BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

JOEL ROGERS, Claimant, vs. THE WALDINGER CORPORATION, Employer, and LIBERTY INSURANCE CORP., Insurance Carrier, Defendants.	:	File No. 5059762 ARBITRATION DECISION Head Note Nos.: 1108.50, 1402.40

STATEMENT OF THE CASE

Joel Rogers, claimant, filed a petition in arbitration seeking workers' compensation benefits from The Waldinger Corporation, employer and Liberty Insurance Corp., insurance carrier as defendants. Hearing was held on November 5, 2019, in Des Moines, Iowa.

The parties filed a hearing report at the commencement of the arbitration hearing. On the hearing report, the parties entered into various stipulations. All of those stipulations were accepted and are hereby incorporated into this arbitration decision and no factual or legal issues relative to the parties' stipulations will be raised or discussed in this decision. In their post-hearing brief defendants state that they are not asserting a notice defense. The parties are now bound by their stipulations.

Claimant, Joel Rogers was the only witness to testify live at trial. The evidentiary record also includes Joint Exhibits JE1-JE5, Claimant's Exhibits 1-2, and Defendants' Exhibits A-M. All exhibits were received without objection. The evidentiary record closed at the conclusion of the arbitration hearing. On December 3, 2019, defendants filed a motion to reopen the hearing record because an October 24, 2018 letter from Dr. Smith was inadvertently left out of the exhibits. Claimant filed a notice of non-resistance. The motion was granted on December 18, 2019. Dr. Smith's letter was admitted into the record and is marked as Defendants' Motion to Reopen Hearing Record.

The parties submitted post-hearing briefs on December 6, 2019, at which time the case was fully submitted to the undersigned.

ISSUE

The parties submitted the following issue for resolution:

1. Whether claimant sustained permanent disability as a result of the stipulated December 31, 2014, work injury? If so, the extent of industrial disability claimant sustained.

FINDINGS OF FACT

The undersigned, having considered all of the evidence and testimony in the record, finds:

Claimant, Joel Rogers, injured his back when he assisted in lifting a 5' x 8' sheet metal damper at a construction site in Altoona, Iowa on December 31, 2014. As soon as Rogers grabbed the damper and picked it up, his back gave out instantly. He had two knots in the middle of his back, approximately 4 or 5 inches below his shoulder blades. Rogers was taken to the onsite paramedic. He was then directed to see doctor Richard S. Bratkiewicz, M.D. (Testimony)

On December 31, 2014, Rogers saw Dr. Bratkiewicz at Methodist Occupational Health and Wellness. He reported that he injured his midback at the Facebook jobsite while lifting a large object weighing over 100 pounds. Rogers felt as though he was not making progress. His pain was mainly in the paraspinous thoracic back, an area that he had never injured. The doctor's assessment was midback strain injury. Dr. Bratkiewicz recommended physical therapy. He also prescribed Flexeril, an injection, and ibuprofen. Rogers was restricted to lifting no more than 5 pounds and he was to avoid twisting his back. (JE1, pages 1-2)

On January 27, 2015, Rogers went to Iowa Ortho where he saw Todd J. Harbach, M.D. His pain was in his middle back, lower back, and gluteal area. He denied any radiation of pain. Rogers reported that he had back pain off and on his entire life. His most recent injury was December 31, 2014 when he was lifting a damper. His pain was now worse with kneeling, lifting, drilling, or climbing. Physical therapy had not helped much. He admitted to not doing his home exercises. His pain was described as a constant ache with some sharper episodes and tingling that went into his thoracic spine and radiated around his chest wall on occasion. His pain was 90 percent back and 10 percent bilateral lower extremity pain. Dr. Harbach recommended an MRI of the lumbar and thoracic spines. He restricted his activities until after the MRI. (JE2, pp. 3-4)

The lumbar MRI was performed on January 29, 2015. The radiologist's impression was mild degenerative disc bulging at L4-5 and L5-S1. There was no frank disc herniation, spinal stenosis or lumbar nerve root impingement. (JE3, pp. 79-80)

Rogers returned to see Dr. Harbach on February 3, 2015 for follow-up on the MRI. He continued to have a tremendous amount of mid and low back pain. He begins his construction job at 6:30 a.m. and by the 9:30 a.m. break he is hurting pretty badly, and by lunchtime he is pretty much finished. The assessment was degenerative disc disease lumbar, lumbar spondylosis, thoracic spondylosis, back pain, and obesity. Dr. Harbach stated, "He has degenerative changes that are chronic in nature and would not predominantly be caused by his work-related injury. I am sure that his work related injury made things worse, but not the predominantly causing factor." (JE2, p. 5) Dr. Harbach recommended strengthening and aerobic conditioning and anti-inflammatories. He restricted him to light duty for two weeks in the office and then planned to release him to full duty. He wanted to see Rogers back in one month for a final rating. Dr. Harbach noted that surgery was not a good solution. (JE2, pp. 5-6)

