IN THE IOWA DISTRICT COURT FOR POLK COUNTY

CITY OF DAVENPORT, Petitioner, vs. ARTHUR L. BARTLESON, Respondent.	)))))))))	Case No. CVCV059021 **ORDER ON JUDICIAL REVIEW**

On October 4, 2019, Petitioner filed a Petition for Judicial Review (the Petition) from a final decision of the Iowa workers' compensation commissioner (the Commissioner). Oral argument was held on February 21, 2020. Petitioner appeared through attorney Brandon Lobberecht. Respondent appeared through attorney Patrick L. Woodward. Oral argument was not reported.

Upon review of the court file, and after careful consideration of the arguments of counsel, the court finds the following facts, reaches the following conclusions and enters the following Order.

BACKGROUND FACTS AND PROCEEDINGS

On April 3, 2012, a member of Respondent's paving crew was having issues with a paving machine part called a sonic. As the crew went on break, Respondent got on the machine. As he was stepping back off, he stepped on a two-by-four, turning and twisting his right ankle. Respondent immediately reported the injury to Petitioner. Respondent was transported to Genesis at Work where he saw Dr. Garrels, Petitioner's company doctor.

Respondent was initially diagnosed with a badly sprained right ankle and was treated with physical therapy and prescribed a cam boot. As his right ankle injury became increasingly symptomatic, he was finally referred by Dr. Garrels to orthopedic surgeon Dr. Pyevich. Dr.

Pyevich diagnosed Respondent with right peroneal tendon tears. As Respondent was being prepped for surgery to repair the peroneal tendons, Dr. Pyevich further diagnosed Respondent as having a lateral talar dome OCD lesion. Dr. Pyevich diagnosed the talar dome OCD lesion as causally related to the ankle injury and obtained approval from workers' compensation to repair it, as well as the peroneal tendons.

Subsequent to his first ankle surgery, Respondent's right ankle was in a cast that ran to his knee. The cast resulted in the development of blood clots in Respondent's right calf. Eventually, the cast was removed. Respondent began physical therapy.

Throughout the spring of 2013, Respondent continued to have stabbing and throbbing pain in his right ankle and foot as well as limited motion. As a result of the right lower extremity pain and lack of motion, Respondent began walking on the outside of his left foot, shifting his weight to his left side. Finally, on June 17, 2013, Dr. Pyevich prescribed a fitted right ankle brace because Respondent continued experiencing difficulty bearing weight on his right ankle.

The brace prescribed for Respondent's right ankle was a pullover brace with metal supports. The brace kept Respondent's foot and ankle more locked in. This made it harder for Respondent to walk on his right ankle. It caused him to favor his left side even more.

Respondent continued to wear the right ankle brace. He began experiencing pain in and around his left knee. By August 14, 2013, Respondent's left knee pain was bad enough that he reported it to Dr. Garrels. Respondent told Dr. Garrels that once he began walking with the right ankle brace, he began to have knee pain. Dr. Garrels described this pain as "left knee, lateral knee, and top of lower left leg." Respondent was using ice, heat, over the counter medication and rest to manage the situation. Dr. Garrels' notes indicate a member of Petitioner's risk department said the left knee issue was part of Respondent's right foot/ankle case number and, if it was really

hurting, Respondent should go to the emergency room or see Dr. Pyevich. Dr. Garrels referred Respondent back to Dr. Pyevich.

Dr. Pyevich saw Respondent five days later on August 19, 2013. Dr. Pyevich documented that Respondent's left patella femoral pain began after Respondent began wearing the brace on his right ankle, and it was worse with walking, standing, twisting, kneeling, and direct pressure. Dr. Pyevich ordered x-rays of Respondent's knee which, as of August 19, 2013, were unremarkable and showed no arthritis or other identifiable pathology.

As Respondent's right ankle continued to cause pain up into Respondent's calf, Dr. Pyevich performed a right ankle fusion on September 16, 2013. Respondent was in a cast for six weeks. He was then placed in a cam boot, followed by further physical therapy.

