BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

ALEXANDER GROCHALA, Claimant, vs. QUIKTRIP CORPORATION, Employer, and MIDWEST EMPLOYERS CASUALTY, Insurance Carrier, Defendants.	File No. 1638239.01 ARBITRATION DECISION Head Notes: 1402.40; 1803.1; 2505

STATEMENT OF THE CASE

Claimant Alexander Grochala filed a petition in arbitration seeking worker's compensation benefits against QuikTrip Corporation, employer, and Midwest Employers Casualty, insurer, for an accepted work injury date of September 17, 2017. The case came before the undersigned for an arbitration hearing on August 18, 2022. Pursuant to an order of the Iowa Workers' Compensation Commissioner, this case proceeded to a live video hearing via Zoom, with all parties and the court reporter appearing remotely. The hearing proceeded without significant difficulties.

The parties filed a hearing report prior to 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. The parties are now bound by their stipulations.

The evidentiary record includes Joint Exhibits 1 through 10, Claimant's Exhibits 1 through 7, and Defendants' Exhibits A through I.

Claimant testified on his own behalf. The evidentiary record closed at the conclusion of the evidentiary hearing on August 18, 2022. The parties submitted post-hearing briefs on September 9, 2022, and the case was considered fully submitted on that date.

ISSUES

1. The nature and extent of claimant's permanent partial disability;

2. The commencement date for permanent partial disability benefits, if any;

3. Payment of certain medical expenses; and

4. Taxation of costs.

FINDINGS OF FACT

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

Claimant's testimony was consistent as compared to the evidentiary record, and his demeanor at the time of hearing gave the undersigned no reason to doubt his veracity. Claimant is found credible.

At the time of hearing, claimant was a 30-year-old person. (Hearing Transcript, p. 10) Claimant graduated from East High School in Des Moines, Iowa in 2010. (Tr., p. 31) While in high school, from 2008 until 2010, claimant worked a part-time job as a clerk at QuikTrip. Following high school he enlisted in the United States Air Force, where he served from 2010 until 2014. Prior to his discharge, he applied for and was awarded disability benefits related to his knees and hearing loss. (Tr., p. 32) At the time of hearing, he continued to receive about $600.00 per month in disability benefits from the military.

After leaving the military, in 2014, claimant applied for a law enforcement position with the Polk County Sheriff's Department. (Tr., p. 34) He did not make it through the application process, however. (Tr., pp. 34-35) Around this time, claimant also started taking classes at Des Moines Area Community College (DMACC). (Defendants' Exhibit I; Deposition Transcript, p. 30) In 2015, claimant went back to part-time work at QuikTrip, again working as a clerk. (Claimant's Exhibit 2, p. 5) Claimant received an associate's degree in criminal justice from DMACC in 2016. (Def. Ex. I, Dep. Tr., p. 31) Claimant then began attending Grand View University. (Tr., p. 34) Claimant also testified that he considered re-enlisting in the military around 2016 or 2017, until the work injury at issue occurred. (Tr., pp. 10-11) In December of 2018, claimant graduated from Grand View with a bachelor's degree in business management. (Tr., p. 10)

In February 2019, claimant resigned from QuikTrip. (Def. Ex. C, p. 9) He then started working for Principal Financial Group, initially as an annuity technician. (Def. Ex. I, Dep. Tr., p. 27) He later changed positions at Principal, and at the time of hearing was working as a client service manager. (Tr., p. 22) In this position, he manages nonqualified deferred compensation plans. Physically, his job involves office work,

mainly typing and using the phone. (Tr., p. 23) At the time of hearing he was making about $66,000.00 per year at Principal. (Tr., p. 50)

Claimant was injured while working at QuikTrip on September 17, 2017. At that time, he was cutting a sandwich in the QuikTrip kitchen, and the knife slipped and cut through the bottom half of his right pinky finger. (Tr., p. 14) He reported the injury to his manager, but managed to stop the bleeding so he did not believe it required medical attention that day. Within a couple of weeks, however, the pain continued, and he asked his employer for medical care. (Def. Ex. I, Dep. Tr., p. 15)

Claimant initially saw Richard Bratkiewicz, M.D., on October 3, 2017. (Joint Exhibit 1, p. 1) Dr. Bratkiewicz noted that the cut had healed, but the pinky finger was swollen and very painful, with swelling and pain starting to go up the right side of his hand. Dr. Bratkiewicz was concerned about a possible tendon injury, so he sent claimant to the urgent injury care clinic at Des Moines Orthopaedic Surgeons (DMOS). (Jt. Ex. 1, p. 2)

Claimant was seen later that day at DMOS by Brian Haupts, PA-C. (Jt. Ex. 2, p. 4) PA-C Haupts was concerned about a possible laceration of the flexor digitorum superficialis (FDS) tendon in the right small finger, so he ordered an MRI and set claimant up for follow-up with a hand surgeon. (Jt. Ex. 2, p. 5) He also recommended claimant engage in active range of motion exercises and focus on extension of his proximal interphalangeal (PIP) joint in the interim.

Claimant had an MRI of his right hand on October 10, 2017. (Jt. Ex. 2, p. 6) The MRI showed a possible partial tear of the fifth digit FDS tendon at the level of the proximal phalanx base. There were also indications of mild tenosynovitis and a pulley injury, along with marrow edema.

The following day, October 11, 2017, claimant saw Andrew Taiber, M.D. (Jt. Ex. 2, p. 7) At that time, claimant's pain was localized over the volar aspect of the right small finger over the metacarpophalangeal (MP) region. He continued to have swelling, and was working light duty and using the hand "a fair amount." He denied numbness or tingling at that time, and rated his pain at a level 6 out of 10. On physical examination, Dr. Taiber noted claimant's finger was swollen and his range of motion was affected. (Jt. Ex. 2, p. 8) He reviewed the MRI, and believed the FDS tendon to be intact. (Jt. Ex. 2, pp. 8-9) He did note a "fairly significant" amount of tenosynovitis, which he did not believe to be infectious, as well as concern for a potential pulley disruption. (Jt. Ex. 2, p. 9) However, he did not see anything that required acute surgical intervention, so they decided to proceed with physical therapy and anti-inflammatory medications for six weeks. He was also given work restrictions of no lifting more than five pounds with his right hand.