On February 13, 2015, Rogers reported to physical therapy that he was feeling better. Rogers indicated he was ready to return to full duty work next week. He rated his pain as a 3 out of 10 at best and 10 out of 10 at worst. (JE4, pp. 81-82)

Rogers returned to see Dr. Harbach on February 18, 2015. He noted that his back pain was getting better until an intense therapy session and now his pain was worse. He was going to return to work on February 17, 2015, but was unable to due to his pain. The plan was to send him for an epidural steroid series and continue him on light duty, preferably office work. The doctor noted that surgical options were not good because fusing his entire lumbar spine together for back pain almost certainly would guarantee that he would never return to the same level of work. Because therapy seemed to make him a lot worse, Dr. Harbach discontinued the therapy. He recommended a home program of core strengthening. (JE2, pp. 8-9)

On March 5, 2015, Rogers saw Anthony Stark, D.O., a colleague of Dr. Harbach's at Iowa Ortho, for a pain management consultation. Dr. Stark reviewed the MRI and noted Rogers had degenerative disk disease at multiple levels in his lumbar spine, worse at L4-5 and L5-S1. His assessment was lumbago, degeneration of lumbar or lumbosacral intervertebral disc, and obesity. He was scheduled for an L5-S1 interlaminar epidural steroid injection. Rogers continued to follow-up with pain management. (JE2, p. 7; Claimant's Exhibit 1)

Rogers returned to see Dr. Stark on March 27, 2015. He continued to have lumbar spine mild tenderness to palpation. The doctor also noted mildly decreased active range of motion of the lumbar spine. He had good pain relief with the first epidural injection. Dr. Stark recommended a complete epidural series. (JE2, p. 10)

Rogers reported back to Dr. Stark on May 28, 2015. He received about two weeks of pain relief after injections. Rogers reported that 90 percent of his pain was in his back. Dr. Stark felt that if his pain was coming from his degenerative disk disease and/or potential nerve root irritation of the lumbar spine, then he would have hoped for longer pain relief from the epidural steroid injection series. He recommended treating the facet joints. (JE2, p. 12)

Rogers saw Dr. Harbach on February 19, 2016. He reported middle back pain that radiated to the back and right thigh. Dr. Harbach noted that Rogers had received some relief from the epidurals and the next step was facet blocks; however, he never received those. The notes indicate that he fell at the beginning of February while walking down icy steps because of a sharp pain in his back. He ended up breaking his foot. He recommended a return to Dr. Stark to discuss possible interventions to decrease his pain and return him to work. He had been laid off last April 2015 and had not been back to work for a year. He cannot sleep well or do anything that he wants to do. (JE2, p. 15)

Dr. Stark saw Rogers on February 25, 2016. He was scheduled for bilateral L2-L5 diagnostic facet medial branch blocks. (JE2, pp. 17-18) The L2-L5 facet blocks were performed on February 29, 2016. On April 15, 2016, Rogers reported significant symptom relief, so Dr. Stark felt it was reasonable to move forward with radiofrequency ablation (RFA). The ablation was done in May of 2016. (JE2, pp. 19-23)

On August 17, 2016, Rogers saw John W. Rayburn, M.D. at Iowa Ortho. He presented for an initial evaluation of low back pain and for follow up of bilateral RFA. Overall he was better, but some of his pain had shifted to just the right side. He had occasional pain going up his back. Dr. Rayburn's assessment was low back pain at multiple sites, sacroiliitis, and chronic pain syndrome. He recommended physical therapy, medications, and consideration for lumbar trigger point injections. Rogers was to call for any follow-up appointment. (JE2, pp. 24-27)

On September 1, 2017 Rogers saw Kurt Smith, D.O. at Iowa Ortho. He reported that he was able to complete activities of daily living without an increase in symptoms. However, he did note an increase in symptoms when he attempted to increase his activity. (JE2, pp. 28-29)

Rogers saw Dr. Smith on October 18, 2016. Dr. Smith described his problem as severe and noted that it had worsened. His pain was constant and located in his left lateral neck and upper back. He also reported radiation of pain to the left arm and hand. Increased pain with C7 distribution weakness and sensory loss in the left upper extremity. He was given a Medrol dosepak and an MRI of the cervical spine was recommended. (JE2, p. 34)

In December of 2016, Rogers underwent trigger point injections. (JE2, p. 37)

In February of 2017, Rogers saw Dr. Rayburn and Dr. Smith. Most of his pain was in the low back musculature soft tissue. The plan included trigger point injections and physical therapy. The injections were done on March 23, 2017. (JE2, pp. 38-44)

