BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

SHANE SCHOENBERGER, Claimant, vs. ZEPHYR ALUMINUM PRODUCTS, Employer, and ACUITY, Insurance Carrier, Defendants.	File No. 1642927.02 R E M A N D D E C I S I O N Head Notes: 1402.40; 1803; 1803.1

This matter is before the Iowa Workers' Compensation Commissioner on remand from a decision of the Iowa Court of Appeals dated April 12, 2023.

On October 30, 2019, claimant Shane Schoenberger filed a petition in arbitration against defendant-employer Zephyr Aluminum Products and defendant-insurer Acuity, alleging he sustained an injury to his body as a whole on September 18, 2017. Defendants filed an answer on November 8, 2019.

An arbitration hearing was held on December 14, 2020. Attorney Thomas Wertz represented claimant. Claimant appeared and testified. Attorney Stephanie Marett represented defendants. Randy Till and Bruce Zimmerman appeared and testified on behalf of defendants. Joint Exhibits ("JE") 1 through 7 and Exhibits 1 through 6 and A through K were admitted into the record.

At the start of the hearing, the parties submitted a hearing report listing stipulations and issues to be decided. Defendants waived all affirmative defenses. A hearing report order was entered following the hearing on December 30, 2020.

STIPULATIONS

1. An employer-employee relationship existed between defendant-employer and claimant at the time of the alleged injury.

2. Claimant sustained an injury on September 18, 2017, which arose out of and in the course of his employment.

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

4. Temporary benefits are no longer in dispute.

5. The alleged injury is a cause of permanent disability.

6. Claimant is entitled to permanent disability benefits.

7. The commencement date for permanent partial disability benefits is September 12, 2018.

8. At the time of the alleged injury claimant's gross earnings were $1,415.49 per week, he was married and entitled to five exemptions, and the parties believe the weekly rate is $895.58.

9. Prior to the hearing claimant was paid 60 weeks of benefits at the weekly rate of $895.58.

10. The costs set forth in Exhibit 6 have been paid.

ISSUES

1. What is the nature of the injury?

2. What is the extent of disability?

3. Is claimant entitled to alternate care under Iowa Code section 85.27?

4. Is claimant entitled to an award of penalty benefits?

5. Are the 2017 changes to Iowa Code chapter 85 unconstitutional?

6. Is claimant entitled to recover costs?

The record was held open through January 11, 2021, for the receipt of post-hearing briefs. The briefs were received, and the record was closed.

On June 21, 2021, a deputy workers' compensation commissioner issued an arbitration decision finding claimant's injury did not extend to the body as a whole. The deputy commissioner concluded claimant sustained 19 percent permanent impairment of the left shoulder, entitling claimant to 76 weeks of permanent partial disability benefits. The deputy commissioner found claimant was not entitled to an award of penalty benefits for the six weeks between the date claimant was found to be at maximum medical improvement (MMI) and the receipt of a rating, or for underpaid benefits. The deputy commissioner found he did not have authority to determine whether Iowa Code sections 85.34(2)(n), 85.34(2)(v), and 85.34(2)(x) violate the Iowa Constitution. The deputy commissioner ordered defendants to pay claimant's costs of the arbitration proceeding.

Claimant appealed the arbitration decision to the Iowa Workers' Compensation Commissioner. On January 5, 2022, the Commissioner affirmed the arbitration decision in its entirety.

Claimant filed a petition for judicial review. On appeal claimant asserted his injury should have been compensated industrially based on injuries to his arm and shoulder under Iowa Code section 85.34(2)(v).

On September 7, 2022, the Iowa District Court for Polk County issued a ruling on the petition for judicial review, affirming the agency decision. The district court found claimant did not preserve error on the issue of whether he should be compensated industrially based on injuries to his arm and shoulder under Iowa Code section 85.34(2)(v). The district court found claimant agreed he waived his claim he is entitled to penalty benefits related to the delay in the initiation of permanent partial disability benefits. The district court affirmed the agency's finding claimant was not entitled to an award of penalty benefits for the underpaid benefits. The district court found claimant waived his claim the changes to Iowa Code sections 85.34(2)(n), 85.34(2)(v), and 85.34(2)(x) violate the Iowa Constitution by failing to mention it is his judicial review brief.

Claimant appealed the ruling on the petition for judicial review. On April 12, 2023, the Iowa Court of Appeals reversed the district court, finding claimant preserved error on the issue of whether he was entitled to industrial disability benefits for a combined shoulder and arm injury and remanded the matter to the agency for adjudication on the merits of the issue. The court of appeals affirmed the remainder of the district court decision.

FINDINGS OF FACT

Claimant is married and lives in Dubuque, Iowa. (Exhibit. 2, p. 24; Hearing Transcript p. 11) Claimant is a high school graduate. (Tr: p. 10) Following high school claimant studied welding at North Iowa Community College. (Ex. 2, p. 24; Tr. p. 10) Claimant enrolled in carpenter training with the Carpenters International Training Center and he received a designation as a journeyman carpenter upon completion of the program. (Ex 2, p. 24; Tr. p. 10) Since completing his carpenter training claimant has worked as a journeyman carpenter. (Ex. 2, p. 25) Claimant is right-hand dominant. (Tr. p. 13) At the time of the hearing claimant was 53. (Tr. p. 10)

In June 2007, claimant commenced employment with defendant-employer as a journeyman carpenter, removing and installing windows and doors in commercial and residential settings. (Ex. 2, p. 25; Tr. p. 12) Claimant continued to work for defendant-employer at the time of the hearing. (Tr. p. 11)

On September 18, 2017, claimant was putting in a bow window with a coworker. (Tr. p. 13) The window did not fit into the hole and when the men pulled it out claimant's left arm took most of the weight and he heard it pop. (Id.) Claimant reported his work injury to the owner of the company. (Id.)

