BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

CHRISTY LINK, Claimant, vs. OPERATION NEW VIEW, Employer, and ACUITY, Insurance Carrier, Defendants.	FILED JUN 09 2016 WORKERS COMPENSATION File No. 5052215 ARBITRATION DECISION Head Note Nos.: 1108; 1402.40; 1402.60

STATEMENT OF THE CASE

Christy Link, claimant, filed a petition in arbitration seeking workers' compensation benefits from Operation New View, and their workers' compensation carrier, Acuity. Hearing was held on March 4, 2016. Presiding at the hearing was Deputy Workers' Compensation Commissioner Erin Q. Pals.

Claimant, Christy Link, was the only witness who testified live at trial. The evidentiary record also includes claimant's exhibits 1-11 and defendants' exhibits A-J. The parties submitted a hearing report at the commencement of the evidentiary hearing. On the hearing report, the parties entered into certain stipulations. Those stipulations are accepted and relied upon in this decision. No findings of fact or conclusions of law will be made with respect to the parties' stipulations.

The parties requested the opportunity for post-hearing briefs, which were submitted on April 7, 2016.

ISSUES

The parties submitted the following issues for resolution:

1. Whether the stipulated February 16, 2012, work injury is the cause of permanent disability. If so, the extent of claimant's entitlement to industrial disability.

2. Whether claimant is entitled to payment of past medical expenses.

3. Whether claimant is entitled to alternate medical care.

4. Whether there should be a suspension of benefits for claimant's failure to attend an evaluation pursuant to Iowa Code section 85.39.

5. Assessment of costs.

FINDINGS OF FACT

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

Claimant has alleged a February 16, 2012, work injury to her low back and legs. Defendants admit Ms. Link sustained a work injury. However, defendants contend Ms. Link sustained a temporary aggravation of a preexisting or underlying condition and did not sustain any permanent impairment or disability as a result of the injury. I find that Ms. Link sustained a temporary aggravation of an underlying condition and did not sustain any permanent impairment or disability as a result of the work injury.

On February 16, 2012, Ms. Link was employed at Operation New View. She was working as a teacher associate for children ranging in age from three to five years old. At the time of the injury she was leaning over to set a child down when she felt a sharp pain in her back. This event occurred around noon. She was able to finish her shift, which ended around 1:30 or 1:45. She reported the incident to the office that same day. She testified that her neck and legs were not affected, just her low back. She had low back pain the remainder of the day. (Testimony)

Ms. Link testified that she did experience low back pain prior to February 16, 2012. Approximately one year before the injury she had some pain for approximately one week as the result of shoveling snow. She treated for this pain one time at Finley Hospital. She was given some muscle relaxers and pain pills. This pain did not cause her to miss any time from work. Prior to this work injury she did not have a lumbar MRI nor did she have any permanent restrictions. (Testimony)

The medical records show that Ms. Link experienced tenderness over her sacroiliac (SI) joint in early 2003, for which she sought treatment. The notes indicate that she had recently delivered a baby. Reconditioning was recommended. (Exhibit A, page 1) There are no additional treatment notes in evidence until 2010. At that time, Ms. Link sought treatment for right flank pain that was radiating closer to her back. The assessment was low back pain. She was treated conservatively for musculoskeletal back pain. (Ex. A, pp. 2-3) The next treatment note is dated February 2, 2011, Ms. Link sought treatment for back pain and pain in her right forearm after shoveling snow. She was assessed as having a back strain and muscle spasm. She was prescribed cyclobenzaprine and Lortab. (Ex. A. pp. 4-5) These are the extent of the pre-February 16, 2012, records in evidence.

