BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

ZLATKO ODOBASIC, Claimant, vs. AREA RESIDENTIAL CARE, INC. Employer, and WEST BEND MUTUAL INS. CO., Insurance Carrier, Defendants.	File No. 1645232.02 ARBITRATION DECISION Head Notes: 1803; 1800

STATEMENT OF THE CASE

The claimant, Zlatko Odobasic, filed a petition for arbitration seeking workers' compensation benefits from Area Residential Care, Inc., ("ARC") and its insurer West Bend Mutual Insurance. Mark Sullivan appeared on behalf of the claimant. Edward Rose appeared on behalf of the defendants.

The matter came for hearing on March 9, 2022, before Deputy Workers' Compensation Commissioner Andrew M. Phillips. Pursuant to an order of the Iowa Workers' Compensation Commissioner related to the COVID-19 pandemic, the hearing occurred via Zoom. The hearing proceeded without significant difficulty.

The record in this case consists of Joint Exhibits 1-13, Claimant's Exhibits 1-8, and Defendants' Exhibits A-K. The claimant testified on his own behalf. Gale Sweeney Christensen was appointed the official reporter and custodian of the notes of the proceeding. The evidentiary record closed at the end of the hearing, and the matter was fully submitted on April 8, 2022, after briefing by the parties.

STIPULATIONS

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

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

2. The claimant sustained an injury arising out of, and in the course of, employment, on February 25, 2018.

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

4. That, if the injury is a cause of permanent disability, the disability is an industrial disability.

5. That the commencement date for permanent partial disability benefits, if any are awarded is March 11, 2018.

6. That the claimant's gross earnings at the time of the injury were seven hundred fourteen and 33/100 dollars ($714.33) per week, and that the claimant was married and entitled to two exemptions. The result is a weekly rate of compensation of four hundred seventy-one and 35/100 dollars ($471.35).

7. That prior to the hearing, the claimant was paid one thousand nine hundred sixty-five and 50/100 dollars ($1,965.50) of temporary compensation at the rate of four hundred forty-nine and 42/100 dollars ($449.42) per week.

8. The defendants would issue a payment to cover an underpayment due to the incorrect rate, and that the claimant waived any negligible interest relating to the temporary compensation.

9. That after the February 25, 2018, injury the claimant returned to ARC, making the same, and eventually more money than at the time of his injury. Further, the parties noted, "although some of the injuries alleged are to the whole body, any [p]ermanent [p]artial [d]isability benefits awarded would be compensated based only upon the employee's functional impairment resulting from the injury, and not in relation to the employee's earning capacity.

10. That the costs listed in Claimant's Exhibit 1 have been paid.

Entitlement to temporary disability and/or healing period benefits are no longer in dispute. Credits against any award are also no longer in dispute. The defendants waived their affirmative defenses.

The parties are now bound by their stipulations.

ISSUES

The parties submitted the following issues for determination:

1. Whether the alleged injury is a cause of permanent disability.

2. The extent of permanent partial disability, should any be awarded.

3. Whether the claimant is entitled to reimbursement for an independent medical examination ("IME") pursuant to Iowa Code section 85.39.

4. Whether the claimant is entitled to alternate medical care pursuant to Iowa Code section 85.27.

5. Whether there should be an assessment of costs.

FINDINGS OF FACT

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

Zlatko Odobasic, the claimant, was 60 years old at the time of the hearing. (Testimony). He resides in Dubuque, Iowa. (Testimony). Mr. Odobasic is originally from Bosnia. (Testimony). While in Bosnia, he graduated from high school, and a four-year diesel mechanic program. (Testimony). He worked for a time as a diesel mechanic prior to the outbreak of war in the Balkans. (Testimony).

Mr. Odobasic then served in the Bosnian army. (Testimony). He was captured and was a prisoner of war for about 6 months in 1992 and 1993. (Testimony). As a prisoner of war, he was forced to dig trenches and cut wood. (Testimony). He eventually survived a harrowing escape from the prisoner of war camp. (Testimony). He made his way to a refugee camp in Croatia, where his family was located. (Testimony).