Later that day defendant-employer sent claimant to occupational medicine, where he was examined by Emily Armstrong, PA-C. (JE 1, p. 1) Claimant complained of sharp pain in his left shoulder following the work injury and relayed the pain went down into his arm and into his neck. (Id.) Claimant reported he had pain in the same spot a month ago while lifting a large window, but the pain went away. (Id.) Armstrong examined claimant, assessed him with acute left shoulder pain, prescribed a Medrol Dosepak, recommended heat and ice, and released claimant to return to work with restrictions of no pushing or pulling above 25 pounds with the left upper extremity and to keep his left elbow at his side. (JE 1, p. 2)

Claimant returned to Armstrong on September 28, 2017, reporting his left shoulder pain had started going away, but reporting his pain increases when he moves his arm up and away from his body, and noted his pain wakes him up during the night. (JE 1, p. 3) Armstrong recommended physical therapy, continued claimant's restrictions, and recommended he use ice and continue left shoulder range of motion exercises. (Id.)

On October 20, 2017, claimant attended a follow-up appointment with Armstrong reporting his condition had not improved, and stating while he can bring his arm up with some pain it is very painful when he brings it down and he feels clicking and popping in his shoulder. (JE 1, p. 4) Armstrong ordered a left shoulder MRI, stopped physical therapy, and continued claimant's restrictions. (JE 1, p. 4)

Claimant underwent a left MRI arthrogram on October 30, 2017. (JE 2, p. 30) The reviewing radiologist listed an impression of a subtle SLAP tear involving the posterior superior glenoid labrum, and tendinopathy involving the supraspinatus and infraspinatus tendons with possible bursal sided fraying involving the posterior insertional aspect of the supraspinous tendon. (JE 2, p. 30)

Claimant attended an appointment with Armstrong on November 3, 2017, to discuss his imaging. (JE 1, p. 5) Armstrong assessed claimant with a left shoulder SLAP lesion and left rotator cuff tendinopathy, imposed restrictions of no lifting, pushing, or pulling over 15 pounds, and keep his left elbow at his side at all times, no use of ladders, and Armstrong referred claimant to orthopedics. (Id.)

On November 17, 2017, claimant attended an appointment with Judson Ott, M.D., an orthopedic surgeon, complaining of left shoulder pain. (JE 1, p. 7) Dr. Ott examined claimant, reviewed his imaging, assessed claimant with left shoulder pain, and administered a subacromial injection. (JE 1, pp. 7-8)

Claimant returned to Dr. Ott on December 8, 2017, reporting he received some, but not complete, relief from the injection, and claimant complained of discomfort anteriorly and laterally when raising his arm out from his body. (JE 1, p. 9) Claimant reported he sustained another minor reinjury at work when he threw his arm up quickly to grab boxes that were falling, and he reported he had some increased discomfort which had resolved to baseline. (JE 1, p. 9) Dr. Ott recommended surgery. (Id.)

On January 17, 2018, claimant attended an appointment with Dr. Ott complaining of significant left shoulder pain and tingling in his fingers during therapy and intermittently during the day. (JE 1, p. 10)

On January 25, 2018, Dr. Ott performed a left shoulder arthroscopy, labral debridement with biceps tenotomy, arthroscopic acromioplasty with conversion of type I acromion, and mini-open rotator cuff repair on claimant. (JE 3, p. 34)

On January 29, 2018, claimant returned to Dr. Ott following surgery complaining of pain in his left forearm. (JE 1, p. 12)

During a follow-up appointment on March 6, 2018, Dr. Ott assessed claimant with complete rotator cuff tear or rupture of the left shoulder, not specified as traumatic, noted claimant's passive motion was satisfactory, discontinued the sling, ordered physical therapy, and imposed a restriction of no use of the left arm. (JE 1, p. 15)

On April 3, 2018, claimant returned to Dr. Ott, reporting his pain had improved a little bit, but he still had moderate discomfort, particularly at the end of the day or after physical therapy. (JE 1, p. 16) Dr. Ott documented claimant's passive range of motion was satisfactory and he was making progress with active range of motion. (Id.) Dr. Ott prescribed medication and continued claimant's physical therapy. (Id.)

Claimant attended an appointment with Dr. Ott on May 4, 2018, reporting he felt better on exam. (JE 1, p. 17) Dr. Ott documented, "[h]e has about 130 active 160 passive forward elevation is about 110 active abduction". Dr. Ott reduced claimant's physical therapy to once per week, and recommended claimant's restrictions be decreased over time. (Id.)

On June 8, 2018, claimant returned to Dr. Ott, complaining of anterior and lateral shoulder pain with activity and reporting he did not believe he could decrease his restrictions at work any further. (JE 1, p. 18) Dr. Ott administered a subacromial injection, continued his work restrictions, and recommended possible repeat imaging if claimant did not make progress as of his next appointment in five to six weeks. (Id.)