During the night after the February 16, 2012, work injury in question, Ms. Link woke with sharp pain during the night. She decided to seek treatment because her pain increased. That next day she was seen at Tri-State Occupational. She reported that while carrying and putting a three-year-old onto a pillow, she felt something in her low back area. She rated her pain as 7-8 out of 10. She denied any pain or numbness down into her legs. She was assessed with low back pain, lumbosacral sprain. Ms. Link was treated conservatively and released back to work with restrictions. She was to stand, walk, and sit as needed, lift up to 10 pounds from knee to shoulder. No climbing, squatting, running or jumping. She was also instructed to limit bending, lifting, or twisting of her back. (Ex. 1, pp. 1- 3; Testimony)

In late February 2012 and early March 2012, Ms. Link received some conservative treatment at Mercy Medical Center. By March 2, 2012, Ms. Link was coming along quite well. She reported some tightness in the early a.m. The assessment was low back pain. (Ex. A, pp. 6-12)

She continued to follow-up with Tri-State for conservative treatment, including physical therapy. While treating at Tri-State she saw Michael Steinberg, M.D. and Joseph Garrity, M.D. Ms. Link testified that during her four months of treatment at Tri-State she had ups and downs, but she knew she was not getting better. She continued working during these four months, but she was not able to get on the floor, run around with the children, or lift them. Her employer accommodated her restrictions. (Testimony: Ex. 1, pp. 4-17)

On April 17, 2012, Ms. Link went to the emergency department at Finley Hospital in Dubuque. She testified that she had severe back pain that was so intense she felt she had to go to the E.R. The notes indicate she was reporting mild to moderate low back pain. She was also reporting bilateral feet pain. (Ex. 2)

Ms. Link reported to Unity Point Health Emergency Department on April 27, 2014. The records indicate she was working as a housekeeper at Mercy. She complained of "kidney pain" for three days. (Ex. B, p. 13) They were not able to determine the reason for her flank pain or blood in her urine. (Ex. B)

Ms. Link was seen by Dr. Garrity at Tri-State on June 18, 2012. She reported her pain as a 2/3 when sitting. However, her concern was developing of numbness in the lateral aspect of her thighs. The notes indicate that the numbness seemed to begin essentially at the time of her last physical therapy appointment in March 2012. Dr. Garrity instructed her to follow up with her family doctor and if he felt this was of work origin then they would readjust. He placed her at maximum medical improvement (MMI) as far as her back was concerned. The notes indicate that Ms. Link had talked to the case manager and the company was scheduling her to see a spine specialist. She was released to return to regular duty on June 18, 2012. (Ex. 1, pp. 18-19; Testimony)

On June 27, 2012, Ms. Link was seen at ORA Orthopedics, P.C. by Timothy P. Millea, M.D. She was referred to Dr. Millea by the workers' compensation carrier for problems related to a back injury on February 19, 2012. Dr. Millea noted an immediate onset of pain in her lower back at the time of the injury. This was followed by some stiffness and a dull aching pain. Her pain had been persistent. The doctor noted she had undergone physical therapy, but she reported that after the manipulation of her lower back she developed numbness over the lateral aspects of her bilateral hips. The notes indicate that she was currently off work for summer break. Dr. Millea's impression was subacute low back pain without radiculopathy. He recommended an MRI. His suspicion of a surgically significant problem was low, but given her lack of improvement, he felt imaging was appropriate. (Ex. 3, pp.28-29)

Ms. Link returned to see Dr. Millea on July 30, 2012, after undergoing the MRI. He felt the MRI demonstrated age-appropriate degenerative changes, most notably at the L4-L5 level. There was also a small protrusion at that level but without significant neurocompression. Dr. Millea felt the MRI scan was reassuring as there was no indication that surgery was warranted. He recommended additional conservative treatment, including a trial epidural injection with Timothy J. Miller, M.D. (Ex. 3, p. 30)

On August 9, 2012, Ms. Link was seen by Dr. Tim Miller at Finley Pain Clinic. She reported a work injury with back pain. She also reported that she developed bilateral paresthesias down the lateral aspect of her thighs to her knees. Dr. Miller felt the pattern was very suspicious for lateral femoral cutaneous neuropathy. He noted that this had occurred after chiropractic or after physical therapy adjustment and he strongly suspected that it may have led from that. He reassured her that this was usually transient and should resolve. He noted that her distribution was wrong for the L4-L5 nerve root. Dr. Miller performed a lumbar epidural steroid injection at L4-L5. (Ex. 4, pp. 47-53)

