IN THE IOWA DISTRICT COURT FOR POLK COUNTY

RACHAEL LOVAN, Petitioner, vs. **BROADLAWNS MEDICAL CENTER, Employer, and SAFETY NATIONAL CASUALTY CORPORATION, Insurance Carrier,** Respondents.	**CASE NO. CVCV056405** **RULING AND ORDER ON PETITION FOR JUDICIAL REVIEW**

NOW on January 30, 2019 this matter came before the Court for oral argument upon Rachael Lovan's petition for judicial review. The Petitioner appeared by her counsel Mr. Richard Schmidt. The Respondent, Broadlawns Medical Center, appeared by its counsel Ms. Valerie Landis. Also present was attorney Peter Renda for the insurance carrier.

The Court, having heard the arguments of the parties, reviewed the briefs, the agency record, as well as the entire court file, finds as follows:

FACTS AND PROCEDURE

Rachael Lovan, (hereinafter referred to as "Rachael") appeals from the Workers' Compensation Commissioner's ruling entered on May 15, 2018. That decision denied Rachael's petition for alternate medical care. The Respondents (hereinafter referred to as "Broadlawns") resists the appeal and requests that the Commissioner and the Agency be affirmed.

In an Arbitration Decision entered on March 30, 2018 the Deputy Workers' Compensation Commissioner, Erin Q. Pals, found Rachael was entitled to 45 weeks of permanent partial disability benefits—commencing on November 12, 2014—for a work related

injury to her extremities. The employer was credited with all weekly benefits paid up to the date of the Arbitration Decision. However, the Deputy Commissioner denied Rachael's request for alternate medical care. The Deputy Commissioner found that because Rachael's ongoing complaints were related to her work injury, employer Broadlawns, pursuant to Section 85.27, the Code of Iowa, had a right to choose her care. Initially, Broadlawns accepted liability for Rachael's work related injury; the date of injury occurring May 1, 2008. Broadlawns, therefore, could choose Rachael's care providers at its expense. However, after years of treatment, including several surgeries, Broadlawns sought an independent medical examination of Rachael. The examination was performed by Dr. Benjamin S. Paulson on March 12, 2018. Dr. Paulson determined the symptoms that Rachael complained of at present were not work related. As a result, Broadlawns denied any further liability for Rachael's injuries and complaints.

Deputy Commissioner Pals found otherwise. The Arbitration Decision, relying upon extensive facts and other medical evidence by several of Rachael's doctors and care providers, determined that Rachael's injuries and complaints were still related to her initial work injury. However, Deputy Commissioner Pals, and later Deputy Commissioner Stephanie J. Copley, found the law allowed Broadlawns to resume control of Rachael's care and choose her medical providers. Broadlawns wanted Dr. Paulson to be that provider. Racheal wished for Dr. Eugene J. Cherny to be her alternate care provider.

Rachael appeals claiming Deputy Commissioner Copley's denial of alternate medical care was in error pursuant to Section 85.27(4), the Code of Iowa. In addition, the reattachment of Broadlawns' right to choose Rachael's care provider, after they denied liability for medical care, was unreasonable under the totality of the facts and circumstances of this case.

The Court adopts the facts as set forth by the Deputy Commissioners in their decisions.

They are set forth verbatim as follows:

Claimant, Rachel Lovan, sustained a stipulated injury to her bilateral upper extremities while working for Broadlawns Medical Center (hereinafter "Broadlawns" or "defendant-employer"). The stipulated date of injury is May l , 2008. Ms. Lovan began working at Broadlawns on July 29, 2001. She was hired as a full-time file clerk. As a file clerk she was responsible for pulling and delivering charts or files around the hospital and clinic. The files varied in size, but some were larger than the size of a phone book. She would push a cart with the files. She was also responsible for filing the charts back on the shelves. She worked in this position for approximately one year. (Testimony).

She continued to work at Broadlawns, but transferred to the position of correspondence clerk. The correspondence clerk performs duties related to the release of medical information. In this position, her duties included helping patients at the window, sometimes completing handwritten forms for the patients, answering the phone, copying charts, and utilizing a typewriter and computer. (Testimony; Claimant's Exhibit 2, pages 3-5).

Around 2007 Ms. Lovan began to experience difficulties with her hands and arms. She had numbness and tingling in her fingertips and hands. She also had shooting pain in her arm, all the way up to her shoulder when she used her hands. She noticed that she used her hands a lot at work, especially when she was working with the charts. Ms. Lovan had problems with her hands at home and noticed that the symptoms in her hands and arms would keep her up at night. (Testimony).