On June 15, 2018, claimant returned to Dr. Ott before his scheduled appointment, reporting he had to leave work the day before because of arm pain and swelling, with some swelling in his hand and forearm. (JE 1, p. 20) Dr. Ott documented he did not really see any detectable swelling on exam and most of claimant's pain was into the triceps area, with some into the forearm and discomfort up in the shoulder. (Id.)

Dr. Ott ordered repeat x-rays, which he found looked fine, and he recommended an ultrasound. (JE 1, pp. 20-21) The ultrasound was negative for deep vein thrombosis. (JE 1, p. 22)

Claimant attended a follow-up appointment with Dr. Ott on July 16, 2018, complaining of difficulty with left shoulder movement. (JE 1, p. 23) Dr. Ott recommended left shoulder saline MRI. (Id.)

Claimant underwent the imaging on July 24, 2018. (JE 2, p. 32) The reviewing radiologist listed an impression of status post superior labral debridement with no recurrent labral tears, status post biceps tenotomy with no biceps tendon tears, status post rotator cuff repair with no evidence of recurrent tears, and status post acromioplasty with minimal fluid in the subacromial bursa. (JE 2:32)

Claimant attended 32 sessions of physical therapy. (JE 4, p. 38) At the time of claimant's discharge from physical therapy, the physical therapist noted claimant continued to complain of severe pain and numbness and tingling in his hand, and the therapist documented claimant's range of motion and strength were very limited due to pain in his shoulder. (Id.) The physical therapist noted claimant had unresolved functional outcomes of decreased mobility, decreased strength, and noted he was unable to perform his normal work duties. (Id.)

On July 31, 2018, claimant attended an appointment with Dr. Ott, reporting he felt stronger, but he still had some soreness when using his arm out away from his body and overhead with some occasional tingling in the fourth and fifth fingers. (JE 1, p. 25) Dr. Ott noted the imaging showed claimant had some rotator cuff tendinopathy with no evidence of any recurrent tear or labral pathology, and Dr. Ott noted he was not convinced all of claimant's symptoms were related to his shoulder. (Id.) Claimant requested to return to full duty and Dr. Ott documented claimant had satisfactory strength and range of motion on exam. (Id.)

Claimant attended an appointment with Dr. Ott on September 12, 2018, complaining of achy discomfort when using his arm above his head and noting his job requires quite a bit of ladder climbing and lifting and moving of heavy windows. (JE 1, p. 27) Claimant relayed he was able to perform his job duties, but he had some concerns regarding the ladder climbing. (Id.) Dr. Ott documented on exam claimant had "about 100º of abduction before he developed pain he has about 120 active forward elevation internal rotation to his left hip pocket. His external rotation strength is satisfactory grade 4+." (Id.) Dr. Ott noted he was not optimistic additional surgery would result in improvement, Dr. Ott offered a second opinion, which claimant declined, Dr. Ott imposed a restriction of no ladder climbing, and found claimant reached MMI and he referred claimant for an impairment rating. (JE 1, pp. 27, 29)

On October 30, 2018, David Field, M.D., an orthopedic surgeon, conducted an independent medical examination (IME) for defendants. (JE 5) Dr. Field reviewed claimant's medical records and examined him. (JE 5) Dr. Field noted on examination,

claimant reported having symptoms of numbness and paresthesias into his hands and from his shoulder. (JE 5, p. 41) Dr. Field documented claimant's right hand grip strength was 48 kilograms and his left hand grip strength was 18 kilograms, claimant had decreased sensation to pin prick in the ulnar nerve distribution of his left hand, his Tinel's sign was equivocal at the median nerve, he had weakness with finger abduction/adduction of the left hand, and strength testing of his shoulder showed decreased strength of the external rotators of 4/5. (Id.) Claimant complained of soreness and tenderness in the bicipital area, he could get his hand into his left back pocket, but he could abduct his arm only actively to 90 degrees with passive abduction or assisted abduction to about 120 degrees, a painful arc, pain with forward flexion, and stretching of the rotator cuff was only 4/5, noting he had lost at least 15 degrees of external rotation. (Id.)

Dr. Field found it did not appear claimant's problems with his left arm grip strength, numbness, and paresthesias had been evaluated, noting hand weakness and neurological symptoms would have a bearing on claimant's functional evaluation for an impairment rating. (Id.) Dr. Field further opined:

> In terms of impairment of the left shoulder, using Table 16-5, the loss of abduction merits approximately a 4% impairment, upper extremity loss of flexion of 6%, external rotation is zero, but internal rotation is 4%. Use of the table for range of motion does not reflect strength in general, but is probably the most accurate way of measuring his impairment rating. Given slight losses of other subtle range of motion, I do feel he merits approximately a 15% impairment of his upper extremity. Using Table 16-3, this is a 9% whole person impairment based on this evaluation.

