BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

RODNEY RUFF, Claimant, vs. SENIOR HOUSING HEALTH CARE, INC., Employer, and WEST BEND MUTUAL INS. CO., Insurance Carrier, Defendants.	File No. 1655383.01 ARBITRATION DECISION Headnotes: 1800; 1803; 2200

STATEMENT OF THE CASE

The claimant, Rodney Ruff, filed a petition for arbitration seeking workers' compensation benefits from employer Senior Housing Health Care, Inc. ("Senior Housing"), and their insurer, West Bend Mutual Insurance Company. Jason Neifert appeared on behalf of the claimant. Charles Blades appeared on behalf of the defendants.

The matter came on for hearing on June 29, 2022, before Deputy Workers' Compensation Commissioner Andrew M. Phillips. Pursuant to an order of the Iowa Workers' Compensation Commissioner related to the COVID-19 pandemic, the hearing occurred electronically. The hearing proceeded without significant difficulty.

The record in this case consists of Joint Exhibits 1-7, Claimant's Exhibit 1-6, and Defendants' Exhibits A-K. The exhibits were received into the record without objection.

The claimant testified on his own behalf. Also present was employer representative Tanner Irwin. Jane Weingart was appointed the official reporter and custodian of the notes of the proceeding. The evidentiary record closed at the end of the hearing, and the matter was fully submitted on September 2, 2022, after briefing by the parties.

STIPULATIONS

Through the hearing report, as reviewed at the commencement of the hearing, the parties stipulated and/or established the following:

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

2. That the claimant sustained an injury which arose out of, and in the course of employment on October 19, 2018.

3. That the alleged injury is a cause of temporary disability during a period of recovery.

4. That the alleged injury is a cause of permanent disability.

5. That the commencement date for permanent partial disability benefits, if any are awarded, is August 12, 2019.

6. That the claimant had gross weekly earnings of one thousand forty-one and 00/100 dollars ($1,041.00) per week, was married, and was entitled to two exemptions at the time of the alleged injury. This provided a weekly compensation rate of six hundred seventy and 82/100 dollars ($670.82).

7. That prior to the hearing, the claimant was paid 40 weeks of permanent partial disability benefits at the agreed upon weekly rate.

8. That the costs listed in Claimant's Exhibit 6 were paid.

Entitlement to temporary disability and/or healing period benefits is no longer in dispute. Medical benefits are no longer in dispute. There is no dispute as to credits. The defendants waived their affirmative defenses.

The parties are now bound by their stipulations.

ISSUES

The parties submitted the following issues for determination:

1. The extent of permanent disability, if any is awarded.

2. Whether the permanent disability should be evaluated as an industrial disability or a scheduled member disability to the left shoulder and left arm.

3. Whether an assessment of costs is appropriate.

FINDINGS OF FACT

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

Rodney Ruff, the claimant, was 51 years old at the time of the hearing. (Testimony). He is married, and has two adult children. (Testimony). He has lived in Iowa for his entire life. (Testimony). He currently resides in Marion, Iowa. (Testimony).

Mr. Ruff graduated from South Tama High School. (Defendants' Exhibit B:15-16). He attended Wartburg College from 1989 to 1990. (DE C:52). He then attended Mount Mercy College and graduated with a degree in criminal justice administration in 1995. (DE B:16; C:52).

Mr. Ruff worked for Four Oaks from 1990 to 2008. (Claimant's Exhibit 3:36). He worked as a residential counselor with delinquent youth. (Testimony). He provided the youths with structure and discipline. (CE 3:36). He also helped train new staff, kept a budget, and completed paperwork. (CE 3:36). The job was not physically demanding unless a youth became aggressive. (Testimony). However, this happened on a rare basis. (Testimony). Mr. Ruff left this job after 18 years due to a change in philosophy by the management of Four Oaks. (Testimony).

From 2008 to 2010, Mr. Ruff was self-employed. (CE 3:36). He performed construction of things like decks, basements, and flooring. (Testimony). He also painted and assisted with home remodeling. (Testimony). This was physically demanding work. (Testimony). He was not injured while on the job and had no issues performing the work. (Testimony). He ended his self-employment because he wanted a steady paycheck. (CE 3:36).

Mr. Ruff returned to Four Oaks from 2010 to 2013. (CE 3:36). He worked in the warehouse and kitchen. (CE 3:36; Testimony). He unloaded food truck deliveries twice per week. (Testimony). Food weighed between 50 and 100 pounds. (Testimony). On days where he was not unloading the food truck, he would divide the food into smaller portions and deliver it in a van to Four Oaks facilities. (Testimony). He used a modified laundry basket to lift food from the van to the facility. (Testimony). He had no issues with the physical requirements of the job and had no injuries on the job. (Testimony).

In 2013, Mr. Ruff left Four Oaks and began working for Garnett Place, which is another name for the defendant-employer in this matter. (CE 3:36; Testimony). Garnett Place is a retirement community. (Testimony). There are 76 units and four condominiums in the community. (Testimony). He was hired to remodel the apartments. (Testimony). He would "gut" an apartment by removing the flooring, cabinets, bathtub, toilet, vanity, and trim. (Testimony). Then he would put new items in. (Testimony). He was in charge of remodeling, maintenance, and landscaping. (CE 3:36; Testimony). He now does a great deal of "upkeep" to the units. (Testimony). This consists of replacing carpets or repainting the units. (Testimony). He also trims bushes, plants flowers, and tends to landscaping. (Testimony). Mr. Ruff also was responsible for compliance with garbage control and assisting in emergencies. (DE E:59). He also needed the ability to work on a ladder and lift between 40 and 50

pounds up to 40 inches. (DE E:60). At the time of his injury, Mr. Ruff earned twenty-four and 50/100 dollars ($24.50) per hour. (DE I:88). He currently earns thirty and 81/100 dollars ($30.81) per hour. (DE I:86). He had no on-the-job injuries or problems doing his work prior to October of 2018. (Testimony).

On October 19, 2018, the claimant was lifting a toilet as part of a remodeling project. (Testimony). He estimated that the toilet weighed 70 pounds. (Testimony). He lifted the toilet into a pickup truck. (Testimony). As he did this, his biceps and rotator cuff tore in his left arm. (Testimony). He felt his biceps tear, heard a pop, and saw his biceps immediately swell. (Testimony; Joint Exhibit 1:1). An ambulance arrived, and the crew observed that the claimant had a deformity to his left biceps with a step-off at the superior aspect. (JE 1:1). The claimant also reported pain in his left shoulder. (JE 1:1). He refused pain medication, as he did not like to take narcotics. (JE 1:1). He was taken to St. Luke's Hospital via ambulance. (Testimony; JE 1:1).

Upon arrival at St. Luke's Hospital, Julie Beard, D.O., examined Mr. Ruff. (JE 2:2). He complained of left biceps pain and a pop in his left shoulder after attempting to load a toilet into his pickup truck. (JE 2:2). Like the ambulance crew, Dr. Beard observed a deformity in the claimant's left bicep. (JE 2:2). Mr. Ruff rated his pain 9 out of 10. (JE 2:2).