Ms. Lovan went to see her primary care physician, William Maher, DO. in 2007 or 2008. Ms. Lovan testified that Dr. Maher referred her to another doctor. (Testimony) In 2008, Ms. Lovan reported her symptoms to the defendant-employer. Ms. Lovan was sent for an EMG in May of 2008. She had an abnormal electrodiagnostic study. There was a mild to moderate degree of bilateral median mononeuropathy consistent with carpal tunnel lesion, left greater than right. The studies showed no convincing electrophysiological evidence of brachial plexopathy, cervical radiculopathy, peripheral neuropathy, myopathic nor focal motor neuronopathic processes. (JEI).

Mark D. Fish, DO, an orthopaedic surgeon at the Iowa Clinic, saw Ms. Lovan for bilateral wrist pain on August 5, 2008. He felt she had bilateral carpal tunnel. He gave her bilateral carpal tunnel injections. He also ordered another set of nerve tests. The second nerve tests were conducted by Todd C. Troll, M.D. on August 5, 2008. The findings were consistent with mild bilateral median neuropathy at the wrist. Ms. Lovan reported that the injections helped for approximately two weeks, but then the pain returned. Dr. Fish felt that because the injections did provide her with some relief, a carpal tunnel release might be beneficial for her. However, Ms. Lovan did not want surgery at that time, This was on September 2, 2008. (JE2).

On November 25, 2008, Ms. Lovan was sent to Delwin E. Quenzer, M.D. for a workers' compensation hand surgery initial consultation. Prior to the evaluation, Dr. Quenzer had reviewed Ms. Lovan's prior treatment and testing records. He noted that Ms. Lovan had a history of wrist pain that began several years ago and worsened in May of 2008. Ms. Lovan reported numbness in all digits bilaterally and said her hand felt heavy. Her symptoms were worse at

night. She had already tried bilateral wrist splints. Dr. Quenzer noted that she had an administrative job at Broadlawns, It was his understanding that the job required occasional moderate lifting. She had to lift medical charts either individually or multiple files at a time. She also reported that she pulled charts. Ms. Lovan said there was repetitive grasping and pinching in her job along with repeated or sustained turning and twisting. Dr. Quenzer's impression was bilateral carpal tunnel syndrome. He felt she was a candidate for bilateral endoscopic carpal tunnel releases. Ms. Lovan wanted to proceed with the procedures. Dr. Quenzer's note indicates that his office would request authorization through workers' compensation. (JE3, pp. 1-4).

On December 22, 2008, Dr. Quenzer performed a left endoscopic carpal tunnel release. (JE4, p. I) Ms. Lovan testified that she experienced approximately one month of relief following the surgery. Ms. Lovan returned to work on December 26, 2008. She believes she returned to work too quickly after the surgery. She returned to her full-time correspondence clerk position. By this time, Broadlawns had transitioned to electronic computer records, thus she no longer needed to make copies. She could generate copies by printing them from the computer. Ms. Lovan did have an increased amount of computer work. (Testimony).

Charles Denhart, M.D. conducted additional nerve testing on July 14, 2009. This was done at the request of Dr. Quenzer. The testing revealed residual left carpal tunnel syndrome. (JE5).

On August 10, 2009, Dr. Quenzer performed a right carpal tunnel release and right median neurolysis at the elbow. (JE4, p. 2) She was eventually released to return to work full duty. Again, Ms. Lovan only experienced approximately one month of relief. (Testimony).

On January 18, 2010, Dr. Quenzer issued his opinion with regard to permanent impairment sustained by Ms. Lovan. He noted that she underwent right carpal tunnel release and right median neurolysis on August 10, 2009 and left endoscopic carpal tunnel release on December 22, 2008. Dr. Quenzer opined that she did not have any ratable impairment of either upper extremity. (JE3, pp. 5-6).

On February 17, 2010, Ms. Lovan returned to see Dr. Quenzer. She continued to have pain and numbness in both her arms. The doctor's impression was postoperative state, both arms with residuals. He recommended repeat electrodiagnostic testing of both upper extremities. (JE3, p. 7).

Ms. Lovan saw Gregory J. Yanish, M.D. on March 5, 2010 for a second opinion regarding her bilateral carpal tunnel syndrome. Ms. Lovan reported that she did not have resolution of her carpal tunnel, her right wrist was especially uncomfortable. She feels that her symptoms have not improved at all, She had a significant amount of numbness and tingling that woke her at night and was very bad during her workday. She reported that her symptoms were much worse when she was sleeping, driving, or talking on the phone. Dr. Yanish's assessment was recurrent carpal tunnel syndrome, right greater than left. He sent her for additional nerve testing. The testing was performed on April I , 2010. The impression from the testing was moderately severe right carpal tunnel syndrome (CTS), mild left CTS with sensory motor involvement and no evidence of ulnar nerve entrapment bilaterally. (JE6, pp. 1-24).

Dr. Yanish performed an open carpel tunnel release revision on her right wrist on June 8,

2010. (JE7) Ms. Lovan underwent some physical therapy to increase her right wrist motion during the summer of 2010. (JE8).