Ms. Link returned to Dr. Millea on August 23, 2012, after undergoing her MRI. Following an epidural injection she reported some rather significant improvement in her symptoms. He updated her restrictions to 20-pound weight limit for lifting and carrying. Sitting, driving, standing, and walking as tolerated. (Ex. 3, p. 31)

Dr. Miller performed a second epidural steroid injection on September 6, 2012. (Ex. 4, p. 54-55)

On September 17, 2012, Ms. Link reported to Dr. Millea that the second injection was providing slow but continuing improvement. Her restrictions were adjusted to a 30 pound lift limit. (Ex. 3, p. 33)

Ms. Link was seen by Dr. Millea on October 22, 2012. She reported that the injection performed on September 6, 2012, had provided some improvement over the first couple of weeks. However, over the past couple of weeks her symptoms had started to recur. She was scheduled for a third injection. However, if there was not

significant lasting improvement with this third injection then the doctor felt perhaps surgical treatment should be considered. Dr. Millea noted that Ms. Link demonstrated more nerve root tension than she had previously. (Ex. 3, p. 35) On October 22, 2012, Dr. Millea also restricted Ms. Link from work on October 8, 2012, due to an acute exacerbation of low back and left hip pain. (Ex. 3, p. 36) Dr. Millea also stated that she was unable to work on October 23, 2012, but the she could return to work on October 24, 2012. (Ex. 3, p. 37)

Dr. Miller performed the third epidural steroid injection on October 22, 2012. (Ex. 4, p. 56-57)

Ms. Link returned to see Dr. Millea on November 5, 2012. She reported that she did not really improve from her third injection. In fact, she thought the second and third injections actually caused her low back to be more painful and irritated. Dr. Millea explained that given her lack of improvement and her MRI scan he was hesitant to recommend operative care. He recommended a repeat MRI. (Ex. 3, p. 38)

On November 26, 2012, Ms. Link saw Dr. Millea. She reported her symptoms were basically the same. Dr. Millea reviewed the second MRI and noted that there really was not a particularly impressive lesion. He did not think there was anything further from an invasive or interventional standpoint that would be likely to provide further improvement. He felt her chances of improvement in the future were greater without surgery than with surgery. He recommended an FCE to obtain a reliable indication of permanent restrictions. (Ex. 3, p. 40)

On January 14, 2013, Ms. Link was seen by David S. Field, M.D. for an evaluation at the request of the defendants. At that time, she reported some low back pain and numbness in the lateral sides of each leg. She reported increased pain with walking. Sitting caused more of a burning sensation in her legs. Dr. Field examined Ms. Link and reviewed the medical records provided to him. He felt that she had a mild degree of degenerative disk wear within her lumbar spine with more of a myofasical pain in her low back. Dr. Field strongly recommended conservative treatment. He also recommended smoking cessation and weight loss. Dr. Field felt her major diagnosis was myofascial-type pain in the low back. However, Dr. Field could not be certain that the February 16, 2012, incident was a continuous source of her pain. Dr. Field opined that Dr. Garrity's MMI date of June of 2012 was appropriate. Dr. Field did not feel there was any impairment as a result of the work injury. (Ex. 5, pp. 89-93)

On February 13, 2013, Acuity sent a letter to Ms. Link advising that, based on Dr. Field's opinion, they were not accepting any future treatment for her February 17, 2012 injury. (Ex. 8)

Dr. Miller saw Ms. Link again on August 8, 2013. He recommended maintenance medication management and exercise therapy. He noted she did not have any

radiating symptoms down her legs. She had relatively modest effect with epidural. She continued to follow-up with Dr. Miller. (Ex. 4, pp. 58-61)

On February 27, 2014, Ms. Link returned to Dr. Miller with back and right leg pain. She reported she was generally doing well. She was working with a dietitian on weight loss with the plan of proceeding with bariatric surgery. Dr. Miller indicated that part of her leg pain was due to lateral femoral cutaneous neuropathy, part was degenerative change with radicular symptoms. At that time, Ms. Link was using hydrocodone for breakthrough pain. Dr. Miller continued this. He felt weight loss would be a huge benefit for her in many ways, including her back and leg pain. (Ex. 4, pp. 62-64)

