BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

FILED
MAR 21 2017
WORKERS' COMPENSATION

MICHAEL SCOTT GREENE, Claimant, vs. TRADESMEN INTERNATIONAL, LLC, Employer, and NEW HAMPSHIRE INSURANCE CO., Insurance Carrier, Defendants.	File No. 5054749 ARBITRATION DECISION Head Note Nos.: 1803; 2700; 2501

STATEMENT OF THE CASE

Michael Scott Greene, claimant, filed a petition in arbitration seeking workers' compensation benefits against Tradesmen International LLC, employer, and New Hampshire Insurance Company, insurer, for an accepted work injury dated August 22, 2011.

This case was heard on January 26, 2017, in Des Moines, Iowa. The case was considered fully submitted on February 16, 2017, upon the simultaneous filing briefs.

The record consists of Exhibits 1-13, defendants exhibits A-C, and the claimant's testimony.

ISSUES

1. The extent of claimant's industrial disability;
2. Whether there is a causal connection between claimant's injury and the medical expenses claimed by claimant;
3. Whether claimant is entitled to alternate care.
4. Whether defendants are entitled to a credit.
5. The proper commencement date of permanent benefits; and
6. Assessment of costs.

STIPULATED FACTS

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

The parties stipulate claimant sustained a work-related injury on August 22, 2011. At the time of the injury, the claimant's gross earnings were $751.59 per week. He was married and entitled to two exemptions. Based on the foregoing numbers, his weekly benefit rate is $500.86.

FINDINGS OF FACTS

Claimant was a 46 year old person at the time of the hearing. He is married, but separated and has no other dependents. He graduated from high school and attended Indian Hills Community college for approximately one year. His goal was to be a teacher and a coach, but did not complete the certification process. He does have various trade certificates. At one time he belonged to a union.

His past work history has been primarily as a manual laborer. He has served as a welder, a laborer on a farm, combine driver, worked with architectural sheet metal, at hog lot and grain handling business. At one time, he owned a company called Greene Commercial where he did retail construction. He employed approximately 10 individuals and his job was to remodel and set up different retail locations. He handled all the logistics including hiring the subs, coordinating work, reading blueprints and supervising crews. In 2008, the market crashed. When the economy revived, there was no work locally for him in that area of business.

He began working for the defendant employer who specializes in the placement of temporary skilled workers. He did carpentry millwright work and pipefitting. Pipefitting and millwright paid the most.

Recently, he recently passed an examination to sell insurance but because of his Medicaid lien was not granted a license. (See Ex. 10) The license was good for only 90 days and he will have to retake the test.

He does maintenance for several rental properties. He has done some physical work such as mowing grass, removing snow, installing an awning. After his injury, he also did food prep work at McDonald's. He was offered a maintenance position but declined because he was unable to do some of the tasks that the job would require of him. (Exhibit 5, page 40) Ultimately, he would like to return to the insurance business where he would sell stocks, bonds and annuities. Unfortunately, the position that he once had has been filled by someone else.

He also does do some work for his uncle who leases tractors to spread manure on farms.

His past medical history is significant for bilateral extremity weakness. On May 28, 2008, claimant was seen by Thoru Yamada, M.D., for "spell of whole-body versus bilateral upper extremity weakness that resolved after about 15 minutes, with incontinence." (Ex. A, p. 1; see also Ex. 7a) A multiplaner MRI of the brain and brainstem was normal but for a small arachnoid cyst in the posterior fossa. (Ex. A, p. 1) There were signs of moderate degenerative changes in the c-spine. (Ex. A, p. 1)

On August 22, 2011, claimant was employed as a millwright helper. His duties included installing, dismantling, and moving machines, conveyors and other equipment. (Ex. 8, p. 261) Physically the workers must be able to stand or walk for long periods, use arms and hands to reach for, handle, and manipulate objects, lift and carry materials weighing 50-100 pounds. (Ex. 8, p. 261) Claimant was working at a pharmaceutical plant as a millwright worker. The 450-500 pound weight fell and struck him on the head and left posterior shoulder. He did not receive immediate care.

On August 23, 2011, claimant was seen at the University of Iowa Hospitals and Clinics emergency room department. (Ex. 7A, p. 56) A CT and MRI of the brain were conducted resulting in normal findings except for the stable posterior fossa arachnoid cyst that existed prior to the injury. A CT and MRI of the C-spine showed degenerative changes. (Ex. 7A, p. 56) The staff physician Jon Van Heukelom, M.D., recommended that claimant refrain from working for two weeks. (Ex. 7, p. 62)

Claimant was then sent to Sarvenaz Jabbari, M.D. (Ex. 7b, p. 66) Claimant reported extreme pain, exacerbated by lifting, and back spasms at the rate of three to four times per day. (Ex. 7b, p. 66) There was shooting pain down the right thigh and leg and through the lateral aspect of his right foot along with left arm heaviness and lethargy. (Ex. 7b, p. 66) On examination, he had pain with palpation on the right thoracic paraspinal musculature and limited range of motion on the neck due to pain. (Ex. 7b, p. 67) Dr. Jabbari wondered if claimant might be suffering some CTS. (Ex. 7b, p. 68) Claimant was sent to physical therapy.