Claimant returned to Dr. Taiber on November 20, 2017. (Jt. Ex. 2, p. 10) He reported no significant change in his symptoms, despite having undergone a course of physical therapy. He reported pain with gripping and grasping objects, but no numbness

or tingling at that time. Dr. Taiber revisited claimant's prior MRI, and noted fairly marked inflammation surrounding the flexor tendons. (Jt. Ex. 2, p. 11) He discussed concern for "potential polyinjury," but noted claimant's laceration was transversely oriented and slightly more distal. As such, he discussed other potential causes for claimant's discomfort, which "could be an infectious etiology or even rheumatologic-type conditions." As such, Dr. Taiber ordered labs, and discussed a potential biopsy of the finger and possible evaluation with Rheumatology.

On November 27, 2017, Dr. Taiber documented a telephone conversation with claimant regarding his lab results. (Jt. Ex. 2, p. 12) Based on the results, he could not rule out a rheumatologic origin, but he wanted to do a biopsy to help rule out infectious etiology. Claimant agreed to surgery, which took place on November 30, 2017. (Jt. Ex. 2, p. 13) The procedures performed included right small finger biopsy, right small finger partial flexor tenosynovectomy, and right small finger tenolysis. Following surgery, claimant started physical therapy on December 4, 2017. (Jt. Ex. 2, pp. 17-21) He followed up with Dr. Taiber on December 11, 2017, at which time he noted that immediately after surgery he was doing great, and the motion in his finger was much better than pre-surgery. (Jt. Ex. 2, p. 22) However, more recently the pain and swelling seemed to return, and he was having more issues bending the finger.

Dr. Taiber noted that the pathology specimen from the biopsy showed findings of mild chronic inflammatory changes consistent with a benign synovial cyst. He noted that claimant's motion had improved due to the removal of adhesions between his tendons, and stressed the importance of continuing with therapy to work on range of motion. (Jt. Ex. 2, p. 23) All cultures were negative for infection, but due to the mild chronic inflammatory changes, Dr. Taiber recommended a referral to Rheumatology. In the meantime, claimant continued with physical therapy. (Jt. Ex. 2, pp. 24-28) By his January 10, 2018 follow-up with Dr. Taiber, he had completed several additional weeks of physical therapy, but had not yet seen Rheumatology. (Jt. Ex. 2, p. 29) Claimant reported intermittent fluctuations in pain and discomfort, and Dr. Taiber noted his motion had worsened slightly since his last examination. He recommended claimant see Rheumatology as soon as possible, and continue with physical therapy and anti-inflammatory medications. (Jt. Ex. 2, p. 30) He was placed on work restrictions of no lifting more than 10 pounds with the right upper extremity.

Claimant saw Petar Lenert, M.D., at University of Iowa Hospitals and Clinics in the rheumatology department on January 23, 2018. (Jt. Ex. 4, p. 90) Dr. Lenert noted claimant's main problems were related to constant pain, coldness, and numbness and tingling in his small finger on the right hand. He also noted a flexion contracture in that finger. Dr. Lenert also noted that claimant's mother had been diagnosed with reflex sympathetic dystrophy (RSD) [1] in her lower extremities, and his aunt had inflammatory spondylopathy. On physical examination, Dr. Lenert documented a flexion contracture

[1] According to the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, the term "RSD" has been replaced by "complex regional pain syndrome, type I (CRPS)," and "causalgia" has been replaced by "CRPS type II." See AMA Guides, p. 495. The terms are commonly used interchangeably in medical records.

of the fifth finger PIP joint with coldness and bluish discoloration. (Jt. Ex. 4, p. 92) His diagnoses were 1) complex regional pain syndrome (CRPS) type 1 of the right upper extremity; 2) tenosynovitis; and 3) family history of ankylosing spondylitis. He stated that claimant's history and symptoms of neuropathic pain with mild vascular compromise following his injury were suggestive of RSD. He did not find any evidence of associated inflammatory rheumatic illness. He recommended a nuclear bone scan to evaluate for RSD, and a referral to a pain clinic.

Claimant continued with physical therapy. (Jt. Ex. 2, pp. 31-35) On February 15, 2018, he saw Jolene Smith, D.O., at Pain Specialists of Iowa. (Jt. Ex. 3, p. 55) By that point, he had also had a bone scan, which Dr. Smith noted showed abnormalities of the right fifth digit. After taking claimant's history and physical examination, Dr. Smith's assessment included complex regional pain syndrome, type 1, affecting the right hand; chronic pain syndrome; and right hand pain. (Jt. Ex. 3, p. 56) With respect to the CRPS, Dr. Smith recommended medication changes and a stellate ganglion block followed by physical therapy.

