BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

BRENDA STONEY n/k/a BRENDA BAILEY,

Claimant,

vs.

FINLEY HOSPITAL,

Employer,
Self-Insured,
Defendant.

FILED
JUN 18 2019
WORKERS COMPENSATION

File No. 5043593

ARBITRATION

DECISION

Head Note Nos.: 1804, 3000, 3002

STATEMENT OF THE CASE

This is a proceeding in arbitration. The contested case was initiated when claimant, Brenda Stoney, n/k/a Brenda Bailey, filed her original notice and petition with the Iowa Division of Workers' Compensation. The petition was filed on June 10, 2016. Claimant alleged she sustained work-related injuries on March 3, 2011. (Original notice and petition)

For purposes of workers' compensation, Finley Hospital, is self-insured. Defendant filed its answer on June 16, 2016. The defendant admitted the occurrence of the work injuries on March 3, 2011. A First Report of Injury was filed on August 25, 2011.

The hearing administrator scheduled the case for hearing on March 7, 2018. The hearing took place at 150 Des Moines Street in Des Moines, Iowa. The undersigned appointed Ms. Roxann Zuniga, as the certified shorthand reporter. She is the official custodian of the records and notes.

Claimant testified on her own behalf. Defendant elected not to call any witnesses to testify at the hearing. Joint Exhibits 1 through 2, 4 through 9, 11 through 15, 17 and 18 were admitted. Claimant offered Exhibits 1 through 8. Defendant objected to Exhibit 6 and it was excluded. Defendant offered Exhibits A through D. Claimant objected to Exhibit B, page 1. However it was admitted, as well as the remainder of defendant's exhibits. The aforementioned exhibits were admitted as evidence. The parties also submitted post-hearing briefs on August 6, 2018. The case was deemed fully submitted on that date. Because there was a need to obtain a permanency rating from Steven I. Grindel, M.D., at the time of the hearing, defendant was allowed 60 days to obtain a permanent impairment rating. Then claimant was allowed another 60 days to get any

additional supplemental independent medical reports that were deemed necessary. Briefs were originally scheduled to be filed on July 27, 2018. However, an extension was requested until August 6, 2018. The case was deemed fully submitted on August 6, 2018.

STIPULATIONS

The parties completed the designated hearing report. The various stipulations are:

1. There was the existence of an employer-employee relationship at the time of the alleged injury;

2. Claimant sustained an injury on March 3, 2011, which arose out of and in the course of her employment;

3. The injury is a cause of temporary disability;

4. The injury is a cause of permanent disability;

5. If permanency is found the parties agree the method of calculation is by the industrial manner;

6. The commencement date for any permanent partial disability benefits that may be due is August 29, 2011, interrupted by subsequent healing period;

7. Defendant waives any affirmative defenses it may have had available to it;

8. Claimant is entitled to be reimbursed for an independent medical examination pursuant to Iowa Code section 85.39 in the amount of $3,445.00 and defendant will hold claimant harmless from the payment of the bill; and;

9. The parties agree claimant has paid the costs listed.

ISSUES

The issues presented are:

1. Whether claimant is entitled to healing period benefits for the period from August 18, 2011 through August 28, 2011; February 13, 2012, through February 25, 2012; May 17, 2012 through May 19, 2012; November 5, 2012 through December 31, 2015; and September 30, 2017 through October 8, 2017. (Claimant admits the benefits were paid by defendant but claimant alleges the benefits were paid at the rate of $314.53 and should have been paid at the rate of $325.56 per week);

2. Although entitlement cannot be stipulated for this period of time, defendant does not admit claimant is even entitled to benefits for this period;

3. There is an issue as to the weekly benefit rate. Claimant alleges the rate is $325.56 per week; defendant maintains the weekly benefit rate is $314.53 per week; and,

4. There is a dispute as to the credit that has been paid to claimant for permanent partial disability benefits. Defendant states it had paid claimant 123 weeks of permanent partial disability benefits at the rate of $314.53 prior to the date of the hearing. Claimant maintains the weekly benefit rate is incorrect.

FINDINGS OF FACT

This deputy, after listening to the testimony of claimant, and after judging the credibility of the claimant, plus after reading the evidence, and the post-hearing briefs, makes the following findings of fact and conclusions of law:

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

Claimant is presently 52 years old and divorced with two adult children. At the time of her work injury, she was married and entitled to 3 exemptions. Claimant graduated from high school in 1985. She described herself as a "B" student. Claimant completed a two-year course in cosmetology from South West Vocational Technical College. However, she never practiced cosmetology. She also received a certificate as a certified nursing assistant in 1988. Claimant is right-hand dominant.

Claimant's prior work history consists of working in a concession stand at a movie theatre; working in a deli and as a cashier in a supermarket; working as a CNA in a hospital in Platteville, Wisconsin; claimant worked as a bank teller at First National Bank in Platteville; then she worked as a personal banker for American Bank in Lancaster.

In 2005, claimant commenced employment at Finley Hospital in Dubuque, Iowa. Personnel at the hospital hired claimant for the position of physical therapy technician at the hourly rate of $9.00 per hour. When claimant left the hospital she was earning $11.42 per hour. There were other benefits too. She worked some overtime hours. There was health insurance and a 401(K) plan for employees. Claimant testified she loved her job.

As a physical therapy technician, claimant assisted patients with their various exercises, she operated the ultrasound equipment, changed the beds, and performed other duties as assigned to her by a physical therapist.

On March 3, 2011, claimant was removing a cap from a CRT machine when she sprained her right thumb and had radiating pain to the right lateral forearm and into the right elbow joint. (Joint Exhibit 2, page 3) There was tingling in the thumb, index, and middle finger. (Jt. Ex. 2, p. 3)

Howard T. Kim, M.D., at Finley Occupational Health, diagnosed claimant with a "Right hand sprain." (Jt. Ex. 2, p. 4) The physician prescribed 800 mg ibuprofen to be taken 3 times per day with food. Dr. Kim dispensed a Colles' splint for claimant to wear on her right hand. (Jt. Ex. 2, p. 4) Claimant was restricted from lifting 2 pounds with her right hand and she was to refrain from gripping with the right hand. (Jt. Ex. 2, p. 5) A referral to occupational therapy was made. (Jt. Ex. 2, p. 6)

X-rays were taken of the right hand. The results showed:

> Impression: Soft tissue swelling thumb and index finger. No fracture or dislocation. Early arthrosis various joints of the hand.

(Jt. Ex. 2, p. 7)

Dr. Kim ordered magnetic resonance imaging (MRI). The results of the test showed:

> Multiple small ganglion cysts and nonspecific joint effusion.

(Jt. Ex. 4, p. 1)

Dr. Kim referred claimant to Ryan Cloos, D.O., at Dubuque Ortho. (Jt. Ex. 5) Dr. Cloos initially examined claimant on April 7, 2011. He found:

> Physical Examination: Distally she is neurovascularly intact. Sensation, motor intact in the ulnar, median, and radial, as well as AIN and PIN nerve distributions. She has negative Tinel's of the median nerve at the wrist. She has no pain with first CMC grind. She has tenderness to palpation along the first dorsal compartment, no significant tenderness to palpation at the anatomic snuff box, a little tenderness to palpation of the volar pole of the scaphoid. Positive Finkelstein's although it is not exquisite. No tenderness to palpation over the ulnar collateral ligament of the MCP joint.

(Jt. Ex. 5, p. 1)

Dr. Cloos injected 40 mg of Kenalog and 1 percent lidocaine into claimant's first dorsal compartment on the right. Claimant tolerated the procedure well. (Jt. Ex. 5, p. 1) However, on April 15, 2011, claimant reported her pain returned after one day. (Jt. Ex. 5, p. 3) The orthopedist placed claimant in a well molded short-arm thumb spica cast. Claimant was restricted from the use of her right upper extremity. Dr. Cloos diagnosed claimant with "Right radial nerve irritation." (Jt. Ex. 5, p. 3)

Mark Fortson, M.D., administered EMG testing on May 25, 2011. (Jt. Ex. 6, p. 1) The physician found: "NO EVIDENCE OF NERVE INJURY IN THE RIGHT RADIAL, MEDIAN OR ULNAR NERVES." (Jt. Ex. 6, p. 2)

On May 26, 2011, claimant had a second injection. The injection was into the right radial styloid and the injection consisted of ½ cc of 1 percent plain lidocaine, 10 mg Kenalog and 1 mg of Decadron. Claimant tolerated the procedure well. (Jt. Ex. 5, p. 5)

Defendant sent claimant to Tyson K. Cobb, M.D., an orthopedist at Orthopedic Specialists in Davenport, Iowa. (Jt. Ex. 7) Dr. Cobb conducted a physical examination of claimant's upper extremities. He found:

> PHYSICAL EXAMINATION: On examination height is 5 feet 5 inches. Weight is 220 pounds. The musculoskeletal form was completed and reviewed. The proximal aspect of the right upper extremity is functional and intact. Range of motion for right and left respectively is flexion 60/70, extension 73/76, radial deviation 26/29, ulnar deviation 37/28, supination 90/90, and pronation 90/90. Jamar manual muscle testing of the upper extremity is carried out in pounds, stages I-V. The right measures 31, 48, 50, 48, and 35. The left measures 55, 75, 66, 60, and 46. Key pinch is 16 on the right and 21 on the left. Three-point is 15 on the right and 18 on the left. Two-point discrimination is 5 mm throughout. The patient has some tenderness over the 1st dorsal compartment and mildly positive Finkelstein maneuver. The patient has marked tenderness over the radial styloid and in the region of the snuffbox. She also has marked tenderness under the FCR tendon in the region of the snuffbox. She also has marked tenderness under the FCR tendon in the region where the cyst was noted on the MRI. The pain is rated as a 6 on a scale of 1-10 over the radial styloid, 3 over the 1st dorsal compartment, 5 over the scapholunate ligament dorsally. Watson maneuver is negative.