Claimant suffered extreme bouts of pain leading him to seek treatment from the Marengo emergency room on September 19, 2011. (Ex. 7d, p. 136) He was advised to take muscle relaxants and pain pills as directed, no lifting or bending of the torso and then follow-up with his primary care provider or return to the emergency room if the symptoms did not improve or they worsened. (Ex. 7d, p. 137) He felt them worsen and thus returned for another emergency room visit on September 22, 2011. (Ex. 7d, p. 137) He was treated for his pain and discharge to follow up with a Worker's Compensation doctor for consideration of the lumbar MRI. (Ex. 7d, p. 137) On the same day he had physical therapy. (Ex. 7c, p. 125)

After five physical therapy appointments, claimant returned to Dr. Jabbari with continued complaints of pain. The neck and left arm pain had resolved but the other pains remained. (Ex. 7B, p. 70) Claimant was given work restrictions of no lifting greater than 10 pounds occasionally. He was also not to bend or twist his back, squat or kneel, climb, reach out or push or pull. (Ex 7B, p. 73)

Claimant was then seen on September 29, 2011, by Tina Stec, M.D. (Ex. 7B, p. 74) She took claimant off work and new MRIs were ordered. (Ex. 7B, p. 177) On October 21, 2011, claimant returned to Dr. Stec. The MRIs showed mild disc disease at L4 – 5 and L5 – S1 with a mild disc protrusion at L4 – L5 with mild foraminal stenosis bilaterally. His thoracic spine showed only mild degenerative disease with no disc protrusion. (Ex. 7B, p. 80) He had resolution of leg pain and indicated that his pain was primarily located in the back. (Ex. 7B, p. 80) She returned claimant to work with restrictions of no reaching above his shoulder, no lifting more than 30 pounds and no bending or twisting of the back. (Ex. 7B, p. 80)

On November 15, 2011, claimant reported a 60 percent improvement on his pain levels. (Ex. 7B, p. 83) Dr. Stec reviewed the physical therapy progress notes which found claimant had some limitation with extension and flexion. (Ex. 7B, p. 83) Claimant remained off of work.

Dr. Stec recommended physical therapy after a lumbar epidural steroid injection. (Ex. 7B, p. 84)

On December 8, 2011, claimant returned to Dr. Stec reporting improvement with the injection but continued pain with prolonged walking or sitting. (Ex. 7B, p. 86) He felt as if he had plateaued. (Ex. 7B, p. 87)

Claimant's examination was mostly normal.

> MUSCULOSKELETAL: Michael moves easily with position changes and has a normal gait. He has tenderness to palpation at the right thoracic paraspinal at approximately T8 through T10. There does appear to be mild palpable spasm compared to the left. He has no point tenderness over the thoracic spine. He has no tenderness to palpation today in the lumbar spine, except for in the right upper gluteal, which is mildly tender. There is no palapable spasm here. The SI joints are not particularly tender. Lumbar flexion reveals fingertips reaching to the distal one third of the shin, and he complains of some discomfort. Lumbar extension is mildly limited. He complains of some mild discomfort in the right. Twisting to the left and right is overall near full, but he complains of some discomfort in the thoracic and lumbar spine. Sitting straight leg is negative bilaterally today.

(Ex. 7B, p. 87)

Dr. Stec discontinued physical therapy and left work restrictions in place due to ongoing pain in the mid thoracic spine. (Ex. 7B, p. 86)

Three weeks later, claimant returned to Dr. Stec with continued low back pain, radiating down into the bilateral gluteals and some pain in the right posterior thigh. (Ex. 7B, p. 90) In reviewing the x-ray of his thoracic spine, mild degenerative changes at the mid to lower thoracic levels were shown along with some small marginal osteophytes. (Ex. 7B, p. 91) Dr. Stec recommended trigger point injections which the claimant agreed to undergo. (Ex. 7B, p. 92) On January 6, 2012, the claimant followed up and reported that he had improvement with the injections and that the left scapular area had resolved. The mid thoracic area was pain free for approximately five days but some of the pain had returned. (Ex. 7B, p. 95) Dr. Stec injected claimant again at the thoracic level. (Ex. 7D, p. 96) He returned on January 26, 2012. (Ex. 7B, p. 9) Dr. Stec noted that "Michael always continues to have complaints, though they are not always consistent with his capabilities and therapy." (Ex. 7B, p. 99) She also noted that claimant has been off of work due to his employer not being able to accommodate any restrictions. "His restrictions have never been overly restrictive. I have discussed with Michael on a number of occasions that there is a lot he is capable of doing that he needs to be as active as possible." (Ex. 7B, p. 99) His examination was largely normal except for tenderness to palpation in the right thoracic paraspinals. (Ex. 7B, page 100)

> MUSCULOSKELETAL: He is non-tender today in the trapezius or the parascapular areas. He has no tenderness in the cervical spine. He has full range of motion of the cervical spine in all direction. He is tender to palpation in the same area on the right thoracic paraspinals, today in the area of T8-T12. There is definitely less hypertonicity. He complains of some discomfort with twisting towards the right and lateral bending towards the right. Low back is mildly tender today at the right lumbar paraspinals, but the SI joint is not particularly tender. Forward flexion with his fingers reaching to the distal shin, and he complains of some discomfort and tightness in the low back, and lumbar extension is essentially full today. He walks with a normal gait.