(JE 5, pp. 41-42)

Dr. Field recommended further evaluation of the neurological status of claimant's left arm, noting "this does not appear necessarily related to his rotator cuff treatments." (JE 5, p. 42) Dr. Field further noted, "[i]n lieu of evaluation of his history, it does not appear to me that we can correlate this examination with the injury which was directly related to his shoulder, resulting in a rotator cuff injury," and recommended claimant be evaluated through his own physician. (JE 5, p. 43)

John Kuhnlein, D.O., an occupational medicine physician, conducted an IME for claimant on June 6, 2019, and issued his report on September 3, 2019. (Ex. 1) Dr. Kuhnlein reviewed claimant's medical records and examined him. (Ex. 1)

Dr. Kuhnlein measured claimant's right and left shoulder range of motion, finding claimant had flexion to 180 degrees on the right and 120 degrees on the left, extension to 80 degrees on the right and 40 degrees on the left, abduction to 180 degrees on the right and 95 degrees on the left, adduction to 20 degrees and internal rotation to 60 degrees for both shoulders, and external rotation to 70 degrees on the right and 50 degrees on the left. (Ex. 1, p. 11) For elbow range of motion Dr. Kuhnlein found

claimant had flexion to 140 degrees on the right and 125 degrees on the left, extension to 0 on the right and -5 on the left, and pronation to 90 degrees and supination to 80 degrees for both elbows. (Id.)

While claimant had problems making a fist with the left ring and small fingers, Dr. Kuhnlein found claimant had normal grip strength. (Id.) Dr. Kuhnlein found claimant had grade 4 strength with left shoulder flexion and extension and grade 5- with left shoulder abduction, normal motor strength in both shoulders, grade 5- strength in left elbow extension, but otherwise normal motor strength in both upper extremities. (Id.)

Dr. Kuhnlein observed claimant had decreased pinprick, vibratory, and light touch sensation in the left axillary nerve distribution, decreased pinprick sensation in the left axillary nerve distribution, decreased pinprick sensation in the left triceps, left ulnar forearm, and left ulnar hand, decreased vibratory sensation only in the left ulnar forearm, decreased vibratory sensation in the left ring and small fingers, decreased light touch sensation in the left ulnar forearm, the ulnar hand, and left ring and small fingers, and decreased pinprick sensation in the left radial forearm but spared the hand. (Id.) Claimant also reported he was insensate to two-point testing in the entire left ring finger and small finger. (Ex. 1, p. 12)

Dr. Kuhnlein diagnosed claimant with left biceps and superior labral pathology with left shoulder area impingement between the acromion and rotator cuff with full-thickness rotator cuff tear with January 25, 2018, arthroscopic labral debridement, biceps tenotomy, arthroscopic acromioplasty, and mini-open rotator cuff repair. (Id.) Dr. Kuhnlein opined claimant sustained an acute rotator cuff tear and labral tear involving the biceps anchor as a result of the September 18, 2017, work injury and that the injury "lit up" the pre-existing impingement syndrome. (Id.)

Dr. Kuhnlein also opined claimant developed ulnar nerve symptoms after the surgery and those symptoms are a sequela of the injury by means of the surgery. (Id.) Dr. Kuhnlein noted the ulnar forearm, hand, and finger symptoms developed after the surgery, with no other known cause for the symptoms and opined it is more likely those symptoms are related to the surgery that was performed for the work injury and are sequelae to that injury. (Ex. 1, p. 13)

Dr. Kuhnlein found claimant reached MMI on or about September 12, 2018, the date Dr. Ott suggested a referral for a rating. (Ex. 1, p. 18) Given claimant's complaints of numbness in the ulnar nerve distribution, Dr. Kuhlein recommended electromyography to determine whether claimant has left ulnar neuropathy and, if so, what treatment is necessary. (Ex. 1, p. 18)

Using the Guides to the Evaluation of Permanent Impairment (AMA Press, 5th Ed. 2001) ("AMA Guides"), Dr. Kuhnlein opined:

> Turning to Figures 16-40, 16-43 and 16-46, and when comparing the left to the unaffected right shoulder, there is a total of 10% left upper

> extremity impairment for deficits in range of motion of the shoulder joint. In this particular case, and turning to Figure 16-34, Page 472, Mr. Schoenberger has 2% left upper extremity impairment for decrements in range of motion of the elbow. There is therefore a total of 12% left upper extremity impairment for deficits in range of motion. Turning to Table 16-35, page 510, there is 5% left upper extremity impairment for the motor deficits. Turning to Table 16-15, page 492, the sensory deficits are in the axillary and ulnar nerve distributions. This would be an initial 5% left upper extremity impairment for the axillary deficit, and a 7% left upper extremity impairment for the ulnar nerve deficit. However, these values must be modified by the value from Table 16-10, page 482. I would use the 25% modifier. When these values are multiplied (5% x25%) and (7% x 25%) rounded according to the instructions on page 20, this would be a 1% left upper extremity impairment for the axillary deficit and a 2% left upper extremity impairment for the ulnar nerve deficit.
>
> Turning to the Combined Values Chart on page 604, when these values are combined (12% x5% x2% x1%) this is 19% left upper extremity impairment. Turning to Table 16-3, page 439, this would convert to 11% whole person impairment.

(Ex. 1:18-19)

Dr. Kuhnlein recommended restrictions of lifting up to 30 pounds occasionally from floor to waist and waist to shoulder, as long as the weight is kept close to the axial plane of claimant's body, lifting up to 20 pounds occasionally from waist to shoulder joint if lifting more than an elbow's distance away from the body, no work at or above shoulder height of the shoulder joint, occasional crawling, gripping and grasping occasionally with the left hand until the ulnar nerve problem is sorted out, no work on ladders or scaffolding, and no work on production lines. (Ex. 1, p. 19) Dr. Kuhnlein noted claimant can work at height as long as he works in a mechanical lift that does not require him to climb up and down. (Id.)