(Jt. Ex. 7, p. 2)

Dr. Cobb diagnosed claimant with:

> 1. Right wrist de Quervain tenosynovitis, minimally symptomatic status post 2 prior injections.
>
> 2. Volar radial cyst deep to FCR tendon.
>
> 3. Probable partial scapholunate ligament tear with radial styloid impingement pain.

(Jt. Ex. 7, p. 3)

Dr. Cobb suggested claimant undergo right wrist arthroscopy with treatment of scapholunate ligament tear, a possible open, and if indicated excision of volar radial

mass, and a possible open release of the first dorsal compartment. Dr. Cobb was willing to perform the surgery if requested by defendant. (Jt. Ex. 7, p. 3)

On August 18, 2011, Dr. Cobb performed a number of surgical procedures on claimant's right wrist. The procedures consisted of:

1. Right wrist arthroscopy with debridement of scapholunate partial tear.

2. Pinning of lax scapholunate joint.

3. 1st dorsal compartment release.

4. Excision of mass volar-radial aspect of right wrist.

(Ex. 8, p. 1)

In a post-surgical appointment on September 7, 2011, claimant complained of stiffness and swelling. (Jt. Ex. 7, p. 6) Dr. Cobb placed claimant in another short-arm thumb spica cast. Therapy was ordered, and claimant was restricted from using her right upper extremity. (Jt. Ex. 7, p. 6)

Claimant returned to Dr. Cobb for follow up care. On October 10, 2011, Dr. Cobb noted the pin site looked good. There was no erythema or drainage. Claimant was apprehensive about the range of motion of her thumb. However, Dr. Cobb found the range of motion to be reasonable. Claimant's skin and nails looked good. She could make a complete fist. Claimant was advised to return within the next two to three weeks.

Claimant's next appointment occurred on October 25, 2011. Claimant complained of a burning pain at her pin site. (Jt. Ex. 7, p. 40) She was slowly able to extend her fingers completely. She was able to flex her fingers to her palm. It did take claimant a longer period of time to flex the index finger than the other ones. (Jt. Ex. 7, p. 10) Dr. Cobb placed claimant back into another short-arm thumb spica cast. She was restricted from working with her right upper extremity. (Jt. Ex. 7, p. 10)

On November 8, 2011, the pins were removed from the scapholunate ligament. (Jt. Ex. 7, p. 11) Claimant was given stretching exercises to perform on her own. Formal therapy was also prescribed. Claimant was restricted from using her right upper extremity for three weeks and then she could use her right upper extremity so long as she did not lift more than five pounds. (Jt. Ex. 7, p. 11)

Even though claimant was treating with Dr. Cobb for her right wrist, she was also treating at Finley Occupational Health with Dr. Cloos for left shoulder symptoms. The initial complaint occurred on October 26, 2011. Claimant described the pain as stabbing in nature. (Jt. Ex. 2, p. 15) Claimant visited with Lois Pancratz, ARNP, on

October 28, 2011. Claimant provided the following medical history to the nurse practitioner:

> SUBJECTIVE: This 44-year-old right-hand dominant employee of Finley Hospital comes into the office today for her initial evaluation of left shoulder pain which has been present for approximately the past 2 days. She is currently under the care of orthopedic specialist in Davenport for a scapholunate ligament tear which was repaired on 08/18/2011. She is currently casted on the right and has absolutely no use of the right hand. As a result she has been doing everything with her left arm and feels that she has gotten herself into her repetitive motion type of injury. She has some intermittent tingling in the left index and [*sic*] finger and thumb, but no locking of the shoulder or any history of any recent injuries.

(Jt. Ex. 2, p. 16)

Dr. Kim examined claimant on November 3, 2011. The physician found claimant had some left shoulder tenderness lateral to the acromioclavicular joint anteriorly. There was abduction to approximately 90 degrees and anterior flexion to approximately 100 degrees actively. Claimant was unable to complete internal and external rotation secondary to pain. Dr. Kim diagnosed claimant with: "Left shoulder impingement syndrome." (Jt. Ex. 2, p. 19) Dr. Kim opined a referral to an orthopedic specialist would be appropriate.

Dr. Cloos examined claimant on November 21, 2011. Claimant explained she had no injury but had been working with her left upper extremity only. She had an overuse type injury. Dr. Cloos performed a physical examination of the left shoulder. He did not surmise there was a rotator cuff tear. This was an overuse type injury because claimant could not use her right upper extremity. The official diagnosis was "Left shoulder pain likely impingement." (Jt. Ex. 5, p. 7)

On the same day, Dr. Cloos injected the left shoulder subacromial space with 2 cc's of 1 percent plain lidocaine, 40 mg of Kenalog, and 4 mg of Decadron. Claimant tolerated the procedure well. Dr. Cloos recommended home exercises for claimant too. (Jt. Ex. 5, p. 7)

Claimant returned to Dr. Cloos on December 19, 2011. Claimant was feeling better following the injection. She had been performing her home exercises. Dr. Cloos told claimant to return in six months. (Jt. Ex. 5, p. 8)

On June 12, 2012, claimant returned to Dr. Cloos. The left shoulder condition had resolved. Claimant reported the injection and home exercises assisted claimant with her recovery. (Jt. Ex. 5, p. 9) Dr. Cloos opined claimant was at maximum medical improvement effective that date. There was a zero percent permanent impairment rating for the left shoulder. Claimant was released to return to work without any restrictions for her left shoulder, she was to return on a prn basis. (Jt. Ex. 5, p. 9)

Claimant returned to see Dr. Cobb on January 10, 2012. Claimant described increasing pain despite the fact she had been attending therapy three times per week and engaging in aggressive stretching. (Jt. Ex. 7, p. 14) Dr. Cobb conducted a physical examination of the right wrist. He found:

> PHYSICAL EXAMINATION: Musculoskeletal examination form was completed and reviewed today. On examination today flexion is 36, extension 60, radical deviation 12, ulnar deviation 17, supination 89 and pronation 90. Jamar manual muscle testing of the upper extremity is carried out in pounds, stages I-V. The right measures 25/38/32/25/24, and the left measures 70/71/67/57/47. Key pinch on the right is 13 and 20 on the left. Three-point on the right is 12 and 18 on the left. Two-point discrimination is 4 mm throughout. There is tenderness over the scapholunate region and also over the ulnar styloid region.

(Jt. Ex. 7, p. 14)

Radiographs of the right wrist were ordered. They showed some widening of the scapholunate with some biomechanical shift. (Jt. Ex. 7, p. 14) Dr. Cobb continued the five pound lifting restriction. Claimant was told to return in one month. (Jt. Ex. 7, p. 14) On January 27, 2012, claimant returned to see Dr. Cobb. The orthopedist conducted a physical examination. The results revealed:

> PHYSICAL EXAMINATION: Musculoskeletal examination form was completed and reviewed today. On physical examination today, Brenda continues to have quite a lot of pain to palpation over the scapholunate interval. Jamar manual muscle testing on right in position 2 is 41 an [*sic*] on the left is 79. Lateral pinch on the right is 14 and on the left is 21. Three-point on the right is 11 and on the left is 19. Active range of motion of the wrist reveals flexion is 56 and extension to 61. She continues to have about a 2-3/10 pain to palpation over the ulnar styloid.

(Jt. Ex. 7, p. 16)

Claimant received an injection of 1 cc of lidocaine and 1 cc of Celestone. The injection went into the scapholunate interval. (Jt. Ex. 7, p. 16) Claimant was advised to return in 2 weeks.