Claimant had the stellate ganglion block on February 22, 2018. (Jt. Ex. 3, p. 59) At his next follow-up with Dr. Smith on March 8, 2018, he reported some relief following the injection. (Jt. Ex. 3, p. 61) His new medication was also helping, and he continued with physical therapy. He was to continue with medication and therapy, and follow up in four weeks. Claimant did continue with physical therapy, and therapy notes indicate varying pain levels with good days and bad days. (Jt. Ex. 2, pp. 36-46) On April 10, 2018, he followed up with Dr. Smith, and reported increased pain in the first knuckle of his pinky finger, along with muscle cramping in his hand, wrist, and arm. (Jt. Ex. 3, p. 63) He also reported numbness in the pinky finger at night. On examination, Dr. Smith noted the right pinky finger was slightly hyperemic compared to the adjacent fingers. She also noted decreased range of motion at all joints, obvious swelling, and pain to palpation. Dr. Smith made some medication adjustments, and recommended another stellate ganglion block since claimant had some improvement with the prior injection. (Jt. Ex. 3, pp. 63-64) She also increased his work restrictions to be able to lift up to 15 pounds, while still avoiding significant use of his right hand. (Jt. Ex. 3, p. 64)

The second injection took place on April 13, 2018. (Jt. Ex. 3, p. 65) Claimant returned to physical therapy following the injection, and continued to report good days and bad days. (Jt. Ex. 2, pp. 47-52) He returned to Dr. Smith on May 22, 2018, at which time he reported 85 percent relief for one to two days following the last injection, with less severe episodes of pain. (Jt. Ex. 3, p. 67) At that time, however, his pain had returned to baseline. On examination, Dr. Smith noted less erythema and an increase in range of motion, although he still had pain and swelling. She recommended a repeat injection since he had so much relief, and claimant agreed. (Jt. Ex. 3, p. 68) That injection took place on May 25, 2018, and was again followed by physical therapy. (Jt. Ex. 3, p. 69; Jt. Ex. 2, pp. 53-54)

At his next follow up with Dr. Smith on July 3, 2018, claimant reported zero pain and a 75 percent decrease in swelling for three days after his last injection. (Jt. Ex. 3, p.

71) At that time he reported the swelling as being the most bothersome symptom, as it significantly limited his mobility. He reported his pain level was generally around a 4 out of 10. However, when the pain got worse, it radiated up into his right wrist and arm. He continued with medications and physical therapy. Dr. Smith noted continued swelling and decreased range of motion on examination. She again adjusted claimant's medications, and did not recommend another stellate ganglion block as the relief had been so temporary. (Jt. Ex. 3, pp. 71-72) She recommended trying a right pinky joint injection under fluoroscopy as a last attempt, and released claimant to work with no restrictions. (Jt. Ex. 3, p. 72)

The right pinky joint injection took place on July 13, 2018. (Jt. Ex. 3, pp. 74-75) Claimant returned to Dr. Smith on August 23, 2018, and reported moderate relief from the swelling following the injection, which unfortunately returned after about one week. (Jt. Ex. 3, p. 76) He reported working full-time with no restrictions, and tolerating his workload well. He complained of intermittent spasms in his right hand, which Dr. Smith thought might be caused by a compressed nerve at the wrist. She recommended an upper extremity EMG, but indicated claimant had essentially reached maximum medical improvement (MMI), even if the EMG came back abnormal.

Claimant had the EMG on October 2, 2018, which was normal. (Jt. Ex. 5, p. 94) He followed up with Allen Eckhoff, M.D., [2] at Pain Specialists of Iowa, on November 20, 2018. (Jt. Ex. 3, p. 78) At that time claimant had discontinued his Lyrica and had been working with no restrictions for six months. He complained of pain bothering him most at night, so Dr. Eckhoff prescribed gabapentin to see if that would help him with the pain and sleep. He placed claimant at MMI and recommended a follow-up visit in six months.

Claimant attended an independent medical evaluation (IME) at defendants' request on December 20, 2018, with Daniel Miller, D.O. (Def. Ex. A) Dr. Miller's report is dated January 21, 2019. (Def. Ex. A, p. 1) Dr. Miller reviewed medical records, took claimant's history, and performed a physical examination. Claimant reported his symptoms at that time included swelling, contracture of the pinky finger, and painful sensations, burning, numbness, tingling, and color changes in the finger. (Def. Ex. A, p. 2) Dr. Miller noted those symptoms were all consistent with CRPS.

On physical examination, Dr. Miller noted that the finger was contracted and swollen with decreased range of motion. (Def. Ex. A, p. 3) There was a dusky color to the digit, and decreased sensation to light touch compared to the other digits on his right hand. There was increased pain with light touch, and the PIP joint was contracted to 25 degrees flexion. Claimant was unable to extend the finger by himself. Dr. Miller provided an impairment rating using the Fifth Edition of the AMA Guides to the Evaluation of Permanent Impairment, which resulted in 53 percent digit impairment to the pinky finger. This was based on 28 percent impairment for range of motion deficits, and 25 percent for sensory loss. Dr. Miller noted that 53 percent impairment of the pinky

[2] Claimant testified that he saw Dr. Eckhoff on this date because Dr. Smith had gone out on maternity leave. (Tr., p. 40)

finger results in 5 percent impairment of the hand, 5 percent impairment of the upper extremity, or 3 percent impairment of the whole person.

Claimant next followed up with Dr. Smith on May 23, 2019. (Jt. Ex. 3, p. 79) He reported the gabapentin had been very helpful and he was stable. By that time claimant had changed jobs and was working at Principal. Dr. Smith felt it was reasonable to continue claimant on the gabapentin, and asked him to follow up in six months. As such, his next visit was November 4, 2019, at which time he reported mild pain in the pinky finger, but no numbness or tingling. (Jt. Ex. 3, p. 81) He reported increased pain when using the finger. Dr. Smith did not recommend any changes in medication and again asked claimant to return in six months.

Claimant saw Kevin Massick, M.D., at Veterans Affairs Central Iowa Health System (VA CIHS) on January 24, 2020. (Jt. Ex. 8, p. 151) He told Dr. Massick that he was on gabapentin for his workers' compensation injury, and wanted to get the medication through the VA as "getting it prescribed on the outside is difficult." He saw his primary care physician at MercyOne Pleasant Hill Family Medicine Clinic on February 17, 2020, complaining of pain in his left second toe and into the top of his foot. (Jt. Ex. 10, p. 171) The record notes he was taking gabapentin at that time.

