BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

PETIT DIKUTOLE,	:	
Claimant,	:	File No. 5054404
vs.	:	APPEAL
TYSON FOODS, INC.,	:	DECISION
Employer, Self-Insured, Defendant.	:	Head Note Nos: 1803; 1803.1

FILED
MAY 11 2018
WORKERS' COMPENSATION

Defendant, Tyson Foods, Inc., employer, appeals from an arbitration decision filed on December 9, 2016. The case was heard on September 15, 2016. The evidentiary record was left open for receipt of an additional exhibit until October 17, 2016, at which time the evidentiary record closed and the case was considered fully submitted in front of the deputy workers' compensation commissioner.

The deputy commissioner concluded that claimant Petit Dikutole carried his burden of proof that his injuries were not confined to two scheduled members. Instead, the deputy commissioner concluded claimant established his injuries went beyond the relevant schedules and should be compensated with industrial disability. The deputy commissioner awarded 40 percent industrial disability as a result of the stipulated injury which arose out of and in the course of claimant's employment with defendant-employer on March 5, 2015, which entitled claimant to receive 200 weeks of permanent partial disability (PPD) benefits, commencing on June 1, 2016.

Defendant asserts on appeal that the deputy commissioner erred in concluding claimant's injuries went beyond the statutory schedule and should be compensated with industrial disability. Defendant concedes the injuries to claimant's left leg and right arm are compensable, but asserts those injuries should be compensated on a 500-week schedule pursuant to Iowa Code section 85.34(2)(s).

Claimant responds to the appeal and asserts the deputy commissioner's award should be affirmed in all respects. Claimant contends the size of the skin graft and the permanent impairment rating from his evaluating physician rendering an impairment to the whole person should take the injuries beyond the schedule and into an industrial disability situation.

Pursuant to Iowa Code section 86.24 and Iowa Code section 17A.15, I performed a de novo review of the evidentiary record and the detailed arguments of the parties. I reach a different result than the deputy commissioner on the issue of whether claimant's injuries are confined to two scheduled members. Therefore, I reverse the award of industrial disability and I enter the following findings of fact and conclusions of law relative to the nature and extent of claimant's permanent disability:

STATEMENT OF FACTS

On March 5, 2015, claimant was assembling boxes and placing meat in the boxes to be placed in cold storage. (Transcript, page 13) Around 7:00 p.m., after a break, claimant tripped over a pallet at work, lost his balance, and fell into a metal ladder. (Tr., p. 14)

A Tyson nurse called for an ambulance, noting claimant had a laceration to his left lower leg with exposed bone. (Exhibit A, p. 1) Claimant was transported to the University of Iowa Hospitals and Clinics ("UIHC") for treatment. (Ex., p. A-1) Mark Graber, M.D., at UIHC documented claimant had a six by ten centimeter open wound to his left tibia with exposed bone, muscle and tendon. (Ex. B, p. 1) X-rays did not reveal any fractures or dislocations. (Ex. B, pp. 3-5)

Claimant was admitted to UIHC, his wound was cleaned, and he received a surgical fasciotomy. (Ex. B, pp. 9-10) Claimant was later diagnosed with a traumatic compartment syndrome of the left lower extremity. (Ex. B, p. 9) Claimant received skin grafts for his condition. (Tr., p. 15; Ex. B, pp. 11-13) Following surgery, claimant was placed in a cast and he received pain medication. (Ex. B., pp. 18-29)

On March 18, 2015, claimant was released from UIHC and admitted to St. Luke's Hospital for acute inpatient rehabilitation, including intensive physical and occupational therapy, rehabilitation nursing, and medical psychology. (Ex. L, pp. 1, 7) Stanley Mathew, M.D., listed an impression of polytrauma, left lower extremity degloving injury, compartment syndrome, status post fasciotomy, status post split-thickness skin grafting of the left lower extremity, and gait, balance, and coordination deficits. (Ex. L, p. 6) During his rehabilitation, claimant continued to receive pain medication. (Ex. L, p. 6)

On April 7, 2015, claimant attended a follow-up appointment at UIHC and hospital staff noted claimant's skin graft to his medial left calf was "healing well except for proximal edge where graft was lost and replaced with hypergranulation tissue." (Ex. B, p. 27) During an appointment on April 14, 2015, hospital staff documented the graft to claimant's left medial lower extremity was almost completely healed, with the exception of a two-by-two centimeter area on the superior border, which was covered with hypergranulation tissue. (Ex. B, p. 30)