On February 2, 2012, claimant returned for another appointment with Dr. Cobb. The orthopedic surgeon determined claimant's condition at the time was:

> IMPRESSION:
>
> 1. Status post scapholunate ligament tear, failed scapholunate debridement and pinning 08/18/11.

2. Atrophy over the region of the 1st dorsal compartment and radial styloid, status post release and multiple prior cortisone injections.

(Jt. Ex. 7, p. 18)

Dr. Cobb discussed a variety of surgical procedures with claimant. On February 13, 2012, Dr. Cobb performed a right wrist open scapholunate ligament repair with denervation and fat grafting. A plastic splint was placed over the incision. (Jt. Ex. 9, pp. 1, 3)

On February 21, 2012, Dr. Cobb placed claimant into a short-arm thumb spica cast. Claimant was restricted to desk work only: she was to ice and elevate her arm as needed and no use of the right upper extremity. (Jt. Ex. 7, p. 21) Claimant continued to see Dr. Cobb for follow up care and to receive different short-arm thumb spica casts.

Claimant injured her right hand on April 4, 2012 when she attempted to open a door. She saw Dr. Cobb on the same day. Claimant explained she felt a very sharp pain moving in her hand through her wrist and upper forearm. She said the pain was so severe she almost dropped to her knees. (Jt. Ex. 7, p. 24) X-rays were taken. There were no significant changes other than a slight radial migration of the most proximal K-wire. (Ex. 7, p. 24) Another short-arm thumb spica cast was supplied. The cast left the fingers free as well as the interphalangeal joint of the thumb. Dr. Cobb encouraged claimant to work on range of motion. (Jt. Ex. 7, p. 24)

The next appointment with Dr. Cobb occurred on April 16, 2012. (Jt. Ex. 7, p. 25) Dr. Cobb discovered claimant's most proximal K-wire had eroded through the skin. The wire was very loose. Dr. Cobb pulled out the pin without any complications. The doctor ordered an antibiotic. (Jt. Ex. 7, p. 25)

Ten days later, claimant returned to see Dr. Cobb. Claimant complained of discomfort over the pin site. She also had numbness and tingling in the ulnar nerve distribution and some pain over the medial side of the elbow. Dr. Cobb found after conducting a physical examination:

PHYSICAL EXAMINATION: Musculoskeletal examination form was completed and reviewed today. On examination the elbow is supple. There is positive Tinel's over the ulnar nerve at the elbow. The elbow range of motion is full. She does have a little bit of irritability over the superficial branch of the radial nerve but overall the pain in the wrist seems to be gradually dissipating. She does continue to have pain over the pin site. There is no erythema. There is no swelling. The pin is not prominent. Skin is well healed. 2 point discrimination is 5mm. throughout.

(Jt. Ex. 7, p. 26)

Dr. Cobb determined the pins in claimant's wrist needed to be removed. The orthopedic surgeon also diagnosed claimant with right cubital tunnel syndrome secondary to the wrist injury. (Jt. Ex. 7, p. 26)

On September 13, 2012, claimant discussed additional surgical options with Dr. Cobb. Claimant reported she was primarily performing drug testing at the hospital. The same restrictions remained in place. (Jt. Ex. 7, p. 37)

On October 31, 2012, claimant and Dr. Cobb discussed additional surgical options to pursue for the right wrist. (Jt. Ex. 7, pp. 40-41) Claimant wanted to proceed with a right wrist fusion. Dr. Cobb explained many people who had a wrist fusion were unhappy with the results. Nevertheless, claimant wanted to proceed with the surgery. (Jt. Ex. 7, p. 41)

Dr. Cobb performed the following surgical procedures on November 5, 2012:

1. Right wrist fusion with Synthes dorsal wrist fusion plate with bone grafting.

2. First dorsal compartment release with synovectomy and tenolysis.

3. Second dorsal compartment release with synovectomy and tenolysis.

4. Open carpal tunnel release.

5. Fat grafting for scar contracture.

6. Denervation including posterior interosseus, anterior interosseus, and superficial branch of radial nerve and superficial branch of ulnar nerve and ulnar recurrent.

(Jt. Ex. 9, p. 5)

The incision was closed and a volar plaster splint was placed over the incision. Claimant left the operating room in satisfactory condition. (Jt. Ex. 9, p. 7)

On November 21, 2012, claimant returned to Dr. Cobb for a post-surgical follow-up examination. (Jt. Ex. 7, p. 45) Claimant reported no significant pain. She was able to extend her middle and ring fingers more than on prior occasions. Claimant could make a good fist. Two-point discrimination was 5 mm throughout. (Jt. Ex. 7, p. 45) Claimant was prohibited from using her right arm. (Jt. Ex. 7, p. 46)

When claimant met with Dr. Cobb on January 7, 2013, she complained of some forearm musculature tenderness on the lateral epicondyle. Claimant did have tenderness to palpation over the lateral epicondyle. Claimant was placed back into another cast. She was restricted from using her right arm. (Jt. Ex. 7, p. 48)

Effective February 19, 2013, Dr. Cobb provided claimant with a splint. The doctor did not want claimant to use her right hand. (Jt. Ex. 7, p. 50)

On March 28, 2013, Dr. Cobb conducted a physical examination of claimant's right wrist. He noted:

> PHYSICAL EXAMINATION: Musculoskeletal examination form was completed and reviewed today. On physical examination today, there is some tenderness over the plate dorsally. There is no erythema. She does have one region centrally over the scar that has an indention or it appears that a fat graft did not take. Otherwise, she has good feeling of the previously contracted scar. Two-point discrimination is 5mm. throughout.

(Jt. Ex. 7, p. 52)

X-rays showed a progression of healing. (Jt. Ex. 7, p. 52) Dr. Cobb imposed a ten pound work restriction. (Jt. Ex. 7, p. 52) The physician also ordered occupational therapy with a focus on dexterity. (Jt. Ex. 7, p. 55) Claimant was very concerned about the cosmetic appearance of her scar. (Jt. Ex. 7, p. 56)

On May 2, 2013, Dr. Cobb performed: "Release of scar adhesions with tenolysis and fat grafting from periumbilical region to scar contracture, right wrist." (Jt. Ex. 9, p. 8) Claimant was removed from the operating room in satisfactory condition. (Jt. Ex. 9, p. 9)

Dr. Cobb examined claimant five days post-surgery. The orthopedic surgeon was very pleased with the results of the surgery. The scar contracture had resolved. The hand was much more cosmetically pleasing to the eye. (Jt. Ex. 7, p. 59)

When claimant returned to see Dr. Cobb on June 19, 2013, there were new complaints voiced. Claimant had ongoing pain in the wrist. She had some weakness in the upper extremity, including the rotator cuff, the right shoulder, and the hand. (Jt. Ex. 7, p. 60) Radiographs of the right hand showed maintenance of position without definite complete union. (Jt. Ex. 7, p. 60) Dr. Cobb wanted claimant to return to therapy for her right upper extremity conditioning with strengthening to include the shoulder, elbow and hand. (Jt. Ex. 7, p. 60) Claimant was kept on a ten pound weight restriction. (Jt. Ex. 7, p. 60)

Claimant continued to complain of wrist pain. On January 2, 2014, Dr. Cobb decided to proceed with right wrist hardware removal. (Jt. Ex. 7, p. 66) On January 13, 2014, Dr. Cobb performed the following surgical procedures:

1. Removal of hardware.

2. Debridement of nonunion site.

3. Bone grafting of nonunion site from distal radius.

4. Open reduction and internal fixation of nonunion site with dorsal plate.

5. Denervation of posterior interosseous nerve and ulnar recurrent nerves.

(Jt. Ex. 9, p. 10) Claimant was removed from the operating room in satisfactory condition.