On October 22, 2018, Mr. Ruff followed-up his emergency room visit with an examination with Gregory Hill, M.D. (JE 3:3-5). Upon examination, Dr. Hill observed a Popeye deformity to the left biceps. (JE 3:3). He also had mild tenderness over the biceps. (JE 3:3). Dr. Hill found the claimant to have full range of motion in the shoulder and elbow. (JE 3:3). He had soreness and weakness with elbow flexion. (JE 3:3). Dr. Hill diagnosed the claimant with a left shoulder proximal biceps tendon rupture. (JE 3:3). Dr. Hill noted that these are not typically surgically repaired, and that he may have some residual biceps fatigue and weakness. (JE 3:3). Dr. Hill recommended that the claimant have therapy to regain some strength. (JE 3:3). If the claimant had continued shoulder difficulties, then Dr. Hill would order a shoulder MRI to evaluate the status of the rotator cuff. (JE 3:3). Mr. Ruff could continue to work, but could not use his right arm. (JE 3:3). His right arm also needed to be kept in a sling. (JE 3:3). If these restrictions could not be accommodated, then Mr. Ruff was to be off work. (JE 3:5).

Dr. Hill examined Mr. Ruff again on December 3, 2018. (JE 3:6-7). Mr. Ruff continued to have pain in his left arm, and difficulties with his activities of daily living. (JE 3:6). Dr. Hill observed that Mr. Ruff had increased pain with testing of his rotator cuff. (JE 3:6). Dr. Hill diagnosed the claimant with a left shoulder biceps tendon tear, suspected residual instability with a labral tear, and a possible partial rotator cuff tear on the left. (JE 3:6). Dr. Hill ordered an MRI arthrogram of the left shoulder. (JE 3:6). He continued to restrict the claimant to not using his left arm. (JE 3:6).

Mr. Ruff had an MRI of his left shoulder on December 10, 2018, as ordered by Dr. Hill. (JE 5:27-28). Scott Truhlar, M.D., interpreted the examination. (JE 5:27-28). Dr. Truhlar opined that the AC joint was unremarkable. (JE 5:27). The tendon of the left long head of the biceps tendon was completely torn and retracted to the superior margin of the bicipital groove. (JE 5:27). There was also a mild abnormal signal in the

superior rotator cuff tendons along with moderate thinning. (JE 5:27). Dr. Truhlar opined that this indicated a partial thickness articular sided tear of the anterior 12 mm of the tendon; however, Dr. Truhlar saw no full-thickness superior rotator cuff tear. (JE 5:27). Dr. Truhlar listed his impression as follows:

1. Proximal complete tear of the tendon of the long head of biceps brachii. The torn end is retracted to the superior aspect of the bicipital groove.
2. Full-thickness tear of the posteroinferior glenoid labrum.
3. Blunting of the entire superior labrum consistent with tearing at the time of the bicipital tendon tear.

(JE 5:27-28).

On December 17, 2018, Mr. Ruff continued his follow-up with Dr. Hill. (JE 3:8-9). Dr. Hill reported the findings of the MRI and radiology report. (JE 3:8). He noted that Mr. Ruff sustained a complete biceps tendon tear off the glenoid attachment site with retraction to the groove. (JE 3:8). He also had anterior superior and anterior inferior labral tears that were likely secondary to the biceps injury. (JE 3:8). The report also noted a moderate partial articular surface rotator cuff tear. (JE 3:8). Dr. Hill reviewed the imaging and opined that the claimant had a large partial thickness undersurface rotator cuff tear. (JE 3:8). Dr. Hill recommended that the claimant have an arthroscopic surgical treatment to his left shoulder. (JE 3:8). The procedure would be a rotator cuff repair, debridement, labral repair, and possible biceps tenodesis. (JE 3:9).

Mr. Ruff reported to UnityPoint Health in Cedar Rapids on January 15, 2019, for a left shoulder arthroscopy. (JE 6:29-30). Dr. Hill performed the surgery. (JE 6:29-30). As part of the arthroscopic surgery, Dr. Hill performed extensive debridement of the superior labrum, inferior labrum, subscapularis, and rotator cuff. (JE 6:29). He also performed lysis of adhesions of the rotator interval and subscapularis, SA space, subcoracoid space, supraglenoid space, and rotator cuff. (JE 6:29). He also performed "SAD" with acromioplasty and an extensive synovectomy. (JE 6:29). Dr. Hill's postoperative diagnoses were: left shoulder proximal biceps tendon rupture; undersurface rotator cuff tear; adhesive capsulitis; extensive significant capsular synovitis; and, extensive thick fibrous adhesions of the RI and subscapularis, subcoracoid space, supraglenoid space and "RTC" and "SA" space. (JE 6:29). Dr. Hill noted that the biceps tendon was not present in the shoulder area, which was consistent with the prior biceps tendon rupture. (JE 6:30).

Dr. Hill examined Mr. Ruff again on January 28, 2019. (JE 3:10-12). This was a post-surgical examination. (JE 3:10). Mr. Ruff had no acute complaints, was wearing a sling, and was "doing good." (JE 3:10). Dr. Hill removed the staples from the incisions, and found minimal swelling. (JE 3:10). Dr. Hill recommended that Mr. Ruff continue physical therapy to progress range of motion, strengthening, and rehabilitation. (JE 3:10). Mr. Ruff had shown good progress early in therapy, but Dr. Hill noted that he had a risk of stiffness developing due to adhesions. (JE 3:10). Dr. Hill continued to restrict Mr. Ruff from working with his left arm. (JE 3:12). If the restrictions could not be accommodated, then Mr. Ruff was to be kept off work. (JE 3:12).

On March 29, 2019, Mr. Ruff returned to Dr. Hill's office. (JE 3:13-15). Mr. Ruff continued to not use his left arm. (JE 3:13). He continued to make progress with physical therapy. (JE 3:13). He had no radicular pain, numbness, or adjacent joint pain or swelling. (JE 3:13). Dr. Hill continued to restrict the claimant's work. (JE 3:15). Specifically, Mr. Ruff was to avoid overhead activity with his left arm. (JE 3:15). He also could only lift, push, or pull 0 to 20 pounds with his left arm. (JE 3:15).

Gregory O'Brien, P.T., provided a shoulder re-evaluation for Mr. Ruff on May 28, 2019. (JE 7:31-33). Mr. Ruff told the therapist that he struggled with comfort when he attempted to fish in the last month. (JE 7:31). He also had issues with playing basketball with his son. (JE 7:31). He rated his pain at the time of the appointment at 2 out of 10. (JE 7:31). Mr. Ruff told the therapist that his overall strength and comfort had improved, but that he struggled to perform a whole day's work due to limited stamina. (JE 7:32). The therapist noted prevalent weakness in the left shoulder, and opined that Mr. Ruff may benefit from work hardening or conditioning. (JE 7:32).

Mr. Ruff continued his follow-up care with Dr. Hill on May 29, 2019. (JE 3:16-18). Mr. Ruff was working light duty. (JE 3:16). He was making further progress with physical therapy when physical therapy was stopped. (JE 3:16). Upon examination, he displayed weakness. (JE 3:16). However, his range of motion was improved. (JE 3:16). Dr. Hill added physical therapy for work hardening. (JE 3:16). Dr. Hill allowed the claimant to work with overhead lifting up to 10 to 15 pounds with his left arm. (JE 3:18). He could also push, pull, and lift 0 to 30 pounds up to his chest level. (JE 3:18).

Mr. Ruff had another shoulder re-evaluation with Mr. O'Brien on July 10, 2019. (JE 7:34-36). He complained of a general ache in his left shoulder after working out, but was otherwise doing well. (JE 7:34). He rated his pain 0-1 out of 10 and told the therapist that he did not feel as though his left shoulder had returned to baseline strength or activity tolerance. (JE 7:34). The therapist opined that Mr. Ruff would be a good candidate to have a functional capacity evaluation ("FCE") with kinetic testing. (JE 7:35).