Unfortunately, the second right ankle surgery and fusion were not successful. Respondent's gait did not improve. The left knee pain continued. Although not noted in the medical records, Respondent continued to advise Dr. Garrels of continued left knee pain. Throughout the fall of 2013 and into 2014, Respondent continued communicating to Petitioner that he was experiencing increasing left knee pain and that he continued to use ice, heat, elevation, and non-prescription medications to address it.

Medical attention at this point appears to have been focused on Respondent's worsening right ankle condition. When Respondent returned to work, the ankle remained painful. He developed numbness and tingling in his right foot and ankle. Subsequent nerve conduction testing found axonal damage in the right peroneal and tibial nerves and possible radiculopathy. Respondent's then supervisor, Eric Longlett, observed that Respondent's gait wasn't fluid and that Respondent walked with a limp at work.

At Petitioner's request, Dr. Pyevich determined Respondent was at maximum medical improvement (MMI) on November 11, 2014. Dr. Pyevich provided a permanency rating of 22% to Respondent's right foot rather than to his right lower extremity.

By the summer of 2015, Respondent's left knee continued to worsen with swelling, and sharp, throbbing pain requiring the frequent use of an ice pack, rest, and over the counter medication. Then, on July 12, 2015, as Respondent stepped from a dock onto a boat ramp, his left knee snapped and popped. Respondent went to the emergency room that day, where the records stated that he "presents with L knee pain for the last 6 months, but especially for the last week." (Cl. Ex. 4, at p. 22; App. Dec. at p. 5, ¶ 2).

Respondent was diagnosed with a left torn meniscus which was surgically repaired. Radiological studies were completed in July 2015 after the left knee injury. In addition to showing the torn meniscus (unlike the x-rays of August 19, 2013), these studies showed for the first time that tricompartmental osteoarthritis had developed in Respondent's left knee. Further, at the time of the meniscus repair, the surgeon observed new findings of some chondromalacia as well as large chondral defects, soft tissue and synovitis. Despite the meniscus repair, Respondent continued experiencing the same and worsening sharp left knee pain which had begun in 2013. As it worsened, Respondent had his left knee drained every ten days to two weeks.

By March 8, 2016, further radiological studies showed that the left knee had continued to deteriorate from the original x-rays of August 2013. Respondent's left knee exhibited bone-on-bone medial compartmental arthritis, and there had been a rapid collapse of the medial compartment since the 2013 x-rays. As a result of the left knee arthritic changes from August 2013 to March 2016, Respondent underwent a total left knee replacement on March 28, 2016.

By 2016, Respondent's right lower extremity was not only painful and numb, but it continued to worsen. A CT scan of Respondent's right ankle showed that the fusion had failed and the screws used to fixate the ankle were moving. A third surgery on the right ankle was performed. This surgery revealed that Respondent was suffering from not only a failed fusion, but a bone infection. This surgery required bone grafting from Respondent's leg to his heel and installation of new screws. As a result of the third surgery, Respondent continues to experience further limited range of motion and numbness from his toes to up the back of his right calf toward his right knee, as well as ongoing pain.

Respondent still occasionally has aching and swelling in his right knee, but no longer has the sharp shooting pain. He still uses ice, heat, and over the counter medication for pain around the knee.

The parties agree that on or about April 3, 2012, Respondent suffered an injury to his right ankle arising out of and in the course of his employment. The parties further agree that as a result of the right ankle injury, Respondent sustained temporary and permanent disability. The parties further agree that the weekly benefit rate was $825.02.

This matter came before deputy workers' compensation commissioner Jennifer S. Gerrish-Lampe (the Deputy), on March 27, 2018, for an arbitration hearing. The issues before the Deputy were:

1. Whether Respondent sustained an injury to his left lower extremity as a sequela of the accepted work injury to the right ankle;

2. Whether the alleged injury was a cause of temporary disability and, if so, to what extent;

3. Whether the alleged injury was a cause of permanent disability and, if so;

4. The appropriate commencement date of permanent disability benefits;

5. The extent of Respondent's scheduled member disability; and

6. Whether there was a causal connection between Respondent's injury and the medical expenses he claimed.

The Deputy found that Respondent proved all of the following by a preponderance of the evidence: His total right knee replacement was related to his right ankle injury as a sequela injury. He was entitled to reimbursement of medical expenses for treatment of left knee arthritis and subsequent surgery as well as his time off due to the two surgeries from his left knee. He was entitled to employer furnished reasonable surgical, medical care. His initial injury was to his right lower extremity and not limited to his right foot.

