BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

TIMOTHY STANTON, Claimant, vs. GLENWOOD RESOURCE CENTER, Employer, and STATE OF IOWA, Insurance Carrier, Defendants.	File No. 1656606.01 ARBITRATION DECISION Head Notes: 1402.40

Claimant, Timothy Stanton, filed a petition in arbitration seeking workers' compensation benefits from Glenwood Resource Center, employer, and State of Iowa, insurer, both as defendants. The hearing occurred before the undersigned via CourtCall on May 10, 2021.

The parties filed a hearing report at the commencement of the hearing. On the hearing report, the parties entered into numerous stipulations. Those stipulations were accepted and no factual or legal issues relative to the parties' stipulations will be made or discussed in this decision. The parties are now bound by their stipulations.

The evidentiary record consists of: Joint Exhibits 1 through 7, Claimant's Exhibits 1 through 5, and Defendants' Exhibits A through D. All exhibits were received without objection.

Claimant testified on his own behalf. No other witnesses testified at hearing. The evidentiary record closed at the conclusion of the evidentiary hearing. Both parties served their post-hearing briefs on June 11, 2021, at which time this case was deemed fully submitted to the undersigned.

ISSUES

The parties submitted the following disputed issues for resolution:

1. Whether claimant sustained permanent disability to his bilateral knees as a result of the September 20, 2018, work injury;

2. Whether claimant is entitled to alternate medical care under Iowa Code section 85.27; and

3. Costs.

FINDINGS OF FACT

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

Timothy Stanton alleges he sustained injuries to his right shoulder, neck, and bilateral knees, arising out of and in the course of his employment with Glenwood Resource Center, on September 20, 2018. This decision will focus solely on issues pertaining to the bilateral knee injury.

On the date of injury, claimant and his co-worker, Scott Burmeister, were sent to the pool area of Glenwood Resource Center to check on a problem with the pool. (Hr. Tr., p. 23) To get to the pool area, claimant had to cross a dark room that he was unfamiliar with. As he was walking across the room, claimant missed a step, lost his balance, and stumbled forward into a metal doorframe. Claimant's neck/right shoulder area struck the metal doorframe and he fell to the ground. (Hr. Tr., pp. 23-24) At hearing, claimant testified that after hitting the metal doorframe, he smashed his knees (plural) onto the floor and folded backwards pinning his legs (plural) underneath him. (Hr. Tr., pp. 23-24)

Mr. Stanton's story at the time of trial is different from the versions of events he provided to emergency personnel and his employer shortly after the injury occurred.

According to the EMS records from Glenwood Fire Department, claimant "struck the door frame and then twisted his right knee." (Joint Exhibit 2, page 33) This account of the accident does not mention claimant falling to the ground. (See id.) Moreover, the medical record only references an injury to the right knee. (See id.) ("twisted his right knee. […] Chief complaint of Right knee pain […]")

Similarly, claimant's handwritten injury report only describes an injury to the right knee. When asked to describe the accident in as much detail as possible, claimant provided,

> Walking through a dark room [and] stepped off a step fell forward into a door hitting my neck and shoulder on doorframe causing me to fall backwards bending my right leg under me.

(Ex. 1, p. 1)

According to the medical records in evidence, Mr. Stanton did not describe the work injury as he did at the evidentiary hearing until he presented to Kevin O'Malley, M.D. on November 28, 2018. (JE5, p. 62) Interestingly, Dr. O'Malley's medical record indicates claimant, "stumbled down nine or ten steps" before striking his right shoulder and falling backwards on both knees. (Id.)

In any event, the State accepted liability and directed medical care for claimant's bilateral knee condition. While the State acknowledges and admits claimant sustained

injuries to his knees as a result of the September 20, 2018, fall, it maintains the fall did not materially aggravate claimant's well-documented pre-existing condition.