Claimant returned to Dr. Cobb on January 22, 2014 for follow up treatment. Dr. Cobb informed claimant he would order a bone stimulator because there was a non-union of the middle finger carpometacarpal ((CMC) joint with bone grafting and replating on January 13, 2014. (Jt. Ex. 7, p. 68) Claimant was restricted from using her right hand. (Jt. Ex. 7, p. 68) Both physical and occupational therapy were ordered. (Jt. Ex. 7, p. 69)

On February 12, 2014, claimant was placed back into a short-arm cast. The bone stimulator was placed directly over the CMC non-union. Claimant was restricted from using her right hand. (Jt. Ex. 7, p. 70)

Claimant returned to Dr. Cobb on March 4, 2014 with complaints about the bone stimulator. The bone stimulator implant in the cast was placing pressure on the fracture site. The cast was removed. There were some marks on the skin consistent with a pressure area. (Jt. Ex. 7, p. 71) Dr. Cobb decided to try a bone stimulator that could be converted to a snap-on stimulator. Claimant could wear the stimulator for 20 minutes per day. Dr. Cobb limited claimant to lifting 3 pounds or less and no repetitive motion. (Jt. Ex. 7, p. 71)

Claimant returned to Dr. Cobb on April 21, 2014. X-rays of the wrist showed no definite change. The bone stimulator was continued. Claimant could perform light duty work only. (Jt. Ex. 7, p. 72)

It was not until July 8, 2014 that claimant again visited Dr. Cobb. X-rays of the right wrist showed only minimal changes. (Jt. Ex. 7, p. 73) Dr. Cobb ordered a CT scan of the right wrist to evaluate whether the plate had loosened and to determine if there had been a complete fusion of the CMC joint of the right middle finger. (Jt. Ex. 7, p. 74)

Dr. Cobb provided the results of the CT scan to claimant on July 16, 2014. The CT scan showed a definite union at the radiocarpal joint. Dr. Cobb opined the third CMC joint appeared healed along the most dorsal margin, it was questionable whether the deeper levels had healed. The orthopedic surgeon believed the plate was fairly well fixed. However, he did not want to remove the plate at that current time. (Jt. Ex. 7, p. 75)

Claimant presented for a second opinion on September 12, 2014. She saw Amy K. Franta, M.D., at Meriter Hospital, Inc., in Madison, Wisconsin. Claimant reported to Dr. Franta:

> The pain is currently localized to the dorsal wrist and radial wrist. She points to an area from the radial wrist extending onto the dorsal wrist along the radiocarpal joint. The pain is dull, sharp, burning, constant and achy. The pain is worse with activity and sometimes weather. She notes pain extending into the middle and index fingers mainly with extension. Notes tightness of these fingers with ROM also. Mainly the burning is along the dorsal distal forearm in the intersection region but also along the palm in the region of her CTR incision. The patient has tried splinting, therapies, injections, Lyrica without improvement. As noted above she has had multiple prior surgeries. None of which have helped her pain. Patient admits to numbness and tingling of the hand and wrist area that mainly involves the wrist and dorsal hand. No tingling in the digits. Notes hypersensitivity and color changes to right hand as compared to the left.

(Jt. Ex. 13, pp. 2-3)

Dr. Franta conducted a physical examination of claimant's right wrist and hand. (Jt. Ex. 13, p. 4) The physician noted:

> Right wrist and hand: Skin is intact. Multiple prior incisions – all well healed including dorsal, radial, and volar. Swelling present radical to distal tip of dorsal incision, and radially along distal forearm.
>
> Range of Motion: N/A-plate pronation 0-90 supination 0-70
>
> Palpation: dorsal wrist, radial sensory nerve distribution, volar palm-carpal tunnel area.
>
> Stability: N/A- plate
>
> Swelling: dorsal right hand, and distal forearm. Mottled skin palm of right hand but not into forearm or dorsally.
>
> Alignment: normal
>
> Special tests: Finkelstein's Not tested, Fromment's sign negative. Flexor and extensor tendons to hand and wrist intact.
>
> Sensory: Phalen's at 60 sec unable to test, [T]inel's at wrist positive, sensation to light touch abnormal in the median distributions to light touch but intact elsewhere. Tinel's positive over superficial radial nerve.

Motor strength: EPL, FPL, FF, EDC, thumb opposition, IO Intact. No atrophy

Pulses: Radial present. Good capillary refill.

(Jt. Ex. 13, p. 4)

Dr. Franta diagnosed claimant with "right wrist pain s/p multiple prior surgeries following an injury at work." (Jt. Ex. 13, p. 4) Dr. Franta tested for reflex sympathetic dystrophy (RSD). However, the test results indicated no findings to suggest RSD. (Jt. Ex. 13, p. 5)

Claimant returned to Dr. Franta on January 9, 2015. (Jt. Ex. 13, p. 7) The doctor explained the following to claimant:

Diagnosis:
Right wrist pain s/p multiple prior surgeries by outside orthopedist including a wrist fusion.

Decision making: The diagnosis and results of the patient's imaging studies were discussed in detail with the patient/family. Reviewed that I do not see a solid fusion at the wrist and 3rd CMC joint. Appears fairly solid along radioscaphoid but not at radiolunate articulation. Some lucencies persist at capitate articulation and 3rd CMC joint see best on prior CT. XR do not show much change from July studies despite continued use of bone stimulator. Reviewed options and expectations today. I have recommended that the patient see Dr. Grindel in Milwaukee for his opinion on whether a repeat fusion would be of benefit. I did explain to patient that I would not feel comfortable at this time removing the plate.

Plan:
Dr. Grindel was contacted for referral. Referral order placed if Dr. Grindel willing to see patient.

(Jt. Ex. 13, p. 7)

Steven Grindel, M.D., practices orthopedic surgery in Milwaukee, Wisconsin. He agreed to treat claimant for her right wrist conditions. (Jt. Ex. 14) Dr. Grindel performed a deep hardware removal and scar revision procedure on February 25, 2015. (Jt. Ex. 14, p. 3) There were no complications. Claimant was discharged to her home. (Jt. Ex. 14, p. 4)

Claimant visited Dr. Grindel on March 5, 2015 for a post-operative review. Sutures were removed. Both physical and occupational therapy were ordered. Claimant was instructed to engage in home therapy and stretching. (Jt. Ex. 14, p. 9)

Claimant reported she was experiencing stress due to the multiple right wrist surgeries she had undergone. (Jt. Ex. 14, p. 14) An external referral for psychology services was ordered. (Jt. Ex. 14, p. 15)

On April 14, 2015, claimant was allowed to return to full-time work with temporary restrictions. Claimant could engage in light paperwork duties with her right upper extremity. She was unable to lift more than one to two pounds with her right upper extremity and she was not to engage in repetitive activities with her right upper extremity. (Jt. Ex. 14, p. 16)

Claimant returned to see Dr. Grindel on May 26, 2015. Claimant indicated her pain was slightly worse than prior to her latest surgery. (Jt. Ex. 14, p. 17) The pain was primarily over the posterior right wrist. (Jt. Ex. 14, p. 17) The physician's assistant examined claimant on May 26th. He found:

> O: Incision is healed. There is no warmth, erythema, or other sign of infection. Digit motion is near full without pain, but still some minor stiffness at the MP joints. All flexor and extensor tendons are intact. She has no active wrist range of motion due to prior fusion. Forearm range of motion is 70 degree supination/full pronation. She has full sensation to the right hand. TTP at the posterior base of the right index metacarpal. Thumb CMC grind test and Finkelstein's test are negative.
>
> Hypersensitivity over the right posterior wrist scar, mildly improved from last visit. Scar is mobile.
>
> Radiographs 3/5/15: Evidence of prior wrist fusion with hardware removed.
>
> A: Status post the above, 3 months out doing appropriately.
>
> Some issues coping with her limitations and pain, pending psych referral.

(Jt. Ex. 14, p. 18)

Pursuant to a request from defendant, claimant underwent a neuropsychology consult by Daniel T. Tranel, PhD, at the University of Iowa Hospitals and Clinics. (Jt. Ex. 17) The consultation occurred on June 16, 2015. Dr. Tranel opined:

> Our evaluation of Ms. Bailey indicates that she has average to low average intellectual functioning and all of her cognitive abilities (memory, speech and language, perception and construction, attention, concentration, problem-solving, concept formation, executive functioning) are intact. Psychological evaluation does not indicate a diagnosable clinical condition or personality disorder. She is reporting some mild levels of depression and anxiety, but not to a degree that would qualify for a

formal diagnosis (e.g., under the DSM-5 nomenclature). She did not have any indication of malingering or symptom magnification in our examination, and she passed multiple direct and embedded performance and symptom validity measures.

In summary, our evaluation does not indicate that Ms. Bailey has a diagnosable psychological or psychiatric disorder or condition. As such, there are no relevant questions about whether the work incident on 3/3/11 caused a psychological/psychiatric disorder or a permanent psychological/psychiatric injury- it did not. Nor do we believe that the work incident produced any temporary psychological injury or material aggravation of pre-existing condition. However, it is our opinion within a reasonable degree of neuropsychological certainty that Ms. Bailey has ongoing pain issues related to her right wrist. Our evaluation indicates that Ms. Bailey would likely benefit from treatment from a clinical psychologist (or similarly credentialed provider) with expertise in treating pain disorders. We recommend that she be referred for cognitive-behavioral therapy with a clinical psychologist in her area (local providers may be found through the Iowa Psychological Association or Wisconsin Psychological Association.) Such treatment may be provided on weekly basis, for a period of approximately 3 to 12 months, and would be expected to significantly increase Ms. Bailey's ability to cope with her chronic pain. This recommendation is related to the 3/3/11 work incident.