The Deputy awarded Respondent (1) fifty-two weeks of permanent partial disability benefits for his right lower extremity, from February 10, 2017, (2) fifty-five and a half weeks of permanent partial disability benefits for the left lower extremity, (3) temporary benefits from September 10, 2015, through October 21, 2015, and March 21, 2016, through May 23, 2016, (4) medical expenses itemized with the pre-hearing report, and (6) all reasonable medical expenses in the future related to Respondent's right and left lower extremities.

Petitioner appealed the Deputy's decision to the Commissioner. In an appeal decision filed on September 24, 2019, the Commissioner adopted the same analysis, findings and conclusions of the Deputy, but for the Deputy's analysis of permanent partial disability. The Commissioner found that the appropriate analysis of permanent partial disability should have been made under Iowa Code section 85.34(2)(*s*).[1] The Commissioner determined that the combined value for the right lower extremity and left lower extremity was 27% of the body as a whole, which is equal to one hundred and thirty five weeks.

[1] In his decision the Commissioner cited Iowa Code section 85.34(2)(*t*) rather than section 85.34(2)(*s*). This was obviously a scrivener's error.

CONCLUSIONS OF LAW

The district court's review of a workers' compensation action is governed by Iowa Code chapter 17(A). *Grundmeyer v. Weyerhaeuser Co.*, 649 N.W.2d 744, 748 (Iowa 2002); Iowa Code § 86.26. The Commissioner's factual determinations are clearly vested by a provision of the law in the discretion of the agency and the court will defer to those factual determinations if they are based upon substantial evidence in the record before the court when that record is viewed as a whole. *Schutjer v. Algona Manor Care Ctr.*, 780 N.W.2d 549, 557 (Iowa 2010) (quoting Iowa Code section 17A.19 (10)(*f*)).

The court may grant relief from an agency action if it determines that the substantial rights of the claimant have been prejudiced because the agency action is unsupported by substantial evidence. *Grundmeyer*, 649 N.W.2d at 748. "Evidence is substantial if a reasonable person would find the evidence adequate to reach the same conclusion." *Id.* "(The) question is not whether there is sufficient evidence to warrant a decision the commissioner did not make, but rather whether there is sufficient evidence to warrant the decision he did make." *Musselman v. Cent. Tele. Co.*, 154 N.W.2d 128, 130 (Iowa 1967).

If the Commissioner's interpretation of law is the claimed error, the question on review is whether the Commissioner's interpretation was erroneous. *Clark v. Vicorp Rests., Inc.*, 696 N.W.2d 596, 604 (Iowa 2005). If the Commissioner's ultimate conclusion is the claimed error, "then the challenge is to the agency's application of the law to the facts, and the question on review is whether the agency abused its discretion by, for example, employing wholly irrational reasoning or ignoring important and relevant evidence." *Meyer v. IBP, Inc*., 710 N.W.2d 213, 219 (Iowa 2006); Iowa Code § 17A.19(10)(*i*), (*j*).

ANALYSIS

A. Permanent Disability to the Left Lower Extremity. Petitioner argues the Commissioner's determination that Respondent sustained a sequela injury to his left knee as a secondary effect of his right ankle injury should be reversed. At the agency level, a claimant must prove by a preponderance of the evidence that the injury actually occurred and that it both arose out of and in the course of the claimant's employment. *Quaker Oats Co. v. Ciha*, 552 N.W.2d 143, 150 (Iowa 1996). The claimant further has the burden at the agency level of proving by a preponderance of the evidence that the injury is a proximate cause of the claimed disability. *Schutjer*, 780 N.W.2d at 560.