(Ex. 7B, p. 100)

On February 28, 2012, claimant returned and reported that the thoracic epidural resolved approximately 30 percent of his pain but that he continued to have pain at a 7 or 8/10 along with difficulty sleeping. (Ex. 7B, p. 103) He was using a TENS unit with some success. (Ex. 7B, p. 104) Dr. Stec's work restrictions including lifting up to 50 pounds and two-thirds bend-twist of the back and one-third squat kneel. (Ex. 7B, p. 104)

On March 30, 2012, Dr. Stec saw claimant again for thoracic pain and low back pain. (Ex. 7B, p. 107) The TENS unit was providing some but not complete relief. (Ex. 7B, p. 107) On examination, his symptoms moved into the L4 – L5 spinous process. (Ex. 7B, p. 108)

> MUSCULOSKELETAL: Michael changes positions easily without any acute distress. He is tender to palpation of the right lower thoracic paraspinals, and reports mild tenderness to palpation in this area. He is not specifically tender over the thoracic spinous processes, but he is mildly tender today at the L4-L5 spinous processes, and slightly in the right paraspinal and the low back. His SI joint today is not specifically focally ender. He is limited with range of motion mildly, and with flexion and extension he complains of pain in the end range. Straight leg is negative. He is able to perform a deep squat without difficulty, walks a normal gait.

(Ex. 7B, p. 108)

Claimant was seen by Michael Dolphin, D.O., on April 3, 2012, for an orthopedic consult. (Ex. 7f, p. 169) Dr. Dolphin did not believe that the claimant had any issues with the spine that could be treated surgically. (Ex. 7f, p. 170) He recommended claimant return to work hardening but that if he continued to have diminished sensation in his right foot that a neurological consult may be helpful. (Ex. 7f, p. 170)

On May 8, 2012, claimant reported to Dr. Stec that the orthopedic surgeon recommended work hardening as he was not a surgical candidate. (Ex. 7B, p. 112) Dr. Stec advised claimant to pursue work hardening and use his TENs unit twice daily as it eased his pain. (Ex. 7B, p. 112) His work restrictions were changed to no lifting more than 30-50 pounds and bending and twisting of the back only 1/3 of the day. (Ex. 7B, p. 113)

On June 12, 2012, claimant returned to Dr. Stec. He reported that the work hardening was making him more sore and that his pain had not changed. (Ex. 7B, p. 115) On examination he walked with a normal gait but was tender to palpation in the right thoracic musculature. He was mildly and diffusely tender across the low back and complained of some discomfort with forward flexion. Lumbar extension was moderately limited due to pain. (Ex. 7B, p. 115) He was able to perform a deep squat.

> MUSCULOSKELETAL: Michael walks with normal gait. He is tender to palpation of the right thoracic musculature, just lateral to approximately T10, and he is mildly and diffusely tender across the low back. He has no focal areas of tenderness, and there are no focal areas of spasm today on exam. His sitting straight leg is negative for radiculopathy. He has forward flexion in the lumbar spine with fingertips reaching to the distal shin, but he does complain of discomfort across the low back. Lumbar extension is moderately limited with complaints of pain. He is able to perform a deep squat.

(Ex. 7B, p. 115)

Claimant was released without any restrictions. (Ex 7B, p. 116) Claimant testified that he was attempting to return to work with defendant employer. They indicated that they might have need of a field representative but did not want to employ anyone who had restrictions. He then asked Dr. Stec to release him without restrictions and she did so at his request. He never did receive an offer of a field rep from the defendant employer. However, none of Dr. Stec's records indicate that he was released at his request. Instead, the release to full duty work followed her conclusion the claimant had achieved maximum medical improvement (MMI) and that the claimant had only mechanical low back pain. (Ex. 7B, p. 115)

On July 15, 2013, radiographs of claimant's chest showed only evidence of old disease but no focal pneumonia. (Ex. B, p. 1)