Dr. Kuhnlein reviewed Dr. Field's IME report, and responded, as follows:

> He quoted Table 16-5, which is on Page 447. This particular table deals with two-point discrimination, not range of motion. Even though basing the impairment on range of motion deficits he did not document all of the ranges of motion within the shoulder area. He noted that "use of the table for range of motion does not reflect strength in general, but is probably the most accurate way of measuring his impairment rating." There are actual ways of signing impairment for motor strength, so I am not sure what Dr. Field was actually doing here. He did not provide formal impairment for the motor weakness he noted on physical exam. It is unknown what table Dr. Field was using. The table he quotes would not be appropriate for

> assigning range of motion from The Guides to the Evaluation of Permanent Impairment, Fifth Edition. In the sixth edition, the shoulder regional grid is Table 15-5. It is unknown if he inadvertently used the Sixth Edition or simply quoted the wrong Table from the Guides to the Evaluation of Permanent Impairment, Fifth Edition when he assigned the impairment rating.

(Ex. 1, p. 8)

Dr. Kuhnlein also noted while Dr. Field indicated he did not believe the sensory deficit was related to his left shoulder rotator cuff repair, claimant reported the numbness and tingling in the distribution developed only after the surgery for the injury and that claimant had denied any other intervening left shoulder area or left upper extremity injuries. (Id.)

On October 21, 2019, claimant underwent left upper extremity electromyography with Ronald Sims, M.D., a neurologist, on a referral from Dr. Field. (JE 7) Dr. Sims interpreted the results to show moderate to severe left ulnar neuropathy at the elbow. (JE 7, p. 49) Dr. Sims recommended claimant seek care with the treating physician and with his primary care provider. (JE 7, p. 50)

James Nepola, M.D., an orthopedic surgeon at the University of Iowa Hospitals and Clinics (UIHC), conducted an IME of claimant for defendants on August 25, 2020. (Ex. B) Dr. Nepola examined claimant and reviewed his medical records. (Ex. B)

On exam, Dr. Nepola noted paresthesia and dysesthesia along the ulnar nerve distribution from the cubital tunnel to the fingertips, a positive Tinel's along the cubital tunnel, and Dr. Nepola was able to reproduce symptoms along the left forearm, hand and fingers with a compression test. (Ex. B, p. 8) For the left shoulder, Dr. Nepola found claimant had passive forward flexion to 170 degrees with pain at the terminal end of range of motion, active elevation to 120 degrees, extension to 30 degrees, active shoulder abduction to 100 degrees, adduction to 20 degrees, and with the left shoulder abducted to 90 degrees, internal rotation to 60 degrees and external rotation to 45 degrees. (Id.) Dr. Nepola documented he heard audible popping with range of motion and claimant was tender to palpation of the bicipital groove and trapezius. (Id.) Dr. Nepola found claimant's muscle strength was 5-/5, internal rotation was 5/5, and biceps, triceps, wrist flexion and extension, and first dorsal interosseous motor strength was 5/5 and symmetrical bilaterally. (Ex. B, p. 8) He documented claimant had positive Yergason's and O'Brien's tests, and a positive belly press. (Id.)

Dr. Nepola diagnosed claimant with left cubital tunnel syndrome and status post left rotator cuff repair. (Ex. B, pp. 8-9) Dr. Nepola did not recommend additional shoulder surgery, but recommended evaluation for possible chronic tendinitis, ulnar nerve irritation, and cubital tunnel syndrome. (Ex. B, p. 9)

Dr. Nepola opined claimant's numbness and tingling along the ulnar nerve distribution of the left upper extremity from the elbow to the fingertips is a sequela of both the work injury and the subsequent rotator cuff repair and biceps tenotomy. (Id.) Dr. Nepola noted his physical exam showed equal muscle function in the bilateral biceps consistent with possible incomplete biceps tenotomy and he recommended additional testing. (Id.) He also recommended a referral for probable cubital tunnel syndrome and an injection into the glenohumeral joint for diagnostic purposes to localize the continued shoulder pain. (Id.)

In response to an inquiry from defendants' counsel, Dr. Nepola issued a supplemental report on September 10, 2020, disagreeing with Dr. Kuhnlein's opinion that claimant had sustained a whole body impairment with respect to his shoulder injury. (Ex. B, p. 11) Dr. Nepola opined claimant's rotator cuff tendon tear and associated connective tissue injuries sustained on September 18, 2017, are solely related to his shoulder as part of the upper extremity and not the body as whole. (Ex. B, p. 16)

At the time of the hearing claimant was working full-duty for defendant-employer with permanent restrictions of no climbing ladders and scaffolding. (Tr. p. 14) Claimant reported he has difficulty with ladders and scaffolding because his left hand goes numb on the left side and after a while he cannot raise his left arm up. (Tr. pp. 14-15) Claimant testified he has to have three points of contact on ladders and scaffolding at all times and sometimes when carrying things up a ladder he will lose grip with his left hand, which could cause him to fall off the ladder. (Tr. p. 15)

Claimant testified he has shoulder pain every day. (Id.) He uses over-the-counter medication to ease the pain when he needs it and he also uses ice. (Tr. p. 16) The week before the hearing claimant iced his shoulder three times. (Tr. p. 17)

Claimant reported he has tingling in his left hand and his small and ring fingers go numb. (Tr. p. 22) Claimant testified the numbness sensation goes up his arm and is irritating. (Id.) Claimant stated he drops things following the work injury, and chiseling out window frames with a hammer is difficult. (Tr. p. 23) Within a few weeks before the hearing claimant had to chisel out a window frame and it caused pain in his arm, shoulder, down his chest, and into his back and neck. (Tr. p. 24)

At the time of the work injury, claimant was earning $22.71 per hour. (Tr. p. 57) At the time of the hearing, claimant was continuing to work for defendant-employer, earning $23.86 per hour. (Id.)