Dr. Yanish saw Ms. Lovan on July 7, 2010 for follow-up of her revision open carpal tunnel release on the right upper extremity. At that time, Ms. Lovan was ecstatic that her symptoms had dramatically improved. She reported that she felt the best she had in a long time. He returned her to work with restrictions. (JE6, pp. 5-6).

By July of 2010, Ms. Lovan reported that she was using her hand normally and was ready to return to work full-duty status. She was ready to consider revision treatment for her left side in a couple of months; first she wanted to get back to work to focus on her job for a while. (JE6, pp. 7-8).

Ms. Lovan returned to Dr. Yanish on November 12, 2010. She reported that her numbness and tingling in her right upper extremity had returned. She was miserable in both upper extremities. Dr. Yanish's assessment was paresthesias of bilateral upper extremities, carpal tunnel syndrome bilaterally and question of cubital tunnel syndrome on the right side. The doctor explained to Ms. Lovan that it was impossible for her to have all fingers numb at the same time. Dr. Yanish stated:

> There is no question in my mind that this patient's carpal tunnel is open. I triple confirmed this prior to closing the wound and her surgery given the fact that this was a revision surgery and this is also my usual protocol during surgery. There is no question in my mind that she does not have recurrent carpal tunnel on this after her second surgery.

Ms. Lovan returned to Dr. Yanish on November 24, 2010. She reported that she had total weakness of her right upper extremity and pain radiating up into her upper arm. She returned with a short paragraph describing her symptoms, not a diary as the doctor had requested. She noted that when she used her computer mouse the tips of her thumb, pointer finger, and middle finger felt numb. The doctor noted she did not complain of any ulnar nerve symptomatology. Dr. Yanish felt strongly that she did not have a nerve compression issue in her upper extremity, but thought she might have something going on with her neck or even possible thoracic outlet syndrome. He recommended she see a specialist, such as Alan R. Koslow, M.D. of Heartland Vascular Medicine and Surgery. Dr. Yanish felt like he did not have any other treatment to offer her. He did not feel it would be worthwhile to revisit her left carpal tunnel. (JE6, pp. 11-12).

On May 4, 2011, Dr. Koslow sent a letter to Dr. Maher. He noted that he had seen Ms. Lovan and that she had a partial response to the CT-guided anterior scalene injection. She reported that her pain went from a 10 to a 5, but most of her residual pain appeared to be in her hand and forearm. Dr. Koslow felt this was likely the residual from her carpal tunnei and uinar release surgeries. She was concerned about the scar from the potential surgery Dr. Koslow would perform and wanted to think about surgical treatment. Dr. Koslow recommended she return to Dr. Yanish. (JE9; Testimony).

On July 15, 2011, Ms. Lovan returned to see Dr. Yanish. She continued to report

discomfort in her hands and was recently sent for a repeat EMG. Dr. Yanish stated:

> She is noted to have had worsening EMG on her right side, which in my entire career I have never seen. I have explained this to the patient today and spent a long time discussing this with her. After seeing the repeat EMG I am convinced that this patient does have something going on in her wrist, and there is a real reason for her continued symptoms. I have been straight forward [sic] with her today and told her that until I saw this EMG I was really quite skeptical. I do feel that there is an actual real issue going on causing continued median nerve compression, even though she has had two releases. I also feel that her second release which was performed by me was successful in that she did have a period of time where she had total resolution of her symptoms. This did come back slowly over time which I feel is caused from the transcarpal ligament regenerating and healing again. (JE6, p. 13).

Dr. Yanish advised Ms. Lovan that she probably needed a repeat carpal tunnel release. He recommended a fat pad be placed between the edges of the transcarpal ligament to prevent regeneration. In the meantime, he gave her an injection into her right carpal tunnel. (JE6, pp. 13-14).

Donna J. Bahls, M.D. released Ms. Lovan to regular duty, no restrictions on March 29, 2012. (JE6, p. 15).

On April 16, 2012, Dr. Bahls assigned 5 percent upper extremity impairment for both arms due to residual carpal tunnel syndromes. Dr. Bahls noted that the symptoms affected her sleep and function at work and at home so she assigned another 3 percent whole person impairment for pain. The total impairment assigned by Dr. Bahls equated to a total of 9 percent whole person impairment. She also stated that Ms. Lovan required medication to help her deal with her bilateral upper extremity symptoms and would need monitoring every 6 to 12 months for the medication, (JE6, p. 16).

On January 20, 2014, Dr. Bahls conducted additional nerve testing. The impression from the testing was bilateral CTS, slightly improved since the July 5, 2011 study. (JE6, pp. 17-18).

On March 10, 2014, Ms. Lovan returned to see Dr. Yanish. She continued to exhibit symptoms of numbness and tingling in both hands. She reported that her symptoms were aggravated by working, driving the car; talking on the phone, and while sleeping at night. Dr. Yanish stated, "[t]he patient has a history of having surgical release of bilateral carpal tunnel with recurrence of her symptoms secondary to scar tissue buildup in the carpal tunnel canal." (JE6, p. 19) Ms. Lovan opted to undergo the open carpal tunnel release with hypothenar fat pad transposition. The doctor noted that the surgery would be performed once approval through workers' compensation was approved. (JE6, pp. 19-20).