To this end, Mr. Stanton's bilateral knee complaints did not begin on September 20, 2018. At hearing, Mr. Stanton acknowledged that he had received treatment for both of his knees prior to the September 20, 2018, work injury, including two surgeries. (See Hr. Tr., pp. 18-23)

Indeed, claimant's medical history is significant for pre-existing issues in his bilateral knees. (JE1, p. 1; see Hr. Tr., p. 18) Medical records indicate claimant has previously sustained two surgical injuries to his knee(s). (See JE1, p. 7) Little is known about the first injury, other than the fact it occurred while claimant was playing basketball in approximately 1987. (See Hr. Tr., pp. 48-49) The second injury occurred in 2000, when he tore his meniscus while working for a different employer. (Hr. Tr., p. 17) As a result of the injury, claimant underwent arthroscopic surgery and participated in physical therapy. (Ex. A, p. 3) Claimant believes both surgeries involved his right knee; however, the evidentiary record does not include the operative reports to confirm the same. (Hr. Tr., p. 48) The evidentiary record does, however, contain medical records from claimant's primary care provider, which date back to 2011. These records indicate claimant had arthroscopies performed on both the left knee and the right knee. (See JE1, pp. 7, 10, 15) I find the pre-injury medical records of his long-time primary care physician to be more accurate than claimant's recollection.

In addition to these two surgeries, claimant submitted to a series of steroid injections and was routinely prescribed pain medication specifically for his bilateral knees. (See JE1, pp. 1-3) Notably absent from claimant's pre-existing medical records, however, is a recommendation for total knee replacements prior to the September 20, 2018, work injury.

The earliest medical record in evidence noting knee pain stems from a January 12, 2011, appointment with Ronald Silvius, D.O. At the appointment, claimant complained of persistent left knee pain that began while golfing in the summer of 2010. Claimant reported that he initially experienced pain in both knees; however, the right knee pain resolved over time. The medical record documents that claimant's left knee was very painful when he was up and moving around. The medical record notes a history of osteoarthritis and gout. On examination, claimant had tenderness over the anterior medial joint line. Dr. Silvius ultimately diagnosed claimant with left knee arthralgia, prescribed the pain medication Vicodin, and administered a Kenalog injection. Following his examination, Dr. Silvius recommended that claimant consider a referral to see a rheumatologist once he obtained health insurance. (JE1, p. 1)

Claimant returned to Dr. Silvius on March 30, 2011, with complaints of ongoing bilateral knee pain and some low back pain. Claimant reported that he was very stiff and sore in the morning and after periods of inactivity. The medical record documents that claimant was still taking Vicodin on a daily basis. Dr. Silvius specifically noted that claimant had been experiencing these chronic pain problems for some time. It is further documented that claimant had tried numerous different NSAIDS, and injections had not been particularly helpful. On examination, Dr. Silvius observed osteoarthritic changes of the bilateral knees. He assessed claimant with osteoarthritis and administered an

intramuscular injection. Dr. Silvius explained that he chose the intramuscular injection because intraarticular injections had not helped claimant in the past. Dr. Silvius refilled claimant's Vicodin prescription and reminded him to use the medication sparingly. (JE1, p. 2)

Less than three months later, claimant presented for medical care and reported a flare-up of his bilateral knee pain. During his visit, claimant asked Dr. Silvius about potentially receiving another Kenalog injection. Claimant reported that the Kenalog injections typically helped his condition for a month or more. Claimant added that the injections were also helpful for his allergies. Again, the record provides claimant had received intraarticular cortical steroid injections in the past and they were not beneficial.