Claimant attended a follow-up appointment with Shalina Shaik, M.D., in family medicine at UIHC on April 28, 2015. (Ex. B, pp. 37-38) Dr. Shaik assessed claimant with a degloving injury, status post skin graft, a crush injury, chronic pain, neuropathic pain of the lower extremity, numbness and tingling of the left leg, and a postoperative stitch abscess. (Ex. B, p. 37) During this appointment, claimant complained of left knee joint pain and swelling. (Ex. B, p. 39) Claimant was also attending the burn/wound clinic. (Ex. B, p. 39) Dr. Shaik noted claimant had a "limping gait." (Ex. B, p. 41)

During his appointment with the burn/wound clinic on May 12, 2015, staff documented claimant continued to take pain medication and his pain had decreased. (Ex. B, p. 44) Claimant received physical therapy and used a cane for ambulation. (Ex. B, p. 49) During his June 2, 2015 appointment, claimant reported he had returned to work. (Ex. B, p. 49)

Claimant continued to complain of left knee pain with ambulation. (Ex. B, p. 52) UIHC staff recommended magnetic resonance imaging of Mr. Dikutole's left knee. (Ex. B, p. 54) On June 26, 2015, claimant received the imaging and the reviewing radiologist listed an impression of a subchondral fracture with adjacent edema in the weight bearing area of the medial femoral condyle, a small joint effusion, and a low-grade strain at the origin of the fibularis longus. (Ex. B, p. 55)

Claimant was off work starting in July 2015 for many months. (Tr., p. 16) While he was off work, claimant received temporary benefits and medical care and treatment. (Tr., pp. 16-17; Ex. G, p. 2)

Claimant attended an appointment with Matthew Bollier, M.D., an orthopedic surgeon at UIHC, on July 20, 2015. (Ex. D, pp. 3-4) Dr. Bollier recommended a medial unloader brace before proceeding with surgery. (Ex. D, p. 4)

During claimant's July 21, 2015 appointment with Dr. Shaik, the doctor noted claimant had been referred to orthopedics and orthopedics had recommended bracing, and if bracing did not help, surgery. (Ex. B, p. 63) Dr. Shaik noted claimant continued to have chronic pain secondary to his left leg injury and he continued to take his pain medication. (Ex. B, p. 63)

Claimant returned to Dr. Bollier on August 7, 2015. (Ex. D, p. 7) Dr. Bollier assessed claimant with "left medial knee pain due to MFC osteochondral fracture related from fall while at work on March 3, 2015. He has failed trial of nonop treatment." (Ex. D, p. 7) Dr. Bollier recommended surgery, a "left knee HTO with I-balance fixation, BioCartilage resurfacing and possible knee arthroscopy." (Ex. D, p. 7) Dr. Bollier restricted claimant to desk duty only until surgery and noted claimant would be off for two weeks after surgery and on "strict" restrictions for a minimum of three months. (Ex. D, p. 7) On September 30, 2015, claimant was admitted to UIHC and the next day Dr. Bollier performed a left osteotomy tibial opening wedge and allograft cartilage resurfacing of "MFC lesion." (Ex. D, pp. 9-12)

On January 26, 2016, claimant presented at the UIHC emergency room, complaining of right wrist pain. (Ex. B, p. 81) Claimant testified in his deposition that he was climbing the stairs as part of his home exercise program and "[w]hen I was on the fourth step, I felt really bad in my knee in the interior, and I couldn't really move. So then I fell, and I tried to brace myself from the shock just because I lost my balance. So I tried to absorb the shock, and when I fell on the ground, I hurt, and I kind of realized I probably broke my wrist." (Ex. G, p. 3, depo p. 11) Claimant complained of pain in his right hand immediately following the fall. (Ex. B, p. 81)

After reviewing x-rays of claimant's right upper extremity, Christopher O'Neill, D.O., in emergency medicine at UIHC, listed an impression of a right distal radius fracture and ulnar styloid fracture, closed. (Ex. B, p. 85) Claimant received a splint to his right wrist and he was discharged to home, with pain medication. (Ex. B, pp. 84-85)

On February 11, 2016, Lindsey Caldwell, M.D., an orthopedic surgeon at UIHC, performed an open reduction and internal fixation on claimant's right upper extremity. (Ex. E, p. 1) Following surgery claimant received a brace for his wrist and therapy. (Id.)