We also recommend that Ms. Bailey participate in vocational rehabilitation. She may not be fit for the types of physically demanding jobs for which she would have been qualified prior to the 3/3/11 injury (this is outside the domain of expertise); however, she has intact cognitive abilities and normal intellectual functioning, and she is an excellent candidate for vocational rehabilitation. We do not see any reason that she could not become a fully functioning member of the work force, in some capacity that does not make demands on her right wrist. Our recommendation for vocational rehabilitation is related to the 3/3/11 work incident (although we would emphasize that the issue of whether the work incident directly caused a chronic physical injury to her right wrist is outside the scope of our expertise).

(Jt. Ex. 17, pp. 1-2)

Claimant participated in counseling services at Pauquette Center for Psychological Services from July 15, 2015 through November 2016. (Jt. Ex. 18, pp. 1-25) The counseling services resumed at the same center from November 24, 2017 through February 14, 2018. (Jt. Ex. 18, pp. 26-35)

During the summer of 2015, claimant returned to the offices of Dr. Grindel. On July 14, 2015, claimant saw Dara J. Mickschl, PA-C because claimant did not feel her

wrist had improved from prior to her surgery. (Jt. Ex. 14, p. 22) Claimant had persistent tenderness centrally along her scar. She also had an episode of swelling to the ulnar side of the scar distally. The episode lasted several days. (Jt. Ex. 14, p. 22) The physician's assistant noted objective signs of improvement to the right wrist in terms of pain, motion and function. (Jt. Ex. 14, p. 23) Claimant was advised to continue with physical therapy. (Jt. Ex. 14, p. 23) Claimant was encouraged to work with the restrictions previously imposed. (Jt. Ex. 14, p. 23)

Claimant returned to the Department of Orthopedic Surgery on August 25, 2015. (Jt. Ex. 14, p. 25) Claimant was placed on a restriction of paperwork only, no lifting greater than five pounds, and no repetitive use of the right hand. (Jt. Ex. 14, p. 25)

On October 6, 2015, Dr. Grindel opined there were signs of objective improvement in the right wrist in terms of pain, motion, and function. (Jt. Ex. 14, p. 26) On December 8, 2015, claimant had some tenderness along her scar. (Jt. Ex. 14, p. 27) She described her pain as constant. (Jt. Ex. 14, p. 27) The pain was unchanged from her prior visit. (Jt. Ex. 14, p. 27)

On January 19, 2016, claimant returned to be seen and examined by Dr. Grindel. (Jt. Ex. 14, p. 28) Claimant complained of left carpal tunnel syndrome and left shoulder pain for approximately four years. There was no traumatic injury to the left shoulder but claimant had to use her left upper extremity since she could not use the right one. The problems in the right shoulder were similar but to a lesser degree. (Jt. Ex. 14, p. 28) There was acromioclavicular joint pain on the left shoulder but not on the right. (Jt. Ex. 14, p. 31) Dr. Grindel opined the upper extremity issues were causally related to claimant's right wrist injury. (Jt. Ex. 14, p. 34)

Claimant's counsel sent his client for an independent medical examination pursuant to Iowa Code section 85.39. Mark C. Taylor, M.D., MPH, examined claimant on January 25, 2016. (Cl. Ex. 3) Dr. Taylor issued his report on March 21, 2016. Firstly, Dr. Taylor was under the mistaken impression claimant was not working at the time of the evaluation and that claimant had not worked since she left the employ of Finley Hospital. (Cl. Ex. 3, p. 6) Claimant had worked since she left her employment as a physical therapy technician.

Dr. Taylor diagnosed the following conditions as related to claimant's work injury on March 3, 2011:

1. Right wrist injury resulting in multiple surgeries and eventual fusion.

2. Left upper extremity carpal tunnel syndrome.

3. Right long trigger finger.

4. Left shoulder pain/impingement.

(Cl. Ex. 3, p. 9)

Dr. Taylor provided a permanent impairment rating for claimant's work-related conditions. He wrote:

> **Impairment Rating**
>
> Based upon the reasonably demonstrable objective findings, and using the *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition*, I would assign impairment as follows:
>
> Ms. Bailey underwent a right wrist fusion and on my evaluation, this appeared to be in a neutral position. As per Figure 16-28, on page 467, I would assign a 21% right upper extremity rating related to her right wrist ankylosis in a neutral position (for flexion/extension). Similarly, in looking at Figure 16-31, on page 469, I would assign an additional 9% right upper extremity impairment related to the ankylosis of the wrist as far as radial and ulnar deviation.
>
> When these values are combined according to the Combined Values Chart on page 604, the result is a 28% right upper extremity impairment rating. As per Table 16-3, on page 439, this converts to a 17% whole person impairment rating, if indicated.
>
> I cannot presently assign an impairment rating with regard to her left shoulder symptoms or with regard to her left carpal tunnel syndrome. These have not yet been fully addressed. If she were to undergo a carpal tunnel release, the instructions on page 495 would likely apply with a maximum 5% left upper extremity impairment related to a carpal tunnel release.
>
> As far as her left shoulder, the impairment rating would depend on multiple factors, especially her range of motion. However, such measurements can only be obtained when she is placed at maximum medical improvement.

(Cl. Ex. 3, pp. 10-11)

Dr. Taylor imposed some restrictions. He opined:

> As far as the right upper extremity, I would recommend that she avoid lifting more than 2 or 3 pounds. She has significant weakness and residual pain, as well as a fused wrist. She can use her right upper extremity occasionally for very light paperwork and occasional handwriting, as tolerated. She should avoid repetitive use of the right upper extremity and no forceful gripping or grasping or any activities that require movement at the level of the wrist.

> Presently, I would recommend that she only engage in occasional overhead work with the left upper extremity and rarely with the right. On the right side, it is mainly due to the right wrist issues. She should not engage in forceful pushing or pulling with the right upper extremity. She should avoid the use of vibratory or power tools. She should avoid repetitive gripping and grasping and forceful gripping and grasping with the left hand due to the paresthesias and carpal tunnel syndrome. I would recommend a maximum of a 20-pound lifting limit mainly because she will have to rely almost exclusively on her left upper extremity.
>
> She should avoid crawling. She can sit, stand, and walk without specific restrictions. She can kneel occasionally. She should avoid ladders. She can climb stairs occasionally but most handrails are on the right and she will have to exercise caution in that regard. The right wrist fusion could also affect her ability to operate certain types of vehicles or equipment.

(Cl. Ex. 3, p. 11)

On February 16, 2016, claimant underwent MRI testing of the left shoulder. (Jt. Ex. 14, pp. 35-36) William H. Kim, M.D., interpreted the results as:

> 1. Very small linear intrasubstance tear at the supraspinatus tendinous insertion.
>
> 2. Tendinosis and bursal-sided fraying of the supraspinatus and anterior fibers of the infraspinatus.
>
> 3. Tendinosis and fraying of the distal fibers of the subscapularis.
>
> 4. Mild subacromioclavicular joint degenerative changes.
>
> 5. Small subacromial/subdeltoid bursal effusion.
>
> 6. Questionable SLAP tear. MR arthrography may be of benefit for further evaluation.
>
> 7. MR imaging findings concerning for adhesive capsulitis.

(Jt. Ex. 14, p. 36)

EMG testing and nerve conduction studies of the left hand were performed on February 16, 2016. (Jt. Ex. 14, pp. 37-48) The EMG studies confirmed claimant had moderate left-sided carpal tunnel syndrome. (Jt. Ex. 14, pp. 37, 47)

On February 23, 2016, claimant complained to Andrew J. Barnett, PA-C, about numbness and tingling throughout the left thumb and index finger, and locking of the right long finger. (Jt. Ex. 14, p. 46) The physician's assistant also found:

> +AC joint pain to the bilateral shoulder, mild TTP over the bilateral rotator cuff insertions, L > R. Positive impingement signs on the left, negative on the right.
>
> Left arm:
> Positive Tinel's at the cubital tunnel. No ulnar nerve subluxation. Intrinsic strength is good. Finger crossover test is negative. Wartenberg's test is negative.
>
> Positive Tinel's at the carpal tunnel. Positive Median nerve compression test.
>
> Sensation is full in the radial, ulnar, and median nerve distributions at rest.
>
> Neurovascular exam is otherwise normal.
>
> Right hand:
> TTP over the long finger A1 pulley. No palpable triggering on exam. Notta's node palpated at the long A1 pulley.
>
> **EMG 2/16/16:**
> 1. There is electrodiagnostic evidence of moderate median mononeuropathy at the left wrist (moderate left carpal tunnel syndrome). There is [*sic*] no electrical signs of active denervation to the left thenar muscles.
>
> 2. There is no electrodiagnostic evidence of ulnar mononeuropathy at the left elbow.
>
> 3. There is no electrodiagnostic evidence of C5-T1 radiculopathy in the left upper extremity.
>
> **Imaging:**
> Left shoulder MRI:
>
> 1. Very small linear intrasubstance tear at the supraspinatus tendinous insertion. 2. Tendinosis and bursal-sided fraying of the supraspinatus and anterior fibers of the infraspinatus. 3. Tendinosis and fraying of the distal fibers of the subscapularis. 4. Mild acromioclavicular joint degenerative changes. 5. Small subacromial/subdeltoid bursal effusion. 6. Questionable SLAP tear. MR arthrography may be of benefit

for further evaluation. 7. MR imaging findings concerning for adhesive capsulitis.

