BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

JOSE MENDEZ-MARQUEZ, Claimant, vs. CRAMER & ASSOCIATES, Employer, and THE TRAVELERS INSURANCE CO. OF CT., Insurance Carrier, Defendants.	:	File Nos. 5058544.01 5067173.01 ARBITRATION DECISION Head Notes: 1803.1, 1803, 1802, 2907

STATEMENT OF THE CASE

Claimant, Jose Mendez-Marquez, has filed a petition for arbitration seeking workers' compensation benefits against Cramer and Associates, employer, and Travelers Indemnity Company of CT, insurer, both as defendants. A claim was originally brought against the Second Injury Fund but the matter was settled prior to hearing.

In accordance with agency scheduling procedures and pursuant to the Order of the Commissioner in the matter of the Coronavirus/COVID-19 Impact on Hearings, the hearing was held on March 1, 2021, via Court Call. The case was considered fully submitted on March 22, 2021, upon the simultaneous filing of briefs.

The record consists of Joint Exhibits 1 through 15, Claimant's Exhibits 1 through 6 and Defendants' Exhibits A through I. Accompanying the exhibits was the testimony of the claimant.

ISSUES

File No. 5058544.01

1. Whether the injury has resulted in a scheduled member or industrial disability;

2. The nature and extent of claimant's permanent disability; and,

3. Whether claimant is entitled to an assessment of costs.

1. Whether the injury has resulted in a scheduled member or industrial disability;

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

3. Commencement date for permanent partial disability benefits if any are awarded; and,

4. Whether claimant is entitled to an assessment of costs.

STIPULATIONS

The parties filed a hearing report at the commencement of the arbitration hearing. On the hearing report, the parties entered into various stipulations. All of those stipulations were accepted and are hereby incorporated into this arbitration decision and no factual or legal issues relative to the parties' stipulations will be raised or discussed in this decision. The parties are now bound by their stipulations.

The parties agree claimant sustained an injury arising out of and in the course of employment on both January 23, 2012, and December 11, 2017. The parties agree the claimant is entitled to permanent benefits, but disagree as to the nature and extent of permanent disability.

The parties stipulate the claimant's gross earnings were $1520.31 per week at the time of the January 2012 injury and $1529.00 per week at the time of the December 11, 2017 injury. At both relevant times, claimant was married and entitled two exemptions. For the January 2012 injury, the stipulated benefit rate is $946.91, and for the December 2017 injury, the weekly benefit rate is $931.78.

The parties stipulate the commencement date for the disputed benefits would be August 25, 2017, for the January 2012 injury. The commencement date for permanent benefits, if any are awarded, for the December 2017 injury is in dispute.

For both matters defendants waive all affirmative defenses. There are no medical benefits in dispute. Of the cost reimbursements requested by claimant, the parties stipulate that they have been paid.

FINDINGS OF FACT

At the time of hearing, claimant was a 51-year-old person. He first emigrated from Mexico to California and then to Iowa when he obtained a position at a meat packing plant. He has a workable grasp of the English language. He can speak and understand most English but reads and writes only very little in the English language.

At the time of his injury, he was married and living with his spouse who has since been deported.

His past work history includes restaurant work as a dishwasher and cook, an assistant to a mechanic, and carpentry work. He performed carpentry work for the defendant employer.

His past medical history is significant for a right knee fracture at the age of 17, and amputation of the right index finger at the first joint in 2000. In 2002 he fell approximately 6 feet, landing on his right knee and elbow.

Currently claimant works as a carpenter. He testifies that if he is not able to perform some of the activities of his job, he requests aid.