On July 23, 2014, Dr. Yanish opined that Ms. Lovan's condition was aggravated by her duties and was related to the original work comp injury. The doctor stated, "[t]his is an extremely unusual situation with recurrent carpal tunnel syndrome secondary to scar tissue, but the scar

tissues stems from the original surgery, therefore, in my medical opinion the current condition is related to her work comp claim." (JE6, p. 22).

On September 9, 2014, Dr. Yanish performed left open carpal tunnel release with hypothenar fat pad flap. (JEIO).

Ms. Lovan returned to Dr. Yanish's office on November 12, 2014 for impairment measurements. The measurements are set forth in the office note. (Defendants' Ex. A).

Dr. Yanish released Ms. Lovan to final restrictions of return to work full duty on November 12, 2014. (JE6, p. 23). On November 20, 2014, Dr. Yanish opined that Ms. Lovan had sustained two percent impairment for her left open carpal tunnel release. The records demonstrate that on February 23, 2016, Todd J. Janus, M.D. conducted additional nerve studies. The impression from the studies was slightly abnormal EMG/nerve conduction study with loss of velocity in both the left and right median nerve. (JEII).

Ms. Lovan returned to see Dr. Yanish on March 23, 2016. She reported that the numbness and tingling had not resolved following the redo of her left carpal tunnel release. Her symptoms improved for a while but recently she had a recurrence of her discomfort. She reported subjective numbness and tingling in her left hand. Dr. Yanish explained to Ms. Lovan that he did not believe that her symptoms of continued numbness and tingling were related to carpal tunnel syndrome and did not feel she would benefit from any more surgical treatments. He was very confident that the left carpal tunnel was released. Dr. Yanish recommended that she seek a second opinion if she so desired. (JE6, pp. 25-26).

Ms. Lovan did not seek any medical treatment for her upper extremities from March 23, 2016 until she saw Eugene J. Cherny, M.D. on September 13, 2016. She testified that she did not seek out an opinion from a pain specialist or a rheumatologist. (Testimony).

At the request of her attorney, Ms. Lovan saw Dr. Cherny on September 13, 2016. Dr. Cherny reviewed Ms. Lcvan's treatment records in addition to examining her. Ms. Lovan reported that she had been employed with Broadlawns for approximately 15 years. At the time of the exam, she was working as a correspondence clerk where she primarily performed clerical work including computer work and filing duties. Ms. Lovan reported to Dr. Cherny that her right upper extremity felt heavy and was often fatigued. Work above her shoulder level seemed to increase the symptoms. She also reported tingling in her fingers, primarily the right index, middle, and ring fingers. She also had an aching pain that limited her work and daily activities. Ms. Lovan reported that she has very similar symptoms in her left upper extremity; however, they were not as severe as in the right upper extremity. Dr. Cherny stated:

> She continues to have symptoms in both upper extremities as indicated above with the right worse than the left. I do feel that her ongoing symptoms can be casually related to her occupation at Broadlawns Medical Center and is a continuation of her prior claims to both upper extremities. Physical findings during today's exam suggest median neuropathy in the proximal forearm with the right greater than the left. I would recommend further exploration of the

> proximal forearm to rule out a pronator syndrome with a traditional longitudinal incision rather than the transverse incision type performed by Dr. Quenzer. It has been my experience that the pronator release surgical procedure has a suboptimal outcome when performing a transverse incision vs. a longitudinal incision. A longitudinal incision allows greater room for exploration to ensure a full release of the median nerve through this region.

He recommended further exploration of the proximal forearm to rule out pronator syndrome with a traditional longitudinal incision rather than the transverse incision performed by Dr. Quenzer. Dr, Cherny noted that it had been "[his] experience that the pronator release surgical procedure has a suboptimal outcome when performing a transverse incision vs. a longitudinal incision. A longitudinal incision allows greater room for exploration to ensure a full release of the median nerve through this region." (Id.) If the procedure was successful, he would recommend similar treatment for the left upper extremity. Dr. Cherny noted that if she did not wish to proceed with surgery then he would agree that she is at maximum medical improvement (MMI). He set forth the basis for his impairment rating and ultimately assigned 39 percent impairment for the right upper extremity and 31 percent impairment to the left upper extremity. Dr. Cherny opined that Ms. Lovan's 15 years of work at Broadlawns including extensive keyboarding and filing activities were a contributing factor to her current conditions in her upper extremities. He recommended a re-exploration of the right forearm. He also recommended further exploration of the right proximal forearm and if she had a positive outcome he would recommend the same for the left upper extremity. He did not place any permanent restrictions on her activities. (JE12, pp. 1-13).