On July 12, 2019, Dr. Hill examined Mr. Ruff again. (JE 3:19-21). Mr. Ruff continued with a home exercise plan. (JE 3:19). He was "doing ok." (JE 3:19). He had no true radicular pain and no adjacent joint pain or swelling. (JE 3:19). Dr. Hill opined that Mr. Ruff had an unremarkable examination, and that he should possibly reach maximum medical improvement ("MMI") in one month. (JE 3:19). Dr. Hill allowed Mr. Ruff to return to work without restrictions on July 12, 2019. (JE 3:21).

Mr. Ruff returned to Dr. Hill's office on August 12, 2019, for continued follow-up care. (JE 3:22-23). Mr. Ruff was working regular duty and "doing ok." (JE 3:22). Upon examination, Mr. Ruff had no focal tenderness. (JE 3:22). He had some generalized residual weakness, but displayed "good strength" that was improving. (JE 3:22). Provocative strength and stability testing were unremarkable. (JE 3:22). Dr. Hill placed Mr. Ruff at MMI effective August 12, 2019, with no permanent restrictions. (JE 3:22).

On December 4, 2019, Mr. Ruff had another follow-up with Dr. Hill. (JE 3:24-25). He presented for an impairment exam. (JE 3:24). He was working regular duty, and "doing ok." (JE 3:24). Mr. Ruff complained of biceps spasm and shoulder fatigue. (JE

3:24). Upon examination, Dr. Hill observed that Mr. Ruff had good strength with some generalized residual weakness. (JE 3:24). Dr. Hill opined that his shoulder fatigue "may or may not" further improve. (JE 3:24). Mr. Ruff remained at MMI with no permanent restrictions. (JE 3:24). Following his appointment, Dr. Hill wrote a letter to Brenna Bass of Paradigm. (JE 4:26). Dr. Hill opined that Mr. Ruff had a "[v]ery [g]ood [o]utcome" following his surgery. (JE 4:26). During his evaluation, Dr. Hill found the claimant to have flexion of 160 degrees, abduction of 110 degrees, external rotation of 80 degrees, and internal rotation of 10 degrees. (JE 4:26). Based upon the measurements, and the Guides to the Evaluation of Permanent Impairment, Fifth Edition, Dr. Hill provided a 9 percent upper extremity impairment. (JE 4:26). This converted to a 5 percent whole person impairment. (JE 4:26).

David Segal, M.D., J.D., completed an independent medical evaluation ("IME") on February 19, 2021. (CE 1:1-30). Dr. Segal is a board certified neurosurgeon who now performs IMEs. (CE 1:1-30). He issued an IME report on April 15, 2021, outlining the results of his examination of Mr. Ruff. (CE 1:1-30). Dr. Segal performed an overview of Mr. Ruff's relevant medical history. (CE 1:1-3, 16-19).

Mr. Ruff rated his pain 0 out of 10 at the time of the examination. (CE 1:2). His highest pain was 8 out of 10, and his average pain was 6 out of 10. (CE 1:2). Mr. Ruff noted that his pain was "[m]ild to [m]oderately [s]evere," depending on the activity or position of his arm. (CE 1:3). He indicated that his pain was on the anterior left upper arm, in the area of the top of the biceps and anterior shoulder, along with the bicipital tendon insertion. (CE 1:3). Lifting, any movement of his left arm above his shoulder height, and quick movement with his left arm aggravated his pain. (CE 1:3). Mr. Ruff also complained of weakness in his left shoulder. (CE 1:3). Mr. Ruff told Dr. Segal that the prior surgery helped; however, his left shoulder was "better" after he finished physical therapy in July of 2019, than at the time of the examination. (CE 1:3). His main weakness was in the left biceps. (CE 1:3).

Mr. Ruff described an inability to complete much overhead work. (CE 1:4). He also told Dr. Segal that he could not perform any activity that required a biceps-curl movement. (CE 1:4). It also took him longer to complete jobs than before his injury. (CE 1:4). He further described that quick movements of his arm can cause pain that can "bring him to his knees." (CE 1:4). He outlined the things that he can no longer do or are much more difficult to do. (CE 1:4). This includes exercising, weightlifting, and riding his bicycle. (CE 1:4). He can no longer do push-ups or planks. (CE 1:4). Mr. Ruff self-reported that he could only lift 40 to 50 pounds from the floor to his waist with his bilateral arms. (CE 1:4). He could only lift 15 pounds maximum with his left arm. (CE 1:4). He reported that he could never do any overhead lifting. (CE 1:4). He felt that he needed no restrictions for walking, sitting, or standing, and occasional restrictions for using ladders. (CE 1:5).

Upon physical examination, Dr. Segal noted the visible Popeye deformity in Mr. Ruff's left arm. (CE 1:5). He also found tenderness to palpation at the location of the biceps tendon insertion in the left arm. (CE 1:5). Dr. Segal found reduced motor measurements in the left upper extremity. (CE 1:5). Dr. Segal documented his observed range of motion for Mr. Ruff's left shoulder. (CE 1:5). He found that the

claimant had 110 degrees of abduction, 30 degrees of adduction, 150 degrees of forward flexion, 20 degrees of extension, 10 degrees of internal rotation, and 40 degrees of external rotation. (CE 1:5).

Dr. Segal continued by opining that Mr. Ruff's injury was "more extensive than a routine shoulder injury." (CE 1:6). He noted that the biceps tendon rupture and permanent Popeye deformity involve his arm more than his shoulder. (CE 1:6). He continued by opining that the synovitis and adhesions seen during the surgery "extended proximally to the shoulder," and involved the upper thorax. (CE 1:6-7). He concluded that the acromial decompression also involved part of the scapular bone, which "is part of the thorax." (CE 1:7). Dr. Segal provided the following diagnoses for Mr. Ruff:

1. Rupture and retraction of Tendon [*sic*] of the long head of the biceps (LHBT)
2. Popeye deformity
3. Rotator cuff tear with partial articular supraspinatus tendon avulsion (PASTA) injury and subscapularis tear
4. Full-thickness tear of the superior and posteroinferior labrum
5. Adhesive capsulitis
6. Extensive significant capsular synovitis
7. Extensive thick fibrous adhesions of RI [*rotator interval*] and subscapularis, Subcoracoid space, Supraglenoid space and RTC, SA [*subacromial*] space
8. Status post repair rotator cuff and Subacromial decompression with acromioplasty

(CE 1:7). Dr. Segal opined that these diagnoses were related to the work injury. (CE 1:7). Dr. Segal continued his report by providing his own definition of the shoulder, which appears unrelated to those adopted by the Iowa Supreme Court or the Commissioner. (CE 1:8). He noted that the retraction of the biceps tendon and Popeye deformity cause Mr. Ruff's injury to be considered the upper extremity and not the shoulder. (CE 1:8). He continued by opining that the inflammatory synovitis with adhesions spread through the upper torso were "proximal to the glenohumeral joint." (CE 1:8).