On or about January 23, 2012, claimant's was working on a bridge project when he fell approximately 10 to 15 feet with no loss of consciousness. (DE B:1) He was taken to the emergency room in Falls City, Nebraska by co-workers. (JE 1) Upon his arrival he was diagnosed with a compound fracture of the left forearm. (JE 1:1) Because of the severity of his injury he was transferred to Bryan LGH Medical Center in Lincoln, Nebraska, where a closed reduction, irrigation and debridement of the skin, subcutaneous tissue, muscle, bone with application of Robert Jones dressing took place. (JE 1:1, 1:2)

Claimant's care was continued with John L. Gaffey, M.D., at Des Moines Orthopaedic Surgeons on February 1, 2012. (JE 3:1) Dr. Gaffey placed claimant in a long arm cast and provided a set of exercises claimant should do at home. (JE 3:1) Because of the large bone loss during the initial surgery on January 24, 2012, Dr. Gaffey recommended a bone graft in the distal ulna. (JE 3:3)

During the March 19, 2012 visit, Dr. Gaffey referred claimant to Dr. Lin for an evaluation of the right hip due to ongoing pain. (JE 3:8) On May 3, 2012, Dr. Gaffey and Dr. Lin performed an open reduction internal fixation of his left distal radius fracture with iliac crest bone graft and left wrist hardware removal. (JE 3:14) Dr. Gaffey noted that claimant was "slow to recover but he has been through a lot." (JE 3:14)

At his August 10, 2012, appointment, claimant expressed improvement with some numbness in the dorsal radial aspect of his small finger. (JE 3:22)

On August 21, 2012, claimant underwent another surgical procedure to have hardware removed. (JE 3:26) He was not worsening but he was not improving either. Id. He rated his pain 3 to 4 on a 10 scale. Id. When Dr. Gaffey saw claimant on September 24, 2012, claimant was undergoing continued therapy and using a TENS unit at home. Because of ongoing pain and sensitivity, Dr. Gaffey recommended work restrictions of no lifting greater than 10 pounds with both hands and no vigorous grasping, pinching, pulling and twisting. (JE 3:27)

On December 11, 2012, Stephen Tuttle of Cramer & Associates signed off on a work restriction form which limited claimant to occasionally sitting, running, and driving, and no jumping. (DE C:1) He was allowed to lift over 50 pounds frequently and carry over 50 pounds occasionally. (DE C:1)

By January 25, 2013, claimant had plateaued. (JE 3:33) He denied any significant difficulties other than the fact that he was still having ongoing pain throughout the wrist. (JE 3:33)

On February 22, 2013, claimant underwent an FCE. (JE 10:2) The FCE was deemed invalid due to poor effort. (JE 10:15)

Dr. Gaffey found claimant to be at MMI as of March 27, 2013, with permanent work restrictions of 20 pounds with both hands. (JE 3:34) On March 29, 2013, defendants voluntarily paid 4% for the right arm at $946.91. (DE D:1) On August 28, 2013, defendants agreed to pay an additional ten weeks based on an opinion of Dr. Gaffey that claimant had sustained an 8% loss to the upper right extremity. (DE E:1)

Claimant began treatment with Steven Quam, D.O., at Metro Anesthesia and Pain Management on January 20, 2014. (JE 7:1) During the examination he had satisfactory range of motion to rotation as well as flexion and extension in the cervical area. Extension with rotation did not significantly increase his discomfort. Grip strength was decreased in the left hand when compared to the right and motor strength was decreased to flexion and extension in the left due to pain. Abduction and adduction were close to equal but slightly decreased on the left when compared to the right through the pain in the left upper extremity, particularly in his left forearm and wrist. Sensory was decreased on the left side compared to the right. He did have motion in fingers but he was not able to squeeze down as much on the left as compared to the right. (JE 7:2) Dr. Quam started claimant on Gralise, Mobic, and an alternative of morphine sulfate. (JE 7:3) The Gralise caused claimant to be tired and he wasn't sure if the medications were abating his pain. (JE 7:7) Dr. Gaffey along with Dr. Quam and Timothy Walsh, M.D., monitored and modified claimant's medication intake during 2014 through mid-2016, but claimant saw no real improvement in terms of pain. (JE 7)

Dr. Quam noted that claimant had equal temperatures in his wrists and arms but that claimant had more hair growth on the left compared to the right with no difference in the nails. (JE 7:15)

On January 20, 2016, Dr. Gaffey noted claimant was doing well and claimant was able to maneuver through a short arc range of motion without significant pain. (JE 3:51)