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 effected by the accuracy of the facts that the expert relied upon as well as the 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, 652 (Iowa 2000); *IBP, Inc. v. Harpole*, 621 N.W.2d 410, 419-20 (Iowa 2001).

Although many injuries have a traumatic onset, there is no requirement for a special incident or unusual occurrence. Injuries that result from cumulative trauma are compensable. *Oldham v. Scofield & Welch*, 266 N.W. 480, 481-82 (Iowa 1936). As the Iowa Supreme Court explained in *Oldham*:

> If the employee suffers a compensable injury and thereafter suffers further disability which is the proximate result of the original injury, such further disability is compensable. Where an employee suffers a compensable injury and thereafter returns to work and, as a result thereof, his first injury is aggravated and accelerated

> so that he is greater disabled than before, the entire disability may be compensated for.

Id. at 481. This is known as a sequela of the original injury. A sequela can be an after effect or secondary effect of an injury. *Powers v. Trimark Physician's Grp.*, 2005 WL 8149431 (Iowa Workers' Comp. Comm'n) at *5 (Sept. 5, 2005). When analyzing worker's compensation appeals, courts recognize the law "should be, within reason, liberally construed" to benefit working men and women. *W. Des Moines Cmty. Schs v. Fry*, No. 13-1391, 2014 WL 5475510, at *3 (Iowa Ct. App. Oct. 29, 2014).

Here, the parties agree that Respondent sustained a right ankle injury arising out of and in the course of his employment on April 3, 2012. Because of ongoing right ankle pain and weakness, Dr. Pyevich had Respondent fitted with a right ankle pullover brace with metal supports. The brace kept Respondent's foot and ankle in a high position, making it difficult for him to walk.

After he was placed in a fitted right ankle brace in 2013, Respondent began to limp and suffered stress to his left knee. He was pain free in that knee in the relevant past prior to that time. Shortly after he was released after his first right ankle surgery, and with continued right lower extremity pain, Respondent began to overcompensate by shifting his weight to his left leg when he walked. His left knee pain began to increase. He had to elevate it and use ice, heat, and over the counter medication for pain management. By August 2013, the left knee pain was bad enough that Respondent complained to Dr. Garrels, who eventually referred him back to Dr. Pyevich.

Respondent's pain was in and around his left knee, described in Dr. Garrels' record as "left knee, lateral knee, top and lower left leg." Further, Dr. Garrels spoke with Petitioner's risk department. Dr. Garrels' notes indicate he was advised that the left knee was part of Respondent's foot/ankle case number and, if it was really hurting, Respondent should go to the emergency room or Dr. Pyevich.

On August 19, 2013, Respondent saw Dr. Pyevich. Dr. Pyevich ordered x-ray studies of Respondent's left knee. Despite Respondent's left knee pain being worse with walking, standing, twisting, kneeling, and direct pressure, the August 19 x-ray studies were unremarkable with no identifiable pathology.[2]

The radiological studies establish that in August 2013, Respondent's left knee was arthritis free. (Arb. Dec. at p. 11, ¶ 4). The next radiographs taken about two years later on July 28, 2015, established that since August 2013, Respondent had developed tricompartmental arthritis and squaring of the femoral condyle, with bone on bone arthritis with osteophyte of the medial femoral condyle. Respondent's independent medical examiner Dr. Jameson opined that:

> I believe [Respondent's] work related injury to his right ankle led to the progressive rapid arthritic condition to his left knee. His multiple surgeries on his right ankle and compensating for his right ankle with his left lower extremity (specifically his left knee) ultimately led to the need for left total knee arthroplasty. When reviewing 08/19/2013 x-rays . . . the medial and lateral compartment of both knees are symmetrical. There is no arthritic condition present. After his left knee injury while on the boat dock, his 07/27/2015 MRI showed his meniscus tear . . . (and) shows significant arthritic change in the medial compartment of the left knee with extrusion of the medial meniscus as well as squaring and flattening of the medial femoral condyle with essentially bone on bone arthritis in the medial compartment of the left knee.