Dr. Segal opined that Mr. Ruff's diagnoses were causally related to the work injury of October 19, 2018. (CE 1:19-20). He opined that Mr. Ruff achieved MMI on January 15, 2020. (CE 1:21). Dr. Segal then began his opinion as to Mr. Ruff's permanent impairment based upon the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition. (CE 1:21). Based upon the above noted ranges of motions in the left shoulder, Dr. Segal opined that the claimant had a 14 percent left upper extremity impairment. (CE 1:22). This converted to an 8 percent whole person impairment. (CE 1:22). Dr. Segal then noted that the claimant had motor weakness in his left shoulder and arm examination. (CE 1:22). This resulted in a 21 percent left upper extremity impairment, or a 13 percent whole person impairment. (CE 1:22). Dr. Segal continued by opining that Mr. Ruff had a permanent impairment based upon his shoulder pain. (CE 1:23). This pain was noted by Dr. Segal to be "severe" with lifting. (CE 1:23). Dr. Segal opined that the "increased burden" of the pain was not accounted

for in range of motion or strength measurements, and therefore, opined that Mr. Ruff should be awarded an additional 3 percent whole person impairment. (CE 1:23). Dr. Segal combined the impairment ratings discussed above to arrive at a 22 percent whole person impairment. (CE 1:23). He did not provide an alternative impairment rating to only the left upper extremity.

If Mr. Ruff developed more symptoms in his left shoulder, Dr. Segal opined that "he will need more aggressive workup and treatment; otherwise, his treatment will be more maintenance, as he is now at maximum recovery." (CE 1:23). Dr. Segal indicated that the claimant may need more x-rays or MRIs. (CE 1:24). He also may require additional pain medication, a TENS unit, physical therapy, and cortisone/PRP injections. (CE 1:24). He also may need a repeat shoulder arthroscopy, repeat subacromial decompression, and a total shoulder replacement; however, Dr. Segal tempers his opinion on the total shoulder replacement by stating, "[t]his is likely not a consideration at this time." (CE 1:24).

Dr. Segal continued his report by opining that the claimant "does not have a realistic ability to sustain unrestricted full-time employment." (CE 1:25). This would not change even with any type of additional medical care. (CE 1:25). Dr. Segal recommended that the claimant have the following permanent restrictions:

- Lifting floor-to-waist: 0-40 pounds: Occasionally
- Lifting floor-to-waist: 41-50 pounds: Rarely
- Lifting floor-to-waist greater than 50 pounds: Never
- Lifting waist-to-shoulder: 0-30 pounds: Occasionally
- Lifting waist to shoulder: 31-40 pounds: Rarely
- Lifting waist to shoulder greater than 40 pounds: Never
- Lifting waist-to-overhead both arms: Never
- Overhead lifting with left arm alone: Never
- Bilateral carrying, 40 pounds, 25 feet: Occasionally
- Pushing with 50 pounds of force, on wheels: Occasionally
- Fine motor left hand: Occasionally
- Ladders: Never

(CE 1:25). Dr. Segal concluded his report by noting that he did not observe Mr. Ruff displaying any symptom magnification. (CE 1:26).

Mr. Ruff was scheduled to attend an IME with Mark Gorsche, M.D. on May 18, 2022. (Defendants' Exhibit A:1-4). Dr. Gorsche is board certified by the American Board of Orthopaedic Surgery and the American Board of Independent Medical Examiners. (DE A:9-10). Dr. Gorsche was also the chief resident of the orthopedic department at the Mayo Clinic. (DE A:9). He also has practiced in general orthopedics since 1986. (DE A:10). Unfortunately, Mr. Ruff chose not to attend the appointment at the urging of his counsel. (CE 5:46). Since Mr. Ruff chose not to attend the IME appointment, Dr. Gorsche issued opinions based upon a records review. (DE A:1-4). Dr. Gorsche diagnosed Mr. Ruff with a partial tear of the left rotator cuff, adhesive capsulitis, extensive significant capsular synovitis, extensive thick fibrous adhesions of

the rotator interval and subscapularis subcoracoid space, the supraglenoid space, and the rotator cuff. (DE A:2). Dr. Gorsche opined that the claimant's injury was to his shoulder. (DE A:2). Dr. Gorsche agreed that the claimant's work injury resulted in an injury to the claimant's left shoulder. (DE A:2). He noted that the shoulder injury referenced in an Iowa Supreme Court decision also involved a tear of the biceps tendon. (DE A:2). Dr. Gorsche continued by noting that the operative report only referenced the glenohumeral joint and/or shoulder. (DE A:2). Dr. Gorsche opined that any permanent impairment would be directly related to the shoulder injury. (DE A:2). Dr. Gorsche continued his report by noting that the Popeye defect in the left biceps does not result in permanent impairment to the arm apart from a shoulder injury. (DE A:2). Dr. Gorsche noted that "[o]ne can base impairment either on loss of motion or strength," and that these are typically not combined. (DE A:2). Dr. Gorsche placed Mr. Ruff at MMI on August 12, 2019, the same date provided by Dr. Hill. (DE A:2).

Dr. Gorsche then endeavored to provide a permanent impairment rating. (DE A:3). Based upon the Guides, Dr. Gorsche felt that Dr. Hill correctly assigned a 9 percent impairment rating based upon loss of range of motion in the left upper extremity. (DE A:3). He also felt that Dr. Segal's 14 percent impairment to the left upper extremity based upon range of motion measurements was accurate. (DE A:3). Dr. Gorsche noted that Dr. Segal's use of motor deficit is an incorrect way to assign an impairment rating in this matter. (DE A:3). He notes that the Guides provide, "in a rare case if the examiner believes individual loss of strength represents an impairing factor that has not been considered adequately by other methods in the Guides [*sic*], the loss of strength may be rated separately." (DE A:3). He continued by noting that the Guides state, "otherwise the impairment ratings based on objective anatomical findings take precedence. Decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximal force in the region being evaluated." (DE A:3). Even if motor deficit is used, Dr. Gorsche opined that it should not be combined with impairment based upon range of motion. (DE A:3). Dr. Gorsche indicated that testing motor deficit, like providing an impairment based upon pain, is "very subjective and difficult to rate." (DE A:3). Dr. Gorsche agreed with Dr. Hill that the claimant required no permanent restrictions for his work activities. (DE A:3). He also anticipated that the claimant would not require further medical care for his October 19, 2018, work injury. (DE A:3).

In a report dated June 1, 2022, Dr. Segal responded to Dr. Gorsche's IME report. (CE 2:31-34). Dr. Segal noted that, after reviewing Dr. Gorsche's report, he affirmed all of his opinions and conclusions from the April 15, 2021, IME report. (CE 2:31). Dr. Segal opined that two issues required further discussion:

1. Mr. Ruff's biceps injury causes arm impairment is appropriately considered an arm injury.
2. Mr. Ruff's shoulder weakness is an independent impairing factor, and Mr. Ruff's impairment analysis requires the consideration of his motor weakness for an accurate rating.

(CE 2:31). Dr. Segal continued, noting that the biceps tendon is "not essential to shoulder function." (CE 2:31). Further, Dr. Segal indicated that "the impairment that the biceps tendon injury causes is primarily related to elbow flexion and pain in the biceps muscle." (CE 2:31). Additionally, Dr. Segal opined that a Popeye deformity is an indicator of biceps dysfunction in the arm and is "anatomically removed from the shoulder and functionally unrelated to the shoulder. (CE 2:31). Dr. Segal attempted to differentiate Mr. Ruff's injury from "other shoulder injury" cases, as "[i]n those cases, the repair and the pathology are more related to shoulder range of motion and pain. Here with Mr. Ruff, there was a complete rupture of the biceps tendon with the main dysfunction in Mr. Ruff's arm." (CE 2:31). Dr. Segal continued by indicating that Mr. Ruff's injury "caused two separate and distinct areas of anatomical and functional impairment: the shoulder and the arm." (CE 2:32).