On January 2018, additional nerve testing was performed on Ms. Lovan. This was performed by Irving Wolfe, D.O. at the request of claimant's attorney. The impression on the testing report indicated that findings supported dysfunction of the left ulnar nerve at the level of the elbow consistent with left-sided cubital tunnel syndrome and dysfunction of the left median nerve at the level of the wrist consistent with left-sided carpal tunnel syndrome. The study of the right upper extremity was normal.

Ms. Lovan returned to Dr. Cherny on February 8, 2018. The doctor also reviewed updated nerve studies. He noted that the January 29, 2018 studies revealed objective findings to support ulnar neuropathy of the left elbow consistent with left cubital tunnel syndrome, as well as left median neuropathy at the level of the wrist consistent with left carpal tunnel syndrome. He felt that Ms. Lovan's range of motion in both of her upper extremities was consistent with the range of motion he noted in September of 2016. Dr. Cherny felt that no change was necessary for the impairment rating based on range of motion. (JE12).

Dr. Cherny did note there was a progression of symptoms involving the median nerve distribution of both hands. He did not change the impairment rating to the right upper extremity; this remained 39 percent. However, he did adjust the impairment rating he assigned to the left upper extremity. He changed this from 31 percent of the left upper extremity to 40 percent of the left upper extremity. Dr. Cherny noted that Ms. Lovan continued to work as a clerk at Broadlawns. He also noted she had increased symptoms since he last saw her in September of 2016. He diagnosed her with possible right median neuropathy at the level of the wrist consistent with carpal tunnel syndrome; right median neuropathy in the proximal forearm consistent with

pronator syndrome; left median neuropathy consistent with left carpal tunnel syndrome; and left ulnar neuropathy at the elbow consistent with left cubital tunnel syndrome. Dr. Cherny stated, "I do feel that the above diagnoses are directly related to her employment at Broadlawns medical center due to the repetitive standing and filing duties which she has performed over the last 15 years." (JE12, p. 19).

With regard to additional treatment, Dr. Cherny recommended injections into the carpal tunnels to see if she received any benefit. Depending on the outcome of the injections, she may or may not be a candidate for additional carpal tunnel release procedures. Dr. Cherny felt Ms. Lovan would benefit from a workstation evaluation and some physical therapy. (JE12).

At the request of the defendants, Ms. Lovan was evaluated by Benjamin S. Paulson, M.D. at Iowa Ortho for purposes of an independent medical evaluation (IME). Dr. Paulson reviewed the medical records provided to him and examined Ms. Lovan. Ms. Lovan reported bilateral hand numbness and tingling. She reported that she worked at Broadlawns for the past approximately 17 years. Her job duties included typing and talking on the phone most of her day. She reported to Dr. Paulson that the previous day her finger went numb and turned completely white. She experienced numbness with her fingertips and achiness and pain in her forearms. She also reported that her sleep was interrupted due to the numbness. (JE 14, pp. 5-10).

Dr. Paulson felt that clinically, Ms. Lovan did not have textbook carpal tunnel syndrome and did not seem to be symptomatic from her cubital tunnel syndrome. He felt her exam was more suggestive of either fibromyalgia or some other type of chronic pain syndrome. Due to her report of some whitening of a finger he also felt a possible diagnosis could be Raynaud's phenomenon. Dr. Paulson indicated that either possible Raynaud's or fibromyalgia would not be related to her work. He felt that even if she was not working at Broadlawns as a correspondence clerk, her upper extremities would have been just as symptomatic. However, he admitted he was not a pain expert and he does not consider himself to be an expert at diagnosing pain syndrome such as fibromyalgia. He would defer to a pain specialist or a rheumatologist.

Because Dr. Paulson felt that Ms. Lovan's current condition was not due to her work he did not recommend any additional work-related treatment. Dr. Paulson did not recommend any surgical intervention. Because Ms. Lovan had no significant improvement with her prior carpal tunnel releases he felt another release would not give her any significant improvement. Dr. Paulson acknowledged that Ms. Lovan seemed symptomatic, but he did not feel it was work related. He recommended a medical workup by a pain specialist or a rheumatologist.

Dr. Paulson felt that her diagnoses of carpal tunnel syndrome and pronator syndrome were not work related. Additionally, he disagreed with Dr. Cherny's impairment rating. He felt it was artificially inflated because it was based on a significant loss of range of motion that was not consistent with the findings in her treatment records and with his own exam of Ms. Lovan. Additionally, he felt the rating was too high because she had a large impairment rating due to peripheral nerve compression on the right even though her nerve conduction study was normal. Based on Dr. Paulson's exam, he would assign four percent of the right upper extremity due to loss of range of motion, combined with two percent for peripheral neuropathy, for a total of six percent of the right upper extremity. For the left upper extremity, he assigned six percent for loss of range of motion and three percent for peripheral nerve compression, for a total of nine percent

of the left upper extremity. He did not feel there was any need for any permanent restrictions. (JE14, pp. 5-10).