He sought treatment with Christopher Ledet, M.D., for pain management on April 9, 2016. (JE 2:1) At that time, claimant had had several surgeries but his pain remained constant, crushing, stinging, and aching. Id. He was then put on opioid therapy for pain and sent for physical therapy. (JE 2:7; 2:22) Dr. Ledet did not find that claimant met the criteria for a diagnosis of CRPS. (JE 2:4)

Claimant was seen again by Dr. Ledet on May 20, 2016 for recurring problems in the left hand. (JE 2:13) The pain level is eight on a scale of 10. His pain medications were continued and he was advised to strictly follow the prescription regimen. (JE 2:16)

On June 14, 2016, claimant returned to Dr. Ledet reporting that the physical therapy sessions had improved the range of motion in his wrist and hands and while there was additional pain accompanying the physical therapy, claimant was requesting continued treatment with physical therapy due to improvement. (JE 2:23). During the visit of July 18, 2016 with Dr. Ledet, there were recommendations to claimant to undergo a second orthopedic opinion and that the Worker's Compensation carrier would begin to make plans to move the patient to physical medicine and rehabilitation or occupational medicine for long-term follow up. (JE 2:30)

On August 12, 2016, claimant began weaning off his opioids but it was noted that with the increased intensive physical therapy and the further reduction of opioid analgesics, claimant's condition was plateauing. (JE 2:33). As the opioid usage was being decreased, claimant began to experience some symptoms of withdrawal. (JE 2:36) By September 28, 2016, claimant was successfully weaned off morphine. He had ongoing pain but was tolerating his new medication of Nucynta. (JE 2:41)

During the October 28, 2016, visit, Dr. Ledet documented that claimant had normal gait, tenderness at the left wrist, no swelling, moderately limited range of motion. (JE 2:44) Claimant's nails were a normal color, texture was normal, there were no lesions and no absent or deformed nails. (JE 2:44) At the November 23, 2016 visit, it was anticipated the December 14, 2016, visit would be claimant's last with Dr. Ledet subject to postoperative care. (JE 2:49)

On December 14, 2016, Dr. Ledet noted claimant's care was being transferred to orthopaedics given that the second opinion obtained by the orthopaedic surgeon recommended surgical intervention. (JE 2:56)

Claimant was seen by the hand and upper extremity team at the UIHC on November 14, 2016. (JE 8:2) Timothy Fowler, M.D., recommended an ulnar shortening osteotomy to improve function and reduce pain. (JE 8:4) This surgery took place on January 23, 2017. (JE 8:19) Following the surgery, claimant was placed in a short arm cast. (JE 8:22) At his follow-up appointment on April 18, 2017, there was some lucency at the osteotomy site and Dr. Fowler contemplated a bone grafting surgery. (JE 8:36) Claimant underwent bone grafting on May 10, 2017. (JE 8:41)

On July 28, 2017, Dr. Fowler recommended the claimant return to work with no lifting greater than 5 pounds and no driving or undertaking any activity requiring alertness if taking sedating medication. (JE 8:68)

On August 8, 2017, defendants agreed to temporarily accommodate claimant's physical restrictions by modifying the regular job of Carpenter. (DE F:1) Claimant still had ongoing pain, weakness, numbness and tingling in his palms and fingers at the August 25, 2017 visit. (JE 8:71) Dr. Fowler felt claimant's complaints were nonanatomic and that claimant should return to work with the five pound lifting restrictions. (JE 8:71) Dr. Fowler wrote that claimant was at MMI upon the completion of an FCE upon which future restrictions would be based. (JE 8:71)

A second opinion was conducted by Justin G. Wikle, M.D., who felt claimant was suffering neuropathic pain in the left forearm, wrist and hand with a musculoskeletal component. (JE 8:76) Given the severe neuropathic pain, Dr. Wikle ruled out CRPS. (JE 8:76)

On September 7, 2017, the FCE was conducted which was deemed valid. (JE 11:16-17) Claimant was able to work at the medium physical demand level with acceptable lifting of 20 pounds to shoulder height and 10 pounds overhead. (JE 11:25)

On October 13, 2017, Dr. Fowler adopted the functional capacity evaluation results:

> Mr. Mendez underwent a Functional Capacity Evaluation on September 7, 2017 with Timothy Salisbury, DPT, at Physical Therapy Specialists, P.C., which was deemed to be a valid assessment of his functional abilities. Per the FCE report he should have permanent restrictions including 2-handed floor to waist lifting of no more than 40 pounds rarely, 30 pounds occasionally, 15 pounds frequently, and 5 pounds constantly; 2-handed waist to shoulder lifting of no more than 25 pounds rarely, 20 pounds occasionally, 10 pounds frequently, and 5 pounds constantly; 2-handed overhead lifting of no more than 15 pounds rarely, 10 pounds occasionally, 5 pounds frequently, and 3 pounds constantly; 2-handed carrying of no more than 20 pounds rarely, 15 pounds occasionally, 10 pounds frequently, and 5 pounds constantly, left arm unilateral carrying of no more than 15 pounds rarely, 10 pounds occasionally, 5 pounds frequently, and 3 pounds constantly, push/pull of no more than 20 pounds rarely, 15 pounds occasionally, 5 pounds frequently, and 5 pounds constantly; rare crawling; left arm forward and overhead reaching are limited to occasionally; and left arm "arm controls" limited to "light" only.

(JE 8:80)

In response to an Inquiry from the defendants, Dr. Fowler opined claimant sustained no additional functional impairment to his left arm due to the surgery of May 10, 2017, and the bone graft. (JE 8:82)

On October 30, 2017, claimant sought out treatment for the left wrist with Anthony Kopp, D.O., on a referral from Dr. Wikle. (JE 6:1)

On or about December 11, 2017, claimant was struck on his left hand by a shackle pin that fell from a height of approximately 10 feet. (JE 9:1; DE G:1) He was treated initially at UnityPoint Occupational Medicine on December 11, 2017, by PA-C Sarah Plueger. (JE 9:4) A day later, his hand and wrist were examined by Douglas Martin, M.D. (JE 9:5) The CT showed no sign of fracture and Dr. Martin concluded claimant sustained a crush-type injury to the web space or soft tissue structures and physical therapy would be ordered. (JE 9:9)

On January 12, 2018, Dr. Kopp noted the increased pain and tenderness as a result of the large bolt falling onto the back of the hand. (JE 6:8) Dr. Kopp thought there might be some tendinopathy from the trauma. (JE 6:8) A February 2018 EMG of the left wrist showed evidence of ulnar nerve neuropathy affecting the sensory greater than motor function of the nerve in the forearm which was consistent with a history of trauma status post surgical repair. (JE 6:12) Dr. Kopp recommended a splint but no surgery. (JE 6:12) Claimant was continuing to work full time with modified restrictions. Dr. Kopp wanted claimant to stop using opioid pain medications and started claimant on naproxen 500 mg twice a day and nortriptyline 25 mg nightly. (JE 6:15) Dr. Kopp also did not believe claimant needed the baclofen prescription recommended by the University of Iowa team. (JE 6:15) There was a possibility claimant was developing or had developed CRPS due to the changes in skin color. (JE 6:15)

On February 27, 2018, Dr. Martin believed the claimant returned to his previous baseline from the December 2017 injury and was released without restrictions for this injury. (JE 9:15) He assigned no impairment rating given that he had, in Dr. Martin's opinion, returned to baseline for his range of motion and strength in the left hand. (DE H:1)

On June 25, 2018 claimant underwent an MRI of the lumbar spine which showed disc extrusion at L3-L4 and moderate bilateral foraminal stenosis at L5-S1. (JE 12:1)

On June 19, 2018, after several months of visits with Dr. Kopp, claimant continued to have ongoing pain with his left arm and wrist. (JE 6:25) Steroid injections were not helping, a bone scan was ordered, and Dr. Kopp's concerns about the development of CRPS continued. (JE 6:25) Claimant's left hand was cooler than the right. (JE 6:24)

On September 26, 2018, Dr. Kopp made a formal diagnosis of CRPS. (JE 6:32) Claimant's pain was in the left wrist traveling up into the arm. (JE 6:30) On examination claimant had reduced range of motion in the left wrist for both flexion and extension as well as supination. The temperature of his left wrist was cooler than on the right. He had some thinning of the skin. There was also color difference secondary to reduced exposure to the sun on the left. (JE 6:32) Dr. Kopp felt that claimant's symptoms were most consistent with complex regional pain syndrome. (JE 6:33)

Dr. Kopp made the referral to Timothy G. Klein, D.O., for pain management.