Dr. Segal indicated that Mr. Ruff's shoulder weakness is "one of the cases that would be considered an exception for allowing the rating of motor weakness" pursuant to the Guides. (CE 2:33). Dr. Segal opined that this was the case because for the claimant, "loss of strength in his left shoulder is one of his primary impairing symptoms." (CE 2:33). Dr. Segal cited to the Guides, page 508, which he noted states, "[if] the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods in the Guides, the loss of strength may be rated separately." (CE 2:33). Dr. Segal continued, "Mr. Ruff's motor weakness is as impairing as his range of motion loss, and on my exam, it was measured without restriction from pain." (CE 2:33).

On June 2, 2022, Dr. Gorsche issued a missive in response to Dr. Segal's June 1, 2022, letter. (DE A:8). Dr. Gorsche noted that the biceps tendon is an interarticular structure in the glenohumeral joint. (DE A:8). The rupture of the biceps tendon "actually occurred inside the joint and then retracted distally to the level of the bicipital groove. Therefore the injury that took place is a shoulder injury." (DE A:8). Dr. Gorsche continued, "[r]upture of the long head of the biceps tendon always occurs interarticular and is the result of shoulder pathology." (DE A:8). Dr. Gorsche expounded on his interpretation of the Guides as it relates to combining impairment ratings for a loss of strength with a loss of motion. (DE A:8). He noted that this is included in the Guides in section 16.8A principles. (DE A:8). He continued, "[i]n my experience, I do not combine the ratings for loss of strength and loss of motion, but instead take the higher of the two. It would be a very rare case in which one would combine these ratings." (DE A:8).

Mr. Ruff eventually returned to work with the defendant in July of 2019. (Testimony). He returned at the same or similar wages. (Testimony). He works without restrictions. (Testimony).

Mr. Ruff has pain in his left arm and shoulder that "comes and goes" two to three times per month. (Testimony). During his deposition, he testified that he had throbbing pain once per week. (DE B:22). He rated his pain 3 out of 10. (Testimony). He takes Aleve, which relieves the pain in 10 to 15 minutes. (Testimony). He also has weakness in his left arm. (Testimony). In the last two to three months before the hearing, he explained that he had a sharp pain in his shoulder that ran all the way to his knuckle.

(Testimony). He further clarified that his shooting pain only occurred two to three times when he over-extended his shoulder or rotated it into an "awkward" position. (Testimony). He had no difficulty with dexterity in his fingers on his left side. (DE B:23).

Mr. Ruff has a Popeye deformity in his left arm. (Testimony). His biceps is not attached, so it has rolled down to his elbow. (Testimony). He demonstrated this phenomenon during the arbitration hearing. (Testimony). When he bends his arm for too long, his biceps begins to cramp. (Testimony). He described his pain as occurring where the biceps attached to the shoulder. (Testimony).

He had no pain or issues into his neck. (Testimony). He also had no issues with dexterity of his left hand or left fingers. (Testimony). He testified that he had no issues with rotating his left elbow. (Testimony).

Prior to October of 2018, Mr. Ruff enjoyed riding his bike, working out, playing pickleball, and jogging. (Testimony). He now lifts lighter weights, and does not lift weights in certain positions. (Testimony). He rides his bike for shorter distances. (Testimony). He limits certain activities at work, and rarely uses his left arm. (Testimony). Rather than lifting toilets to move them, he breaks them into pieces and then carries the pieces out. (Testimony). When he installs new toilets, he installs them one piece at a time. (Testimony). He can no longer hang sheet rock above his head, and cannot get on a ladder. (Testimony). However, these changes have not caused any issues or difficulties between him and his employer. (DE B:26). When he has issues with a task, he requests help from a maintenance coordinator. (DE B:26-27).

Mr. Ruff testified that he enjoys fishing and has had to change how he fishes. (Testimony). He no longer mows his lawn or shovels his snow because they cause pain to his arm and shoulder. (Testimony).

Mr. Ruff opined that he could still do his first job with Four Oaks. (Testimony). He also could still work in construction, but he would "have to pick and choose" his jobs. (Testimony). He felt that he could no longer do his second job with Four Oaks because the weights would be too much for him to carry. (Testimony).

CONCLUSIONS OF LAW

The party who would suffer loss if an issue were not established has the burden of proving that issue by a preponderance of the evidence. Iowa Rule of Appellate Procedure 6.904(3).

The parties stipulated that the claimant sustained an injury, which arose out of, and in the course of his employment on October 19, 2018. At that time, the claimant lifted a toilet, felt a pop, and had pain in his left shoulder. The claimant suffered an injury to his shoulder, and also a ruptured biceps tendon. His ruptured biceps tendon resulted in a Popeye deformity in his left arm. The parties stipulated further that the claimant's injury is a cause of permanent disability. The parties agree that the claimant suffered permanent disability to the left shoulder. They dispute whether that disability extends to the remainder of the left upper extremity, and to what extent the claimant was disabled.

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 medical causation is "essentially within the domain of expert testimony." Cedar Rapids Cmty. Sch. Dist. v. Pease, 807 N.W.2d 839, 844-45 (Iowa 2011). The commissioner, as the trier of fact, must "weigh the evidence and measure the credibility of witnesses." Id. The trier of fact may accept or reject expert testimony, even if uncontroverted, in whole or in part. Frye, 569 N.W.2d at 156. When considering the weight of an expert opinion, the fact-finder may consider whether the examination occurred shortly after the claimant was injured, the compensation arrangement, the nature and extent of the examination, the expert's education, experience, training, and practice, and "all other factors which bear upon the weight and value" of the opinion. Rockwell Graphic Sys., Inc. v. Prince, 366 N.W.2d 187, 192 (Iowa 1985). Unrebutted expert medical testimony cannot be summarily rejected. Poula v. Siouxland Wall & Ceiling, Inc., 516 N.W.2d 910 (Iowa App. 1994). Supportive lay testimony may be used to buttress expert testimony, and therefore is also relevant and material to the causation question.

Under the Iowa Workers' Compensation Act, permanent partial disability is compensated either for a loss of use of a scheduled member under Iowa Code 85.34(2)(a)-(u) or for loss of earning capacity under Iowa Code 85.34(2)(v). The extent of scheduled member disability benefits to which an injured worker is entitled is determined by using the functional method. Functional disability is "limited to the loss of the physiological capacity of the body or body part." Mortimer v. Fruehauf Corp., 502 N.W.2d 12, 15 (Iowa 1993); Sherman v. Pella Corp., 576 N.W.2d 312 (Iowa 1998).

An injury to a scheduled member may, because of after effects or compensatory change, result in permanent impairment of the body as a whole. Such impairment may in turn be the basis for a rating of industrial disability. It is the anatomical situs of the permanent injury or impairment which determines whether the schedules in Iowa Code 85.34(a) – (u) are applied. Lauhoff Grain v. McIntosh, 395 N.W.2d 834 (Iowa 1986); Blacksmith v. All-American, Inc., 290 N.W.2d 348 (Iowa 1980); Dailey v. Pooley Lumber Co., 233 Iowa 758, 10 N.W.2d 569 (1943); Soukup v. Shores Co., 222 Iowa 272, 268 N.W. 598 (1936).