Claimant attended a follow-up appointment with Dr. Bollier on February 22, 2016. (Ex. D, p. 18) Dr. Bollier noted claimant's leg had "gotten stronger with less pain", but he still had knee soreness with activity, but "overall is doing better." (Ex. D, p. 18) During his examination, Dr. Bollier noted claimant's incisions had healed well, he had increased quad strength and girth, his gait was much better, and he had full range of motion. (Ex. D, p. 19) Dr. Bollier recommended physical therapy. (Ex. D, p. 20)

On June 1, 2016, claimant attended an appointment with Dr. Caldwell. (Ex. E, p. 2) Dr. Caldwell found claimant was at maximum medical improvement, and determined he could return to full unrestricted activities. (Ex. E, p. 3)

Nathan Sels, PT, performed a functional capacity evaluation of claimant on June 7, 2016. (Ex. F, p. 1) Mr. Sels determined claimant "demonstrates the physical capabilities and tolerances to function at the Medium physical demand level" and noted the physical demand for his position with Tyson is at a "Very Heavy physical demand level." (Ex. F, p. 1) Mr. Sels noted claimant did not demonstrate the physical capabilities and tolerances necessary to perform all of the essential functions of his job and recommended claimant engage in work hardening to increase his overall physical capabilities and tolerances to return to work. (Ex. F, p. 1) Mr. Sels determined claimant could occasionally lift 50 pounds from twelve inches to his waist, occasionally lift 40 pounds from his waist to his shoulder, frequently lift 25 pounds from 12 inches to his waist, frequently stand, and repetitively squat, kneel, and climb stairs occasionally. (Ex. F, pp. 1-2)

On July 7, 2016, Dr. Bollier reviewed the results of the functional capacity evaluation and found that it was a valid assessment and that claiman "should have

permanent restrictions including 2-handed lifting of no more than 50 pounds from 12 [sic] waist occasionally and 25 pounds frequently, 2-handed lifting of no more than 40 pounds from waist to shoulder height occasionally and 15 pounds frequently, occasional squatting, kneeling, and stair climbing, and frequent walking." (Ex. D, p. 21)

Using the Guides to the Evaluation of Permanent Impairment (AMA Press, 5th Ed. 2001) ("AMA Guides"), Dr. Bollier assigned a permanent partial impairment rating of twenty-five percent of the lower extremity. (Ex. D, p. 22) Dr. Bollier noted, "[t]his rating is the result of proximal tibial osteotomy with 'Good' result per table 17-33 on page 547 of the Guides." (Ex. D, p. 22) Dr. Bollier noted that future treatment for the injury could include medications, injections, physical therapy, and revision surgery. (Ex. D, p. 22)

On July 13, 2016, Dr. Caldwell assigned claimant a permanent impairment rating of seven percent of the upper extremity, finding "[t]his rating is the result of loss of active wrist flexion (2% upper extremity) and extension (4% upper extremity) per figure 16-28 on page 467 and loss of active forearm pronation (1% upper extremity) per figure 16-37 on page 474 of the Guides." (Ex. E, p. 6) Dr. Caldwell released claimant without work restrictions and noted that future treatment could include nonsteroidal anti-inflammatory medication and occupational therapy. (Ex. E, p. 6)

Farid Manshadi, M.D., physiatrist, performed an independent medical examination of claimant on July 18, 2016, at the request of claimant's attorney. (Ex. H) Dr. Manshadi reviewed claimant's medical records and examined him. (Ex. H, p. 1) During the examination, claimant complained of pain in his right wrist, but denied having problems with grip strength, and complained of pain in his left knee while going up and down steps, numbness involving the left medial and lateral aspect of his left leg, weakness in the left leg, and pain with long distances. (Ex. H, p. 3) Claimant told Dr. Manshadi he could walk two to three miles before having increased pain and reported he could not run anymore. (Ex. H, p. 3) Claimant denied having problems performing activities of daily living. (Ex. H, p. 3)

Using the AMA Guides, Dr. Manshadi opined:

> Specifically[,] in regard to the skin grafting into the defect involving the medial lower leg area, I used Chapter 8, Table 8-2, page 178 and he falls under Class 1 and I assign five (5) percent impairment of the whole person.
>
> In regard to the high tibial osteotomy, he had a good result and I assign twenty-five (25) percent impairment of the left lower extremity using Table 17-33, Page 547.
>
> In regard to the peroneal nerve injury, I used Table 17-37 and I assign another five (5) percent impairment of the left lower extremity.

> Further, in regard to the left ankle with reduced range of motion, I used Table 17-11 and I assign seven (7) percent impairment of the left lower extremity.
>
> In regard to the right wrist, I used Chapter 16, Pages 466 through 469 and I assign seven (7) percent impairment of the right upper extremity.