Left shoulder radiographs with maintained glenohumeral joint space with appearance of cyst formation with the glenoid. No fracture or dislocation.

Right shoulder radiographs with maintained glenohumeral and acromiohumeral joint space. No fracture or dislocation identified.

A:
Left shoulder partial rotator cuff tearing and early adhesive capsulitis

Moderate left carpal tunnel syndrome

Right long trigger finger

Right shoulder pain – no management yet

(Jt. Ex. 14, pp. 47-48)

After all of the test results and assessments were analyzed, Dr. Grindel recommended a left shoulder injection. The injection was comprised of 4 cc of 1 percent lidocaine with epinephrine and 6 mg of betamethasone. The injection was placed into the left shoulder subacromial space under sterile conditions. There was some immediate improvement. (Jt. Ex. 14, p. 48)

Dr. Grindel also recommended a left carpal tunnel release. Claimant agreed with the recommendation. (Jt. Ex. 14, p. 48)

On April 6, 2016, Dr. Grindel performed a left carpal tunnel release, a left long finger trigger release, and a right long finger trigger release injection. (Jt. Ex. 14, p. 51) There were no complications. Claimant was taken to the recovery room and eventually discharged to home. (Jt. Ex. 14, p. 52)

Claimant followed-up with the physician's assistant on April 14, 2016. Claimant appeared to be improving following surgery. She was taking Norco for pain at night. (Jt. Ex. 14, p. 52) The sutures were removed and claimant was instructed on proper care for her conditions. (Jt. Ex. 14, p. 53)

On May 18, 2016, claimant saw Darren S. Nabor, M.D., for a six week post-surgical examination. Dr. Nabor found claimant to be doing well. The patient was released and told to follow up with Dr. Grindel on a prn basis. (Jt. Ex. 14, p. 54)

On July 19, 2016, Ms. Ann Vrotsos, a claims adjuster with the third party administrator for CBCS, sent a letter to Dr. Grindel relative to issues of permanent impairment. (Jt. Ex. 14, pp. 55-56) There were 12 questions posed to the doctor.

Dr. Grindel provided handwritten responses. The undersigned deputy found the answers nearly illegible. Counsel for claimant drafted a letter to Dr. Grindel on November 2, 2017 requesting a clarification of Dr. Grindel's previous answers. (Jt. Ex. 14, pp. 65-66) Unfortunately, Dr. Grindel again provided hand-written responses which were extremely difficult to interpret. (Jt. Ex. 14, pp. 68-69)

On May 30, 2018, Dr. Grindel provided his final written report in which he clarified his opinions. The orthopedic surgeon assigned the following permanent impairment ratings for the various injuries as follows:

1. 35 percent permanent partial impairment rating for the right upper extremity for the right wrist injury with a maximum medical improvement (MMI), date of December 8, 2015;

2. 12 percent permanent partial impairment rating for the right shoulder with the MMI date of April 14, 2016;

3. 2 percent permanent partial impairment rating for the left shoulder with the MMI date of April 14, 2016;

4. 16 percent permanent partial impairment rating for the left carpal tunnel with the MMI date of June 6, 2016;

5. 2 percent permanent partial impairment rating for the right long trigger finger with the MMI date of October 9, 2017.

(Jt. Ex. 14, p. 69)

Both claimant and defendant agreed in their respective briefs; Dr. Grindel clarified his permanent impairment ratings in his letter dated May 30, 2018. Dr. Grindel confirmed his prior 16 percent permanent partial impairment rating of the left upper extremity included the trigger finger release. Dr. Grindel additionally rated claimant's right carpal tunnel release at 10 percent of the upper extremity. The new and final "combined" whole-body permanent partial impairment rating was 41 percent when taking into account each condition and related impairment rating. (Jt. Ex. 14, p. 30)

Dr. Grindel provided final permanent restrictions for the right upper extremity. Claimant is restricted to paperwork. She is not to lift greater than five pounds with her right upper extremity. She is not to engage in repetitive use of the right upper extremity. With respect to the left upper extremity, claimant is not to engage in repetitive or forceful work. (Jt. Ex. 14, p. 30)

Each party retained the services of a vocational expert to provide expert opinions. Claimant retained the services of Ms. Barbara Laughlin, M.A. to provide an employability assessment. She was not retained to find employment for claimant. (Cl. Ex. 4) Counsel for claimant supplied various documents to Ms. Laughlin for her review. Ms. Laughlin stated she based her assessment on claimant's age, education, past work,

her transferable skills, the site of claimant's injuries, her work restrictions, and claimant's ability to engage in employment for which she is fitted. (Cl. Ex. 4, p. 1)

Ms. Laughlin concluded:

> It is my opinion Ms. Bailey has sustained a debilitating injuries [*sic*] to her upper extremities. Any reduction in handling, reaching or fingering is enormously limiting. Fingering involves keying and this would preclude work involving repetitive data entry or keyboarding. She lacks competitive computer abilities, but could not perform slower repetitive data entry. She has difficulty writing. It is my opinion she will be unable to locate and maintain any work in any quality, quantity or dependability. As well, she lives in a resort area, and many jobs are seasonal. [*sic*] It is my opinion that she is so handicapped that she is not regularly employable in any well known branch of the labor market. It is unlikely that she can sell her services in a competitive labor market undistorted by such factors as business booms, sympathy of a particular employer or friend, or temporary good luck.

(Cl. Ex. 4, p. 11)

Defendant retained the vocational services of Ms. Lana Sellner, MS, CRC, a vocational case manager with ENCORE UNLIMITED, LLC. Ms. Sellner prepared a vocational assessment, dated January 19, 2018. (Defendant's Ex. C) The vocational consultant performed a file review only. Ms. Sellner concluded:

> **Recommendations and Conclusions**
>
> Based on the information presented, it is this consultant's opinion that Ms. Bailey is employable in the Baraboo, WI geographical locations [*sic*]. Ms. Bailey has had interviews and has attempted returning to work since her reported date of injury. She was working as a personal care attendant but due to a personal matter, was no longer able to remain employed. Ms. Bailey reported she was able to successfully complete the job duties for the position. As for other interviews, it is unknown of the status of these interviews. In regards to her attempt to work as a housekeeping, [*sic*] it was just not a good fit due to reaching. In regards to hostess position, some employers, such as Texas Roadhouse, do not require hostess [*sic*] to do more than seat the guests and some do require it so it is very employer-specific and should not be precluded.
>
> This consultant identified positions and potential employers which are available within her labor market which continues to change. This consultant her work history, education and medical restrictions. [*sic*] This consultant has considered her limitations, especially with upper extremities limitations. To note, keying on a computer does not involve

> gripping or grasping. Neither medical professional restricted Ms. Bailey from keying. Again, as the workforce is evolving in the understanding of wellness, many ergonomics are in place or self-modifications are allowed for better worker/job match. This consultant would recommend Ms. Bailey to utilize the Wisconsin Job Center, located at 505 Broadway St. #232, Baraboo, WI 53913.

(Def. Ex. C, pp. 8-9)

Claimant last worked at Finley Hospital on November 4, 2012. That was the day before she underwent her fourth surgery by Dr. Cobb. She was never allowed to return to work after that fourth surgery.

In April of 2013, claimant received a telephone call from Ms. Wendy Scholbrock. Claimant was informed her position was combined with another position held by Mr. Blake Pickle. Ms. Scholbrock informed claimant that she could reapply for her job. Claimant did so and had an interview. However, the position was awarded to Mr. Pickle. (Allegedly, Mr. Pickle was the cousin of claimant's supervisor, and Mrs. Pickle worked in the Department of Human Resources at Finley Hospital.) On May 7, 2013, claimant received a letter from Ms. Carla Walkedig in the Human Resources Department at the hospital. Management offered claimant a severance package. She did not take the package. She applied and interviewed for several other positions at the hospital. One position was an appointment clerk in the physical therapy department. Despite having several interviews, claimant was not offered any positions.

In 2014, claimant and her then fiancé assisted her fiancé's mother with operating her group home called Spring Acres or Willis Springs. Claimant worked with seven to eight residents. She received some compensation and room and board.