CONCLUSIONS OF LAW

I. Nature of the Injury

The court of appeals found claimant preserved error on the issue of whether he sustained a whole body impairment based on the combined injuries to his left shoulder and left arm, and remanded the matter for a determination on the merits. The parties

agree claimant sustained a permanent injury to his left shoulder caused by the work injury but disagree whether claimant sustained a permanent injury to his left arm caused by the work injury, and the parties disagree on the extent of disability.

To receive workers' compensation benefits, an injured employee must prove, by a preponderance of the evidence, the employee's injuries arose out of and in the course of the employee's employment with the employer. 2800 Corp. v. Fernandez, 528 N.W.2d 124, 128 (Iowa 1995). An injury arises out of employment when a causal relationship exists between the employment and the injury. Quaker Oats Co. v. Ciha, 552 N.W.2d 143, 151 (Iowa 1996). The injury must be a rational consequence of a hazard connected with the employment, and not merely incidental to the employment. Koehler Elec. v. Wills, 608 N.W.2d 1, 3 (Iowa 2000). The Iowa Supreme Court has held, an injury occurs "in the course of employment" when:

> it is within the period of employment at a place where the employee reasonably may be in performing his duties, and while he is fulfilling those duties or engaged in doing something incidental thereto. An injury in the course of employment embraces all injuries received while employed in furthering the employer's business and injuries received on the employer's premises, provided that the employee's presence must ordinarily be required at the place of the injury, or, if not so required, employee's departure from the usual place of employment must not amount to an abandonment of employment or be an act wholly foreign to his usual work. An employee does not cease to be in the course of his employment merely because he is not actually engaged in doing some specifically prescribed task if, in the course of his employment, he does some act which he deems necessary for the benefit or interest of his employer.

Farmers Elevator Co., Kingsley v. Manning, 286 N.W.2d 174, 177 (Iowa 1979).

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, 844-845 (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 v. Smith-Doyle Contractors, 569 N.W.2d 154, 156 (Iowa 1997). 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).

It is well-established in workers' compensation that "if a claimant had a preexisting condition or disability, aggravated, accelerated, worsened, or 'lighted up' by an injury which arose out of and in the course of employment resulting in a disability

found to exist," the claimant is entitled to compensation. Iowa Dep't of Transp. v. Van Cannon, 459 N.W.2d 900, 904 (Iowa 1990). The Iowa Supreme Court has held,

> a disease which under any rational work is likely to progress so as to finally disable an employee does not become a "personal injury" under our Workmen's Compensation Act merely because it reaches a point of disablement while work for an employer is being pursued. It is only when there is a direct causal connection between exertion of the employment and the injury that a compensation award can be made. The question is whether the diseased condition was the cause, or whether the employment was a proximate contributing cause.

Musselman v. Cent. Tel. Co., 261 Iowa 352, 359-60, 154 N.W.2d 128, 132 (1967).

An employer is responsible for a sequela injury "that naturally and proximately flow[s] from" an injury arising out of and in the course of employment. Oldham v. Schofield & Welch, 266 N.W.2d 480, 482 (Iowa 1936) ("[i]f an employee suffers a compensable injury and thereafter suffers further disability which is the proximate result of the original injury, such further disability is compensable"); see also Mallory v. Mercy Med. Ctr., 2012 WL 529199, File No. 5029834 (Iowa Workers' Comp. Comm'n Feb. 15, 2012). A sequela may occur as the result of a fall during treatment, an altered gait, or a later injury caused by the original injury.

In this matter, three physicians have provided opinions as to whether the injury to claimant's left shoulder and subsequent treatment caused claimant to develop a sequela left arm injury, Dr. Field, an orthopedic surgeon who performed an IME for defendants, Dr. Kuhnlein, an occupational medicine physician who performed an IME for claimant, and Dr. Nepola, an orthopedic surgeon who performed an IME for defendants. I find the opinions of Dr. Kuhnlein and Nepola more persuasive than the opinion of Dr. Field.

Dr. Field examined claimant on October 30, 2018. (JE 5) Dr. Field noted claimant's left arm neurological symptoms would have a bearing on claimant's functional evaluation for an impairment rating and he recommended treatment for claimant's left arm condition, but opined claimant's left arm condition is not "directly related to his shoulder." (JE 5, pp. 41-43) Dr. Field, an orthopedic surgeon, has superior training to Dr. Kuhnlein, an occupational medicine physician.