(Ex. H, p. 4) Dr. Manshadi agreed with the functional capacity evaluation and the permanent restrictions and future treatment recommended by Dr. Bollier. (Ex. H, p. 4)

Defendant provided Dr. Bollier with Dr. Manshadi's IME report and requested his opinion. (Ex. D, p. 23) Dr. Bollier concluded the report did not change his rating, and he opined:

> Dr. Manshadi concurred with my assignment of diagnosis-based impairment for proximal tibial osteotomy with "Good" result, and my opinion regarding that has not changed. Dr. Manshadi also assigned additional impairment for a diagnosis of a "peroneal nerve injury". Upon review of my documentation as well as other documentation from UIHC regarding treatment for this injury I did not find any objectively verified documented peroneal nerve injury. Despite Mr. [Dikutole] treating with me for many months for the left lower extremity, there is no documentation of peroneal nerve dysfunction or dysethesia. I have not seen any EMG/NCV confirmation of peroneal nerve dysfunction. In fact, the only documentation I have found of any peroneal nerve complaints are Dr. Manshadi's somewhat confusing documentation of Mr. [Dikutole] reporting "numbness involving the left medial and lateral aspect of the left leg" and "reduced sensation to light touch and pinprick along the left peroneal nerve in comparison to the opposite side". Given the lack of any previous documentation of this problem, as well as the lack of any objective verification of peroneal nerve dysfunction, it is not appropriate to assign impairment for peroneal nerve issues based only on one provider's unverified and non-specific clinical exam (e.g. Dr. Manshadi did not document specific 2-point discrimination differences between the affected leg and non-affected leg, or get independent provider confirmation of reduced sensation in the affected leg, as is recommended by the AMA Guides). Therefore, I do not agree with Dr. Manshadi's assignment of impairment due to peroneal nerve dysfunction.
>
> Dr. Manshadi also assigned impairment due to a skin graft on Mr. [Dikutole's] lower extremity. I did not treat him for this condition. My documentation indicates that when we did remark on the graft it appeared to be in very good condition.

> My opinion regarding his level of impairment for the left knee has not changed.

(Ex. D, pp. 23-24)

Defendant offered claimant a job as a freezer janitor, which is within his restrictions, and he returned to work on August 8, 2016. (Tr., pp. 22, 25; Ex. C-3) Claimant sweeps and cleans things off the ground. (Tr., p. 22) He also labels boxes and works in the cold and storage areas where the animal carcasses are stored, and removes ice from the walls, windows, and floors. (Ex. O, p. 2) Claimant is able to perform his job duties, but reports his knee hurts when he works in the freezer area. (Tr., p. 23; Ex. O, p. 3) Claimant works full-time for defendant. (Ex. C, p. 2)

Claimant testified he has a loss of sensation on the inside of his left lower leg where his scar is and on the outside of his knee. (Tr., pp. 17-19) Claimant reported the interior side of his knee hurts and is weak. (Tr., pp. 18, 20) Claimant stated he experiences pain in his left foot when he goes up and down stairs and walks. (Tr., p. 24) Claimant is able to drive to work. (Tr., p. 27; Ex. O, p. 5) Claimant testified that since his fall he has had pain in his wrist, and a loss of strength. (Tr., pp. 23-24) Claimant was not taking pain medication at the time of the hearing and did not have any appointments scheduled in the future. (Tr., p. 29)

Having reviewed the competing impairment ratings of Dr. Bollier, Dr. Caldwell, and Dr. Manshadi, I concur with the deputy commissioner's analysis that the opinion of Dr. Manshadi regarding a peroneal nerve condition is not persuasive. Nor is his impairment rating for that condition. I find the opinions of Dr. Bollier and Dr. Caldwell, as the treating surgeons, most persuasive on the issue of permanent impairment. Specifically, I accept the opinion of Dr. Caldwell and I find claimant has proven he sustained a seven percent permanent impairment of the right upper extremity as a result of his wrist fracture. I similarly accept the opinion of Dr. Bollier and find claimant has proven he sustained a 25 percent permanent impairment of his left leg.

With respect to the issue of the skin grafting, Dr. Bollier noted at one of his evaluations that it had good healing. However, Dr. Bollier did not treat the skin graft and appears to have elected not to offer a direct opinion on the skin graft and any potential permanent impairment related to the skin graft. By way of contrast, Dr. Manshadi directly addresses the skin graft and permanent impairment related to the skin graft. I find Dr. Manshadi's opinion more convincing on the issue of the skin graft. Therefore, I find claimant has proven he sustained a five percent permanent impairment of the whole person as a result of the skin graft on his left leg.

However, I also find the injury to claimant's left leg is confined and limited to his left leg. His laceration was clearly contained within the left leg. A skin graft was taken from claimant's left thigh and utilized on his lower left leg. All injury, impairment, and effects of the left leg injury remain within the left leg.

Therefore, I find claimant sustained a left leg injury and developed a right arm injury as a sequela of the left leg injury. Pursuant to Table 17-3 of the AMA Guides, Fifth Edition, the 25 percent permanent impairment of the left leg converts to a ten percent impairment of the whole person. As noted, claimant proved an additional five percent permanent impairment of the whole person as a result of the skin grafting on his left leg.