On February 13, 2014, claimant returned to the emergency room to seek treatment for pain that radiated down his right leg. He was treated by Gregory Neyman, M.D. (Ex. 7g, p. 171) Dr. Neyman assisted claimant in filling out paperwork that would provide claimant regular medical care under Medicaid. Claimant was given a right hip Kenalog injection. (Ex. 7g, p. 172) On February 18, 2014, claimant returned and saw Dr. Neyman again with continued complaints of back spasms. (Ex. 7f, p. 173) Percocet was given pending an MRI. The MRI was performed on February 20, 2014. (Ex. 7D, p. 139) At the lower levels of L4 to L5 and L5 to S1, there was mild to moderate foraminal narrowing bilaterally. (Ex. 7D, p. 139) On March 4, 2014, claimant returned to the clinic where he was seen by Joy Mohr, PA-C. (Ex. 7, p. 175) He asked for a refill of his oxycodone as he had run out of his prescription and needed more painkillers to last him until his appointment with Dr. Neyman. (Ex. 7g, p. 175) PA Mohr wrote out the prescription but urged him to follow up with Dr. Neyman in the future. Claimant was seen by Dr. Neyman on March 30, 2014, reporting primarily lower back pain. Medications were refilled. (Ex. 7G, p. 178) A note in the records indicates claimant had an appointment at the pain clinic. (Ex. 7g, p. 178)

On March 24, 2014, claimant was seen by William Barnhill CRNA at the pain clinic. (Ex. 7d, p. 141) He described pain radiating down the right leg and occasionally down the left. He had good, but not lasting relief, from injections. (Ex. 7d, p. 141) Mr. Barnhill performed a lumbar interlaminar epidural steroid injection. (Ex. 7d, p. 142)

Claimant returned to Dr. Neyman on April 15, 2014 complaining of back pain. Dr. Neyman encouraged claimant to attend a surgical consultation which claimant did on April 24, 2014 with Loren Mouw, M.D. (Ex. 7g, p. 180) Dr. Mouw did not recommend any surgery and returned claimant to his family care provider. (Ex. 7H, p. 200)

On May 1, 2014, claimant reported that Dr. Mouw wanted claimant to undergo injection therapy. (Ex. 7g, p. 182) Therefore claimant was referred back to the pain clinic. (Ex. 7H, p. 183) It should be noted that there was nothing in the medical record supporting the claim that Dr. Mouw prescribed injection therapy for claimant. (Ex. 7h, p. 200)

On May 20, 2014, claimant was seen by PA Mohr for his chronic back pain. (Ex. 7g, p. 184) He reported that he was going to undergo a series of epidurals which he did with Mr. Barnhill. (Ex. 7d, p. 145-150) The pain would abate temporarily and then reappear. (Ex. 7g, p. 149) Throughout the summer, claimant returned to PA Mohr for management of his pain. (Ex. 7g, pp. 186-190) On July 7, 2014, claimant was seen for a complete physical with PA Joy Mohr. (Ex. C, p. 3) He reported chronic pain but had a generally unremarkable examination. (Ex. C, p. 5) On September 8, 2014, he was seen by Mr. Barnhill who recounted that claimant had received three epidural injections from April through August with transient relief. (Ex. 7d, p. 155) Mr. Barnhill recommended claimant seek a surgical opinion. (Ex. 7d, p. 155)

On December 31, 2014, claimant's drug screen was returned as positive. (Ex. 7g, p. 197) PA Mohr advised him that due to the positive drug screen, she would no longer prescribe narcotics. (Ex. 7g, p. 197)

> He went back over to the hospital and demanded a repeat urine drug screen. This again was positive for Benzodiazipines and negative for Opiates. He requested that the urine be sent out for repeat drug testing. Lab tech stated that there was barely a faint line for marijuana, pt advised her that the marijuana should be negative as he recently quit doing that.

(Ex 7g, p. 197)

Claimant requested a restart of his Percocet on January 26, 2015 but PA Mohr refused. (Ex. 7d, p. 158)

While the claimant testified that he was not taking any inappropriate drugs, the second test was positive along with a faint line for marijuana. While I would like to find the claimant credible in this respect, the two positive tests sway me in the opposite direction.

On February 12, 2015, claimant presented to the emergency room requesting a refill of his narcotic medication.

> Advised the patient that I wasn't comfortable restarting Percocet and that I wouldn't be prescribing any controlled substances for him. He became angry with me. He left the clinic. I later received a call from Dr. Irland in the ED that pt was at the ED wanting pain meds. Dr. Irland advised that if he gave him a one-time supply of pain meds this would then break his pain contract and he would be terminated from the clinic. The patient advised he understood this and accepted an Rx of Percocet from Dr. Irland.