In October of 2014, claimant moved into the home of her fiancé's aunt. Two brothers with disabilities were also living in the home. Claimant assisted the two brothers. The business was called, "Hilltop Homestead." Claimant was paid $756.00 bi-weekly for her full-time job. In addition to socializing with the brothers, claimant performed laundry, cooked, cleaned and provided transportation for the individuals. Claimant held the position until September 29, 2017. Because she and her fiancé parted from one another, it was difficult for claimant to remain working and living at "Hilltop Homestead." Claimant stated she missed working with the two brothers.

Subsequently, claimant moved near the Wisconsin Dells. She obtained a job as a housekeeper at Great Wolf Lodge on October 16, 2017. For her services, she was paid $10.50 per hour. Claimant terminated the position after 1 week because the duties were too physically challenging for her to perform.

Claimant applied for several other positions. She applied to be a hostess at a Pizza Parlor, she had a telephone interview at a Quick Trip, she applied as a cashier at a Dollar Store, she applied for kitchen work in the Wisconsin Dells, and she applied to

be a cashier at an ALDI Grocery Store. She applied to be a companion for someone who needed assistance in the home but claimant could not physically perform the tasks. Claimant also applied for restaurant work. Claimant was unsuccessful in obtaining employment. All of the jobs for which she applied, required the use of her hands and upper extremities.

Claimant lives in a trailer home. She testified she rarely cooks. She can perform laundry duties. She drives to the grocery store and purchases her own groceries. She handles her own finances. She performs her activities of daily living. Claimant testified she has disturbed sleep. She sleeps three or four hours per night. She is able to dress herself but zippers and snaps are problematic. Claimant testified she is constantly dropping objects from her right hand. It is difficult for her to open a bottle or jar. It is even hard for her to turn a doorknob.

RATIONALE AND CONCLUSIONS OF LAW

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

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

A personal injury contemplated by the workers' compensation law means an injury, the impairment of health or a disease resulting from an injury which comes about, not through the natural building up and tearing down of the human body, but because of trauma. The injury must be something that acts extraneously to the natural processes of nature and thereby impairs the health, interrupts or otherwise destroys or damages a part or all of the body. Although many injuries have a traumatic onset, there is no requirement for a special incident or an unusual occurrence. Injuries which result from cumulative trauma are compensable. Increased disability from a prior injury, even if

brought about by further work, does not constitute a new injury, however. St. Luke's Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); Ellingson v. Fleetguard, Inc., 599 N.W.2d 440 (Iowa 1999); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995); McKeever Custom Cabinets v. Smith, 379 N.W.2d 368 (Iowa 1985). An occupational disease covered by chapter 85A is specifically excluded from the definition of personal injury. Iowa Code section 85.61(4)(b); Iowa Code section 85A.8; Iowa Code section 85A.14.

While a claimant is not entitled to compensation for the results of a preexisting injury or disease, its mere existence at the time of a subsequent injury is not a defense. Rose v. John Deere Ottumwa Works, 247 Iowa 900, 908, 76 N.W.2d 756, 760-61 (1956). It the claimant had a preexisting condition or disability that is materially, aggravated, accelerated, worsened or lighted up so that it results in disability, claimant is entitled to recover. Nicks v. Davenport Produce Co., 254 Iowa 130, 135, 115 N.W.2d 812, 815 (1962); Yeager v. Firestone Tire & Rubber Co., 253 Iowa 369, 375, 112 N.W.2d 299, 302 (1961).

When an expert's opinion is based upon an incomplete history, it is not necessarily binding on the commissioner or the court. It is then to be weighed, together with other facts and circumstances, the ultimate conclusion being for the finder of the fact. Musselman v. Central Telephone Company, 154 N.W.2d 128, 133 (Iowa 1967); Bodish v. Fischer, Inc., 257 Iowa 521, 522, 133 N.W.2d 867 (1965).

The weight to be given an expert opinion may be affected by the accuracy of the facts the expert relied upon as well as other surrounding circumstances. St. Luke's Hospital v. Gray, 604 N.W.2d 646 (Iowa 2000).

The commissioner as trier of fact has the duty to determine the credibility of the witnesses and to weigh the evidence. Together with the other disclosed facts and circumstances, and then to accept or reject the opinion. Dunlavey v. Economy Fire and Casualty Co., 526 N.W.2d 845 (Iowa 1995).

When the injury develops gradually over time, the cumulative injury rule applies. The date of injury for cumulative injury purposes is the date on which the disability manifests. Manifestation is best characterized as that date on which both the fact of injury and the causal relationship of the injury to the claimant's employment would be plainly apparent to a reasonable person. The date of manifestation inherently is a fact based determination. The fact-finder is entitled to substantial latitude in making this determination and may consider a variety of factors, none of which is necessarily dispositive in establishing a manifestation date. Among others, the factors may include missing work when the condition prevents performing the job, or receiving significant medical care for the condition. For time limitation purposes, the discovery rule then becomes pertinent so the statute of limitations does not begin to run until the employee, as a reasonable person, knows or should know, that the cumulative injury condition is serious enough to have a permanent, adverse impact on his or her employment. Herrera v. IBP, Inc., 633 N.W.2d 284 (Iowa 2001); Oscar Mayer Foods Corp. v. Tasler,

483 N.W.2d 824 (Iowa 1992); McKeever Custom Cabinets v. Smith, 379 N.W.2d 368 (Iowa 1985).

Because claimant's injury is an injury to the body as a whole, her disability is to be calculated by the industrial method.

Total disability does not mean a state of absolute helplessness. Permanent total disability occurs where the injury wholly disables the employee from performing work that the employee's experience, training, education, intelligence and physical capacities would otherwise permit the employee to perform. See McSpadden v. Big Ben Coal Co., 288 N.W.2d 181 (Iowa 1980); Diederich v. Tri-City R. Co., 219 Iowa 587, 258 N.W. 899 (1935).

A finding that claimant could perform some work despite claimant's physical and educational limitations does not foreclose a finding of permanent total disability, however. See Chamberlin v. Ralston Purina, File No. 661698 (App. October 29, 1987); Eastman v. Westway Trading Corp., II Iowa Industrial Commissioner Report 134 (App. 1982).

It is the determination of the undersigned; claimant is permanently and totally disabled as a result of her work injury on March 3, 2011. Claimant not only sustained an original right upper extremity injury, she had the sequellae injuries to the left upper extremity and to both shoulders. There was permanent functional damage to her right upper extremity, excessive strain on the left upper extremity and the overuse syndrome resulted in permanent damage to the left shoulder, left arm and left middle finger.

Claimant has very severe work restrictions. Dr. Grindel's final permanent work restrictions are onerous. Claimant may engage in paperwork. She is not to lift greater than five pounds with her right upper extremity. She is not to engage in repetitive use of the right upper extremity. With respect to the left upper extremity, claimant is not to engage in repetitive or forceful work.

Dr. Taylor's restrictions are even more onerous. He recommended claimant avoid lifting no more than two or three pounds with the right upper extremity. Because of the wrist fusion, Dr. Taylor suggested claimant use the right upper extremity for occasional light paperwork and occasional handwriting. There should be only occasional repetitive use of the right upper extremity. Claimant was informed to avoid forceful gripping and grasping. The wrist movement is restricted due to the fusion.

Dr. Taylor recommended claimant only engage in occasional overhead work with the left upper extremity and rarely with the right. There should never be any forceful pushing or pulling with the right upper extremity. Claimant should avoid repetitive gripping and grasping with the left hand. She should never lift more than 20 pounds with the left upper extremity.

Dr. Taylor opined claimant should avoid crawling, and climbing on ladders. It would be imperative for claimant to use caution when climbing stairs because handrails are usually on the right side of steps. Dr. Taylor believed claimant's fused wrist would affect her ability to operate certain vehicles and equipment. (Cl. Ex. 3, p. 11)

Dr. Grindel's overall impairment rating was 30 percent to the body as a whole. That was an extremely large and significant whole body impairment number. Dr. Taylor assigned a 17 percent whole body impairment rating.

Claimant has a high school diploma. She also attended SW Vocational Technical College in Wisconsin to become a cosmetologist. She never practiced in the profession.

In 1988, claimant returned to vocational school for six months to become a certified nursing assistant (CNA). She did work in that field for a number of years but the hourly wages were low. The job required some lifting and hands on patient care. Working as a CNA required heavy physical labor. Claimant no longer holds a valid certificate as a CNA.

Claimant also worked for several banks as a teller and a general banker. She had to count money, lift heavy bags of coins, fill ATM machines, and engage in other paperwork activities. Because of the lifting, claimant is unable to return to the banking industry.

Claimant is considered an older worker. Retraining seems unlikely. Ms. Sellner suggested claimant could perform work at a keyboard because the work does not involve gripping and grasping. Claimant would need some training to improve her computer skills. Keyboarding does not seem like a viable option, given the fact claimant has a fused right wrist and, she has had carpal tunnel surgeries on each upper extremity.