On March 31, 2017, Rogers returned to Iowa Ortho. His low back pain continued to limit his mobility and functional status. He had not started the physical therapy that Dr. Rayburn recommended. If he did not have a response to the additional physical therapy then he would likely be placed at MMI. His restrictions continued. (JE2, pp. 45-46)

In May of 2017 Dr. Rayburn stopped his physical therapy because it seemed to be flaring his problems more than helping. An RFA was recommended. On May 30, 2017, a left L2-L5 medial branch RFA was performed. (JE2, pp. 48-53)

Rogers saw Dr. Smith on August 3, 2017. He was participating in physical therapy for one month and was to follow-up with Dr. Rayburn. (JE2, p. 54)

On September 1, 2017 Rogers participated in a functional capacity evaluation (FCE) at Athletico Physical Therapy. (JE4) Rogers demonstrated the physical capabilities and tolerances to function in at least the heavy physical demand level. The report stated: "Variable Performance/Questionable effort indicates that the client's perceived limitations and return to work confidence are mildly to moderately affecting symptom expression, consistency of effort, reliability of pain, and/or quality of effort. The client likely could have performed at higher levels than willing during musculoskeletal and functional testing." (JE4, p. 86)

By September 20, 2017, Dr. Smith felt that Rogers had plateaued in his treatment. He reviewed the FCE and noted that Rogers could perform at the heavy category of work. He placed Rogers at MMI and assigned work restrictions pursuant to the FCE. Dr. Smith did not recommend any further treatment relating to the December 31, 2014 work injury. (JE2, p. 56)

On September 28, 2017, at the request of his attorney, Rogers saw Sunil Bansal, M.D. for an IME. Rogers provided Dr. Bansal with a description of the December 31, 2014 lifting injury. Dr. Bansal diagnosed Rogers with "L4-L5 and L5-S1 disc bulges, with annulus tears, and an aggravation of lumbar facet arthropathy." (Cl. Ex. 1, p. 11) He opined that the described mechanism of injury was consistent with his lumbar disc bulging. He placed Rogers in the DRE Category II and assigned 8 percent whole person functional impairment. He agreed with the restrictions as set forth in the September 1, 2017 FCE. Additionally, he restricted Rogers to no frequent bending or twisting based on the increased aggravation to the disc bulging and annular tearing. (Cl. Ex. 1)

On October 31, 2017, Dr. Smith assigned 5 percent impairment of the whole body due to muscular spasms. Dr. Smith later clarified that this was for the lumbar

spine. He noted Rogers had underlying degenerative changes of the lumbar spine which preexisted the December 31, 2014 injury. (JE2, pp. 57-58, 60) On January 10, 2018, Dr. Smith reiterated his opinion that Rogers did not need any additional treatment as the result of the work injury. (JE2, p. 59)

Rogers returned to Iowa Ortho on April 13, 2018 with increased arm numbness and tingling and weakness, left greater than right. They felt he was a candidate for epidural steroid injection, as well as surgical intervention. He recommended an MRI of his cervical spine and EMG/NCS. He was to continue with therapy. (JE2, pp. 62-63)

On April 17, 2018, Rogers saw Timothy G. Kenney, M.D. at Iowa Ortho. A discussion was held regarding the order of treatment. He was most symptomatic from his left shoulder and might need surgical treatment for a rotator cuff tear and some labral treating. He is going to discuss this with Dr. Galles. In the meantime, he was to continue with Dr. Harbach. He was also to continue his restrictions and his stretching at home. (JE2, pp. 64-65)

On May 4, 2018, Rogers saw Dr. Harbach for follow up on his cervical MRI and EMG/NCS studies. The nerve conduction study showed bilateral carpal tunnel syndrome. His MRI showed a herniated disk at C4-C5 and C5-C6, but the EMG portion was negative. He recommended a hand surgeon. (JE2, pp. 69-73)

Rogers saw Ze-Hui Han, M.D. at Iowa Ortho on May 7, 2018, for an initial evaluation of bilateral hand numbness. The notes indicated he owns a logging company. He reported numbness and tingling in his left thumb and index finger the last couple of years. His numbness and tingling had been worsening over the last couple years. Rogers elected to proceed with right carpal tunnel release surgery. For his left lateral epicondylitis, Dr. Harbach recommended ice, heat, over-the-counter pain medication, activity modifications, and soft tissue massage. (JE2, pp. 74-76)

Dr. Smith issued a letter with his opinions on August 1, 2018. Dr. Smith had reviewed video surveillance of Rogers dated September 26, 2017. Dr. Smith noted that Rogers was clearly identified and driving a motor tractor grabbing logs. He stated, “He is twisting, turning frequently without obvious distress, bouncing over rough terrain, rapidly turning the steering wheel and walking on uneven ground, bending and twisting. He is doing this freely. He does not stop and demonstrate any evidence of distress.” (JE2, p. 77) The doctor also noted that Rogers had an FCE which demonstrated inconsistent effort. That FCE indicated Rogers could function at least at the level of heavy duty labor. Based on the FCE and the video, Dr. Smith opined that Mr. Rogers did not require any restrictions. (JE2, pp. 77-78)

On October 24, 2018, Dr. Smith authored a missive to defendants. Dr. Smith stated that he had reviewed surveillance video of the Rogers logging business.