(Ex 7g, p. 199, 7B, pp. 120-122)

On April 14, 2015, claimant sought to establish care with Leck Read, M.D. (Ex. 7i, p. 201) He reported that he was discharged from the last clinic due to not taking pain medication consistently and not refilling it often enough which was a mischaracterization of his treatment with PA Mohr. (Ex. 7i, p. 201; Ex. 7G, p. 197) He reported low back pain and that he was stable on his current medications. (Ex. 7i, p. 204) He returned to Dr. Read on May 29, 2015 to follow up with the back pain. He reported some marijuana usage but did not ask for any narcotics. (Ex. 7i, p. 208)

On June 11, 2015, claimant returned to Dr. Read's office due to an assault that occurred four days prior. (Ex. 7i, p. 212) Claimant had suffered a fracture of the lumbar spinous processes at L2-L3. (Ex. 7d, p. 162) He was given a prescription for oxycodone. (Ex. 7i, p. 213) On June 30, 2015, he reported that his low back pain flared after sneezing attack due to allergies. (Ex. 7i, p. 217) The prescription from oxycodone was changed to hydrocodone with the intent to wean claimant off the narcotics. (Ex. 7i, p. 219) On September 17, 2015, claimant was seen again at Dr. Read's office for an injury to his right calf. He was still taking one tablet of hydrocodone in the evenings. (Ex. 7i, p. 225) In a follow-up visit on October 29, 2015 claimant reported chronic pain and left sided neck swelling. (Ex. 7i, p. 27) He was no longer being prescribed hydrocodone. (Ex. 7i, p. 231)

On February 25, 2016, claimant was seen primarily in follow-up for his back pain. This time it was noted that he was given a prescription for hydrocodone three times a day for 10 days. (Ex. 7i, p. 235) He returned to Dr. Read's office on March 31, 2016 in follow-up to his chronic back pain. (Ex. 7i, p. 239) He reported that he began working at McDonald's around March 2016 working 8 hours per week. The work was increasing his back pain. (Ex. 7i, p. 239) He was given another short-term prescription of hydrocodone. (Ex. 7i, p. 242) On June 7, 2016, he was seen for allergy issues. (Ex. 7i, p. 241) He was given another short-term hydrocodone refill of up to 30 pills per month. (Ex. 7i, p. 246) He returned the following month and was given another refill of hydrocodone prescription. (Ex. 7i, p. 253)

October 7, 2016, claimant returned to Dr. Read. Claimant was no longer working at McDonald's but with his uncle spreading manure. (Ex. 7i, p. 254) His hydrocodone was refilled. (Ex. 7l, p. 257)

Claimant was admitted to the hospital on March 27, 2014 due to suicidal ideation and unconstrained tearfulness. He had an acute onset of depression with insomnia after discovering his wife had a new boyfriend. "He has had multiple other stressing recently such as a work related back injury that caused financial hardship including loss of 2 homes and his vehicle, but he did not become depressed after this." (Ex. B, p. 2) He entertained some suicidal ideation but rejected it because he felt that it would place an increased financial burden on his stepchildren. (Ex. B, p. 2) There was a note that he had chronic cannabis use which he later denied. (Ex. C, p. 1) He was treated and then discharged from Dr. Judith Crossett, M.D.'s care on March 31, 2014. (Ex. B, p. 1)

On May 11, 2015, claimant underwent an independent medical examination with David S. Tearse, M.D. (Ex. 3, p. 25) In this visit, claimant's symptoms were as follows: minimal soreness in the shoulder, numbness if he lays on his arms wrong, numbness in the morning, pain in the posterior aspect of the left shoulder, a combination of aching, burning, and stabbing in the posterior aspect of the upper thoracic and lower cervical area in the back, as well as similar symptoms in the thoraco-lumbar junction and along the whole lower back. He also indicated some burning pain extending from the right buttock down to the right foot. (Ex. 3, p. 26)

Upon examination he showed mild tenderness in the left upper trapezius and the superior medial border of the scapula, extending to the midportion of the scapula. He had some reduced abduction in the left shoulder along with pain in the posterior aspect of the shoulder with rotation. He had trace weakness with resisted abduction and external rotation. (Ex. 3, p. 27) Dr. Tearse diagnosed claimant is suffering very mild left shoulder limitation of motion and strength deficit, but did not recommend any further medical treatment. He set his maximum medical improvement date as of August 22, 2012 and assigned 2 percent whole person impairment. (Ex. 3, p. 28) Dr. Tearse did not have an explanation or diagnosis for the remainder of the claimant's back pains including his mid thoracic to lower lumbar pains. (Ex. 3, p. 28)

Claimant underwent another independent medical examination on August 2, 2016, this time with John D. Kuhnlein, M.D. (Ex. 5, p. 33) His current clinical symptoms included some cognitive issues, chronic and constant mid to lower back pain in the 6 to 7 out of 10 range. The upper lumbar was stiff and knotted up. He had pain radiating to the right buttock and right leg. He also reported intermittent neck pain and a knot in the left upper midscapular area. Infrequently he drops things and experiences weakness in his left arm and hand. (Ex. 5, p. 40) His cervical range of motion was largely normal on examination, but he did have pain on palpation in the left scalene muscle was painful with muscle spasm. He also had muscle spasm in the left midscapular region. (Ex. 5, p. 42) The Spurling's maneuver to the left produced a popping in the neck and there was a knot in the left biceps that was painful with biceps testing, Speeds testing, and O'Briens testing. (Ex. 5, p. 42) Popping was noted with right side bending and the claimant had pain with palpation of the right sacroiliac joint in the right gluteal muscle. There was a spasm of the muscles near the left scapula and percussive tenderness at the L5 – S1 level. (Ex. 5, p. 43) Pinprick sensation was decreased in the entire right foot and vibratory sensation was decreased in the sole of the right foot. Light touch was decreased in the entire right foot and the right straight leg generated tight hamstrings at 80 degrees. (Ex. 5, p. 43)