(Arb. Dec. at p. 7, ¶ 3; Appeal Dec. at pp. 2-3).

Dr. Jameson further opined that the only cause for the rapid progression of Respondent's left knee arthritic condition, based upon the comparison of the 2013 x-rays and the 2015 MRI, is his compensation for his right ankle condition with his left lower extremity. The Deputy—and ultimately the Commissioner—found Respondent's left knee condition was a sequela injury of the

[2] Dr. Pyevich noted that "[Respondent's] left patella femoral pain began since [Respondent] started wearing the brace on his right ankle." This appears not to have been relied upon by the Deputy in her analysis.

right ankle injury and was a permanent injury. Likewise the Commissioner found that Dr. Jameson's opinion was the most sound:

> Based on claimant's historical testimony and the x-rays and MRIs which show rapid degeneration of claimant's left knee, it is found the claimant's left knee pain leading up to July 2015 was related to the right ankle injury. While the meniscus tear was the result of the boat injury on July 12, 2015, the knee replacement was necessitated by the arthritis according to Dr. Jameson. Dr. Jameson's examination of the x-rays and MRIs is consistent with claimant's history and are more convincing than the medical note of Dr. Bries and the opinion of Dr. Jacobson.
>
> Dr. Jacobson's opinion argues that the rapid degeneration occurred after the removal of the meniscus, but a comparison between the 2013 x-rays and the MRI of 2015 reveal the degeneration occurred prior to the first knee surgery. Thus, Dr. Jameson's opinion is more sound.
>
> Therefore, it is found that the claimant's total knee replacement is related to the right ankle injury.

(Arb. Dec. pp. 11-12; Appeal Dec. at pp. 2-3).

Petitioner criticizes Dr. Jameson's opinion and, more specifically, the findings of the Commissioner. Petitioner's argument is based primarily upon the records Dr. Garrels. Petitioner argues Dr. Garrels did not note in his records complaints of left knee pain. The radiological studies establish that in August 2013, Respondent's left knee was arthritis free. The next radiographs taken on July 28, 2015, established that in the intervening two years since Respondent began wearing the right ankle brace, he developed tricompartmental arthritis and squaring of the femoral condyle with bone on bone arthritis and osteophyte formation of the medial femoral condyle.

The court must give "due regard to the Commissioner's discretion to accept or reject testimony based on his assessment of witness credibility." *Presbyterian Homes & Servs., Inc*. No. 19-0010, 2020 WL 108373, at *9 (Iowa Ct. App. Jan. 9, 2020) (citation omitted). The evidence cited above coupled with the findings of the Commissioner that both Respondent and his wife were

credible, as well as the testimony of Respondent's supervisor that Respondent's gait was not fluid and that Respondent limped at work sufficiently support the Commissioner's ultimate finding.[3]

It is well-settled that the ultimate determination of whether to accept or reject an expert opinion in whole or in part is within the peculiar province of the Commissioner. *Deaver v. Armstrong Rubber Co*., 170 N.W.2d 455, 464 (Iowa 1969). The Deputy was entitled to weigh the expert opinions as well as the lay testimony and accept that information she found more credible. In his de novo review of the evidentiary record from the arbitration hearing, the Commissioner was entitled to affirm the Deputy's findings of fact on the experts' opinions. Each of Petitioner's criticisms are met with credible contradictory evidence in the record.

The Commissioner's decision adopting the Deputy's decision is supported by substantial evidence and is not arbitrary, capricious, irrational or illogical. This outcome dispenses with Petitioner's unavailing arguments regarding whether Respondent's left knee injury, arthritis, and need for corrective left knee surgery arose of out and in the course of Respondent's employment.

B. Temporary Total Disability/Healing Benefits for the Time Periods of September 10, 2015, Through October 21, 2015, and March 21, 2016 through May 23, 2016. Petitioner also argues the award of temporary total benefits for September 10, 2015, through October 21, 2015 (for surgery to repair the torn left meniscus), and March 21, 2016, through May 23, 2016 (for total knee replacement surgery), was improper because neither the meniscal tear nor the total knee replacement were sequela of the injury to Respondent's right ankle. Petitioner further argues that the Deputy failed to perform an analysis of each surgery individually.