In 1997, Mr. Odobasic arrived in the United States of America with his family as refugees. (Testimony). He originally worked in Washington, in a meatpacking plant. (Testimony). He worked on beef for Costco. (Testimony). He also worked as a mechanic for a short time. (Testimony). He and his family moved to Dubuque, Iowa, in 2000, as he had extended family that settled in Iowa. (Testimony).

In Dubuque, Mr. Odobasic began working for ARC. (Testimony). ARC runs group homes for physically or mentally disabled adults. (Testimony). He worked as a night instructor for ARC. (Testimony). His standard work hours were from 11:00 p.m. to 7:00 a.m. (Testimony). He was the only staff member on duty during the evening. (Testimony). As a night instructor, he supervised the home during the evenings. (Testimony). He also cleaned the facility, and did laundry while the residents slept. (Testimony). In the morning, he cooked breakfast for the residents, assisted them with showering or bathing, provided them with medications as prescribed, and helped ready the residents for their days. (Testimony). He documented all actions taken according to plans for each individual resident. (Testimony). Mr. Odobasic testified that some of the residents worked in workshops, and others went to adult daycare programs. (Testimony). ARC required employees in similar positions to Mr. Odobasic to be able to lift 20 pounds regularly and 50 pounds occasionally. (Claimant's Exhibit 2:4).

Employees were also expected to prompt, escort, and physically restrain individuals as necessary. (CE 2:4).

Some residents of ARC facilities included people confined to wheelchairs. (Testimony). These residents required assistance with lifting, bathing, and dressing. (Testimony). Other residents needed less assistance. (Testimony).

Mr. Odobasic enjoyed working with residents at ARC. (Testimony). He could generally meet the requirements of his job. (Testimony).

In 2003, Mr. Odobasic had a left and right carpal tunnel repair in Dubuque. (Joint Exhibit 13:107; JE 13:115). He also had treatment for a chronic history of low back and right leg pain. (JE 13:108). A medical record from 2003 indicated that Mr. Odobasic was mistreated as a prisoner of war, which caused his continued aches and pains. (JE 13:108). An MRI done in 2003 showed degenerative changes at L4-5 with narrowing lateral recesses. (JE 13:109). One doctor noted that a repair of his lumbar spine issues would require a "fairly significant decompression," should he elect surgery. (JE 13:120). Physicians attempted epidural steroid injections at L4-5, which provided minimal relief. (JE 13:121).

On February 25, 2018, Mr. Odobasic left work at an ARC home. (Testimony). He walked to his vehicle in the dark, and slipped on black ice. (Testimony). He fell on his left side, and immediately felt pain. (Testimony). He does not remember if he lost consciousness or how long he was on the ground. (Testimony). Eventually, he was able to get up and went back into the home. (Testimony). The left side of his head was bleeding. (Testimony). Another staff member helped to stop the bleeding and clean his cut. (Testimony). Mr. Odobasic then drove himself home and called his supervisor. (Testimony). His supervisor told him to go to an acute care facility. (Testimony).

Mr. Odobasic did not drive himself to the acute care facility due to ongoing dizziness and pain. (Testimony). He reported to Medical Associates acute care clinic on February 25, 2018. (Joint Exhibit 2:3-4). Marc Dicklin, PA-C, examined him for a constant, moderate headache following a slip and fall incident. (JE 2:3). He also had nausea and dizziness. (JE 2:3). Mr. Dicklin determined that Mr. Odobasic should be immediately transferred to the emergency room. (JE 2:4). Mr. Odobasic was placed in a wheelchair and taken to the emergency room. (JE 2:4).