On February 27, 2020, claimant saw Bryan Trout, D.P.M., at Iowa Ortho, for the unrelated problem with his left foot. (Jt. Ex. 6, p. 96) Dr. Trout noted claimant's RSD in his hand. Dr. Trout noted the sudden onset of the foot pain, along with the amount of swelling, and recommended screening for inflammatory diseases. (Jt. Ex. 6, p. 97) At his follow-up visit in March, Dr. Trout noted that steroids had helped his condition, telling him it was more inflammatory in nature. (Jt. Ex. 6, p. 99)

On June 2, 2020, claimant returned to his primary care physician at MercyOne with complaints of left thumb pain. (Jt. Ex. 10, p. 175) He was still taking gabapentin at that time. (Jt. Ex. 10, p. 176) He was given an injection in his thumb by Illa Chandani, M.D., on June 11, 2020. (Jt. Ex. 10, p. 180) On June 24, 2020, he returned to Dr. Chandani and reported the pain was worse since getting the injection. (Jt. Ex. 10, p. 181) He was referred to Scott Shumway, M.D., at Iowa Ortho, who he saw the same day. (Jt. Ex. 6, p. 101) Dr. Shumway diagnosed left trigger thumb and gave claimant a Kenalog injection. (Jt. Ex. 6, p. 103) The injection did not resolve his symptoms, so on August 6, 2020, Dr. Shumway performed a left trigger thumb release. (Jt. Ex. 9, p. 168)

Claimant returned to Dr. Chandani on September 2, 2020, and complained of continued pain and swelling in the left thumb, along with some elbow and foot pain. (Jt. Ex. 10, p. 183) He asked about a referral to Rheumatology. Dr. Chandani's assessment was arthralgia of multiple sites, and she agreed to get a rheumatological evaluation. (Jt. Ex. 10, p. 185) Claimant returned to Dr. Chandani on September 17, 2020, this time with bilateral hand pain. (Jt. Ex. 10, p. 189) He had not yet gotten into Rheumatology. He reported the prednisone he had been prescribed helped, but he still had ongoing pain.

Dr. Chandani noted claimant's work injury to his pinky finger, resulting in RSD. Her note indicates he continued on gabapentin at that time. Dr. Chandani noted claimant's rheumatology panel was negative, and her assessment included arthralgia of multiple sites, left thumb pain, and RSD. (Jt. Ex. 10, p. 191) She ordered a bone scan and continued the prednisone while he waited to see Rheumatology.

Claimant saw Susan Jacobi, M.D., at Iowa Arthritis and Osteoporosis Center on September 24, 2020. (Jt. Ex. 7, p. 104) Dr. Jacobi reviewed claimant's history, including his work injury and RSD diagnosis. She noted he continued to take gabapentin. She reviewed his recent bone scan and noted that the bone scan interpretation did not show evidence that would be suggestive of RSD on either hand. Instead, there was localized inflammation at the right fifth PIP joint that could be consistent with osteomyelitis/inflammation, and inflammation on the left hand in the area of the thumb into the wrist. Because of the osteomyelitis, he was set up for an infectious disease evaluation.

On physical examination, Dr. Jacobi noted a chronic flexion deformity of the right fifth PIP joint related to his work injury. (Jt. Ex. 7, p. 107) Dr. Jacobi's assessment notes that the clinical scenario with respect to this left thumb, right elbow, and left foot was more consistent with an inflammatory arthritis than infection. (Jt. Ex. 7, p. 108) She again noted that claimant did not have findings on exam that would necessarily suggest chronic RSD of the right hand. At his follow up on October 16, 2020, Dr. Jacobi noted that his infectious disease evaluation did not identify any concerns about osteomyelitis. (Jt. Ex. 7, p. 111) Her assessment was asymmetrical polyarthritis with dactylitis. (Jt. Ex. 7, p. 113) She continued his medication regimen, including prednisone, and they discussed starting DMARD therapy when he returned from an upcoming vacation.

At his next follow up visit on December 18, 2020, claimant reported "somewhat migratory joint complaints." (Jt. Ex. 7, p. 116) He was having a flare in his left wrist. (Jt. Ex. 7, p. 118) Dr. Jacobi adjusted his medications, and noted that claimant reported he had been "on gabapentin in the past without much success even with increasing the dose." As such she prescribed zolpidem on a temporary basis to help with sleep.

Claimant had a telehealth visit with Dr. Smith on January 7, 2021. (Jt. Ex. 3, p. 83) [3] At that time, he reported a constant dull pain from his right pinky finger, up his arm into his elbow. He stated it was very painful to put pressure on that aspect of his arm. He did not feel the gabapentin was helpful at that point, so Dr. Smith advised he should stop taking it. Dr. Smith thought that due to compensation from his pinky finger, he may have developed an olecranon bursitis. She recommended a one-time ultrasound-guided right olecranon bursa joint injection.

On January 15, 2021, claimant saw Dr. Jacobi. (Jt. Ex. 7, p. 120) He was not making much progress at that time, and still reported significant morning stiffness in his

[3] The appointment took place via audiovisual conference due to the COVID-19 pandemic. (Jt. Ex. 3, p. 83)

hips, left wrist, and feet, and also more swelling in his left first and fifth toes. Dr. Jacobi recommended changing his medication to biologic treatment, and got insurance approval to start claimant on Humira. (Jt. Ex. 7, pp. 123-125) Claimant followed up with Dr. Jacobi on February 19, 2021, and reported that the Humira had dramatically improved his symptoms. (Jt. Ex. 7, p. 127) She noted that claimant's "right hand pain is back to his baseline low-grade issues with regional pain syndrome." She also noted that claimant had been able to go back to his usual exercise program.

