr. Dolphin for a second opinion. Dr. Dolphin felt that her back pain was more likely related to her altered gait following the right foot surgery.

Dr. Bedell testified in his deposition that he believed claimant's back pains were associated with both falls. He did not differentiate whether claimant's back pain was exacerbated by the fall in the cafeteria or was a new injury.

It is the claimant's burden to prove that her condition is causally connected to her work injury. In this case, the only medical evidence she can point to that connects her back pain to a fall at work is Dr. Bedell's summary conclusion. She exhibited Waddell symptoms during the examination with Dr. Candler. She sought out no medical care for her back pain from February 2, 2014, until around August of 2014, despite pain being so severe she could not walk. She was in regular contact with several medical doctors during the summer of 2014 and the issue regarding her back pain was not mentioned.

It is determined that claimant has failed to prove that the alleged injuries of left arm, left leg, low back pain were associated with any fall that occurred on February 5, 2014.

Claimant shall take nothing from File No. 5049111.

File No. 5049112 (Date of injury July 23, 2014). Affected body parts: Upper extremities, mid/upper body.

Claimant seeks workers' compensation for bilateral carpal tunnel and bilateral epicondylitis as well as her cervical and thoracic spine. She bases this claim on the testimony and opinions of Dr. Bedell, her long-time family physician.

This claim does not assert a new injury above and beyond the previously pled injuries. Instead, they appear duplicative and rising from the same repetitive injury that underpinned File Nos. 5049103, 5049106, 5049107, 5049109 and 5049110. In the brief itself, there was no mention of any new traumatic injury but instead that the upper body injuries that manifested in November of 2012 were exacerbated by ongoing work activities.

The neck, upper body, shoulder pain were found to be sequelae of the original right shoulder injury and more appropriately addressed in a review-reopening. This issue was raised during the prehearing period but turned aside by the claimant. Claimant argues in her brief that she has continued to sustain injuries subsequent to July 23, 2014, and may continue to sustain these injuries as she continues to work. However, this statement (and the multitude of repetitive filings previously mentioned) demonstrates a misunderstanding of the workers' compensation system. When

claimant makes a claim for damages based on ongoing work conditions, these are known as cumulative injuries. The cumulative injury rule applies when an injury develops over a period of time; then the compensable injury itself is held to occur at the later time. 1B A. Larson, Worker's Compensation Law, Section 39.10 (1985) (hereafter cited as Larson). See McKeever Custom Cabinets v. Smith, 379 N.W.2d 368 (Iowa 1985) (upholding the application of the cumulative injury rule). The date of injury under the cumulative injury rule is considered to be the manifestation date. See supra Meyer v. IBP, Inc., 710 N.W.2d at 221 (Iowa 2006).

The manifestation date for claimant's bilateral carpal tunnel has been deemed to be January 14, 2013. According to the opinions of Dr. Milas, this injury has resulted in a 5 percent functional loss. Therefore, claimant has already been compensated for the bilateral CTS. If the injury worsens beyond the 5 percent functional loss, that is a matter for a review-reopening. In this case, based on Dr. Milas' expert opinions, claimant's upper extremity loss is set at 5 percent for each upper extremity.

There is no finding for industrial disability because the shoulder and upper back pain relate to a previous injury that is the subject of a settled right shoulder claim. There is no review-reopening issue that is raised and it would not be appropriate to render a ruling on an issue the defendant was not on notice to defend.

Therefore, File No. 5059112 is determined to be duplicative and the claimant shall take nothing.

Claimant seeks reimbursement of costs including $100.00 filing fee, $22.00 UIHC medical report fee, $65.50 deposition transcript fee, $307.40 Bedell deposition transcript fee, and $664.00 for the examination and evaluation of Dr. Milas for his October 16, 2015, and November 3, 2015 reports.

Iowa Code section 85.39 fees are not to be awarded as a cost according to Des Moines Area Regional Transit Authority v. Young, 856 N.W.2d 383 (2014). Dr. Bedell's deposition fee is an appropriate cost to assess as it is in lieu of live testimony at hearing. Therefore, claimant is entitled to reimbursement of the following costs:

$100.00 filing fee

$22.00 UIHC medical report fee

$65.50 deposition transcript fee

$307.40 deposition transcript fee of Dr. Bedell

ORDER

THEREFORE IT IS ORDERED:

File No. 5049103 (Date of injury October 2, 2012). Affected body parts: Upper body, neck, and left shoulder.

Claimant shall take nothing.

File No. 5049104 (Date of injury November 6, 2012). Affected body part: Left arm.

Claimant shall take nothing.

File No. 5049105 (Date of injury December 20, 2012). Affected body part: Low back.

Claimant shall take nothing.

File No. 5049106 (Date of injury January 14, 2013). Affected body parts: Bilateral hands.

That defendant is to pay unto claimant twenty-five (25) weeks of permanent partial disability benefits at the rate of four hundred fifty-seven and 31/100 dollars ($457.31) per week from May 14, 2015.

That defendant shall pay accrued weekly benefits in a lump sum.

That defendant shall pay interest on unpaid weekly benefits awarded herein as set forth in Iowa Code section 85.30.

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

That defendant shall pay the costs of this matter pursuant to rule 876 IAC 4.33 as follows:

$100.00 filing fee

$22.00 UIHC medical report fee

$65.50 deposition transcript fee

$307.40 deposition transcript fee of Dr. Bedell

The costs of the hearing transcript.

That claimant is entitled to ongoing treatment as it relates to her bilateral CTS.

File No. 5049107 (Date of injury April 11, 2013). Affected body parts: Bilateral elbows.

That it is found claimant's bilateral epicondylitis arises out of and in course of her employment.

The finding of permanency for this injury was included in File No. 5049106.

That claimant is entitled to ongoing treatment as it relates to her bilateral elbow pain and dysfunction.

File No. 5049108 (Date of injury June 21, 2013). Affected body parts: Bilateral feet.

That it is found claimant's bilateral plantar fasciitis arises out of and in the course of her employment.

She has sustained no permanent injury.

Claimant was off work from Marcy 19, 2014, through May 15, 2014, and would be entitled to temporary benefits during this time. Defendant is entitled to a credit from the short-term disability.

That claimant is entitled to a reimbursement of two thousand four hundred seventy and no/100 dollars ($2,470.00) for medical care and ongoing treatment as it relates to her bilateral foot issue.

File No. 5049109 (Date of injury August 13, 2013) and File No. 5049110 (Date of injury September 10, 2013). Affected body parts: Left hand.

There is separate finding of liability and permanency for File No. 5049109. It is duplicative and the claimant shall take nothing from this claim.

As it relates to File No. 5049110, claimant sustained a work related injury resulting in a left index finger and hand injury. There was no permanent injury.

Therefore claimant shall take nothing from File No. 5049110.

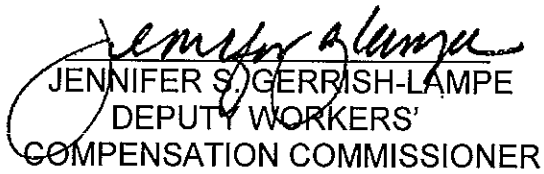
File No. 5049111 (Date of injury February 5, 2014). Affected body parts: Left arm, left leg, low back.

Claimant shall take nothing.

File No. 5049112 (Date of injury July 23, 2014). Affected body parts: Upper extremities, mid/upper body.

The finding of permanency for this injury as well as entitlement to costs and medical benefits were previously decided in the aforementioned claims. Claimant shall take nothing from File 5049112.

Signed and filed this 12th day of April, 2016.



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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.