Pursuant to Table 16-3 of the AMA Guides, Fifth Edition, the seven percent permanent impairment of claimant's right arm converts to four percent impairment of the whole person. Using the Combined Values Chart located at pages 604-605 of the AMA Guides, Fifth Edition, the ten percent rating due to the leg injury and the five percent rating due to the skin graft combine to a 15 percent impairment of the whole person. When this 15 percent rating is combined with the four percent whole body rating for the arm, it results in an 18 percent impairment of the whole body.

Having considered the situs and severity of the injury, claimant's residual work abilities, restrictions, as well as claimant's testimony about his residual symptoms and difficulties, I find that the 18 percent whole body impairment rating adequately and accurately reflects the functional loss claimant sustained as a result of the March 5, 2015, left leg and resulting right arm injuries.

CONCLUSIONS OF LAW

The primary or initial fighting issue in this case is the nature of claimant's injury and resulting disability. Claimant contends the skin graft performed on his left leg, coupled with the whole person impairment rating from Dr. Manshadi, converts this claim to an industrial disability, or unscheduled, injury. Defendant contends that all functional limitations are confined to claimant's left leg and right arm, such that this case should be compensated as a scheduled injury of two listed body parts pursuant to Iowa Code section 85.34(2)(s).

Under the Iowa Workers' Compensation Act, permanent partial disability is compensated either for a loss or loss of use of a scheduled member under Iowa Code section 85.34(2)(a)-(t) or for loss of earning capacity under section 85.34(2)(u). The extent of scheduled member disability benefits to which an injured worker is entitled is determined by using the functional method. Functional disability is "limited to the loss of the physiological capacity of the body or body part." Mortimer v. Fruehauf Corp., 502 N.W.2d 12, 15 (Iowa 1993); Sherman v. Pella Corp., 576 N.W.2d 312 (Iowa 1998). The fact finder must consider both medical and lay evidence relating to the extent of the functional loss in determining permanent disability resulting from an injury to a scheduled member. Terwilliger v. Snap-On Tools Corp., 529 N.W.2d 267, 272-273 (Iowa 1995); Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417, 420 (Iowa 1994).

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

In Smith v. Aramark, File No. 1199677 (Appeal April 2001), the claimant sustained a right leg burn injury that required skin grafting. Similar to this case, the permanent impairment rating rendered by the physician was to the "body as a whole." Chief Deputy Heitland, acting under delegation of authority from the Commissioner, concluded that "[a] finding of impairment to the body as a whole found by a medical evaluator does not equate to industrial disability. Impairment and disability are not synonymous." Id.

Therefore, the agency, through Chief Deputy Heitland, rejected the theory that merely obtaining a permanent impairment rating to the whole person was sufficient to convert an otherwise scheduled member into an industrial disability claim. However, Chief Deputy Heitland ultimately did award industrial disability benefits in the Smith case because he found the claimant in that case also sustained a permanent psychological condition as a result of the leg injury. Therefore, that case is persuasive but not entirely on point.

Former Commissioner Trier also issued a couple of decisions relevant to this situation. However, his decisions were issued while he was a deputy commissioner and not at the agency appellate level. Therefore, those are instructive and persuasive, but not necessarily binding precedent.

Deputy Trier faced a similar situation involving skin grafting and an impairment rating rendered to the whole person. Deputy Trier "noted that all the impairment ratings under chapter 13 (of the AMA Guides) are couched in a percentage of impairment of the whole person, even in those examples where the injury was limited to a scheduled member. It is noted that the Guides contain a system for determining equivalent impairments to hands or arms." Haley v. Dave McAlpin Motors, File No. 1212609 (Arbitration October 2000).

Deputy Trier noted "[t]he only permanent disability that exists is in Boyd's hands and arms." Id. Therefore, Deputy Trier concluded that the injury remained confined to the scheduled members, awarded permanent disability as a scheduled member, and rejected claimant's request to award industrial disability benefits. Id.

Deputy Trier again faced a similar situation in Nieland v. Heartland Builders, Inc., File No. 1200390 (Arbitration July 2001). In that case, Deputy Trier concluded that the "resulting damage from the injury is entirely contained within his left arm and right leg." Id. Therefore, benefits were awarded in Nieland pursuant to Iowa Code section 85.34(2)(s) and the claimant's request in that case to award industrial disability benefits was rejected.

Prior deputy commissioners have considered this issue several times. In 1981, a deputy commissioner considered this argument in Lauden v. Walker Manufacturing Co., 1 Iowa Industrial Commissioner 202 (Arbitration February 1981). In that case, the deputy noted the physician rendered a permanent impairment to the body as a whole. However, the deputy noted, "[t]here is no loss of earning capacity in this case as a result of the skin graft from the hip, and claimant's otherwise limited scheduled injury may not be so transformed into an injury that resulted in disability to the body as a whole." Id.