Claimant reported that he had noticed some dysesthesias in his left hand in the fourth and fifth fingers. Dr. Jacobi noted that claimant had stopped taking gabapentin for CRPS because he did not think it was helping. (Jt. Ex. 7, p. 128) She was concerned about ulnar nerve impingement, separate from his arthritis, and suggested he resume gabapentin to help with the dysesthesias and sleep. (Jt. Ex. 7, p. 130)

On February 26, 2021, Dr. Smith responded to a letter from the claims administrator handling claimant's workers' compensation claim. (Jt. Ex. 3, pp. 84-85) She opined that the need for the ultrasound-guided injection she recommended was causally related to the work injury to claimant's pinky finger. The injection took place on April 9, 2021. (Jt. Ex. 3, p. 86) Claimant had a follow-up visit with Dr. Jacobi on April 16, 2021, at which time he noted pain in his left wrist and right elbow had been keeping him from doing some of the exercises he wanted to do, but in general his pain was "markedly improved," and his functional status was good. (Jt. Ex. 7, p. 131) She again noted claimant was taking gabapentin and that his CRPS has returned to baseline. (Jt. Ex. 7, p. 133)

Claimant followed up with Dr. Smith on July 9, 2021, at which time he reported the ultrasound-guided injection in April did not provide benefit. (Jt. Ex. 3, p. 89) He continued to have pain from his pinky to his elbow, and had no range of motion in his pinky. Movement continued to aggravate his pain. He reported that overall, "he does not feel that he has obtained any benefit in his pain management since originally coming to pain center." [4] With respect to his elbow, he noted that he felt relief when exercising, especially doing triceps pull-downs, but not otherwise. Dr. Smith had nothing further to offer at that point, and released claimant from care.

Claimant followed up with Dr. Jacobi on July 16, 2021. (Jt. Ex. 7, p. 136) At that time, he continued to have a "reasonable but not complete" response to the Humira. He continued to have episodic joint pain. The note indicates he did have gabapentin but did not find it to be very helpful. Dr. Jacobi ordered "baseline hand x-rays," which showed chronic flexion deformity of the right fourth PIP with loss of joint space. (Jt. Ex. 7, pp. 138; 140) Otherwise the alignment was good and there were no other areas of erosions. The left hand showed good alignment, good joint spaces, and no erosions. (Jt. Ex. 7, p. 140) Claimant's next visit with Dr. Jacobi was December 27, 2021. (Jt. Ex. 7, p. 141) He was doing well, and had returned to his normal exercise routine without difficulty.

[4] In Dr. Kuhnlein's IME report, he notes that claimant did not recall saying this, and said he had problems because he could not get in to see Dr. Smith. (Cl. Ex. 1, p. 5)

Claimant attended an IME with John Kuhnlein, D.O., on January 4, 2022. (Cl. Ex. 1, p. 1) Dr. Kuhnlein's report is dated January 19, 2022. Dr. Kuhnlein took a history from claimant and reviewed medical records, all of which is consistent with the testimony and other records in evidence. (Cl. Ex. 1, pp. 2-5) At the time of claimant's IME, he had not seen Dr. Smith since July 2021, and he had no scheduled appointments. (Cl. Ex. 1, p. 5) Dr. Kuhnlein's report notes that claimant was no longer taking gabapentin, and had not taken it for months. He reported taking four ibuprofen daily and melatonin when necessary to help with sleep. He reported using heat and ice on his elbow, hand, and digits, and massaging the scar on his finger, as well as edema massage.

Claimant reported constant right medial elbow pain at rest and with motion. He denied problems with his right forearm, wrist, or hand. He denied temperature changes, sweat changes, or hair or skin changes in the elbow, but complained of swelling in the medial elbow. He told Dr. Kuhnlein that his problem began at the right MCP joint, describing constant pain with light touch and decreased range of motion. (Cl. Ex. 1, pp. 5-6) He reported the finger can change color from red to purple, and may be cold or hot and may swell. (Cl. Ex. 1, p. 6) He was able to move the MCP joint, but could not move the PIP or DIP joints.

Claimant reported no work restrictions related to his work injury. At the time of the IME he was working at Principal. He reported problems with material handling functions, gripping and grasping, and using hand or power tools. He also reported problems using the right small finger when writing, typing, and using a computer mouse. He complained that the pain affects his ability to concentrate. He reported using heat to the elbow and finger to relieve pain, stretching his finger when it is stiff, scar massage, and trying to avoid using the right hand to mitigate symptoms.

Dr. Kuhnlein provided detailed findings regarding his physical examination, including decreased sensations and tenderness to palpation in certain areas of the right small finger. (Cl. Ex. 1, pp. 7-8) Dr. Kuhnlein provided the following diagnoses:

1) Right small finger laceration injury
    a. Right small finger tenosynovitis with November 30, 2017 right small finger partial flexor tenosynovectomy and tenolysis with biopsy (Dr. Taiber)
    b. CRPS type I – improved with residual neuropathic pain
    c. Chronic right small finger pain and dysfunction
2) Right medial epicondylitis

(Cl. Ex. 1, p. 9)

With respect to causation, Dr. Kuhnlein opined that the injury claimant sustained while working on September 17, 2017 was the cause of him developing CRPS type I. However, he stated that it appeared "the CRPS type I has improved clinically with residual neuropathic pain consistent with CRPS type II, so this would still be the same

type of pain syndrome." He again stated claimant's current symptoms in his right small finger and hand would be related to the September 17, 2017 work injury. Dr. Kuhnlein noted claimant also has arthropathic psoriasis with polyarthropathy. As such, he could not state whether claimant developed right medial epicondylitis as a sequela of the work injury. (Cl. Ex. 1, p. 9)

With respect to future treatment, Dr. Kuhnlein recommended claimant continue with digital massage. He did not know whether further orthopedic intervention would help, but suggested claimant see Shane Cook, M.D., at DMOS, to determine if any further intervention is necessary. [5] He did not recommend any additional pain management. He opined that claimant reached MMI on November 20, 2018. (Cl. Ex. 1, p. 9)

Dr. Kuhnlein provided an impairment rating using the AMA Guides. His combined rating came to 91 percent impairment of the small finger, based on decrements in range of motion, and the findings consistent with CRPS type II. (Cl. Ex. 1, pp. 9-10) He noted that the 91 percent impairment of the small finger converts to 9 percent of the hand, 8 percent of the upper extremity, or 5 percent of the whole person. (Cl. Ex. 1, p. 10) Finally, he recommended restrictions of lifting up to 40 pounds occasionally, and using the right hand for gripping and grasping only occasionally as well. He noted claimant may also have problems with writing or typing on certain types of keyboards in his current job.