Dr. Kuhnlein concluded that given the mechanism of injury it was more likely than not that the claimant sustained a cervical strain and thoracolumbar pain as a result of the work injury. (Ex. 5, p. 44) As for the chronic neck symptoms, Dr. Kuhnlein was reluctant to ascribe those pains to the work injury given that discussion of the neck pain essentially ceased after the September 29, 2011, visit of Dr. Stec and complaints were not revived until February 12, 2015. (Ex. 5, p. 44) Dr. Kuhnlein also opined that any close head trauma or concussion reached maximum medical improvement within four

weeks of the injury date and that the neck strain reached maximum medical improvement by September 29, 2011. (Ex. 5, p. 45) As for the thoracolumbar strain, Dr. Kuhnlein set the maximum medical improvement date as of April 24, 2014. Care after those dates were of a maintenance nature. (Ex. 5, p. 45)

Dr. Kuhnlein assessed an 8 percent whole person impairment but acknowledged that the intervening assault likely contributed some impairment percentage. (Ex. 5, p. 46) He disagreed with Dr. Mathew's assessment given that Dr. Mathew was not familiar with the claimant's past abuses of drugs and alcohol, as well as Dr. Mathew's inaccurate use of the AMA guidelines. (Ex. 5, p. 46) In regards to claimant's restrictions, Dr. Kuhnlein recommended claimant lift 30 pounds occasionally from floor to waist, 40 pounds occasionally from waist to shoulder, and 30 pounds occasionally over the shoulder. He could also stoop, bend, squat and crawl occasionally, work at or above shoulder height occasionally, and kneel without restriction. (Ex. 5, p. 46) Dr. Kuhnlein did not believe the claimant should work on ladders or at heights as long as he is taking the hydrocodone and gabapentin.

Sunil Bansal, M.D., conducted an IME on October 31, 2016. (Ex. 1) Dr. Bansal recorded claimant as continuing to have significant constant back pain and varying pain in the neck. He occasionally experienced numbness in his arm in the morning and while driving. There was constant low back pain that radiates down his right leg to his foot involving all of his toes. Both his feet were numb. He had occasional headaches and some difficulty with memory. He is able to lift 20 pounds on a regular basis but extended periods of lifting generated pain. He was able to sit comfortably for approximately an hour. (Ex. 1, p. 16) On examination he exhibited tenderness to palpation over the cervical paraspinal musculature, greater on the left. He had full range of motion. There was tenderness to palpation over the left trapezius with reduced range of motion in the left abduction. (Ex. 117) He had tenderness to palpation over the lower lumbar paraspinals with some guarding in a positive straight leg test on the right at 60 degrees. (Ex. 1, p. 18) He exhibited a loss of sensory discrimination over the midfoot on the right as well. (Ex. 1, p. 18)

Dr. Bansal concluded that claimant incurred a strain when the pipe hit him on the head. Dr. Bansal opined that the August 22, 2011 caused an L4 – L5 disc protrusion with an annular tear and aggravated his underlying spondylosis, as well as his lumbar facet arthropathy. (Ex. 1, pp. 19 – 20) Dr. Bansal believes that the chemicals resulting from the annular tear was irritating the nerve threat causing the radiculopathy. (Ex. 1, p. 20) As a result of the disc protrusion with annular tear and radicular complaints, guarding and loss of range of motion, Dr. Bansal assessed an 8 percent whole person impairment rating. (Ex. 1, p. 21)

Dr. Bansal set claimant's date of maximum medical improvement on April 3, 2014 at the time of his consultation with Dr. Dolphin. (Ex. 1, p. 21) He would place lifting restrictions of 30 pounds occasionally or 20 pounds frequently and no frequent bending or twisting. Sitting, standing, and walking should be as tolerated, avoiding any sitting, standing, or walking for more than 60 minutes at a time. (Ex. 1, p. 22)

Currently, he has pain in his head, neck, shoulder, and mid to lower back. He experiences right foot numbness and stabbing pain down the right leg. When his shoulder tightens and develops a knot, he will then have neck pain. Claimant was straightforward and no-nonsense in his answers and direct. At times, he was combative on cross-examination; however, he is clearly a hard worker and is trying to find work within his restrictions, even if that work is unfamiliar to him. However, the information that he related to his medical doctors and the way in which he characterized his misuse of prescription drugs was troubling. Further, during his care with Dr. Stec, his pain was described as inconsistent with his therapy and his abilities. There was a further discrepancy in regards to claimant's release from Dr. Stec with no restrictions. He testified that she released him to full duty with no restrictions at his request, but her medical records reveal something different. He reported to Dr. Neyman that Dr. Mouw wished for claimant to undergo injection therapy. Dr. Mouw's records did not state that. Instead, Dr. Mouw released claimant to return to the care of his family physician.