On December 12, 2018, claimant returned to Dr. Kopp with essentially the same symptoms. (JE 6:34). Claimant's pain and limited range of motion prevented him from lifting more than 5 pounds. He continued to work full-time with the weight restrictions as follows:

Hand to waist: 40 pounds rarely, 30 pounds occasionally, 15 pounds frequently, and 5 pounds constantly

Hand to shoulder 30 pounds rarely, 20 pounds occasionally, 10 pounds frequently, and 5 pounds constantly.

(JE 6:36) Dr. Kopp repeated the diagnosis of complex regional pain syndrome and that claimant continued to have issues with grasping and limited flexion extension in his left wrist secondary to a bony outgrowth at the distal end. (JE 3:36) Dr. Kopp recommended claimant follow up with Dr. Klein. (JE 6:37) Dr. Kopp also wrote out a work restriction form that limited claimant to light duty work only on the left arm. (JE 6:38)

On February 5, 2019, Dr. Kopp wrote an opinion letter opining that claimant did not suffer complex regional pain syndrome arising out of claimant's work. (JE 6:39) This apparent change of heart appears to be attributed to the medical diagnosis of Dr. Klein who stated he did not observe any atrophy, hair loss or temperature changes in the left arm compared to the right. (JE 6:39) In the notes section, Dr. Kopp wrote "He had temperature difference which is part of the criteria. He also had a bone scan that was equivocal. I do not feel he has CRPS at this time." (JE 6:40)

However, Dr. Kopp continued to include CRPS in his medical records following this. See e.g. JE 6:42, 6:44. During the October 1, 2019, visit, Dr. Kopp wondered if wrist replacement surgery was an option for claimant. (JE 6:46)

On November 5, 2019, claimant was seen by Timothy G. Klein, D.O., for left wrist pain. (JE 5:29) The plan was to refill claimant's Lyrica prescription and Voltaren gel and continue CMC joint injections every 3-4 months. (JE 5:30) He continued to have pain and reported this to Dr. Klein throughout 2020, during which time he received periodic injections which provided temporary relief. (JE 5 et seq.)

On March 27, 2020, Dr. Kopp saw claimant via a televisit and revised his diagnosis to de Quervain's tenosynovitis. (JE 6:47) Dr. Kopp recommended claimant follow up with Dr. Klein, continuing usage of Lyrica, diclofenac sodium 1% transdermal gel, the use of a neoprene brace (which claimant had to replace monthly due to the brace getting worn out by use due to the demands of his job), and increasing tramadol to 100 mg three times a day. (JE 6:48)

On September 29, 2020, Dr. Kopp returned claimant to opioid therapy due to the previous treatments being unhelpful.

> Given that he has tried physical therapy, injections which helped initially but the most recent ones were not effective, duloxetine, gabapentin, nortriptyline, Lyrica without benefit to his pain in the past, Tramadol provides some benefit as does Naproxen but it does not last all day and his pain has increased and he is having to take breaks during work, he is recommended to start taking morphine sulfate 15 mg, immediate release, twice a day for his pain. We can increase if needed he will keep close follow up with Kevin McVey PhD, and myself to work on dosing. [*sic*]

(JE 6:53)

On November 3, 2020, Dr. Kopp noted that Dr. Klein was working to refer claimant for a wrist replacement surgery. (JE 6:57)

On November 10, 2020, Dr. Kopp composed a letter at the request of the Worker's Compensation carrier. (JE 6:59) The defendants did not want claimant working while taking morphine.