Dr. Kuhnlein's IME report is highly credible. He provided a detailed summary of claimant's relevant medical history, and performed an exhaustive examination. While Dr. Miller also provided a credible IME, his examination took place on December 20, 2018. (Def. Ex. A, p. 1) Dr. Kuhnlein's more recent IME report documents that the PIP joint had become ankylosed and immobile, and he found greater loss of motion at the DIP and MCP joints as well. (Cl. Ex. 1, pp. 8-10) The portion of his rating related to decrements in range of motion is more recent than Dr. Miller's, and therefore given greater weight as a more accurate representation of claimant's functional capabilities.

With respect to the portion of the rating based on sensory deficit, both Dr. Miller and Dr. Kuhnlein found that claimant had partial transverse sensory loss of the entire length of the digit, resulting in 25 percent digit impairment. (See Def. Ex. A, p. 3; Cl. Ex. 1, p. 10) The only difference in the ratings relates to range of motion deficits. As I found Dr. Kuhnlein's rating to be more accurate, I adopt his rating.

Claimant returned to Dr. Jacobi on June 17, 2022. (Jt. Ex. 7, p. 144) At that time, he continued to do well with Humira. He reported very mild residual aching in his left wrist and thumb, but nothing limiting. He had resumed his regular exercise program, and "feels better than he has in years." That appointment was his last visit prior to the arbitration hearing. (Tr., p. 50) Claimant requested to return to Dr. Smith on June 24,

[5] The parties indicated at hearing that defendants had authorized an appointment for claimant to see Dr. Cook. (Tr., p. 5)

2022. (Def. Ex. D, p. 10) At that time, defendants contacted Dr. Smith, and were advised that she did not need to see him as she had nothing further to offer for treatment. (Def. Ex. D, pp. 10-11; Tr., p. 18) Thereafter, claimant requested to see Dr. Cook as Dr. Kuhnlein suggested, which was authorized just prior to hearing. (Def. Ex. D, p. 11; Tr., p. 5)

Claimant testified that his current symptoms include pain in the pinky finger, and pain up his arm into his elbow. (Tr., p. 19) He testified that he cannot move the furthest joint on his finger, that it is "basically dead," and he cannot bend the pinky or grip with it. He also has swelling. He testified the symptoms are constant, but they do flare and become worse at times. He testified that he tries ice, heat, and massage, consistent with what he told Dr. Kuhnlein. (Tr., pp. 19-20) The symptoms are aggravated by activity, including mowing or trying to play sports, or even trying to use his computer mouse while working. (Tr., pp. 20-21) He testified that exercise can be difficult, including lifting weights, pushing weights, running, biking, golfing, and he even has difficulty washing his body in the shower with his right hand. (Tr., p. 25) He testified that he limits activities such as golfing, as it is difficult to grip a golf club.

Claimant also testified that he believes the right pinky finger injury has affected his career path, as it "closed the door" on him reenlisting in the military or taking a job in law enforcement. (Tr., p. 24) He does not believe the military would take him back due to his painful nerve condition, and the decreased use of his dominant right hand would put him at risk in law enforcement. However, it should be noted that claimant has not officially tried to reenlist in the military. (Tr., pp. 32-33) Additionally, while he did apply for the Polk County Sheriff's Department in 2014, he did not make it through the application process, and has not attempted to reapply since that time. (Tr., pp. 34-35) Claimant continues to work at Principal with no issues, and has not been denied any employment as a result of his injury. (Tr., pp. 50-51)

CONCLUSIONS OF LAW

It is claimant's position that the injury to his right pinky finger resulted in CRPS, which requires it be evaluated as an industrial disability. Defendants argue that claimant's CRPS type I has resolved, meaning the injury is confined to his right pinky finger. In the alternative, if the injury is evaluated as a whole body injury, defendants argue that claimant is not entitled to additional permanency benefits under Iowa Code section 85.34(2)(v).

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 R. App. P. 6.904(3)(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).

Iowa Code section 85.34(2) governs permanent partial disabilities. The statute lists certain body parts in a schedule, including the hand and each finger, and a catch-all that governs injury to any body part not listed. See Iowa Code § 85.34(2). Disabilities to the scheduled members are compensated based only on the injured employee's functional loss, without consideration of the impact on the injured employee's earning capacity. Simbro v. Delong's Sportswear, 332 N.W.2d 886, 887 (Iowa 1983) (citing Graves v. Eagle Iron Works, 331 N.W.2d 116, 117–18 (Iowa 1983)). However, under Barton v. Nevada Poultry Co. and its progeny, an injury to a scheduled member that causes CRPS is considered an injury to the nervous system, which is not included in the statutory schedule. 110 N.W.2d 660 (Iowa 1961); see also Collins v. Dep't of Human Serv., 529 N.W.2d 627, 628–30 (Iowa App. 1995) (discussing, but ultimately not addressing, reflex sympathetic dystrophy—or CRPS, a name by which the condition is also known—as an unscheduled injury triggering industrial disability analysis). Therefore, a diagnosis of CRPS results in an unscheduled injury, making any resulting disability industrial in nature.