He told Dr. Read that he was discharged from his last clinic due to not taking pain medication consistently and not refilling it often enough. Instead, he was discharged due to a positive drug screen.

Claimant came across earnest and sincere at the hearing, but the testimonial discrepancies are difficult to get past. Unfortunately, his testimony at hearing is given low weight.

There was a period of time when he was released from care and had no medications. He started drinking heavily and smoking pot and buying painkillers.

After the assault by several individuals and the resulting fracture, claimant felt that he had healed after three to four weeks.

Currently, he uses a TENS unit to treat his back pain. Medical treatment has made his pain bearable but has not resolved the pain entirely. He admits that he has quite a lot of contacts from the time that he owned his own company, but there are no jobs available to him in the Midwest near his family. He was an active individual prior to his injury, golfing approximately four times per week. He has been unable to do that since the injury. He sold his bow as he can no longer climb a tree or pullback the bowstring.

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 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.

Since claimant has an impairment to the body as a whole, an industrial disability has been sustained. Industrial disability was defined in Diederich v. Tri-City R. Co., 219 Iowa 587, 258 N.W. 899 (1935) as follows: "It is therefore plain that the legislature intended the term 'disability' to mean 'industrial disability' or loss of earning capacity and not a mere 'functional disability' to be computed in the terms of percentages of the total physical and mental ability of a normal man."

Functional impairment is an element to be considered in determining industrial disability which is the reduction of earning capacity, but consideration must also be given to the injured employee's age, education, qualifications, experience, motivation, loss of earnings, severity and situs of the injury, work restrictions, inability to engage in employment for which the employee is fitted and the employer's offer of work or failure

to so offer. McSpadden v. Big Ben Coal Co., 288 N.W.2d 181 (Iowa 1980); Olson v. Goodyear Service Stores, 255 Iowa 1112, 125 N.W.2d 251 (1963); Barton v. Nevada Poultry Co., 253 Iowa 285, 110 N.W.2d 660 (1961).

Compensation for permanent partial disability shall begin at the termination of the healing period. Compensation shall be paid in relation to 500 weeks as the disability bears to the body as a whole. Section 85.34.

Claimant was released to full duty work by Dr. Stec. On June 12, 2012, the claimant maintains that he was released at his own request but the medical records do not support that. Given the claimant's credibility problems combined with the medical record in which Dr. Stec found claimant to be at maximum medical improvement along with the admonitions that he could be doing more work and activities than he was currently undertaking while in her care, it is more likely than not that claimant was released to full duty work because Dr. Stec deemed him physically able to do full duty work.

Dr. Bansal and Dr. Kuhnlein both agreed that claimant sustained an 8 percent impairment rating although Dr. Kuhnlein noted that some of the impairment rating was due to claimant's assault that occurred after the claimant's work injury. Claimant's access to narcotic pain killers was cut off at the end of 2014. On April 14, 2015, when claimant established care with Dr. Read, he was stable on his current medications. After the June 11, 2015, assault, claimant began a course of regular hydrocodone prescriptions which continued up until his last visit with Dr. Read on October 7, 2016. The course of claimant's medication history would indicate that his pain worsened after the assault and did not return to pre-assault levels.

Dr. Bansal's opinion did not address what impact the assault and subsequent fracture of the lumbar spinous processes at L2-L3 had on claimant's overall impairment picture. While claimant maintains he has significant pain in his left shoulder and low back which radiates into his right leg, the medical records from Dr. Read state that claimant's pain was localized and not radicular. He also did not have neck pain. (See e.g., Ex. 7i, p. 234) While he complained of sleep deprivation at hearing, again, his medical records dispute that. On February 25, 2016, the record notes, "can almost sleep through most nights." (Ex. 7i, p. 234) On March 31, 2016, he had "no sleep disturbances." (Ex. 7i, p. 240) On July 25, 2016 and October 7, 2016, there were "no sleep disturbances." (Ex. 7i, p. 249, 254)

As of his most recent medical visit with Dr. Read, claimant had localized pain in the low back, no sleep disturbances, no headaches, no dizziness, and an abnormal gait. (Ex. 7i, p. 256) While claimant has not been offered new work via defendant employer, his medical picture does not portray him as an individual who cannot do manual labor. He was given a full work release from Dr. Stec and a modified work release from Dr. Kuhnlein, both who are given more weight than Dr. Bansal who did not even record Dr. Stec's full work release. (See e.g., Ex. 1, p. 8) Dr. Bansal incorrectly notes that claimant was released with work restrictions on June 12, 2012. (Ex. 1, p. 8)

On the positive side, claimant is attempting to undergo retraining and find new employment. He has marketable skills. During the time when he owned his own business, he was involved in bidding, logistics, supervision of crews, and managing significant building projects.