After considering all of the factors involving industrial disability and those factors involving permanent and total disability; it is the determination of the undersigned; claimant is permanently and totally disabled. However, claimant did not become permanently and totally disabled until she reached maximum medical improvement for all of her injuries on October 9, 2017. Prior to that time frame, claimant was in various healing periods; she was working at several group homes owned by relatives of her former fiancé; and she spent one week as a housekeeper at Great Wolf Lodge in the Wisconsin Dells. Defendant shall take credit for all benefits previously paid to date. Those benefits were paid as healing period benefits or permanent partial disability benefits while claimant was actively employed.

The next issue for resolution is the matter of the weekly benefit rate. If the employee is paid on a daily or hourly basis or by output, weekly earnings are computed by dividing by 13 the earnings over the 13-week period immediately preceding the

injury. Any week that does not fairly reflect the employee's customary earnings is excluded, however. Section 85.36(6).

Claimant alleges the correct weekly benefit rate should be $325.56. Claimant relies on her Exhibit 7 to explain how she arrived at her calculation. The calculation is duplicated below:

Weeks	**Pay Period Start**	**Hours Wked**	**Straight Time Hrly Rate**	**Average Weekly Wage**
1	3/12/11	47	$11.05	
2	2-12-11	44.6	$11.05	
3	1-15-11	40.1	$11.05	
4	1-15-11	40.1	$11.05	
5	1-1-11	40.0	$11.05	
6	1-1-11	40.0	$11.05	
7	12-18-10	40.0	$11.05	
8	12-18-10	40.0	$11.05	
9	12-4-10	40.00	$11.05	
10	12-4-10	40.0	$11.05	
11	11-20-10	42.4	$11.05	
12	11-6-10	41.9	$11.05	
13	10-23-10	40.85	$11.05	
		536.95	X $11.05=	$5,933.30
			÷ 13 = **$456.41**	

GROSS WEEKLY WAGE: **456.41**
MARITAL/EXEMPTION STATUS: **M/3**
WEEKLY COMPENSATION RATE: **$325.56**

(Cl. Ex 7, p. 1)

Claimant maintains the issue is whether the weeks listed should be calculated at the various pay rates shown or at the rate of pay claimant was earning during the final eight weeks of her employment at Finley, preceding the injury date in this case. Claimant's calculation uses the same representative weeks and hours as defendant's calculation. However, claimant used the hourly rate of pay of $11.05 for all 13 weeks.

Defendant argues the statute clearly conveys the actual amount(s) earned by the claimant for each of the preceding 13 weeks shall be used to determine the applicable average weekly wage.

Defendant is absolutely correct. Counsel for defendant writes in his post-hearing brief:

> [Section 85.36(6)] clearly conveys the **actual amount(s) earned** by the claimant for each of the suitable **preceding 13 weeks** shall be used to determine the applicable average weekly wage. Nowhere in the statute does the legislature allow for only the highest hourly rate, or only the hourly rate in place as of the injury date, to be used for each of the 13 preceding weeks. If this had been the legislature's intention, then it would have expressly been stated via the statutory language. It obviously is not.
>
> Claimant's AWW calculation methodology does not comport with section 85.36(6) because it permits her wages she did not in reality earn. Defendant's application of section 85.36(6) to the facts is proper as it utilizes only the hourly rates and thus earnings that Claimant actually **earned** for each of the suitable 13 weeks preceding the injury date. Accordingly, there was no rate underpayment and thus TTD/HP underpayment.

(Defendant's post hearing brief, pp. 13-14)

Defendant has calculated the average weekly rate according to Iowa Code section 85.36(6). Claimant's weekly benefit rate is $314.53 per week. All weekly benefits shall be paid at this rate. There has been no underpayment of benefits previously paid to claimant.

Defendant shall pay accrued weekly benefits in a lump sum together with interest at the rate of ten percent for all weekly benefits payable and not paid when due which accrued before July 1, 2017, and all interest on past due weekly compensation benefits accruing on or after July 1, 2017, shall be payable 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. See Gamble v. AG Leader Technology, File No. 5054686 (App. April 24, 2018).

Claimant is also entitled to be reimbursed for an independent medical examination with Dr. Taylor pursuant to Iowa Code section 85.39. Defense counsel

agreed at the hearing to reimburse claimant's counsel for the cost in the amount of $3,615.00.

Claimant is requesting alternate medical care in the form of psychological counseling with Tiffany G. Gaumond, MS, therapist at the Pauquette Center for Psychological Services. Dr. Tranel, PhD, a professor at the University of Iowa Hospitals and Clinics recommended claimant see someone for pain issues related to claimant's right wrist. Dr. Tranel opined cognitive-behavioral therapy would be appropriate. Claimant testified the visits with Ms. Gaumond have been especially helpful. Claimant believes future sessions will be beneficial as well. The undersigned finds the therapy sessions are reasonable and necessary. Defendant shall be liable for the payment of those therapy sessions with Ms. Gaumond.

The final issue is the matter of costs.

Iowa Code section 86.40 states:

> Costs. All costs incurred in the hearing before the commissioner shall be taxed in the discretion of the commissioner.

Iowa Administrative Code Rule 876—4.33(86) states:

> Costs. Costs taxed by the workers' compensation commissioner or a deputy commissioner shall be (1) attendance of a certified shorthand reporter or presence of mechanical means at hearings and evidential depositions, (2) transcription costs when appropriate, (3) costs of service of the original notice and subpoenas, (4) witness fees and expenses as provided by Iowa Code sections 622.69 and 622.72, (5) the costs of doctors' and practitioners' deposition testimony, provided that said costs do not exceed the amounts provided by Iowa Code sections 622.69 and 622.72, (6) the reasonable costs of obtaining no more than two doctors' or practitioners' reports, (7) filing fees when appropriate, (8) costs of persons reviewing health service disputes. Costs of service of notice and subpoenas shall be paid initially to the serving person or agency by the party utilizing the service. Expenses and fees of witnesses or of obtaining doctors' or practitioners' reports initially shall be paid to the witnesses, doctors or practitioners by the party on whose behalf the witness is called or by whom the report is requested. Witness fees shall be paid in accordance with Iowa Code section 622.74. Proof of payment of any cost shall be filed with the workers' compensation commissioner before it is taxed. The party initially paying the expense shall be reimbursed by the party taxed with the cost. If the expense is unpaid, it shall be paid by the party taxed with the cost. Costs are to be assessed at the discretion of the deputy commissioner or workers' compensation commissioner hearing the case unless otherwise required by the rules of civil procedure governing discovery. This rule is intended to implement Iowa Code section 86.40.

Iowa Administrative Code rule 876—4.17 includes as a practitioner, "persons engaged in physical or vocational rehabilitation or evaluation for rehabilitation." A report or evaluation from a vocational rehabilitation expert constitutes a practitioner report under our administrative rules. Bohr v. Donaldson Company, File No. 5028959 (Arb. November 23, 2010); Muller v. Crouse Transportation, File No. 5026809 (Arb. December 8, 2010). The entire reasonable costs of doctors' and practitioners' reports may be taxed as costs pursuant to 876 IAC 4.33. Caven v. John Deere Dubuque Works, File Nos. 5023051, 5023052 (App. July 21, 2009).

Claimant is requesting certain costs as detailed on page 2 of the hearing report.

The following costs are taxed to defendant:

Filing fee:	$100.00
Vocational Reports	$995.00 and $517.00
Mental Health Report	$195.00
Total $1,807.00	

ORDER

THEREFORE, IT IS ORDERED:

Defendant shall pay unto claimant permanent and total disability benefits commencing from October 9, 2017 at the rate of three hundred fourteen and 53/100 dollars ($314.53) per week and said benefits shall be paid for the duration of claimant's permanent and total disability period.

Defendant shall pay unto claimant healing period benefits for the period of time claimant was in a healing period and said benefits shall be paid at the rate of three hundred fourteen and 53/100 dollars ($314.53) per week.

Defendant shall pay unto claimant permanent partial disability benefits for the period claimant was permanently and partially disabled and all benefits shall be paid at the rate of three hundred fourteen and 53/100 dollars ($314.53) per week.

All past due benefits shall be paid in a lump sum together with interest as allowed by law and as discussed in the body of the decision.

Defendant shall take credit for all benefits paid to date, and at the rate of three hundred fourteen and 53/100 dollars ($314.53) per week.

Defendant shall pay the cost of the independent medical exam performed by Dr. Taylor.

Defendant shall pay costs as detailed in the body of the decision.

Defendant shall file all reports as required by law.

Signed and filed this 18th day of June, 2019.

Michelle A. McGovern

MICHELLE A. MCGOVERN
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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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.