The medical record further notes that Mr. Stanton was still taking Vicodin fairly regularly "for his knee pain" on the date of the appointment. The record explains, "He has a gutter and roofing business, and he is up and down ladders all of the time. He is, also, the girls' softball coach, and finds this time of the year to be particularly taxing on his joints." On examination, Dr. Silvius observed crepitus and osteoarthritic changes over both knees. Dr. Silvius administered another Kenalog injection, refilled claimant's Vicodin prescription, and instructed claimant "to try to take it easy on his knees as much as possible, and supervise his gutter jobs as much as he can." When discussing the Kenalog injection, Dr. Silvius provided, "Do not want to do this regularly, but every 3-4 months, we could." (JE1, p. 3)

On November 14, 2011, claimant returned to Dr. Silvius complaining of worsening problems in his bilateral legs. According to claimant, he could barely stand up if he had been sitting for a while. He reported his legs felt weak and there was "aching constantly in the knees." Dr. Silvius documented claimant's history of osteoarthritis and chronic pain. He further documented that claimant, "takes Vicodin for that[.]" Claimant attempted to distinguish between his then current pain and his osteoarthritis and chronic pain. According to claimant, the then current pain had progressed over time and he thought there was something very wrong with his legs. Dr. Silvius diagnosed claimant with lower extremity weakness and pain, as well as osteoarthritis. (JE1, p. 5)

The evidentiary record does not contain any medical records documenting claimant's bilateral knee condition between December 2011 and December 2014. (See JE1, pp. 5-6)

Mr. Stanton's medical history also includes low back pain. Claimant sustained an injury to his low back after attempting to bend over and pick something up on or about November 4, 2014. He presented to Dr. Silvius on November 15, 2014, and reported debilitating pain in his low back, as well as numbness and tingling in his left leg. Dr. Silvius noted that claimant was "on hydrocodone chronically." He told claimant that he would not be able to continue refilling the hydrocodone prescription if claimant was not able to come in for regular visits. (JE1, p. 6)

Guy Music, M.D. performed surgery on claimant's low back on February 19, 2015. The surgery consisted of a decompressive lumbar laminectomy at L4-L5, and a bilateral microdiscectomy at L5-S1. (See JE1, p. 18) Claimant asserts he also

underwent a spinal fusion at L4-L5 in 2017; however, there are no medical records in evidence to confirm the same. (See Hr. Tr., p. 18) There is evidence that claimant presented to Dr. Silvius for a preoperative evaluation on December 21, 2017; however, the only procedure discussed in that record is sedation for an upcoming MRI of the lumbar spine. (JE1, p. 18) Neither the December 21, 2017, medical record, nor the July 24, 2018, medical record, detail a spinal fusion occurring under the "Surgical Records" or "Procedures" tabs. (See JE1, pp. 18, 20)

Mr. Stanton testified that he experienced an improvement in his bilateral knee pain after undergoing surgery on his low back. (Hr. Tr., p. 19) However, there appears to be a difference between the symptoms claimant experienced because of his osteoarthritis, and the radicular symptoms claimant experienced in his lower extremities as a result of the low back injury. In 2011, claimant complained of constant knee pain with activity. Claimant's knees felt weak and there was a constant aching. (JE1, p. 5) During this time, Dr. Silvius consistently discussed claimant's history of osteoarthritis, diagnosed claimant with osteoarthritis, and prescribed treatments specifically for claimant's bilateral knees. Then, when claimant reported lower extremity symptoms that were "different" from his history of osteoarthritis and chronic pain, Dr. Silvius noted his concern about the possibility for spinal stenosis. (Id.) Additionally, claimant presented to Dr. Silvius with neuropathic complaints of numbness and tingling in his left leg in 2014. (JE1, p. 6) Dr. Silvius connected these symptoms to claimant's lumbar spinal stenosis and degenerative disc disease. (JE1, p. 9)

When asked about the improvements he experienced following his most recent spinal surgery, claimant seemingly confirmed the differences between the symptoms attributable to osteoarthritis and the symptoms attributable to the spinal stenosis: "I think you get that nerve pain radiating down your legs, and that causes a lot of what feels like – it feels like knee issues or ankle issues. Once you get your spine taken care of you find that those things – they weren't what you thought they were." (Hr. Tr., pp. 19-20)

While it is unclear when claimant underwent the spinal fusion at L4-L5, it is clear that claimant believes the surgery helped with the radicular symptoms he was experiencing between 2014 and 2017. (See Hr. Tr., pp. 19-20) Unfortunately, complaints of bilateral knee pain, similar to those reported in 2011, returned after the spinal fusion surgery but before the September 20, 2018, work injury.