> To whom it may concern, I was asked to compose this letter at the request of the workers compensation company who is responsible the care of his left UE. Diane McCarthy who is involved in the case requested that the patient be switched back to tramadol for pain control. She stated that the employer did not want him working with his current prescription of morphine.
>
> Have been working with Jose for the last several years. We have tried multiple pain medications to control his pain to allow him to continue to work. We have tried several other medication classes and therapies trying to reduce his pain and optimize his function. In spite of all of these efforts

> Jose continues to report significant pain in his left wrist which is aggravated with work. He reports that in the past he was on morphine for 5 years following his injury which allowed him to work. He denied any negative side effects from the medication at that time. He did not feel that it clouded his judgment and he did not feel that it made him have slow reaction time nor did he feel any feelings of euphoria.
>
> After a long process of different treatment interventions that I decided to trial morphine. We have reviewed the risks and benefits of opioid medications during our clinic we also signed a pain contract both in English and in Spanish to set expectations. My pharmacist and I reviewed previous dosing which included more frequent and higher doses of morphine. At that time he was able to function at work and did not have any new injuries nor was anyone else injured on the job because of his actions. Currently he is prescribed 15 mg twice a day. He has been on this medication since September 29, 2020. He reports that the deep ache from his wrist itself is significantly improved with the current medication. He feels that he is able to work more effectively and with less disruptions secondary to pain. He does not feel any euphoria or clouding of his thinking.
>
> I had a long discussion with Jose in regards to the request of the workers compensation insurance company. He also stated that he does not want to put anyone else at risk and if he felt cognitive effects from this medication he would tell his supervisor and we would stop using them and transition to different medications immediately. Jose gave me permission to contact his direct supervisor who has known him for over 20 years. On speaking with the supervisor, the supervisor did not notice any alterations in Jose's actions, nor had he received any negative reports from Jose or others during that time.
>
> I do understand that opioids can affect cognition as well as put people at risk when doing anything, especially when it involves construction tasks when the risks of injury are high. Though I am unable to perfectly predict the future and am not the habit of attempting to do so, I have put in a lot of thought to our current plan. I have attempted to gather data wherever I felt appropriate and available in order to make the best decision both for my patient and those around him. At this time the data supports our current plan to allow Jose to have improved pain control and continue to work.
>
> Please feel free to contact me with further questions. [*sic*]

(JE 6:59)

Currently, claimant has difficulty lifting more than 25 pounds occasionally, cannot use pneumatic tools, has constant pain in the left elbow radiating to the wrist, and problems driving. He does mow his own lawn but finds the vibrations painful. (JE 13:1)

Claimant needs to see another hand surgeon for a possible wrist replacement surgery. He works at least forty hours per week if not more operating a backhoe.

Scott Doughty, the representative of the company, testified that claimant is a good employee who is relied upon by the supervisor. It was the opinion of the employer that it would be dangerous for claimant to handle power equipment while using narcotics and claimant was asked to sign a paper that he would not come to work under the influence of morphine. Claimant switched from morphine to tramadol due to this. Claimant does not find tramadol as effective.

At the time of his examination with Dr. Bansal, claimant was unable to grasp items with his left hand and frequently suffered drops due to his left hand weakness. Further he complains of difficulty in the right hip and thigh with numbness and tingling, constant pain in the left elbow radiating to the wrist. He sometimes experienced sharp pain in the left arm and changes in sensation in the left arm. He is unable to lift more than 10 pounds with the left arm and is unable to lift anything over the shoulder level. (CE 6:27)

He also reported numbness and tingling of the right leg and foot after driving for more than three hours. He has suffered cramping of the right leg as well as difficulty kneeling on the right side. (CE 6:28)

On examination, claimant exhibited tenderness to palpation over the left wrist and forearm, negative Tinel's and Phalen's sign, negative Finkelstein's test, weakness with thumb adduction, loss of two-point sensory discrimination over the distal forearm as well as the ring and small fingers, swelling over the mid to distal forearm, tenderness to palpation over the elbow, dysesthesias over the palm, allodynia over the dorsum of the hand. (CE 6:28-29) The dorsal surface over the distal forearm and wrist was also cooler to touch than on the right but no color changes. (CE 6:29) There was reduced range of motion in the wrist.

On the right, he had no tenderness to palpation on the right hip with full range of motion.