Ms. Lovan testified that when she left Dr. Paulson's office she was under the impression that he was going to request authorization from workers' compensation to provide her treatment. She was willing to receive treatment from him at that time. However, since that appointment she has had the opportunity to read his report. In light of his opinion regarding causation, she no longer wants to treat with Dr. Paulson. Rather, she wants to treat with Dr. Cherny. (Testimony).

Ms. Lovan testified that she believes her current symptoms are related to her work at Broadlawns. These include numbness, tingling, and shooting pain in her upper extremities. She testified that her symptoms are constant. Both hands feel numb when she sleeps. Her primary care physician, Dr. Maher proscribes medication that she takes to help her sleep at night. Ms. Lovan feels that her symptoms now are the same as they were around the time of the date of injury. She feels her symptoms have not changed, if anything they have gotten worse. Any relief she received from the various treatments was temporary. She experiences pain while driving or talking on the phone. She has a headset when she talks on the phone at work. (Testimony).

Ms. Lovan has returned to her job as a correspondence clerk working regular duties, full-time. She is earning more now than she was at the time of the injury. She does not have any restrictions placed on her activities. She performs a lot of computer and typewriter work. She also helps patients complete handwritten forms. Her hand goes numb when she writes. She no longer needs to lift heavy files or push carts of files because the records are now electronic. She has not had to pull charts since before the 2014 surgery. In other words, she no longer has to perform the physical chart work that she had to perform in 2008. She loves her job and wants to continue working there. (Testimony).

Jeffrey Johannes, claimant's significant other, also testified at the hearing. He attended most of the medical appointments with Ms. Lovan. He testified about his observations of the examinations that Dr. Paulson and Dr. Cherny performed. He was not certain why treatment with Dr. Cherny had been put on hold. (Testimony).

Dr. Yanish treated Ms. Lovan for several years and performed two of her four surgeries. Throughout his treatment of Ms. Lovan, he causally connected her conditions to her work and obtained authorization from the workers' compensation carrier for the surgeries he performed. Dr. Yanish provided convincing rationale for why he felt her symptoms were related to her work. He stated, "[t]he patient has a history of having surgical release of bilateral carpal tunnel with recurrance [sic] of her symptoms secondary to scar tissue buildup in the carpal tunnel canal." (JE6, p. 19) At another point during his treatment he further explained, "[t]his is an extremely unusual situation with recurrent carpal tunnel syndrome secondary to scar tissue, but the scar tissues stems from the original surgery, therefore, in my medical opinion the current condition is related to her work comp claim." (JE6, p. 22). However, the last time Dr. Yanish saw Ms. Lovan, he stated that he did not believe her symptoms of continued numbness and tingling were related to carpal tunnel syndrome. The only explanation he provided was that he was very confident that the ieft carpal tunnel was released. He provides no explanation of how he can be so confident that the left carpal tunnel was released in light of the patient's previous recurrent carpal tunnel

secondary to scar tissue. The undersigned finds that the rationale provided by Dr. Yanish in his March of 2016 note is not persuasive. Thus, I find Dr. Yanish's prior opinions regarding causation to be more persuasive.

Dr. Cherny has also provided his opinion on causation, Dr. Cherny has not provided any treatment to Ms. Lovan, but he has examined her on two separate occasions. Dr. Cherny first saw Ms. Lovan in September of 2016. At that time, he opined that her 15 years of work at Broadlawns, which included extensive keyboarding and filing activities were a contributing factor to her upper extremity conditions. (JE12, p. 12). In his report, Dr. Cherny set forth his rationale for why he felt she had obtained suboptimal results from the surgical treatment and made recommendations for additional treatment. He saw Ms. Lovan again in February of 2018. He still causally connected her condition to her employment. (JE12, pp. 19-20).

. . . .

The Deputy Workers' Compensation Commissioner found Dr. Paulson's opinions unpersuasive stating:

> Dr. Paulson's report lacks convincing rationale to support his opinion that her current condition, which he does not have a definitive diagnosis for, is not work related. Dr. Paulson simply suggested other potential diagnoses and then stated he would defer to a pain specialist or rheumatologist regarding those diagnoses. (JE14) I find that Dr. Paulson's opinion regarding causation does not carry great weight.

(Arbitration Decision, March 30, 2018, p.11). The Deputy Workers' Compensation Commissioner further found that:

> [T]he greater weight of the persuasive expert opinions demonstrates that claimant's ongoing upper extremity complaints are related to the work injury.

(Arbitration Decision, March 30, 2018, p.12).