Just two months before the September 20, 2018, work injury, claimant returned to Dr. Silvius reporting an insidious onset of left knee pain. Claimant told Dr. Silvius that his left knee pain began the evening of July 20, 2018; however, he denied any injury or unusual activity. Claimant's pain was worse on July 21, 2018, and he began "limping and hobbling around." Claimant relayed that he was taking 900 mg of ibuprofen and Aleve; however, the medications were not working to reduce his pain. Dr. Silvius referenced claimant's history of arthritis in multiple joints and noted claimant's left knee was edematous, erythematous, and tender over the patellar tendon. Dr. Silvius obtained an x-ray of claimant's left knee and prescribed a prednisone taper. Dr. Silvius noted that the x-ray revealed "significant osteoarthritic changes." (JE1, p. 20; see JE1, p. 23)

The July 24, 2018, x-ray revealed "tricompartment degenerative changes most pronounced medially where there is joint space narrowing, sclerosis of paratracheal [*sic*] or osteophytes." It also revealed enthesopathic changes at the patella. (JE1, p. 23)

On September 17, 2018, three days prior to the date of injury in this case, claimant returned to Dr. Silvius with complaints of "lots of pain" in multiple joints, including his knees. Claimant reported that he experienced an increase in pain with any kind of movement or activity. Claimant relayed that he was taking 800 mg of ibuprofen and two Aleve tablets each morning, "just to get going." Dr. Silvius ordered inflammatory arthritis labs and indicated he would consider a referral to rheumatology if the inflammatory labs were abnormal. He also opined claimant should consider a pain management program. (JE1, p. 24)

Claimant presented as a poor historian. Such a conclusion stems from claimant's testimony regarding the causes of his pre-existing knee pain.

At his deposition, claimant acknowledged he presented for medical treatment for his right knee prior to the September 20, 2018, work injury. However, when asked if he ever had any other complaints or treatment for his knees before the date of injury, claimant asserted that he only presented to a physician once for left knee pain, and the left knee pain "turned out to be gout." (Ex. A, Deposition Transcript pages 18-19) At hearing, claimant attributed his pre-existing knee problems to his poorly-controlled diabetes. (See Hr. Tr., pp. 19, 22) The contemporaneous medical records summarized above do not support claimant's contentions. (See JE1) As discussed in defendants' post-hearing brief, there is no evidence that claimant has ever experienced a gout flare-up in his knees. The medical records in evidence only document gout flare-ups in claimant's right foot. (See JE1, p. 5) Similarly, claimant testified that Dr. Silvius prescribed him medication to control his diabetes, and therefore his knee pain, following his July 24, 2018, appointment. (Hr. Tr., p. 21) However, Dr. Silvius' medical records provide claimant was prescribed a prednisone taper solely to address the arthralgia in his left knee. (JE1, p. 20) No physician, including Dr. Silvius, has provided an opinion relating claimant's pre-existing bilateral knee pain to gout or diabetes.

On September 20, 2018, claimant was initially examined by the emergency medical technicians of the Glenwood Fire Department. (See JE2, pp. 33-35) Following the examination, claimant declined emergency transportation to the hospital. Instead, he elected to have his wife pick him up and drive him to Concentra Occupational Health. Claimant presented with complaints of right shoulder, neck, and bilateral knee pain. (JE3, p. 36) Dr. West observed swelling and assessed sprains in both of claimant's knees. (JE3, p. 37) Dr. West ordered x-rays of claimant's right shoulder and cervical spine. He did not order x-rays or diagnostic imaging of claimant's knees. (JE1, p. 38)