Dr. Smith stated:

> It is my opinion that he had a temporary exacerbation of an underlying degenerative process of his lumbar spine. Any ongoing muscular pain, limitations in range of motion or skeletal pain would be the result of the degenerative process and not the work injury of December 31, 2014. Certainly, the injury of December 31, 2014 could have caused back symptoms, but within a temporary exacerbation of his underlying degenerative disease.

(Def. Mot. to Reopen R.)

With regard to restrictions and permanent impairment, Dr. Smith stated:

> On examination, the patient indeed did have ongoing muscular spasms and limited range of motion of the lumbar spine. In light of the surveillance video and inconsistencies identified in the functional capacity evaluation, it is my opinion that he has a 0% impairment of the lower body as it relates to the work injury of December 31, 2014, and his present limitations and pain complaints are the result of the degenerative process of his lumbar spine and not the work injury of December 31, 2014.

(Def. Mot. to Reopen R.)

Rogers contends that he sustained permanent disability as the result of the December 31, 2014 injury. In support of his position, claimant relies heavily on the September 28, 2017 opinions of Dr. Bansal. Dr. Bansal opined that Rogers sustained permanent functional impairment and required permanent restrictions as the result of the December 31, 2014 injury. In October of 2017, Dr. Smith also felt that Rogers had sustained permanent impairment and required permanent restrictions. However, after Dr. Smith was provided additional information, including surveillance footage, he amended his opinions. In October of 2018, Dr. Smith opined that Rogers had sustained 0 percent impairment and no longer related his lumbar problems to the work injury. Rather, Dr. Smith related any limitations and pain complaints Rogers had to the degenerative process of his lumbar spine. Based on the record, it appears that Dr. Bansal did not have the benefit of observing Rogers at his logging business. If he did have access to the surveillance footage, he failed to comment on it in his report. Additionally, Dr. Bansal did not address the inconsistencies noted in the FCE report. Thus, I find Dr. Bansal's opinions were based on an incorrect or incomplete history. For these reasons, I find the opinions of Dr. Smith to be more persuasive than those of Dr. Bansal. I find Rogers sustained a temporary exacerbation of an underlying degenerative process of his lumbar spine. I further find that he has failed to demonstrate by a preponderance of the evidence that he sustained any permanent disability or has any permanent restrictions as the result of the December 31, 2014

injury. I find Rogers has not demonstrated entitlement to any permanent partial disability benefits.

CONCLUSIONS OF LAW

The party who would suffer loss if an issue were not established ordinarily has the burden of proving that issue by a preponderance of the evidence. Iowa Rule of Appellate Procedure 6.14(6)(e).

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).

Based on the above findings of fact, I conclude claimant failed to carry his burden of proof to demonstrate by a preponderance of the evidence that he sustained any permanent disability as the result of the December 31, 2014 injury. I conclude that Rogers failed to prove that he sustained any permanent functional impairment as the result of the injury. I further conclude that he failed to demonstrate that he has any permanent restrictions as the result of the alleged injury. I further conclude that Rogers has failed to prove that he has sustained any industrial disability as the result of the December 31, 2014 injury. Thus, claimant has failed to show entitlement to any permanent partial disability benefits.

Claimant is seeking an assessment of costs. Costs are to be assessed at the discretion of the deputy hearing the case. I find that claimant was generally not successful in his claim. Therefore, I exercise my discretion and do not assess costs against either party; rather, each party shall bear their own costs.

ORDER

THEREFORE, IT IS ORDERED:

Claimant shall take nothing from these proceedings.

Each party shall bear their own costs.

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

Signed and filed this 18th day of February, 2020.

ERIN Q. PALS
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served, as follows:

Anita Dhar Miller (via WCES)

Ryan Beattie (via WCES)

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 filed via Workers' Compensation Electronic System (WCES) unless the filing party has been granted permission by the Division of Workers' Compensation to file documents in paper form. If such permission has been granted, the notice of appeal must be filed at the following address: Workers' Compensation Commissioner, Iowa Division of Workers' Compensation, 150 Des Moines Street, Des Moines, Iowa 50309-1836. The notice of appeal must be received by the Division of Workers' Compensation 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 legal holiday.