While there is no dispute between the parties that claimant was diagnosed with CRPS related to his work injury, defendants argue that the condition has resolved, limiting his permanent disability to the scheduled member. Defendants point to the September 2020 bone scan, which no longer showed evidence of CRPS/RSD in his right hand. (Jt. Ex. 7, p. 104) Defendants also note that Dr. Jacobi indicated claimant did not have findings on examination that would necessarily suggest chronic RSD of the right hand. (Jt. Ex. 7, p. 108) [6] However, Dr. Jacobi acknowledges the diagnosis of CRPS in several records, and notes that it returned to baseline after he started treatment with Humira. (See Jt. Ex. 7, pp. 127-146) Additionally, while Dr. Kuhnlein noted that claimant no longer exhibited symptoms consistent with CRPS type I, he opined that claimant continues to have findings consistent with CRPS type II, or

[6] Defendants cite several of Dr. Jacobi's records that repeat the same statement regarding no findings on exam to suggest chronic RSD. (See Def. Brief, p. 11) However, that statement appears in each record as a carbon copy of the prior record, under "History of Present Illness." In other words, it is not a new finding at each visit, as defendants seem to suggest.

causalgia. (Cl. Ex. 1, p. 10) I found Dr. Kuhnlein's report to be credible, and adopted his findings. Therefore, I find claimant has proven that he has CRPS related to his work injury, which is an unscheduled injury compensated under Iowa Code section 85.34(2)(v).

The next issue to determine is whether claimant is entitled to industrial disability. The applicable statutory provision that governs this issue is Iowa Code section 85.35(2)(v) (2017). This statute was modified in 2017 and introduced a new concept into the worker's compensation analysis of unscheduled injuries. Section 85.34(2)(v) provides:

> If an employee who is eligible for compensation under this paragraph returns to work or is offered work for which the employee receives or would receive the same or greater salary, wages, or earnings than the employee received at the time of the injury, the employee shall be compensated based only upon the employee's functional impairment rating from the injury, and not in relation to the employee's earning capacity. Notwithstanding section 85.26, subsection 2, if an employee who is eligible for compensation under this paragraph returns to work with the same employer and is compensated based only upon the employee's functional impairment resulting from the injury as provided in this paragraph and is terminated from employment by that employer, the award or agreement for settlement for benefits under this chapter shall be reviewed upon commencement of reopening proceedings by the employee for a determination of any reduction in the employee's earning capacity caused by the employee's permanent partial disability.

In this case, claimant returned to work at QuikTrip at the same or higher wages following his injury. He subsequently voluntarily resigned his employment, and took a higher paying job at Principal, where he remained employed at the time of hearing. Claimant argues that pursuant to agency precedent, he is entitled to an industrial disability analysis due to his separation of employment with QuikTrip. Defendants argue that under section 85.34(2)(v), claimant's award is limited to the functional impairment rating given his voluntary resignation and significantly higher earnings at Principal.

The Iowa Workers' Compensation Commissioner has addressed this issue in a similar case. In Martinez v. Pavlich, Inc., File No. 5063900 (App. July 2020), the Commissioner held:

> Thus, though claimant in this case was earning greater wages at the time of hearing than he was when he was injured, I conclude his earlier voluntary separation from defendant-employer removed claimant from the functional impairment analysis and triggered his entitlement to benefits using the industrial disability analysis.

Defendants point out that judicial review was taken from the Commissioner's Martinez decision. See Pavlich, Inc. v. Martinez, Ruling on Petition for Judicial Review,

Case No. CVCV060634 (Iowa D. Ct. Polk Co., April 21, 2021). Defendants assert that the Iowa District Court disagreed with the Commissioner's interpretation of Iowa Code section 85.34(2)(v) and held that claimant should only be compensated under the functional impairment methodology because the claimant was earning the same or greater wages at the time of the arbitration hearing, even if through a subsequent employer. Neither the Iowa Supreme Court nor the Court of Appeals have provided a definitive interpretation of this statutory provision.

Other deputy commissioners have analyzed the issue since the district court decision was filed. In Dungan v. Den Hartog Industries, File No. 21700246.01 (Arb. Sept. 30, 2022), the deputy determined the district court's analysis of section 85.34(2)(v) is *obiter dicta*, and does not control. (See also Weimerskirch v. Progressive Processing, File No. 1655936.01 (Arb. Oct. 21, 2022)) In Dague v. Unisys Corp., File No. 1645503.02 (Arb. March 28, 2022), the deputy applied the Commissioner's analysis in Martinez, while acknowledging the District Court's decision. The deputy noted that until a definitive interpretation is provided by the Iowa appellate courts, agency precedent stands. Likewise, in Carte v. Whirlpool, File Nos. 1643167.01, 1656980.01, and 19700417.01, (Arb. Jan. 25, 2022), the deputy commissioner accepted the Commissioner's interpretation in Martinez as the binding authority and applied the industrial disability analysis.

The facts of this case are most similar to Martinez. I agree with other deputies who have determined that agency precedent applies unless and until the Iowa appellate courts rule otherwise. Therefore, I find that while claimant was earning greater wages at the time of hearing than he was when he was injured, his earlier voluntary separation from QuikTrip removed him from the functional impairment analysis and triggered his entitlement to benefits using the industrial disability analysis.

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). The commissioner may also consider claimant's medical condition prior to the injury, immediately after the injury, and presently in rendering an evaluation of industrial disability. IBP, Inc. v. Al-Gharib, 604 N.W.2d 621, 632-633 (Iowa 2000) (citing McSpadden, 288 N.W.2d at 192).

The focus of an industrial disability analysis is on the ability of the worker to be gainfully employed and rests on comparison of what the injured worker could earn before the injury with what the same person can earn after the injury. Second Injury Fund of Iowa v. Nelson, 544 N.W.2d 258, 266 (Iowa 1995); Anthes v. Anthes, 258 Iowa 260, 270, 139 N.W.2d 201, 208 (1965). Changes in actual earnings are a factor to be considered, but actual earnings are not synonymous with earning capacity. Bergquist v. MacKay Engines, Inc., 538 N.W.2d 655, 659 (Iowa App. 1995), Holmquist v.