At his return visit on September 24, 2018, claimant reported improved neck pain, improved right shoulder pain, but worsening left anterior knee pain. Associated symptoms included clicking, stiffness, and swelling. In comparison, claimant reported that the condition of his right knee was improving. Claimant reported no swelling or clicking in the right knee. Dr. West observed no swelling in either knee, however, claimant did have a positive McMurray test. (JE3, p. 41) Dr. West kept his initial diagnoses and referred claimant to physical therapy. (JE3, p. 42)

On October 24, 2018, claimant reported constant, moderate pain in his knees, bilaterally. He described the pain as sharp and aching, with associated stiffness. (JE3, pp. 47-48) After obtaining MRIs of claimant's knees, Dr. West diagnosed acute medial meniscus tears in the bilateral knees and referred claimant's medical care to Dr. O'Malley. (JE1, p. 52; see JE1, pp. 28, 30)

Claimant first presented to Dr. O'Malley on November 28, 2018. (JE5, p. 62) He described increasing discomfort over the inside aspect of both knees, left generally greater than right. (Id.) Similar to reports from July 2018, claimant reported that he had tried several anti-inflammatories without success. (Id.) After reviewing claimant's diagnostic imaging, Dr. O'Malley assessed claimant with an exacerbation of the advanced degenerative arthritis in his bilateral knees. (JE5, p. 63) Dr. O'Malley opined the injury on September 20, 2018, aggravated his advanced degenerative arthritis. Claimant asked Dr. O'Malley about undergoing an arthroscopy to assess his meniscus tear. In response, Dr. O'Malley explained to claimant that his underlying problem was degenerative arthritis with extrusion of the meniscus, and, according to Dr. O'Malley, a knee arthroscopy would likely exacerbate his symptoms rather than make them better. Instead, Dr. O'Malley offered to provide claimant with injections based on his age and continued symptoms. Claimant declined Dr. O'Malley's offer, noting that the same injections had not worked for him in the past. (JE5, p. 64) Dr. O'Malley told claimant the only surgical option that would be available to claimant for his condition would be total knee arthroplasties. (Id.)

After giving it some thought, claimant returned to Dr. O'Malley's office on December 12, 2018, and requested injections to his bilateral knees. (JE5, p. 65) Dr. O'Malley released claimant and noted he would let claimant's symptoms dictate any follow-up appointments. Claimant received repeat injections five months later, on May 6, 2019. (JE5, p. 79) Dr. O'Malley subsequently placed claimant at maximum medical improvement on May 7, 2019. (JE5, p. 81)

On May 7, 2019, Dr. O'Malley authored a letter addressing causation to the State's third-party administrator. The causation opinion is poorly worded; however, the main takeaway is that Dr. O'Malley's diagnosis of exacerbation of advanced degenerative arthritis was caused by the work injury on September 20, 2018. (JE5, p. 81) This is the same diagnosis he provided following his initial assessment. That is, claimant sustained an exacerbation of his underlying, advanced degenerative arthritis on the date of injury. (See JE5, p. 63) Dr. O'Malley next opined that any surgical intervention would be a result of his pre-existing arthritis and the natural progression of the same. (JE5, p. 81) In other words, the need for surgical intervention would not be causally related to the September 20, 2018, work injury. Inherent in these two opinions is Dr. O'Malley's belief that the exacerbation that occurred on September 20, 2018, was not a substantial factor in bringing about the need for a total knee replacement. (Id.)

Claimant underwent a right shoulder superior capsular reconstruction with biceps tenodesis on February 1, 2019. (JE6, pp. 100-103) He was released to return to work without restrictions on July 30, 2019. (JE6, p. 91) Claimant remains employed in the same position for which he was hired. (Ex. A, p. 4) Dr. Rosipal placed claimant at maximum medical improvement and released him from care on September 10, 2019.

(JE6, p. 97) There is no evidence claimant presented for medical treatment related to his knee between May 6, 2019, and October 2, 2019.