Ms. Link presented to Dr. Miller on June 2, 2014, with back and right leg discomfort. She reported being stable on hydrocodone. She was considering switching to a job that would be less stressful. (Ex. 4, p. 65)

On June 8, 2014, Dr. Millea authored a letter expressing his opinions regarding Ms. Link. Dr. Millea stated: "Ms. Link's reported injury would seem to be related to her reported work injury. I do not have any information regarding a prior history of low back-related problems. She does, indeed, have degenerative changes of the lumbar spine of an age-appropriate nature, but in the absence of symptoms prior to the work injury, the reported incident would be at least aggravation of an underlying degenerative process." (Ex. 3, p. 45) He diagnosed her with chronic low back pain without significant radiculopathy. He recommended a functional capacity evaluation (FCE) to help determine her permanent restrictions. (Ex. 3, pp. 44-45)

Ms. Link underwent an FCE on September 11, 2014. She was found to have given maximum effort. The FCE placed her in the light work category for 8 hours per day, 40 hours per week. (Ex. 6)

Ms. Link returned to Dr. Miller on September 25, 2014 with low back pain that radiated down her bilateral posterior thighs. She reported numbness and tingling and the pain was an 8 at its worst. It was noted that she had gastric bypass surgery last month and had been doing very well since. She would like a little bit overall better pain relief. Dr. Miller refilled her hydrocodone and also started her on Cymbalta. She continued to follow-up with his office. (Ex. 4, pp. 66-80)

On February 4, 2015, Dr. Millea opined that Ms. Link sustained 8 percent whole person functional impairment related to the work injury. He assigned permanent work restrictions as follows: 20-pound lift limit between waist and shoulder levels; 10-pound lift limit below waist level and above shoulder level; no repetitive work activities below waist or above shoulder levels; no repetitive being or twisting of the lower back; and she should be allowed to change between sitting and standing positions as needed for comfort. (Ex. 3, p. 46)

Ms. Link returned to Dr. Miller's office on August 19, 2015. She reported persistent low back pain that did not radiate down either lower extremity. She had been increasing her activity and had noticed a certain increase in the pain and she was concerned because she was starting back to work in a couple of weeks and she would have to stand a lot for her job. She is concerned about potential pain. Her oxycodone was increased. (Ex. 4, pp. 81-82) She continued to follow-up with his office. The last in evidence is dated December 7, 2015. (Ex. 4, pp. 87-88)

On February 4, 2016, Joshua D. Kimelman, D.O. of Iowa Ortho performed a records review at the request of the defendants. (Ex. D) Dr. Kimelman was originally scheduled for an independent medical evaluation (IME), but due to difficulty in the availability of the patient he was only able to perform a records review. After reviewing the records, Dr. Kimelman's impression was lumbosacral strain with lateral femoral cutaneous nerve irritation, most likely related to impingement over the brim of the pelvis as was typical for meralgia paresthetica, and therefore, this was not related to work. He explained that she had no evidence of femoral stretch test on prior exams and thus it was not related to any manipulation she had received. He noted she had lost 125 pounds, which was probably very helpful to her meralgia paresthetica. In the records he reviewed she complained of back pain, but not paresthesias in her lateral thighs. (Ex. D)

Dr. Kimelman opined that Ms. Link did sustain an injury to her back/legs as a result of the work injury. She was subsequently treated, her pain was brought down to a level 2, and she was able to resume full active duty. He believes that an appropriate diagnosis was lumbosacral strain with subsequent development of meralgia paresthetica which was unrelated to her back injury. He agreed with Dr. Field that she had reached MMI by February 16, 2012. Dr. Kimelman noted that she was taking reasonably high doses of narcotic pain medications. However, based on Dr. Garrity and Dr. Field's notes, he noted she had been able to return to full functional level without narcotic pain medication and her pain was 2 out of 10 so he opined she did not have any impairment. He did not recommend any additional treatment as a result of the work injury. Dr. Kimelman also did not assign any permanent restrictions as a result of the work injury. (Ex. D)