Dr. Kuhnlein examined claimant on June 6, 2019, eight months after Dr. Field's examination. Dr. Kuhnlein diagnosed claimant with left biceps and superior labral pathology with left shoulder impingement between the acromion and rotator cuff with full-thickness rotator cuff tear with January 25, 2018, arthroscopic labral debridement, biceps tenotomy, arthroscopic acromioplasty, and mini-open rotator cuff repair. (Ex. 1, p. 12) Dr. Kuhnlein opined claimant developed ulnar nerve symptoms after the surgery, and Dr. Kuhnlein opined those symptoms are a sequela of the injury by means of the surgery. (Ex. 1, p. 13)

Dr. Kuhnlein reviewed Dr. Field's opinion, and pointed out deficiencies in his opinion, as follows:

> [Dr. Field] quoted Table 16-5, which is on Page 447. This particular table deals with two-point discrimination, not range of motion. Even though basing the impairment on range of motion deficits he did not document all of the ranges of motion within the shoulder area. He noted that "use of the table for range of motion does not reflect strength in general but is probably the most accurate way of measuring his impairment rating." There are actual ways of assigning impairment for motor strength, so I am not sure what Dr. Field was actually doing here. He did not provide formal impairment for the motor weakness he noted on physical exam. It is unknown what table Dr. Field was using. The table he quotes would not be appropriate for assigning range of motion from The Guides to the Evaluation of Permanent Impairment, Fifth Edition. In the sixth edition, the shoulder regional grid is Table 15-5. It is unknown if he inadvertently used the Sixth Edition or simply quoted the wrong Table from the Guides to the Evaluation of Permanent Impairment, Fifth Edition when he assigned the impairment rating.

(Ex. 1, p. 8)

Dr. Kuhnlein also noted while Dr. Field indicated he did not believe the sensory deficit was related to his left shoulder rotator cuff repair, claimant reported the numbness and tingling in the distribution developed only after the surgery for the injury and that claimant had denied any other intervening left shoulder area of left upper extremity injuries. (Id.)

Dr. Nepola is also an orthopedic surgeon. Dr. Nepola practices at UIHC, a premiere medical institution. He most recently examined claimant on August 25, 2020. (Ex. B) Dr. Nepola diagnosed claimant with left cubital tunnel syndrome and status post left rotator cuff repair. (Ex. B, pp. 8-9) Dr. Nepola opined claimant's numbness and tingling along the ulnar nerve distribution of the left upper extremity from the elbow to the fingertips is a sequela of the work injury and the subsequent rotator cuff repair and biceps tenotomy. (Ex. B, p. 9)

Dr. Field did not indicate what version of the AMA Guides he used in reaching his opinion, as discussed by Dr. Kuhnlein. The Iowa Legislature has directed the Division of Workers' Compensation to use the AMA Guides in evaluating the extent of permanent impairment for functional disability. Iowa Code § 85.34(2)(x). The Division of Workers' Compensation has adopted the AMA Guides 5th Edition for evaluating permanent impairment. 876 IAC 2.4. Dr. Field did not indicate whether he used the AMA Guides 5th Edition in reaching his conclusions, as noted by Dr. Kuhnlein. I find Dr. Kuhnlein's additional criticisms of Dr. Field's opinion persuasive.

Dr. Kuhnlein's report is clear, thorough, and properly applies the correct version of the AMA Guides. His opinion is also supported by Dr. Nepola, a recognized expert in orthopedic surgery. I find claimant has established he sustained a sequela injury to his left upper extremity caused by the work injury to his left shoulder and subsequent surgery.

II. Extent of Disability

Claimant alleges he sustained an impairment to his body as a whole as a result of the combined left shoulder and left arm injuries, entitling him to industrial disability benefits under Iowa Code section 85.34(2)(v). Defendants reject claimant's assertion he sustained a whole body impairment, and further assert, even if claimant sustained a whole body impairment, he is not entitled to industrial disability benefits because he returned to work for defendant-employer following the injury earning the same or greater wages.

The parties' arguments raise issues involving statutory interpretation. The goal of statutory interpretation is "to determine and effectuate the legislature's intent." Rameriz-Trujillo v. Quality Egg, L.L.C., 878 N.W.2d 759, 770 (Iowa 2016) (citing United Fire & Cas. Co. v. St. Paul Fire Marine Ins. Co, 677 N.W.2d 755, 759 (Iowa 2004)). The court begins with the wording of the statute. Myria Holdings, Inc. v. Iowa Dep't of Rev., 892 N.W.2d 343, 349 (Iowa 2017). When determining legislative intent, the court looks at the express language of the statute, and "not what the legislature might have said." Id. (citing Schadendorf v. Snap-On Tools Corp., 757 N.W.2d 330, 337 (Iowa 2008)). If the express language is ambiguous the court looks to the legislative intent behind the statute. Sanford v. Fillenwarth, 863 N.W.2d 286, 289 (Iowa 2015) (citing Kay-Decker v. Iowa State Bd. of Tax Review, 857 N.W.2d 216, 223 (Iowa 2014)). A statute is ambiguous when reasonable persons could disagree as to the statute's meaning. Rameriz-Trujillo, 878 N.W.2d at 769 (citing Holstein Elect. v. Breyfogle, 756 N.W.2d 812, 815 (Iowa 2008)). An ambiguity may arise when the meaning of particular words is uncertain or when considering the statute's provisions in context. Id.

When the legislature has not defined a term in a statute, the court considers the term in the context in which it appears and applies the ordinary and common meaning to the term. Id. (citing Rojas v. Pine Ridge Farms, L.L.C., 779 N.W.2d 223, 235 (Iowa 2010). Courts determine the ordinary meaning of a term by examining precedent, similar statutes, the dictionary, and common usage. Sanford, 863 N.W.2d at 289.

Iowa Code section 85.34(2) governs compensation for permanent partial disabilities. The law distinguishes between scheduled and unscheduled disabilities. The Division of Workers Compensation evaluates disability using two methods, functional and industrial. Simbro v. Delong's Sportswear, 332 N.W.2d 886, 887 (Iowa 1983).