After being released from Dr. O'Malley's care, claimant began presenting to Craig Hansen, M.D. of Ortho Nebraska. (See JE7, p. 104) He first presented to Dr. Hansen on October 3, 2019. (JE7, p. 104) Dr. Hansen obtained x-rays of claimant's bilateral knees and reviewed the prior MRI reports. (JE7, p. 105) Dr. Hansen administered bilateral knee injections and placed claimant in basic hinged knee braces. (JE7, p. 105) Repeat injections were administered on January 8, 2020, April 8, 2020, July 8, 2020, October 8, 2020, and January 8, 2021. (JE7, pp. 106, 112, 114, 116, 118)

Claimant's counsel penned a letter to Dr. Hansen requesting that he provide opinions on causation. (See JE7, pp. 108-109) The letter does not indicate what, if any, medical records were provided to Dr. Hansen for review. Moreover, Dr. Hansen's invoice does not include a charge for medical records review. The invoice only provides a "Fee for Medical Report." (JE7, p. 110)

Dr. Hansen responded to claimant's request on April 7, 2020. (JE7, p. 111) In his letter, Dr. Hansen diagnosed claimant with bilateral knee degenerative joint disease and opined the fall at work on September 20, 2018, aggravated claimant's pre-existing condition. (Id.) In support of this conclusion, Dr. Hansen explained that claimant did not have severe pain in his knees prior to the date of injury. Dr. Hansen concluded his letter by recommending claimant undergo knee replacement surgery. (Id.)

Defendant subsequently requested updated opinions from Dr. O'Malley.

Dr. O'Malley expanded upon several of his opinions in an April 30, 2020, letter to defendant. (See JE5, p. 98) In the letter, Dr. O'Malley diagnosed claimant with severe bilateral knee arthritis. He opined, within a reasonable degree of medical certainty, that claimant sustained a minor irritation of his severe bilateral knee arthritis on September 20, 2018, and the injury neither caused nor accelerated the underlying, pre-existing condition. He therefore concluded claimant's current complaints and need for surgical intervention are not related to the September 20, 2018, work injury. Dr. O'Malley explained the only surgical options available to claimant at this point are bilateral total knee replacements. Again, Dr. O'Malley opined that his surgical recommendation "is not and has never been" a result of the September 20, 2018, work injury. (JE5, p. 98)

Additional treatment for claimant's bilateral knees was denied on May 4, 2020, as a result of Dr. O'Malley's opinions. (Ex. 4, p. 1)

Claimant sought a follow-up report from Dr. Hansen on February 16, 2021. (See JE7, pp. 120-121) Dr. Hansen responded to claimant's request on April 5, 2021. (JE7, p. 123) Dr. Hansen acknowledged that claimant had degenerative joint disease in both of his knees prior to the date of injury, and that he did not have the opportunity to physically examine claimant prior to the date of injury. He again opined that the September 20, 2018, fall at work aggravated claimant's pre-existing condition. He further opined conservative treatment was starting to fail, and claimant's condition would require total knee replacements in the near future. (JE7, p. 123)

On the issue of whether the September 20, 2018, fall materially aggravated, accelerated, or lit up claimant's underlying bilateral knee condition, it is difficult to say that there is a stark difference of opinion among the medical professionals. Both physicians opined that the injury aggravated claimant's pre-existing condition; however, neither physician specifically opined that the work injury substantially or materially aggravated claimant's pre-existing condition. Similarly, neither physician opined that the work injury accelerated the arthritic condition such that it became symptomatic and progressed claimant toward total knee replacement surgery.

In the battle of the experts, I note the opinions of Dr. O'Malley are more logical and consistent with the pre-existing condition and the medical records in evidence. Dr. O'Malley is the only physician to provide definitive answers with respect to the nature and extent of claimant's injuries. In his April 30, 2020, letter, Dr. O'Malley opined claimant's injury was a minor irritation that neither caused nor accelerated the underlying, pre-existing condition or need for total knee replacements. He further opined claimant's current complaints and need for surgical intervention are not related to the September 20, 2018, work injury. (JE5, p. 98) Dr. O'Malley concluded his report by stating the recommendation for bilateral knee replacements, "is not and has never been a result of his most recent work injury." (Id.)