On March 1, 2016, defense counsel took the deposition of Dr. Millea. (Ex. J) During the deposition it became clear that Dr. Millea formed his opinions on an incomplete history. At the time Dr. Millea issued his opinions in this matter, he did not have the benefit of treatment records both before and after the work injury. He was not aware that Ms. Link experienced symptoms in her low back and treated for the symptoms prior to February 16, 2012. Additionally, he did not have the benefit of the records which demonstrate that Ms. Link described the pain she was initially experiencing after the work injury as the same as what she had experienced while shoveling snow a year or two before the work injury. (Ex. J, pp. 5-8, 14-15, 16-31; Ex. 1, p. 1) Unfortunately, Dr. Millea was also not provided copies of the Tri-State Occupational progress notes or physical therapy notes. These notes show that

Ms. Link made steady progress during her treatment with Dr. Stenberg and Dr. Garrity as well as during physical therapy. (Ex. J, pp.18-19, 27-28) He did not know that Ms. Link reported being pain-free at her visit with Dr. Garrity. (Ex. J, pp.26-28; Ex. 1, p. 16) Dr. Millea testified that it was important to have all the information regarding a patient's prior medical history and treatment before forming and expressing an opinion regarding causation. (Ex. J, pp. 19, 31) In his deposition, Dr. Millea agreed that it would have been important to have this type of information. It is unknown whether Dr. Millea's opinions would have been different if he had been provided this information prior to rendering his opinions. Dr. Millea was not asked if his opinions remained the same in light of the additional medical evidence. (Ex. J) Therefore, as defendants point out, there is no evidence as to Dr. Millea's opinions on causation, impairment, or restrictions after he had a full and accurate understanding of the facts. I find that because Dr. Millea rendered his opinions without a complete and accurate history, his opinion cannot be relied upon.

The first issue that must be addressed is whether the February 16, 2012 work injury was the cause of permanent disability. There are conflicting expert medical opinions regarding permanency. Claimant relies on the opinion of Dr. Millea to support her claim for permanency benefits. Defendants rely on the opinions of Dr. Garrity, Dr. Field, and Dr. Kimelman, all of whom opined that Ms. Link was at MMI by June 18, 2012 and sustained no permanent impairment causally connected to the February 16, 2012 work injury. (Ex. 1, p. 19, Ex. 5, p. 93, Ex. D, pp. 27-31) In the present case, the record is void of a reliable expert opinion that supports claimant's contention that she sustained permanent disability as a result of the work injury. As noted above, because Dr. Millea rendered his opinions without a complete and accurate history his opinion cannot be relied upon. I find that claimant has demonstrated that she sustained a soft tissue injury which arose out of and the course of her employment on February 16, 2012. This soft tissue injury was a temporary aggravation. I find that she reached maximum medical improvement as of June 18, 2012. (Ex. 1, p. 18; Ex. 5; Ex. D) Therefore, I find claimant has not carried her burden of proof to show that she sustained permanent injury as a result of the work injury.

We now turn to the issue of whether claimant is entitled to payment of medical expenses. Specifically, claimant is seeking an award of medical expenses for low back treatment incurred after her care was terminated by the defendants. In a February 13, 2013, letter defendants terminated claimant's care. (Ex. 8) As noted above, claimant has failed to offer any expert opinion, which is based on an accurate and complete history, to show that her ongoing symptoms are related to the work injury. There is no reliable expert opinion which supports claimant's contention that the low back treatment she received after February 13, 2013, is related to the work injury. Thus, I find that claimant has failed to show entitlement to medical expenses for low back treatment incurred after her care was terminated by the defendants.

Claimant is also seeking as award of further medical care under Iowa Code section 85.27. Because there is no reliable medical opinion to support claimant's

contention that her ongoing symptoms are related to the work injury, I find claimant has failed to demonstrate entitlement to ongoing medical care under Iowa Code section 85.27.