[3] The emergency room record at the time of the boat dock incident on July 12, 2015, indicates that Respondent presented to the emergency room with complaints of left knee pain for the past six months that had increased in the past week. (App. Dec. at p. 5, ¶ 2).

In her decision, the Deputy set forth a detailed analysis for each of her findings. The Deputy chronicled the development of Respondent's left knee pain, which appeared prior to the incident on the boat dock. Respondent complained of left knee pain for months leading up to that incident as well as worsening pain within the week prior to the incident and documented that the injury in July 2015 was secondary to the right ankle injury.

According to Dr. Jameson, the MRI of July 27, 2015, showed bone on bone arthritis which was significantly advanced before the boat dock incident. Further, it was Dr. Jameson's opinion, adopted by the Deputy, that the total knee replacement was the result of the quickly progressing arthritis which began as a result of (1) Respondent compensating for his right ankle when he walked and (2) the bracing of his right ankle placing greater strain on his left knee. The question is not whether the evidence in this record supports a different finding than the finding made by the Commissioner, but rather whether the evidence supports the finding the Commissioner actually made. *IBP, Inc*., 710 N.W.2d at 218.

There is substantial evidence in the record from which the Commissioner could and ultimately did find that the periods of temporary disability from September 10, 2015, through October 1, 2015, and March 21, 2016, through May 23, 2016, for Respondent's left knee surgeries were sequela injuries of Respondent's right ankle injury. This is not, as Petitioner appears to argue, a case where the Commissioner failed to consider important facts. The Commissioner considered and interpreted the important facts differently from the way Petitioner argues they should be interpreted. The Deputy evaluated the conflicting medical evaluations of Respondent's various treating doctors and properly identified Respondent's left knee injury as a work-related sequela injury of Respondent's right ankle injury. The Commissioner's decision adopting the Deputy's findings and conclusions on this issue is supported by substantial evidence and is not irrational,

illogical, arbitrary, capricious or an abuse of discretion. Petitioner's contrary arguments are unavailing.

C. <u>Past and Future Medical Expenses Related to the Left Knee Injury</u>. Petitioner argues it should not be responsible for medical expenses related to Respondent's left knee. This argument is primarily based upon Petitioner's position that Respondent's left knee injury was not a sequela injury of his right ankle injury.

The analysis directly above applies with equal force here. Iowa Code section 85.27(1) provides that an employer shall furnish reasonable medical services and supplies for injuries compensable under workers' compensation. *Midwest Ambulance Serv. v. Ruud*, 754 N.W.2d 860, 867 (Iowa 2008). As discussed above, the Deputy's decision—adopted by the Commissioner—that Respondent's left knee injury is a sequela injury of Respondent's right ankle injury is supported by substantial evidence. Because the knee injury and related surgeries are sequela, the Commissioner correctly found that the medical bills related to treatment of the left knee condition are compensable and that Petitioner is responsible for future care and treatment to the left knee. The Commissioner's determination adopting the Deputy's decision on this issue is supported by substantial evidence and is not irrational, illogical, arbitrary, capricious or an abuse of discretion. Petitioner's contrary argument on this issue is unavailing.

CONCLUSION

The Commissioner's ultimate decision on all issues raised by Petitioner is supported by substantial evidence and should affirmed. The Petition should be dismissed. Costs should be assessed to Petitioner.

ORDER

IT IS THEREFORE ORDERED, ADJUDGED AND DECREED that the final agency decision by the Commissioner is affirmed and the Petition is dismissed.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that costs are assessed to Petitioner.

State of Iowa Courts

Type: OTHER ORDER

Case Number	**Case Title**
CVCV059021	CITY OF DAVENPORT VS ARTHUR L BARTLESON

So Ordered

Jeanie Vaudt, District Court Judge,
Fifth Judicial District of Iowa