Dr. Bansal agreed with the restrictions assigned by Dr. Fowler on October 13, 2017. (CE 6:32)

> Per the FCE, he should have permanent restrictions including two-handed floor to waist lifting of no more than 40 pounds rarely, 30 pounds occasionally, 15 pounds frequently, and 5 pounds constantly. Two-handed waist to shoulder lifting of no more than 25 pounds rarely, 20 pounds occasionally, 10 pounds frequently, and 5 pounds constantly. Two-handed overhead lifting of no more than 15 pounds rarely, 10 pounds occasionally, 5 pounds frequently, and 3 pounds constantly. Two-handed carrying of no more than 20 pounds rarely, 15 pounds occasionally, 10 pounds frequently, and 5 pounds constantly. Left arm unilateral carrying of no more than 15 pounds rarely, 10 pounds occasionally, 5 pounds frequently, and 3 pounds constantly. Pushing and pulling of no more than 20 pounds rarely, 15 pounds occasionally, 5 pounds frequently, and 5

> pounds constantly. Rare crawling, left arm forward and overhead reaching are limited to occasionally, and left arm "arm controls" are limited to light only.

(CE 6:32-33)

Dr. Bansal assigned 9% body as a whole impairment rating for the left upper extremity due to having a Class II impairment for a nondominant extremity. (CE 6:33) Alternatively, based on loss of range of motion of the left wrist and forearm, Dr. Bansal would assign a 15% upper extremity impairment. (CE 6:33)

For the partial amputation of the index finger, Dr. Bansal assessed a 9% hand impairment rating. (CE 6:33) For the right knee fracture, Dr. Bansal assigned a 5-7% lower extremity impairment rating. (CE 6:34)

Dr. Bansal also diagnosed claimant with CRPS although did not elaborate on the symptoms that he believed were consistent with the CRPS, but instead included a screenshot of guidelines in the AMA Guides, Sixth Edition. (CE 6:35)

For the left wrist, Dr. Bansal opined claimant incurred an aggravation of his degenerative joint disease and that he reached MMI as of September 9, 2019, with no additional restrictions or impairments for the injury. (CE 6:36)

CONCLUSION OF LAW

The parties have stipulated claimant sustained an injury arising out of and in the course of his employment on January 12, 2012 (file no. 5058544.01), and December 11, 2017 (File No. 5067173.01), to the right wrist/hand area. The primary dispute is whether the injury to his wrist and forearm has become a body as a whole injury entitling claimant to industrial disability benefits.

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 R. App. P. 6.904(3).

The claimant has the burden of proving by a preponderance of the evidence that the alleged injury actually occurred and that it both arose out of and in the course of the employment. Quaker Oats Co. v. Ciha, 552 N.W.2d 143 (Iowa 1996); Miedema v. Dial Corp., 551 N.W.2d 309 (Iowa 1996). The words "arising out of" refer to the cause or source of the injury. The words "in the course of" refer to the time, place, and circumstances of the injury. 2800 Corp. v. Fernandez, 528 N.W.2d 124 (Iowa 1995).

An injury arises out of the employment when a causal relationship exists between the injury and the employment. Miedema, 551 N.W.2d 309. The injury must be a rational consequence of a hazard connected with the employment and not merely incidental to the employment. Koehler Electric v. Wills, 608 N.W.2d 1 (Iowa 2000); Miedema, 551 N.W.2d 309. An injury occurs "in the course of" employment when it happens within a period of employment at a place where the employee reasonably may be when performing employment duties and while the employee is fulfilling those duties or doing an activity incidental to them. Ciha, 552 N.W.2d 143.

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).

Claimant appears to concede in the brief that there are no issues of permanency as it relates to file number 5067173.01. Dr. Martin opined that claimant suffered no additional impairment as a result of the injury and no additional restrictions were imposed due to the injury. Dr. Bansal opined that claimant suffered an aggravation of a pre-existing condition on December 11, 2017, but agreed there were no additional impairments or restrictions as a result of this injury. Therefore, as it relates to file number 5067173.01, claimant shall take nothing.

The primary thrust of claimant's argued entitlement to industrial benefits arises out of the possibility claimant developed CRPS as a result of the chronic pain.