We now turn to the issue of suspension of benefits. On the hearing report, defendants assert that there should be a suspension of benefits for claimant's failure to attend an evaluation pursuant to Iowa Code section 85.39. However, because claimant failed to prove entitlement to any benefits during the timeframe in question, the issue is moot.

The final issue to be addressed is costs. Costs are to be assessed at the discretion of the deputy commissioner hearing the case. Because claimant was generally not successful in her case, I find it is not appropriate to assess costs in this matter. Each party shall pay their own costs.

CONCLUSIONS OF LAW

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

The claimant has the burden of proving by a preponderance of the evidence that the injury is a proximate cause of the disability on which the claim is based. A cause is proximate if it is a substantial factor in bringing about the result; it need not be the only cause. A preponderance of the evidence exists when the causal connection is probable rather than merely possible. George A. Hormel & Co. v. Jordan, 569 N.W.2d 148 (Iowa 1997); Frye v. Smith-Doyle Contractors, 569 N.W.2d 154 (Iowa App. 1997); Sanchez v. Blue Bird Midwest, 554 N.W.2d 283 (Iowa App. 1996).

The question of causal connection is essentially within the domain of expert testimony. The expert medical evidence must be considered with all other evidence introduced bearing on the causal connection between the injury and the disability. Supportive lay testimony may be used to buttress the expert testimony and, therefore, is also relevant and material to the causation question. The weight to be given to an expert opinion is determined by the finder of fact and may be affected by the accuracy of the facts the expert relied upon as well as other surrounding circumstances. The expert opinion may be accepted or rejected, in whole or in part. St. Luke's Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); IBP, Inc. v. Harpole, 621 N.W.2d 410 (Iowa 2001); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995). Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417 (Iowa 1994). Unrebutted expert medical testimony cannot be summarily rejected. Poula v. Siouxland Wall & Ceiling, Inc., 516 N.W.2d 910 (Iowa App. 1994).

Based on the above findings of fact, I conclude that claimant has failed to carry her burden of proof to show by a preponderance of the evidence that she sustained any

permanent disability as a result of the February 16, 2012, work injury. I further conclude that Ms. Link has failed to prove entitlement to any permanent partial disability benefits.

The employer shall furnish reasonable surgical, medical, dental, osteopathic, chiropractic, podiatric, physical rehabilitation, nursing, ambulance, and hospital services and supplies for all conditions compensable under the workers' compensation law. The employer shall also allow reasonable and necessary transportation expenses incurred for those services. The employer has the right to choose the provider of care, except where the employer has denied liability for the injury. Section 85.27. Holbert v. Townsend Engineering Co., Thirty-second Biennial Report of the Industrial Commissioner 78 (Review-Reopening October 16, 1975).

As noted in the above findings of fact, I conclude that claimant has failed to carry her burden of proof to demonstrate that the medical expenses she is seeking reimbursement for were incurred as a result of the work injury. Because the evidence does not demonstrate that the expenses were incurred as a result of the work injury, I conclude that defendants are not liable for the medical expenses for which claimant seeks reimbursement.

Likewise, based on the above findings of fact, I conclude that claimant has failed to prove that any ongoing symptoms she may have are related to the work injury. Therefore, defendants are not liable for ongoing medical care.

Costs are to be assessed at the discretion of the deputy commissioner hearing the case. Because claimant was generally not successful in her claim, I conclude it is not appropriate to assess costs against the defendants. Thus, each party shall bear their own costs.

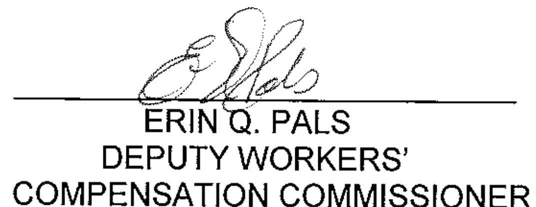
ORDER

THEREFORE, IT IS ORDERED:

Claimant shall take nothing further from these proceedings.

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 9th day of June, 2016.



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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.