Generally, permanent partial disability falls into two categories. A scheduled member, as defined by Iowa Code section 85.34(a) – (u), or a loss of earning capacity, also known as industrial disability, as defined by Iowa Code section 85.34(2)(v). Lauhoff Grain v. McIntosh, 395 N.W.2d 834 (Iowa 1986); Blacksmith v. All-American, Inc., 290 N.W.2d 348 (Iowa 1980); Dailey v. Pooley Lumber Co., 233 Iowa 758, 10 N.W.2d 569 (1943); Soukup v. Shores Co., 222 Iowa 272, 268 N.W. 598 (1936); Diederich v. Tri-City Ry. Co. of Iowa, 219 Iowa 587, 258 N.W. 899 (1935). Iowa Code

section 85.34(2)(v) provides an alternative to the scheduled member and/or industrial disability compensation methods.

> Iowa Code section 85.34(2)(v) states, in relevant part:
>
> If an employee who is eligible for compensation under this paragraph returns to work or is offered work for which the employee receives or would receive the same or greater salary, wages, or earnings than the employee received at the time of the injury, the employee shall be compensated based only upon the employee's functional impairment resulting from the injury, and not in relation to the employee's earning capacity.

In determining whether the above provision of Iowa Code section 85.34(2)(v) applies, there is a comparison between the pre- and post-injury wages and earnings. McCoy v. Menard, Inc., File No. 1651840.01 (App. April 9, 2021). A claimant's hourly wage must be considered in tandem with the actual hours worked by that claimant or offered by the employer. Id. The parties previously stipulated that the claimant has returned to work for the defendant at the same, or greater wages than he received at the time of the injury. There is no information in the record to indicate that the claimant is working less hours than prior to the injury. Therefore, should it be determined that the claimant sustained an injury to both the left shoulder and the left upper extremity, the claimant would be compensated for his functional impairment only.

> Iowa Code section 85.34(2)(x) states:
>
> In all cases of permanent partial disability described in paragraphs 'a' through 'u', or paragraph 'v' when determining functional disability and not loss of earning capacity, the extent of loss or percentage of permanent impairment shall be determined solely by utilizing the guides to the evaluation of permanent impairment, published by the American medical association, as adopted by the workers' compensation commissioner by rule pursuant to chapter 17A. Lay testimony or agency expertise shall not be utilized in determining loss or percentage of permanent impairment pursuant to paragraphs 'a' through 'u', or paragraph 'v' when determining functional disability and not loss of earning capacity.

I am bound by statute to only consider the functional disability ratings issued by the various medical providers.

The claimant was lifting a toilet on October 19, 2018, when he felt his biceps tendon rupture, and immediately heard a pop. At that time, he also had pain in his left shoulder, and a deformity formed in his left arm. Eventually, Mr. Ruff was diagnosed with a proximal complete tear of the tendon of the long head of the biceps brachii with the torn end retracted to the superior aspect of the bicipital groove. He was also diagnosed with a full thickness tear of the posteroinferior glenoid labrum, and blunting of the entire superior labrum, which a radiologist opined was consistent with tearing at the time of the bicipital tendon tear. Dr. Hill also noted that the claimant had a large, partial thickness undersurface rotator cuff tear.

On January 15, 2019, Mr. Ruff had an arthroscopic surgery, which included debridement of the superior labrum, inferior labrum, subscapularis, and rotator cuff. The surgeon also performed lysis of adhesions of the rotator interval and subscapularis, SA space, subcoracoid space, supraglenoid space, and rotator cuff. Finally, the surgeon performed "SAD" which appears to mean subacromial decompression with acromioplasty and synovectomy. Dr. Hill noted the absence of the biceps tendon in the shoulder area, which he opined was consistent with the prior biceps tendon rupture. Dr. Hill's postoperative diagnoses were listed as: left shoulder proximal biceps tendon rupture; undersurface rotator cuff tear; adhesive capsulitis; extensive significant capsular synovitis; and, extensive thick fibrous adhesions of the RI and subscapularis, subcoracoid space, supraglenoid space and "RTC" and "SA" space.

Mr. Ruff then had various conservative treatments. During subsequent follow-up visits, Mr. Ruff was found to have no focal tenderness, and only residual weakness. Dr. Hill placed Mr. Ruff at MMI effective August 12, 2019, with no permanent restrictions. During a December 4, 2019, visit, Mr. Ruff complained to Dr. Hill of biceps spasm and shoulder fatigue. Dr. Hill performed strength testing, and found Mr. Ruff to have good strength in his shoulder with generalized residual weakness. During his evaluation, Dr. Hill found the claimant to have flexion of 160 degrees, abduction of 110 degrees, external rotation of 80 degrees, and internal rotation of 10 degrees. Based upon the range of motion measurements, Dr. Hill used the Guides to provide the claimant with a 9 percent upper extremity impairment.

Dr. Segal then completed an IME of the claimant. It is important to note that Dr. Segal is a board certified neurosurgeon. He previously treated patients for spinal and brain issues. Dr. Segal's report indicated that the claimant had "[m]ild to [m]oderately [s]evere" pain in his left arm depending on the position. Mr. Ruff told Dr. Segal that the pain was on the anterior left upper arm, in the area of the top of the biceps and anterior shoulder, and the bicipital tendon insertion. Mr. Ruff described things that aggravated his pain, such as lifting, any movement of his left arm above shoulder height, and quick movement with his left arm. Mr. Ruff also complained of weakness in his left shoulder.

Upon examination, Mr. Ruff complained of tenderness to palpation at the location of the biceps tendon insertion in the left arm. Dr. Segal tested the claimant's range of motion of his left shoulder. He found that the claimant had 110 degrees of abduction, 30 degrees of adduction, 150 degrees of forward flexion, 20 degrees of extension, 10 degrees of internal rotation, and 40 degrees of external rotation. Dr. Segal opined that Mr. Ruff's biceps tendon rupture and permanent Popeye deformity involved his arm more than his shoulder, and that some of the synovitis and adhesions in the left shoulder "extended proximally to the shoulder" and involved the upper thorax. Dr. Segal, despite his experience as a neurosurgeon and not an orthopedic doctor, provided his own diagnoses for the claimant.

Dr. Segal opined that the claimant achieved MMI on January 15, 2020. He then provided an impairment rating based upon the Guides. Based upon the above noted ranges of motions in the left shoulder, Dr. Segal opined that the claimant had a 14 percent left upper extremity impairment. He converted this to an 8 percent whole person impairment. Dr. Segal also opined that the claimant had motor weakness in his

left shoulder and arm examination, which resulted in a 21 percent left upper extremity impairment. He further opined that Mr. Ruff had "severe" pain with lifting, which caused an increased burden of pain not accounted for in range of motion or strength measurements. This resulted in an addition 3 percent permanent impairment to the left upper extremity and/or shoulder. The combined rating was 22 percent of the whole person. Dr. Segal concluded his report by providing restrictions for the claimant.

Interestingly, Dr. Segal notes in his report that the upper end of the biceps muscle has two tendons which attach it to bones in the shoulder. The long head attaches to the top of the shoulder socket, which is the glenoid. The short head attaches to the coracoid process in the shoulder blade. Dr. Segal continued by explaining that the long head is involved with the subscapularis muscle and tendon. The Supreme Court has previously held that these are parts of the rotator cuff and thus, the shoulder.