Based on the foregoing, it is determined that claimant's permanent disability arising out of his work injury is 25 percent. The majority of claimant's current symptomatology is related to his assault which resulted in fractures of the lumbar spinous process.

After Dr. Stec's release, claimant sought and obtained non-authorized care from Dr. Neyman and Dr. Read. Claimant testified that he attempted to obtain care from defendants and was denied. This was unrebutted and is deemed true for the purposes of this decision.

Under Bell Bros. Heating v. Gwinn, 779 N.W. 2d 193 (Iowa 2010), an employee can recover expenses for unauthorized medical care if the unauthorized care is "reasonable and beneficial under all the surrounding circumstances, including the reasonableness of the employer-provided care, and the reasonableness of the decision to abandon the care furnished by the employer in the absence of an order from the commissioner authorizing alternative care."

The care provided to claimant included pain medication, injections and therapy. Dr. Kuhnlein characterized the care after April 24, 2014, as maintenance care. Maintenance care is still beneficial in the face of no care at all. Therefore, it is determined that the care rendered to claimant by Dr. Neyman and Dr. Read as included in Exhibit 10 is deemed beneficial to the claimant and reasonable in light of the lack of care offered.

Therefore the expenses and liens in Exhibit 10 are awarded.

Claimant seeks additional healing period benefits. Dr. Stec released claimant to full duty work without restrictions on June 12, 2012. However, Dr. Tearse, another physician authorized by defendants set claimant's MMI date as of August 22, 2012. Dr. Kuhnlein set the MMI date as of April 24, 2014.

Section 85.34(1) provides that healing period benefits are payable to an injured worker who has suffered permanent partial disability until (1) the worker has returned to work; (2) the worker is medically capable of returning to substantially similar employment; or (3) the worker has achieved maximum medical recovery. The healing period can be considered the period during which there is a reasonable expectation of improvement of the disabling condition. See Armstrong Tire & Rubber Co. v. Kubli, Iowa App 312 N.W.2d 60 (1981). Healing period benefits can be interrupted or intermittent. Teel v. McCord, 394 N.W.2d 405 (Iowa 1986).

Therefore, it is determined that claimant is entitled to healing period benefits up to April 24, 2014. After that date, Dr. Kuhnlein characterized claimant's care as maintenance.

Finally, in Exhibit 13, claimant seeks reimbursement of an expert witness fee. Pursuant to Des Moines Area Reg'l Transit Auth. v. Young, 867 N.W.2d 839, (Iowa 2015), expert witness fees are permitted only to the extent that the report is in lieu of testimony at the hearing. The examination of the claimant by Dr. Bansal is an independent medical examination and therefore is only reimbursable under 85.39. Under 85.39, only the examination is permitted and not the report. Dr. Bansal's fee is not itemized. Dr. Kuhnlein said that he spent two hours examining the claimant and four and a half hours preparing the report. (Ex. 5, p. 33) Using that time delineation, it is determined that the appropriate amount of reimbursement of Dr. Bansal's fee is $823.08. ($2,675 divided by 6.5 hours=$411.54 per hour). (Ex 13, p. 297; Ex. 1)

ORDER

THEREFORE, it is ordered:

That defendants are to pay unto claimant one hundred twenty-five (125) weeks of permanent partial disability benefits at the rate of five hundred and 86/100 dollars ($500.86) per week from April 25, 2014.

That defendants are to pay until claimant healing period benefits from August 22, 2011 to April 24, 2014.

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

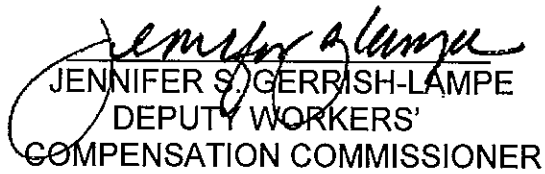
That defendants shall pay interest on unpaid weekly benefits awarded herein as set forth in Iowa Code section 85.30.

That defendants are to be given credit for benefits previously paid.

That defendants shall pay eight hundred twenty-three and 08/100 dollars ($823.08) under 85.39 for the examination of Dr. Bansal.

That defendant shall pay the costs of this matter pursuant to rule 876 IAC 4.33 as itemized in Exhibit 13 except for the fees of Dr. Bansal.

Signed and filed this 21st day of March, 2017.



JENNIFER S. GERRISH-LAMPE
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

Copies to:

Emily Anderson
Attorney at Law
425 2ND St SE, Ste. 1140
Cedar Rapids, IA 52401
eanderson@fightingforfairness.com

Thomas D. Wolle
Attorney at Law
PO Box 1943
Cedar Rapids IA 52406-1943
twolle@simmonsperrine.com

JGL/kjw

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.