SCOPE OF REVIEW

On judicial review of agency action, this Court functions in an appellate capacity to apply the standards set forth in Iowa Code § 17A.19. *Iowa Planners Network v. Iowa State Commerce Comm'n*, 373 N.W.2d 106, 108 (Iowa 1985). The review is limited to corrections of errors of law and is not de novo. *Harlan v. Iowa Dep't of Job Serv.*, 350 N.W.2d 192, 193 (Iowa 1984). The Court has no original authority to declare the rights of the parties. *Office of Consumer*

Advocate v. Iowa State Commerce Comm'n, 432 N.W.2d 148, 156 (Iowa 1988). Nearly all disputes in the field of administrative law are won or lost at the agency level. *Iowa-Ill. Gas & Elec. Co. v. Iowa State Commerce Comm'n*, 412 N.W.2d 600, 604 (Iowa 1987). Judgment calls are to be left to the agency. *Burns v. Bd. of Nursing*, 495 N.W.2d 698, 699 (Iowa 1993).

The Court may affirm the agency decision or remand to the agency for further proceedings. Iowa Code § 17A.19(10). The Court "shall reverse, modify, or grant other appropriate relief from agency action, equitable or legal and including declaratory relief, if it determines that substantial rights of the person seeking judicial relief have been prejudiced" for any of the grounds listed under the statute. *Id.*

The level of deference afforded to an agency's interpretations of law depends on whether the authority to interpret that law has "clearly been vested by a provision of law in the discretion of the agency." *Compare* Iowa Code § 17A.19(10)(c), *with id.* § 17A.19(10)(l). If the agency has not been clearly vested with the authority to interpret a provision of law, such as a statute, then the reviewing court must reverse the agency's interpretation if it is erroneous. *Id.* § 17A.19(10)(c). If the agency has been clearly vested with the authority to interpret a statute, then a court may only disturb the interpretation if it is "irrational, illogical, or wholly unjustifiable." *Id.* § 17A.19(10)(l).

ANAYLSIS

Rachel's argument is that Broadlawns lost its right to control and choose the care for her once it contested or denied the compensability of the injuries after the independent medical examination of Dr. Paulsen. Section 85.27(4), the Code of Iowa states:

> [T]he employer is obliged to furnish reasonable services and supplies to treat an injured employee, and has the right to choose the care. If the employer chooses the care, the employer shall hold the employee harmless for the cost of care until the employer notifies the employee that the employer is no longer authorizing all

or any part of the care and the reason for the change in authorization.

In Iowa, the medical care provision in Section 85.27, the Code of Iowa, "requires the employer to furnish a wide range of reasonable medical services for compensable injuries to employees." *Bell Bros. Heating & Air Conditioning v. Gwinn*, 779 N.W.2d 193, 202 (Iowa 2010). The right to choose the medical care provider for an injured employee rests with the employer. Iowa Code § 85.27. There are three circumstances under which the employer's right to choose medical care can be modified.

> First, an employee is permitted to choose his or her own medical care at the employer's expense "[i]n an emergency" when the employer "cannot be reached immediately." Iowa Code § 85.27(4). Second, the employee and employer may consent to alternative medical care paid by the employer. *Id.* Finally, the workers' compensation commissioner may order alternative care paid by the employer following a prompt, informal hearing when the employee is dissatisfied with the care furnished by the employer and establishes the care furnished by the employer was unreasonable. *Id.*

Bell Bros. Heating & Air Conditioning, 779 N.W.2d at 203–04.

There may be circumstances where it is unreasonable for an employee to seek alternative or unauthorized medical care. As recognized in *Bell Brothers*, there may be legitimate differences of opinion by doctors and medical professionals as to the diagnosis and treatment of an injury. *Bell Bros. Heating & Air Conditioning*, 779 N.W.2d at 206.

> While it may, in some circumstances, be unreasonable for an employee to seek unauthorized medical care, we recognize that legitimate differences of opinion over the diagnosis and treatment of an injury can arise between an employer and employee, as well as between medical doctors.

Bell Bros. Heating & Air Conditioning, 779 N.W.2d at 206.

Equally so, there may also be differences as to the causation of the employee's injury, *i.e.*, was it work related or not work related. If there is a difference of medical opinion as to whether the injury was work related or not, once it is established that it is work related either by

the employer's admission or by agency or court ruling then the duty of the employer is to provide the reasonable care necessary. If one or more of the medical experts finds that there was no causal connection between the injury and the employee's work and that opinion is rejected, it would seem unreasonable under the circumstances to allow the employer to authorize medical treatment for the employee with those providers who found no work related injury. If their diagnosis is contrary to the evidence, but still their professional opinion, how can one expect to be reasonably treated by these medical professionals for a condition or diagnosis that is either contrary to their medical opinion or, at least, unaccepting of how the injury actually occurred? As pointed out by the Iowa Supreme Court in *Bell Brothers*:

> We do not believe the statute can be narrowly construed to foreclose all claims by an employee for unauthorized alternative medical care solely because the care was unauthorized. Instead, the duty of the employer to furnish reasonable medical care supports all claims for care by an employee that are reasonable under the totality of the circumstances, even when the employee obtains unauthorized care, upon proof by a preponderance of the evidence that such care was reasonable and beneficial. In this context, unauthorized medical care is beneficial if it provides a more favorable medical outcome than would likely have been achieved by the care authorized by the employer. The allocation of this significant burden to the claimant maintains the employer's statutory right to choose the care under section 85.27(4), while permitting a claimant to obtain reimbursement for alternative medical care upon proof by a preponderance of the evidence that such care was reasonable and beneficial.