The statute requires the agency to use the functional method for scheduled enumerated body parts listed in the statute. Iowa Code § 85.34(a)-(u); Westling v. Hormel Foods Corp., 810 N.W.2d 247, 252 (Iowa 2012). Each subsection provides a maximum number of weeks of compensation for the complete loss of a scheduled member or body part.

Before 2017, shoulder injuries were treated as injuries to the body as whole and were compensated industrially, under Iowa Code section 85.34(2)(u) (2016), now under Iowa Code section 85.34(2)(v) (2017). Second Injury Fund of Iowa v. Nelson, 544 N.W.2d 258 (Iowa 1995). Since 2017, compensation or functional loss for scheduled injuries is determined by taking the number of weeks allowed for a complete loss of the body part or scheduled member, multiplied by a percentage of impairment determined using the AMA Guides. Iowa Code § 85.34(2)(x). "For the loss of an arm" compensation is limited to 250 weeks. Id. § 85.34(2)(m). "For the loss of a shoulder," compensation is limited to 400 weeks. Id. § 85.34(2)(n).

Under Iowa Code section 85.34(2)(t) compensation for the loss of both arms, both hands, both feet, both legs, both eyes, or "any two thereof, caused by a single accident," equals 500 weeks unless the employee is permanently and totally disabled as set forth in Iowa Code section 85.34(3). This subsection does not address the loss of both shoulders or the loss of a shoulder and an arm caused by a single accident.

The statute is silent on how an injury to a shoulder and to an arm caused by a single accident should be compensated. What is clear is the statute's mandate is in all other cases of permanent partial disability not set forth in paragraphs "a" through "u" of Iowa Code section 85.34(2) "compensation **shall** be paid during the number of weeks in relation to five hundred weeks as the reduction in the employee's earning capacity caused by the disability bears in relation to the earning capacity that the employee possessed when the injury occurred." Id. § 85.34(2)(v) (emphasis added). Thus, if a body part or parts are not included in Iowa Code section 85.34(2)(a)-(u), the injury is unscheduled and should be compensated on the basis of 500 weeks.

In the case of Anderson v. Bridgestone Americas, Inc., File No. 5067475, 2021 WL 4132332, (Iowa Workers' Comp. Comm'n Sept. 2, 2021), the claimant sustained an injury to his right arm and right shoulder caused by the work injury. The deputy commissioner found the statute did not address claimant's combined injury to his right arm and right shoulder and found the "catch-all" section of Iowa Code section 85.34(2)(v) applied, and that his injury should be compensated based on the 500 weeks for unscheduled injuries. Because the claimant did not return to work with the same employer, the deputy commissioner found claimant's compensation should not be based on his functional disability, but rather in relation to his loss of earning capacity. The deputy commissioner's decision was affirmed in its entirety on appeal. File No. 5067475, 2022 WL 301799, (Iowa Workers' Comp. Comm'n Jan. 25, 2022).

Unlike the situation in Anderson, claimant in this case returned to work with the same employer and he was earning greater wages at the time of the hearing than he was at the time of the injury.

Iowa Code § 85.34(2)(v), provides, in 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. Notwithstanding section 85.26, subsection 2, if an employee who is eligible for compensation under this paragraph returns to work with the same employer and is compensated based only upon the employee's functional impairment resulting from the injury as provided in this paragraph and is terminated from employment by that employer, the award or agreement for settlement for benefits under this chapter shall be reviewed upon commencement of reopening proceedings by the employee for a determination of any reduction in the employee's earning capacity caused by the employee's permanent partial disability.

I find claimant's recovery is limited to his functional loss under Iowa Code section 85.34(2)(v) because the earnings he has received after he returned to work for defendant-employer are greater than the earnings he received at the time of the injury.

Two experts provided opinions on claimant's extent of functional loss, Dr. Field, and Dr. Kuhnlein. Dr. Field assigned claimant nine percent whole person impairment. (JE 5, pp. 41-42) Dr. Kuhnlein assigned claimant eleven percent whole person impairment. (Ex. 1, pp. 18-19) As analyzed above, I found Dr. Kuhnlein's opinion on causation more persuasive than Dr. Field's opinion on causation. For the same reasons I also find Dr. Kuhnlein's opinion on extent of functional impairment more persuasive than Dr. Field's opinion. I find claimant has established he sustained eleven percent functional impairment as a result of the work injury, which entitles claimant to receive 55 weeks of permanent partial disability benefits, commencing on the stipulated commencement date of September 12, 2018, at the stipulated weekly rate of $895.58. I also find Dr. Kuhnlein's permanent restrictions are claimant's permanent restrictions.

ORDER

IT IS THEREFORE ORDERED:

Defendants shall pay claimant 55 weeks of permanent partial disability benefits commencing on September 12, 2018, at the weekly rate of eight hundred ninety-five and 58/100 dollars ($895.58).

Defendants shall receive credit for all benefits paid to date.

Defendants shall pay accrued weekly benefits in a lump sum together with interest 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.

Pursuant to rule 876 Iowa Administrative Code 3.1(2), defendants shall file subsequent reports of injury as required by this agency.

Signed and filed on this 6th day of June, 2023.

Joseph S. Cortese II

JOSEPH S. CORTESE II
WORKERS' COMPENSATION
COMMISSIONER

The parties have been served as follows:

Thomas Wertz (via WCES)

Stephanie Marett (via WCES)