Volkswagen of America, Inc., 261 N.W.2d 516, 525, (Iowa App. 1977), 4-81 Larson's Workers' Compensation Law, §§ 81.01(1) and 81.03. The loss of earning capacity is not measured in a vacuum. Such personal characteristics as affect the worker's employability are considered. Ehlinger v. State, 237 N.W.2d 784, 792 (Iowa 1976). Loss of future earning capacity is measured by the employee's own ability to compete in the labor market.

There are no weighting guidelines that indicate how each of the factors is to be considered. Neither does a rating of functional impairment directly correlate to a degree of industrial disability to the body as a whole. In other words, there are no formulae which can be applied and then added up to determine the degree of industrial disability. It therefore becomes necessary for the deputy or commissioner to draw upon prior experience, as well as general and specialized knowledge to make the finding with regard to degree of industrial disability. See Christensen v. Hagen, Inc., Vol. 1 No. 3 Industrial Commissioner Decisions, 529 (App. March 26, 1985); Peterson v. Truck Haven Cafe, Inc., Vol. 1 No. 3 Industrial Commissioner Decisions, 654 (App. February 28, 1985).

In assessing an unscheduled, whole body injury case, the claimant's loss of earning capacity is determined as of the time of the hearing based upon industrial disability factors then existing. The commissioner does not determine permanent disability, or industrial disability, based upon anticipated future developments. Kohlhaas v. Hog Slat. Inc., 777 N.W.2d 387, 392 (Iowa 2009). In this case, claimant has obtained a college degree and moved to a much higher-paying position with Principal since the injury occurred. No treating physician assigned permanent work restrictions, although Dr. Kuhnlein recommended he limit lifting to 40 pounds on an occasional basis. Claimant's current job does not require lifting, and he is able to perform his job duties with no difficulty. No employer has turned him down for a job because of his injury, and he could have continued to work at QuikTrip had he not resigned. Claimant's earning capacity has not been dramatically affected by the injury. While he may not be eligible for a position in law enforcement, he has not made any attempts to apply since 2014, years prior to the injury. Considering all the factors of industrial disability, I find claimant is entitled to five percent permanent partial disability to the body as a whole related to the September 17, 2017 injury. This entitles him to 25 weeks of benefits.

Claimant contends the proper date for commencement of PPD benefits is November 20, 2018; the date Dr. Eckhoff placed him at MMI. Defendants have not presented an alternate date. Therefore, PPD benefits will commence on November 20, 2018.

The next issue to determine is whether claimant is entitled to reimbursement for disputed medical expenses. The bill at issue is for a prescription for gabapentin that claimant received through the VA Medical Center, dated August 17, 2020. (Cl. Ex. 6, p. 1) The gabapentin was prescribed by Dr. Massick on January 24, 2020, related to his work injury, and the record reflects that claimant wanted to get it prescribed through the VA because "getting it prescribed on the outside is difficult." (Jt. Ex. 8, p. 151)

Claimant testified that Dr. Smith told him to get the gabapentin prescribed through his primary care doctor, because he did not need to see pain management every three months just to get a prescription refilled. (Tr., p. 26) While this is not reflected in Dr. Smith's records, claimant saw her on November 4, 2019, and noted taking the medication rarely at that time. (Jt. Ex. 3, p. 81) About two and a half months later, he asked for a refill at the VA, and testified that was because he did not want to use his personal health insurance to see his primary care doctor. (Tr., p. 26) This is the only time he had the prescription refilled through the VA. (Tr., pp. 26-27) His next visit with Dr. Smith was not until January 7, 2021, at which point she took him off gabapentin as he did not feel it was helpful at that time. (Jt. Ex. 3, p. 83) He has since gone back to occasional use, as he realized it does help him sleep. (Tr., p. 27)

While the employer did not authorize this particular prescription through the VA, the Iowa Supreme Court has held that an employer's duty to furnish reasonable medical care includes unauthorized care if the employee can prove "by a preponderance of the evidence that such care was reasonable and beneficial" under the totality of the circumstances. Bell Bros. Heating and Air Cond. v. Gwinn, 779 N.W.2d 193, 206 (Iowa 2010). Claimant testified that Dr. Smith told him to get the prescription filled through a primary care physician, and I found claimant to be a credible witness. The prescription was related to his work injury, reasonable, and beneficial. Claimant is entitled to reimbursement for the gabapentin prescription, in the amount of $15.00.

Finally, claimant seeks costs. He claims $103.00 for the filing fee for his petition. (Cl. Ex. 7, p. 1) Assessment of costs is a discretionary function of this agency. Iowa Code § 86.40. Costs are to be assessed at the discretion of the deputy commissioner or workers' compensation commissioner hearing the case. 876 IAC 4.33. As claimant was generally successful in his claim, I use my discretion and award claimant costs in the total amount of $103.00.

ORDER

THEREFORE, IT IS ORDERED:

Defendants shall pay claimant twenty-five (25) weeks of permanent partial disability benefits, commencing November 20, 2018, at the stipulated rate of two hundred seventy-eight and 49/100 dollars ($278.49).

Defendants shall be entitled to a credit for all permanent partial disability benefits previously paid.

Defendants shall pay accrued weekly benefits in a lump sum together with interest at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two percent.

Defendants shall reimburse claimant for medical bills in the amount of fifteen and 00/100 dollars ($15.00).

Defendants shall reimburse claimant's costs in the amount of one hundred three and 00/100 dollars ($103.00).

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 15th day of February, 2023.

JESSICA L. CLEEREMAN
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served, as follows:

Nick Platt (via WCES)

Jennifer Clendenin (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.