Another deputy commissioner reached a similar conclusion of law in Waterman v. Bridgestone/Firestone, File Nos. 102437, 1002115 (Arbitration December 1995). In 1999, a deputy commissioner held, "[t]he mere fact that Dr. Foster's impairment rating is to the body as a whole does not mean that claimant's benefits must be calculated pursuant to an industrial disability method." Topete v. Global Food Processing, File No. 1167910 (Arbitration June 1999). The deputy specifically concluded that "the mere fact that the skin covers the entire body does not render an injury to the skin of the arm an injury to the body as a whole." Id.

The issue came before a deputy commissioner again in 2002. That deputy noted that certain conditions such as CRPS and phantom pain will convert an otherwise scheduled injury into an unscheduled injury. However, the deputy commissioner noted those cases "should not ... be read as requiring that any damage to the nervous system, vascular system, or skeletal system is 'unscheduled,' because doing so would largely do away with the statutory schedule altogether." Nelson v. Artistic Waste Services, Inc., File No. 1304096 (Arbitration September 2002). The deputy noted the injury in that case was to the skin and a peripheral nerve in claimant's left leg. Therefore, he concluded there "is no evident reason why such an injury should be compensated as anything other than a scheduled loss to the leg." Id.

A similar issue came before the agency in Hansen v. Codycal, Inc. d/b/a Greenbriar Restaurant & Bar, File No. 5001522 (Arbitration February 2003). Mr. Hansen worked as a cook and spilled hot butter and water onto his left forearm. The burn resulted in keloid scarring on his left forearm, which required scar revision surgeries and resulted in painful itching of the left forearm. The physicians utilized the AMA Guides and opined that the claimant sustained five percent impairment of the whole person as a result of the burn. The claimant urged that the whole person impairment rating converted the claim to an industrial disability claim.

The deputy commissioner held:

> The only basis for claimant's argument that his injury extends into the body as a whole is the fact that the AMA Guides rate disorders of the skin, including scarring from burns, to the body as a whole. Whether a condition is rated to an extremity or to the body as a whole under the AMA Guides is not controlling under Iowa law, however. For example, the Guides rate impairment in the shoulder as impairment to the upper extremity. Under Iowa law, an impairment to the shoulder is a body as a whole injury. Second Injury Fund of Iowa v. Nelson, 544 N.W.2d 258 (Iowa 1995).

Hansen v. Codycal, Inc. d/b/a Greenbriar Restaurant & Bar, File No. 5001522 (Arbitration February 2003).

The issue was re-examined in 2009, with the deputy commissioner noting that an amputation of a finger results in injury to the skeletal system, the vascular system, as well as neurologic system. Yet, the injury remains limited to a scheduled member. The deputy commissioner analogized that an injury to the skin that is limited to one scheduled member similarly is confined to and compensated as a scheduled member loss. Armstrong v. Second Injury Fund, File No. 5026632 (Arbitration July 2009).

The Armstrong case was appealed. On delegation of authority, another deputy commissioner affirmed the arbitration decision. Ultimately, the case was heard by the Iowa Court of Appeals. In an unpublished decision, the Iowa Court of Appeals concurred with the presiding deputy commissioner's analysis. The court noted it agreed "with the finding ... that 'there is nothing in the record to support the argument that Armstrong suffers from any systemic condition extending beyond his left lower leg.'" Second Injury Fund v. Armstrong, 801 N.W.2d 628 (Iowa App. 2011) (Table of Unpublished Decisions).

In 2011, a deputy commissioner again considered this issue in a Second Injury Fund claim. In Gacek v. Second Injury Fund, File No. 5030637 (Arbitration February 2011), the claimant sustained acid burns on his feet. The Second Injury Fund argued that the burns injured only the skin on claimant's feet and that the skin is an unscheduled body part, not specific to the feet. The deputy commissioner rejected that argument finding that the burns affected claimant's feet only and held that the acid burns were a scheduled member foot injury.

The issue has been raised and litigated before this agency more recently as well. A deputy commissioner reached a similar result in Singleton v. Newton Correctional Facility, File No. 5041430 (Arbitration October 2013). Most recently, another deputy commissioner concluded that a permanent impairment rating to the whole person does

not automatically convert an injury into an industrial disability claim. Deffebaugh v. 1st Interiors, Inc., File No. 5047330 (Arbitration April 2018).