Initially, Dr. Kopp believed that there were signs and symptoms of CRPS including changes in temperature, color difference and thinning of the skin. However, Dr. Klein and Dr. Wikle did not find claimant had suffered CRPS. Dr. Wikle ruled out CRPS due to claimant's severe neuropathic pain. Dr. Klein did not observe any atrophy, hair loss or temperature changes. Dr. Quam, in 2014, observed abnormal hair growth but no changes in temperature and no changes in the nail beds.

Dr. Bansal includes a screenshot from the AMA Guidelines, sixth edition, which lays out the criteria for diagnosing CRPS. Dr. Bansal does not identify which specific symptoms claimant has in the opinion section. One can draw inferences from the physical examination section where Dr. Bansal documents dysesthesias over the palm and allodynia over the dorsum of the hand and temperature changes. However, the dysesthesias over the palm and the allodynia over the dorsal region of the hand are not addressed in previous medical records.

Dr. Klein did not observe temperature changes, but Dr. Kopp had more experience with claimant and did observe temperature changes over the course of several months of treatment. Dr. Wikle did not note whether there were other criteria meeting the CRPS diagnosis, but rather ruled it out because claimant had what Dr. Wikle characterized as neuropathic pain. Dr. Quam felt claimant did not have sufficient criteria to meet a CRPS diagnosis.

Dr. Kopp, who has followed the claimant the longest, and began noticing changes in the quality of claimant's skin and the temperature and color of the claimant's left arm compared to the right arm, diagnosed claimant with CRPS after observing claimant for several months, but then later changed his opinion after a discussion with defendants and based on the review of Dr. Klein. Even after the discussion and opinion letter, Dr. Kopp continued to use CRPS as a differential diagnosis but then later changed to de Quervain's.

Dr. Kopp has the most intimate knowledge of claimant's condition. He has treated and observed claimant since 2017. During the course of treatment, with no involvement from attorneys or outside parties, Dr. Kopp made note of changes in the temperature and color of claimant's skin on the left compared to the right. He did not immediately make the diagnosis of CRPS, but instead watched and monitored the situation. It was only after several months (from February 2018 to September 2018) that Dr. Kopp made the formal diagnosis of CRPS. Yet, Dr. Kopp did change his opinion, moving on from CRPS due to the equivocal bone scan and made a new diagnosis of de Quervain's.

In review of the medical records, it is found that claimant has not carried his burden of proof that the wrist injury has given rise to CRPS. This may change in the future, but at the present time, the unfortunate and debilitating wrist injury of January 2012 is limited to claimant's wrist.

Claimant has significant limitations. Dr. Fowler recommend the claimant return to work with no lifting greater than 5 pounds constantly and no driving or undertaking any activity requiring alertness while taking sedating medication. Claimant continues to take narcotics to manage his pain. As such, claimant is entitled to an 85%[1] functional loss of his left upper extremity.

Claimant is also entitled to costs as itemized in Exhibits 1, 2, and 3. In claimant's brief, he requests an order of medical care to address the possible negative side effects of his Tramadol intake.

This issue was not presented at hearing, however, claimant is entitled to medical care arising out of and pertaining to his accepted left upper extremity injury.

[1] The date of injury is January 23, 2012, which requires application of the code predating the 2017 changes.

ORDER

THEREFORE, it is ordered:

That defendant employer and insurer are to pay unto claimant two hundred twelve point five (212.5) weeks of permanent partial disability benefits at the rate of nine hundred forty-six and 91/100 dollars ($946.91) per week from August 25, 2017.

That defendant employer and insurer shall pay accrued weekly benefits in a lump sum.

That claimant is entitled to ongoing care for both accepted work injuries.

That defendant employer and insurer shall pay interest on unpaid weekly benefits awarded herein as set forth in Iowa Code section 85.30.

That defendant employer and insurer shall pay the costs of this matter pursuant to rule 876 IAC 4.33.

That defendants shall file subsequent reports of injury as required by this agency pursuant to rule 876 IAC 3.1(2).

Signed and filed this 25th day of October, 2021.

JENNIFER S. GERRISH-LAMPE
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served, as follows:

Greg Egbers (via WCES)

Julie Burger (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.