Bell Bros. Heating & Air Conditioning, 779 N.W.2d at 206.

Thus, the right of the employer to choose the medical care for the employee is balanced against the right of the employee to receive proper medical care. This should be a "safeguard" for the employee. *Bell Bros. Heating & Air Conditioning*, 779 N.W.2d at 207. Here—after Broadlawns lost its argument by a preponderance of the evidence that the existing condition of Rachel was not related to her work injury many years ago—they still wished to direct her treatment and care to a physician totally at odds with the founded causation of her injury.

The Court agrees with the Petitioner that to allow Broadlawns to choose Dr. Paulsen as the person to provide the authorized care for Rachel would be unreasonable and contradictory to the purpose of the workers' compensation statutes. In an application for alternate medical care neither the commissioner nor the court cannot automatically sustain the application just because the employee is dissatisfied with the care he or she has been receiving. Rather, the Petitioner must show that the care was not offered promptly, was not reasonably suited to treat his or her injuries, or that the care was unduly inconvenient for him or her. *See* Iowa Code § 85.24(4). The Court agrees with Rachel that each of one of these factors has been sufficiently shown to allow for the application for alternate medical care to be granted. Rachel has been suffering from a recurrence of her bilateral carpal tunnel syndrome since early 2016. Additional nerve testing done in January of 2018 by Dr. Wolfe and later in February by Dr. Cherny resulted in both doctors agreeing as to the causations of Rachel's suffering. These causations were due to the work injuries sustained by Rachel in 2008. A year and half after the tests done by Drs. Wolfe and Churney, Dr. Paulsen finds, by his testing, that Rachel's injuries are not the result of her work injuries but rather are the result of either a chronic pain syndrome or Raynaud's phenomenon.

Additionally, Dr. Paulsen's own report admits he is not an expert in diagnosing either injury and would need to defer to either a pain specialist or a rheumatologist. Not only does this illustrate that Dr. Paulsen is not qualified to provide reasonable care to Rachel, but it places the workers' compensation statutes on its head. As noted by the Petitioner, the rational for allowing an employer to choose medical care for the injured employees is because an injured employee might select a doctor based on his or her personal relationship or acquaintance and, therefore, an individual who may not be qualified to deal with a particular type of case or who, at any rate,

may be incapable of providing service of the quality required for an optimum rehabilitation process. *Bell Brothers Heating & Air Conditioning*, 779 N.W.2d at 203. This rationale works both ways. The Petitioner correctly points out that she is being forced to receive treatment from a physician whose own diagnosis ignores previous test results and who questions his own qualifications to interpret the results. Further, because of Dr. Paulsen's examination and opinions, it shows a breakdown in the physician/patient relationship between Rachel and Dr. Paulsen. The Court finds that there is a trust factor here which is an important consideration.

> The perennial controversy on the "choice of doctor" question is the result of the necessity of balancing two desirable values. The first is the value of allowing an employee, as far as possible, to choose his own doctor. This value stems from the confidential nature of the doctor-patient relation, from the desirability of the patient's trusting the doctor, and from various other considerations. The other desirable value is that of achieving the maximum standards of rehabilitation by permitting the compensation system to exercise continuous control of the nature and quality of medical services from the moment of injury.

IPB, Inc. v. Harker, 633 N.W.2d 322, 326-27 (Iowa 2001) (quoting 5 Arthur Larson, *Larson's Workers' Compensation Law* § 94.02(2), at 93-13 (2001)).

In balancing all the factors and the totality of the circumstances in this case, to allow Broadlawns to choose the medical care for Rachel with Dr. Paulsen is unreasonable, not in the best interests of the employee, and is contrary to the policy considerations of the workers' compensation statutes. Indeed, Dr. Paulsen's opinion that Rachel's injuries are no longer work-related is so contrary to all previous medical testimony in this matter that it rises to the level of the employer choosing improper medical care for the employee.

Therefore, the Court reverses the decision of the Deputy Workers' Compensation Commissioner and grants the petition for alternate medical care in this matter.

State of Iowa Courts

Type: OTHER ORDER

Case Number	**Case Title**
CVCV056405	RACEL LOVAN VS BROADLAWNS MEDICAL CENTER ET AL

So Ordered

Scott D. Rosenberg

Scott D. Rosenberg, District Court Judge,
Fifth Judicial District of Iowa