Throughout his post-hearing brief, claimant attributes a number of opinions to Dr. O'Malley that are not supported by the medical records in evidence. At one point, claimant asserts, "[Dr. O'Malley] clearly states that all of [claimant's] ongoing bilateral knee problems are causally related to an exacerbation of his preexisting degenerative arthritis when he fell at work on September 20, 2018." (PHB, p. 7) Claimant further asserts it is clear, "Dr. O'Malley feels strongly that the fall at work materially aggravated, exacerbated and lit up [claimant's] preexisting arthritis and the need for ongoing medical treatment is related to that exacerbation." (Id.) I do not share claimant's understanding of Dr. O'Malley's opinions. While it is true that Dr. O'Malley has opined that the work injury caused an aggravation of claimant's pre-existing, degenerative condition, Dr. O'Malley has not opined that the aggravation was material or permanent. Moreover, Dr. O'Malley has not opined that claimant's ongoing bilateral knee problems are causally related to the fall at work on September 20, 2018. In fact, Dr. O'Malley expressly opined just the opposite. In his April 30, 2020, letter, Dr. O'Malley opined claimant's injury was a minor irritation that neither caused nor accelerated the underlying, pre-existing condition or need for total knee replacements. He further opined claimant's current complaints and need for surgical intervention are not related to the September 20, 2018, work injury. (JE5, p. 98)

Comparatively, Dr. Hansen's opinions are vague and imprecise as to the nature and extent of claimant's injuries. Dr. Hansen opined that the injury aggravated claimant's pre-existing degenerative condition; however, he did not specifically address whether the work injury substantially or materially aggravated claimant's pre-existing condition, or whether the work injury was a substantial factor in bringing about the need for bilateral total knee replacements. While Dr. Hansen was asked if the fall at work on September 20, 2018, aggravated claimant's pre-existing condition "to the extent that he now needs to have [right and left knee replacements]," Dr. Hansen did not directly address the question in his April 5, 2021, letter. Instead, Dr. Hansen merely provided,

"With both his knees being advanced degenerative joint disease, the medical treatment will require knee replacements for both his right and left knee." (JE7, p. 123)

Claimant stresses the fact that the February 17, 2020, and February 16, 2021, letters to Dr. Hansen set forth the proper legal standard for causation under Iowa law. Given this information, claimant asserts Dr. Hansen clearly used the correct definition of causation as accepted by the Iowa Workers' Compensation Commissioner in his reports. While claimant's letters set forth the proper definition of causation, this is of little relevance when the questions posed, and the answers provided, do not incorporate the very language utilized in the definition. Dr. Hansen was not asked if the fall at work on September 20, 2018, substantially aggravated, worsened, accelerated, or lit up his pre-existing degenerative condition; rather, he was simply asked – on two occasions – if the fall aggravated the pre-existing condition. (JE7, p. 121)

While Dr. Hansen was asked if the fall at work on September 20, 2018, aggravated claimant's pre-existing condition "to the extent that he now needs to have [right and left knee replacements]," Dr. Hansen did not directly address the question in his April 5, 2021, letter. (JE7, p. 123) Moreover, such a question does not address whether the aggravation was a substantial factor in bringing about the need for total knee replacements. Dr. Hansen's opinion, "With both his knees being advanced degenerative joint disease, the medical treatment will require knee replacements for both his right and left knee" is not dissimilar from Dr. O'Malley's opinion. Both physicians agree that the only surgery that will address claimant's degenerative joint disease is a total knee replacement; however, Dr. O'Malley is the only physician to explain whether the work injury accelerated the need for a total knee replacement.