Mr. Ruff was scheduled to attend an IME with Dr. Gorsche on May 18, 2022. Dr. Gorsche is board certified in orthopedic surgery and is a certified independent medical examiner. Dr. Gorsche has substantial qualifications in orthopedic surgery, including as the chief resident of the orthopedic department at the Mayo Clinic, and has specialized in general orthopedics since 1986. Unfortunately, at the advice of his counsel, Mr. Ruff chose not to attend this IME. This is concerning behavior on the part of the claimant. Dr. Gorsche was unable to complete an IME on behalf of the defendants, thus allowing the claimant to be the only one to present an IME as evidence.

Even though he could not complete an examination of the claimant, Dr. Gorsche, completed a records review. While this would normally be less reliable than an actual examination, it was the claimant's choice to not attend the IME. Therefore, Dr. Gorsche and the defendants' only option was to have a records review. Dr. Gorsche noted the results of the surgery and diagnosed the claimant with a partial tear of the left rotator cuff, adhesive capsulitis, extensive significant capsular synovitis, extensive thick fibrous adhesions of the rotator interval and subscapularis subcoracoid space, the supraglenoid space, and the rotator cuff. Dr. Gorsche opined that the claimant's injury was to his shoulder.

Dr. Gorsche noted that the Popeye defect in the claimant's left biceps does not result in a permanent impairment to the arm apart from the shoulder injury. Dr. Gorsche was critical of Dr. Segal's combined impairment rating in which he included impairment for both a loss of range of motion and a loss of strength. Dr. Gorsche noted that these impairment measurements are not typically combined, and that the Guides provide that only in a rare case should a loss of strength be included if it represents an impairing factor not adequately considered by other methods in the Guides. Dr. Gorsche also noted that, due to its subjective nature and difficulty in rating, pain should not be included as a measurement for permanent impairment. Dr. Gorsche felt that both Dr. Segal's and Dr. Hill's impairment ratings based upon a range of motion deficit were appropriate.

Dr. Segal was afforded the opportunity to respond to Dr. Gorsche's report via letter. Dr. Segal affirmed his previous opinions, and expounded on his opinions further.

Dr. Segal opined that the biceps tendon is "not essential to shoulder function." He also indicated that the impairment of the biceps tendon injury is "primarily related to elbow flexion and pain in the biceps muscle." Interestingly, Mr. Ruff complained of pain in the area where his biceps attached to the shoulder during the hearing. He noted that he would have cramping in his left arm near his shoulder if he bent his left arm for too long, but he had no issues with using his left elbow, left hand or left fingers. His pain occurs when he overextends his shoulder, based upon his testimony. Dr. Segal opines that the Popeye deformity indicates biceps dysfunction in the arm and is both anatomically and functionally unrelated to the shoulder itself. Dr. Segal opined that Mr. Ruff's injury "caused two separate and distinct areas of anatomical and functional impairment; the shoulder and the arm."

Dr. Segal proceeded to explain that Mr. Ruff's shoulder weakness is "one of the cases that would be considered an exception for allowing the rating of motor weakness" pursuant to the Guides. Dr. Segal indicated that the loss of strength in the claimant's left shoulder was one of the primary impairing symptoms, and that this was not adequately considered by other methods in the Guides. Dr. Segal also explained that pain did not impede his measurements of impairment during his examination.

Dr. Gorsche replied to Dr. Segal's opinions. Dr. Gorsche explained that the biceps tendon rupture occurred inside of the glenohumeral joint and then retracted to the level of the bicipital groove. He opined that, based on this, the injury that occurred was a shoulder injury. Dr. Gorsche continued, "[r]upture of the long head of the biceps tendon always occurs interarticular and is the result of shoulder pathology." Dr. Gorsche cited to the principles of section 16.8A of the Guides.

The principles of section 16.8A of the Guides allow for the loss of strength to be rated separately, "if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods in the Guides." The Guides note, [i]f the examiner judges that loss of strength should be rated separately in an extremity that presents other impairments, the impairment due to loss of strength *could be combined* with other impairments, *only* if based on unrelated etiologic or pathomechanical causes." Guides, Section 16.8a, page 508. The Guides emphasize, "[o]therwise, the impairment ratings based on objective anatomic findings take precedence." Id. The Guides do not allow for rating based upon decreased strength in the presence of decreased motion, painful conditions, deformities, or absence of parts that prevent effective application of maximal force in the evaluated area. Id. Manual muscle testing of major groups is to be used for testing shoulder strength. Id.

The Guides define normal ranges of motion for the shoulder. Specifically, normal range of motion is from 180 degrees flexion to 50 degrees extension. Guides, page 475. Dr. Segal found Mr. Ruff to have forward flexion of 150 degrees and extension of 20 degrees. The Guides define normal abduction to be 180 degrees and normal adduction to be 50 degrees. Id. at 476. Dr. Segal found Mr. Ruff to have abduction of 110 degrees and adduction of 30 degrees. The Guides define normal internal and external rotation to be 90 degrees. Id. at 478. Dr. Segal found Mr. Ruff to have internal rotation of 10 degrees and external rotation of 40 degrees. Dr. Segal also found Mr.

Ruff to have tenderness to palpation at the biceps tendon insertion. While Mr. Ruff complained of pain of 0/10 at the time of the examination, it is still questionable whether Mr. Ruff should be rated based upon a loss of strength when the Guides do not allow for rating based upon decreased strength in the presence of a loss of range of motion which prevents the effective application of maximal force in the evaluated area.

Dr. Gorsche opined that, "[i]n my experience, I do not combine the ratings for loss of strength and loss of motion, but instead take the higher of the two. It would be a very rare case in which one would combine these ratings."

Recently, our Supreme Court affirmed a ruling of the Commissioner regarding the definition of a shoulder pursuant to Iowa Code section 85.34(2)(n) as amended in 2017. The court provided the most analysis of this issue in Chavez v. MS Technology LLC, 972 N.W.2d 662 (Iowa 2020). The claimant in that case injured her right shoulder while working. Id. at 665. She felt a pop in her right shoulder, and suffered a full thickness rotator cuff tear, which retracted to the glenoid. Id. at 668. She also was diagnosed with severe AC arthrosis, tendonitis, and tearing of her biceps tendon. Id. The Commissioner and court ruled that the shoulder includes the shoulder structure, including injuries to the tendons, ligaments, muscles, and articular surfaces connected to the glenohumeral joint. Id. The court ruled that the legislature did not intend to limit the definition of the shoulder solely to the glenohumeral joint. Id. The Commissioner and court also noted that the claimant suffered biceps tendonitis and tearing, and that she underwent a biceps tenotomy along with her shoulder surgery. Id. at 671. The Court continued by noting that Ms. Chavez did not suffer a permanent impairment to her right arm due to her biceps injury. Id. at 671.

This case bears similarities to Chavez. The claimant in this case injured his left shoulder with a proximal biceps tendon rupture; undersurface rotator cuff tear; adhesive capsulitis; extensive significant capsular synovitis; and, extensive thick fibrous adhesions of the RI and subscapularis, subcoracoid space, supraglenoid space and "RTC" and "SA" space. Namely, the case involves injuries to the labrum and rotator cuff in the claimant's left shoulder. These have previously been determined to be part of the "shoulder" pursuant to Iowa Code section 85.34(2)(n).