Within the past couple of months, the agency issued yet another arbitration decision by a deputy commissioner that analyzed a case involving burns to the left arm. In that decision, the deputy commissioner provided some good rationale and analysis of the issue. He noted the claimant's contention that "scarring is a skin disorder, which is not a scheduled impairment and should be assessed industrially." Bryan v. Kiowa Line Builders, Inc., File No. 5062947 (Arbitration March 2018). However, the deputy commissioner rejected that argument and, instead, explained:

> [T]he nature of scarring is specific in its location. It is not the sort of skin disorder that may be intermittent or spread around the body from one location to another such as dermatitis or psoriasis. A scar by its nature is permanently located in a particular area. In this case, the scarring does not enter into the shoulder, neck or torso and is limited to the upper extremity. Also, there was no evidence that the scarring limited function to any unscheduled part of his body. Therefore, I conclude that the injury is to a scheduled member, the left arm, and not the body as a whole.

Id.

In that case, the deputy commissioner acknowledged the whole person impairment rendered for the scarring. He also noted that the AMA Guides permit conversion of impairment ratings from the whole person to a scheduled member. Appropriately recognizing the AMA conversion tables, the deputy commissioner stated, "I convert this 3 percent whole person rating pursuant to Table 16-3, page 439, of the AMA Guides to 5 percent of the upper extremity and conclude that claimant has sustained 5 percent permanent impairment to the upper extremity due to this work injury and the resultant scarring." Id.

The only contrary arbitration decision I found was Jones v. Vogt Plumbing & Heating, File No. 5010214 (Arbitration August 2005). In that case, claimant experienced an electrocution which resulted in significant burns on his hands. Extensive skin grafting was required and the grafting donor site was claimant's abdomen. Much like the other cases cited above, the physicians rendered whole person impairment ratings based on the skin impairment. The deputy commissioner cited no precedent for his determination, but held: "[g]iven the doctors' impairment whole person ratings, the site of the donor graft (the abdomen), the size of the donor graft ... and the size of the graft site ... the assessment of a skin disorder of the whole body is appropriate. Claimant has proven he has an unscheduled disability." Id.

The deputy commissioner's analysis and opinion in Jones v. Vogt Plumbing & Heating, File No. 5010214 (Arbitration August 2005), arguably support the findings and

conclusion of the presiding deputy commissioner in this case. However, the deputy's analysis in Jones can be and should be distinguished. Holding that an impairment rating to the whole person alone is sufficient to convert an injury from a scheduled member claim to an industrial disability claim will essentially render the legislatively mandated schedule irrelevant. Claimant attorneys will simply find a way for their evaluating physician to offer a whole person impairment rating and argue that every claim is converted from a scheduled member injury into a body as a whole claim. This would lead to an absurd result, clearly not intended by the legislature.

Instead, the evidence is clear in this case that claimant sustained a left leg injury and a right arm injury. The skin graft was taken from claimant's left leg and placed onto claimant's left leg. The entirety of the injury was confined to the anatomical situs of the left leg and the right arm. The mere fact that skin grafting was performed, or that a whole person impairment rating was rendered, does not convert the case from scheduled member injuries to be compensated pursuant to Iowa Code section 85.34(2)(s) into an unscheduled injury to be compensated pursuant to Iowa Code section 85.34(2)(u).

Where an injury is limited to scheduled member the loss is measured functionally, not industrially. Graves v. Eagle Iron Works, 331 N.W.2d 116 (Iowa 1983).

The courts have repeatedly stated that for those injuries limited to the schedules in Iowa Code section 85.34(2)(a-t), this agency must only consider the functional loss of the particular scheduled member involved and not the other factors which constitute an "industrial disability." Iowa Supreme Court decisions over the years have repeatedly cited favorably the following language in the 66-year-old case of Soukup v. Shores Co., 222 Iowa 272, 277; 268 N.W. 598, 601 (1936):

> The legislature has definitely fixed the amount of compensation that shall be paid for specific injuries . . . and that, regardless of the education or qualifications or nature of the particular individual, or of his inability . . . to engage in employment . . . the compensation payable . . . is limited to the amount therein fixed.

Our court has even specifically upheld the constitutionality of the scheduled member compensation scheme. Gilleland v. Armstrong Rubber Co., 524 N.W.2d 404 (Iowa 1994). Permanent partial disabilities are classified as either scheduled or unscheduled. A specific scheduled disability is evaluated by the functional method; the industrial method is used to evaluate an unscheduled disability. Graves, 331 N.W.2d 116; Simbro v. DeLong's Sportswear 332 N.W.2d 886, 887 (Iowa 1983); Martin v. Skelly Oil Co., 252 Iowa 128, 133, 106 N.W.2d 95, 98 (1960).

When the result of an injury is loss to a scheduled member, the compensation payable is limited to that set forth in the appropriate subdivision of Code section 85.34(2). Barton v. Nevada Poultry Co., 253 Iowa 285, 110 N.W.2d 660 (1961). "Loss of use" of a member is equivalent to "loss" of the member. Moses v. National Union C.