Lastly, it is unclear what, if any, pre-existing medical records Dr. Hansen reviewed prior to forming his opinions. The only medical record pre-dating the September 20, 2018, fall at work referenced by Dr. Hansen is claimant's July 24, 2018, x-ray. (JE7, p. 123) There is no evidence that Dr. Hansen knew of claimant's past arthroscopic surgeries, claimant's 2011 or 2015 complaints, or that claimant was "limping and hobbling around" after an insidious onset of pain in his left knee occurred in July, 2018. I find Dr. Hansen did not have a complete understanding of claimant's medical history pre-dating the September 20, 2018, fall at work.

There is a lack of convincing medical evidence that the fall on September 20, 2018, is the cause of claimant's current condition. Ultimately, I find the opinions of Dr. O'Malley to be the most consistent and credible. As such, I find that Mr. Stanton proved he sustained a work related injury, but that the injury was only a temporary aggravation of his underlying and pre-existing degenerative condition. Accordingly, I find claimant failed to prove the September 20, 2018, work injury resulted in permanent disability to his knees. I further find that claimant failed to prove his need for bilateral total knee replacements is causally related to the September 20, 2018, fall at work.

CONCLUSIONS OF LAW

Claimant is seeking a determination as to whether his current bilateral knee condition is causally related to the September 20, 2018, work injury, and, if so, a transfer of medical care to Craig Hansen, M.D.

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).

In this case, I found the opinions of Dr. O'Malley to be the most credible and convincing in the evidentiary record. Accordingly, I found that Mr. Stanton proved he sustained a work related injury, but that the injury was only a temporary aggravation of his underlying and pre-existing degenerative condition. Further relying upon his medical opinions, I found that claimant failed to prove he sustained permanent functional impairment or permanent disability as a result of the September 20, 2018, work injury. Accordingly, I conclude that Mr. Stanton failed to prove entitlement to an award of permanent disability benefits.

Claimant seeks alternate medical care and specifically requests an order transferring care to Dr. Hansen.

Iowa Code section 85.27(4) provides, in relevant part:

> For purposes of this section, the employer is obliged to furnish reasonable services and supplies to treat an injured employee, and has the right to choose the care .... The treatment must be offered promptly and be reasonably suited to treat the injury without undue inconvenience to the employee. If the employee has reason to be dissatisfied with the care offered, the employee should communicate the basis of such dissatisfaction to the employer, in writing if requested, following which the employer and the employee may agree to alternate care reasonably suited to treat the injury. If the employer and employee cannot agree on such alternate care, the commissioner may, upon application and reasonable proofs of the necessity therefor, allow and order other care.

To prove entitlement to ongoing or future medical care, Mr. Stanton had to prove that the care requested is causally related to his work injury. I found that claimant failed to prove that his need for bilateral total knee replacements is causally related to, or was materially aggravated, exacerbated, or accelerated by the September 20, 2018, fall at work. Having found claimant's injury to be only a temporary aggravation of an underlying and pre-existing degenerative condition, I conclude claimant failed to prove that the need for total knee replacement surgeries is causally related to the temporary injury he sustained on September 20, 2018. Claimant's request for alternate medical care is not related to the September 20, 2018, work injury. As such, I deny claimant's request for alternate medical care.

Finally, the hearing report identifies costs as a disputed issue. Costs are taxed at the discretion of the agency. Iowa Code section 86.40. In this instance, Mr. Stanton has not proven entitlement to any additional benefits and has failed to secure an award in this case. I decline to award any costs to Mr. Stanton under these circumstances. Rather, I conclude that all parties should bear their own costs.

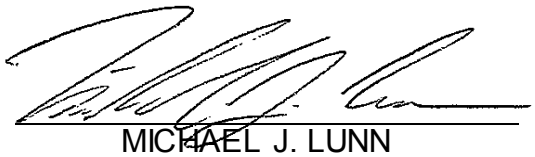
ORDER

Claimant shall take nothing further.

Each party shall bear their own costs.

Defendant shall timely file all reports as required by 876 IAC 11.7.

Signed and filed this ____13th____ day of January, 2022.



MICHAEL J. LUNN
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served as follows:

Jacob Peters (via WCES)

Meredith Cooney (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.