The question is whether the injury to the claimant's left biceps, including a Popeye deformity, caused the claimant to suffer permanent impairment to his left upper extremity. The claimant suffered a rupture or tear to the long head of his left biceps. According to Dr. Segal, the long head of the biceps attaches to the glenoid in the shoulder. The glenoid is the shallow socket in the shoulder blade in which the humeral head rests. Shoulder Joint Labral Tear, Online orthoinfo.aaos.org/en/diseases—conditions/shoulder-joint-tear-glenoid-labrum-tear/ (last visited September 9, 2022). While the biceps itself is not vital to the functioning of the shoulder, the biceps tendon itself originates in the shoulder as defined by Iowa law. The injury in this case is to the biceps tendon, not the biceps. Furthermore, the claimant testified that his pain occurred in close proximity to his shoulder. He demonstrated the same by pointing to that area during his arbitration hearing. He also only appears to get pain in his left upper extremity when he over-extends his shoulder.

I also find the opinions of Dr. Gorsche more persuasive on this issue. Dr. Gorsche is an orthopedic doctor with lengthy experience. He has practiced in general orthopedics since 1986, and was the chief resident of the orthopedic department at the Mayo Clinic. Dr. Gorsche explained that the biceps tendon rupture occurred inside of the glenohumeral joint and then retracted to the level of the bicipital groove. He opined that, based on this, the injury that occurred was a shoulder injury. Dr. Gorsche also noted that the Popeye defect in the claimant's left biceps does not result in a permanent impairment to the arm apart from the shoulder injury. I would note that the claimant did not have a separate impairment rating from any doctor for his left upper extremity due to his biceps issues. Therefore, the claimant did not sustain an impairment to his left upper extremity. His only permanent impairment is due to his left shoulder injuries.

The question then becomes the proper impairment rating for Mr. Ruff's left shoulder injury. As I noted above, I find the opinions of Dr. Gorsche to be more persuasive. Dr. Gorsche, as well as the Guides provide that an impairment rating based upon reduced strength, and pain should not be used to generate a permanent impairment rating except in rare instances. According to Dr. Gorsche this is not one of those cases. However, Dr. Gorsche also opined that both Dr. Hill and Dr. Segal provided valid impairment ratings as they relate to range of motion measurements. While I did not find much of Dr. Segal's impairment rating valid as it related to providing for impairment based upon muscle weakness and pain, he did provide the most up to date measurements and impairment based upon the Guides. Dr. Gorsche also noted that Dr. Segal's impairment rating was valuable as it related to the range of motion. Therefore, I find that the claimant had a 14 percent permanent impairment based upon the range of motion issues in his left shoulder.

Iowa Code section 85.34(2)(n) provides for compensation based upon 400 weeks for an impairment to the shoulder. Iowa Code section 85.34(2)(w) provides that compensation shall be paid during the lesser number of weeks of disability determined, "as will not exceed a total amount equal to the same percentage proportion of said scheduled maximum compensation." Accordingly, the claimant is entitled to 56 weeks of compensation. (0.14 x 400 weeks = 56 weeks).

Costs

Claimant seeks the award of costs as outlined in Claimant's Exhibit 6. Costs are to be assessed at the discretion of the deputy commissioner hearing the case. See 876 Iowa Administrative Code 4.33; Iowa Code section 86.40. 876 Iowa Administrative Code 4.33(86) provides:

> [c]osts 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, including convenience fees incurred by using the WCES payment gateway, and (8) costs of persons reviewing health service disputes.

Pursuant to the holding in Des Moines Area Regional Transit v. Young, 867 N.W.2d 839 (Iowa 2015), only the report of an IME physician, and not the examination itself, can be taxed as a cost according to 876 IAC 4.33(6). The Iowa Supreme Court reasoned, "a physician's report becomes a cost incurred in a hearing because it is used as evidence in lieu of the doctor's testimony," while "[t]he underlying medical expenses associated with the examination do not become costs of a report needed for a hearing, just as they do not become costs of the testimony or deposition." Id. (noting additionally that "[i]n the context of the assessment of costs, the expenses of the underlying medical treatment and examination are not part of the costs of the report or deposition"). The commissioner has found this rationale applicable to expenses incurred by vocational experts. See Kirkendall v. Cargill Meat Solutions Corp., File No. 5055494 (App. Dec., December 17, 2018); Voshell v. Compass Group, USA, Inc., File No. 5056857 (App. Dec., September 27, 2019).

The claimant requests reimbursement of costs as follows:

• Dr. David Segal IME of 2021	$4,000.00
• Filing Fee	$ 100.30
• Service Costs	$ 13.92
• Huney-Vaughn Court Reporters – cost of claimant's deposition transcript	$ 94.30
• Dr. David Segal Rebuttal Report of June 22, 2022	$ 250.00
Total:	$4,458.52

Dr. Segal's IME invoice for the 2021 IME indicates $250.00 was charged for a records review, $750.00 was charged for the IME itself, and $3,000.00 was charged for "[c]omponents of the report (includes images)." I am unsure as to what "components of the report (includes images)" means. It may be for drafting the report, but the invoice is not sufficiently detailed to indicate that this portion of the invoice pertains to the drafting of the report. Therefore, I decline to award these costs.

Dr. Segal's rebuttal report invoice does not break down Dr. Segal's time between reviewing Dr. Gorsche's report and drafting the rebuttal report. It simply bills for 20 minutes of Dr. Segal's time at $250.00. However, this is not an expense of an examination. Therefore, it is appropriate to award these costs.

The costs of the filing fee and service costs are awarded per my discretion. Therefore, the defendant shall reimburse the claimant one hundred fourteen and 22/100 dollars ($114.22) for costs. Any remaining costs listed are not awarded.

ORDER

THEREFORE, IT IS ORDERED:

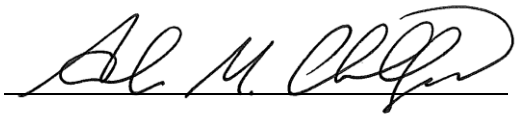
That the defendants shall pay the claimant fifty-six (56) weeks of permanent partial disability benefits at the stipulated rate of six hundred seventy and 82/100 dollars ($670.82) per week commencing on the stipulated date of August 12, 2019.

That the defendants shall reimburse the claimant one hundred fourteen and 22/100 dollars ($114.22) for costs incurred.

That the defendants shall pay accrued weekly benefits in a lump sum together with interest. All interest on past due weekly compensation benefits 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. Apr. 24, 2018).

That the defendants shall file subsequent reports of injury (SROI) as required by this agency pursuant to 876 Iowa Administrative Code 3.1(2) and 876 Iowa Administrative Code 11.7.

Signed and filed this 19TH day of October, 2022.



ANDREW M. PHILLIPS
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served, as follows:

Jason Neifert (via WCES)

Charles Blades (via WCES)

Right to Appeal: This decision shall become final unless you or another interested party appeals within 20 days from the date above, pursuant to rule 876-4.27 (17A, 86) of the Iowa Administrative Code. The notice of appeal must be filed via Workers' Compensation Electronic System (WCES) unless the filing party has been granted permission by the Division of Workers' Compensation to file documents in paper form. If such permission has been granted, the notice of appeal must be filed at the following address: Workers' Compensation Commissioner, Iowa Division of Workers' Compensation, 150 Des Moines Street, Des Moines, Iowa 50309-1836. The notice of appeal must be received by the Division of Workers' Compensation within 20 days from the date of the decision. The appeal period will be extended to the next business day if the last day to appeal falls on a weekend or legal holiday.