M. Co., 194 Iowa 819, 184 N.W. 746 (1921). Pursuant to Iowa Code section 85.34(2)(v) the workers' compensation commissioner may equitably prorate compensation payable in those cases wherein the loss is something less than that provided for in the schedule. Blizek v. Eagle Signal Co., 164 N.W.2d 84 (Iowa 1969).

Evidence considered in assessing the loss of use of a particular scheduled member may entail more than a medical rating pursuant to standardized guides for evaluating permanent impairment. A claimant's testimony and demonstration of difficulties incurred in using the injured member and medical evidence regarding general loss of use may be considered in determining the actual loss of use compensable. Soukup, 222 Iowa 272, 268 N.W. 598. Consideration is not given to what effect the scheduled loss has on claimant's earning capacity. The scheduled loss system created by the legislature is presumed to include compensation for reduced capacity to labor and to earn. Schell v. Central Engineering Co., 232 Iowa 421, 4 N.W.2d 339 (1942).

The right of a worker to receive compensation for injuries sustained which arose out of and in the course of employment is statutory. The statute conferring this right can also fix the amount of compensation to be paid for different specific injuries, and the employee is not entitled to compensation except as provided by statute. Soukup, 222 Iowa 272, 268 N.W. 598.

Having found claimant's left leg and right arm injuries were confined to each scheduled member and having found the anatomical site of any disability or impairment related to the left leg and right arm injuries were confined to the left leg and right arm, I conclude claimant's injuries should be compensated as scheduled member injuries. Having found claimant sustained a left leg scheduled member injury and a right arm injury as a sequela of the left leg injury, I conclude claimant has sustained injuries to two scheduled members, injuries specifically identified in Iowa Code section 85.34(2)(s) such that the functional disability resulting from each injury should be combined and benefits should be awarded on a 500-week schedule. Iowa Code section 85.34(2)(s).

I find claimant proved a functional loss equivalent to ten percent of the whole person as a result of his left leg injury. I also find claimant sustained an additional permanent functional loss equivalent to five percent of the whole person as a result of his skin graft. Finally, I find claimant sustained a functional loss equivalent to four percent of the whole person as a result of his right arm injury.

Utilizing the AMA Guides, I combined the functional loss ratings and I find claimant proved a permanent functional loss resulting from his left leg and right arm injuries equivalent to 18 percent of the whole person. Pursuant to Iowa Code section 85.34(2)(s), a 500-week schedule is used because the injury involves two scheduled members. Claimant is entitled to an award of permanent partial disability benefits equivalent to the proportional loss relative to 500 weeks of benefits. Iowa Code section 85.34(2)(v). Eighteen (18) percent of 500 weeks equals 90 weeks. I conclude claimant is entitled to 18 percent of 500 weeks, or 90 weeks of permanent partial disability

benefits. Iowa Code section 85.34(2)(s), (v); Blizek v. Eagle Signal Co., 164 N.W.2d 84 (Iowa 1969).

No other issues were appealed and the findings of fact, conclusions of law, and orders rendered in the December 9, 2016, arbitration decision are adopted in all other respects.

ORDER

IT IS THEREFORE ORDERED that the arbitration decision filed on December 9, 2016, is MODIFIED as follows:

Defendant shall pay claimant ninety (90) weeks of permanent partial disability benefits, commencing on June 1, 2016, at the rate of four hundred fifteen and 36/100 dollars ($415.36).

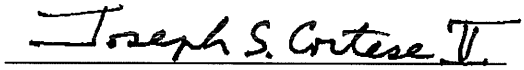
Defendant is entitled to a credit for all benefits previously paid.

Defendants shall pay accrued weekly benefits in a lump sum together with interest at the rate of ten percent for all weekly benefits payable and not paid when due which accrued before July 1, 2017, and all interest on past due weekly compensation benefits accruing on or after July 1, 2017, shall be payable at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two percent. See Gamble v. AG Leader Technology, File No. 5054686 (App. Apr. 24, 2018).

Pursuant to rule 876 IAC 4.33, defendant shall pay claimant's costs of the arbitration proceeding in the amount of $1,615.52 and claimant shall pay the costs of the appeal, including the cost of the hearing transcript.

Pursuant to rule 876 IAC 3.1(2), defendant shall file subsequent reports of injury as required by this agency.

Signed and filed this 11th day of May, 2018.



JOSEPH S. CORTESE II
WORKERS' COMPENSATION
COMMISSIONER

Copies To:

Gary B. Nelson
Attorney at Law
PO Box 637
Cedar Rapids, IA 52406-0637
gary@rushnicholson.com

Jean Z. Dickson
Attorney at Law
1900 E. 54th St.
Davenport, IA 52807
jzd@bettylawfirm.com