Upon arrival in the emergency room at Mercy Medical Center, Kevin Zettek, D.O., examined the claimant. (JE 3:5-8). Mr. Odobasic reported head pain, and swelling. (JE 3:5). Dr. Zettek ordered a cervical spine CT and a head CT. (JE 3:6-8). The CT scan of the cervical spine showed some multilevel degenerative changes including mild disc space narrowing at C4-5. (JE 3:7). There were no acute abnormalities noted in the cervical spine. (JE 3:7). The CT scan of the head showed no intracranial abnormalities, or acute issues. (JE 3:8). Dr. Zettek diagnosed the claimant with a cervical strain and a head injury. (JE 3:6).

On February 26, 2018, Mr. Odobasic presented to Tri-State Occupational Health, where he was examined by Emily Armstrong, PA-C. (JE 4:12-21). Mr. Odobasic indicated on a pain chart that he had pain in his left head, left shoulder, left elbow, left

wrist, left neck, left lower back, and left hip. (JE 4:13). He rated his pain between 7 and 8 out of 10. (JE 4:13). He recounted to Ms. Armstrong how the injury occurred. (JE 4:14). He indicated that he had a throbbing pain around his left eye, had some lightheadedness, and felt "foggy" mentally. (JE 4:13). He also reported seeing intermittent flashing lights in his left eye. (JE 4:13). He had no dizziness, phonophobia, photophobia, or loss of vision. (JE 4:13). Mr. Odobasic reported chronic low back pain with radicular symptoms into his right lower extremity. (JE 4:13). Ms. Armstrong ordered an x-ray of the lumbosacral spine and left wrist. (JE 4:16). She diagnosed Mr. Odobasic with a left hip contusion, left wrist pain, posttraumatic headache, left arm strain, and thoracic strain. (JE 4:16). Ms. Armstrong ordered a left wrist x-ray, which was negative. (JE 4:17). She also ordered x-rays of the thoracic and lumbar spine, which showed mild degenerative changes, but were otherwise normal. (JE 4:17; 20).

Ms. Armstrong discussed the possibility of a retinal injury with the claimant. (JE 4:16). The claimant elected to see if the symptoms resolved, but Ms. Armstrong told him that if the "flashing" persisted, he would need a referral to an ophthalmologist. (JE 4:16). Ms. Armstrong prescribed a Medrol dosepack. (JE 4:16). She took him off work for the day and released him to return the next day with restrictions. (JE 4:16). The restrictions were a maximum lifting/pushing/pulling of 5 pounds with the left arm, wearing a left wrist splint, only occasional bending of the neck and back, and sitting/standing/walking as tolerated. (JE 4:16). She recommended that he return in one week. (JE 4:16).

Kent Baumann, M.D., an ophthalmologist, examined Mr. Odobasic on February 28, 2018, due to light sensitivity and new floaters. (JE 5:60-62). Dr. Baumann diagnosed Mr. Odobasic with a retinal tear in the left eye and left retinal detachment. (JE 5:60). Dr. Baumann referred Mr. Odobasic to the University of Iowa for further evaluation and treatment. (JE 5:62).

Mr. Odobasic presented at the University of Iowa on February 28, 2018, where Ryan Dick-Perez, D.O., examined him. (JE 6:73-76). He complained of flashes in his left eye after a slip and fall. (JE 6:73). Upon examination, Mr. Odobasic was found to have a retinal tear and detachment that required surgical intervention. (JE 6:73). Daniel Feiler, M.D. assumed care for the claimant and examined him on March 1, 2018. (JE 6:76). Dr. Feiler diagnosed Mr. Odobasic with retinoschisis of the left eye and localized retinal detachment of the right eye. (JE 6:76). The physicians at the University of Iowa performed a laser barricade to the claimant's right eye. (JE 6:76).

Ms. Armstrong examined Mr. Odobasic again on March 6, 2018. (JE 4:23-25). Mr. Odobasic indicated that he was doing better, but that he had soreness in his right eye. (JE 4:23). Mr. Odobasic reported that he had surgery to his right eye, as outlined above, at the University of Iowa. (JE 4:23). The flashing symptoms in his left eye resolved. (JE 4:23). He had a "global mild headache," but told Ms. Armstrong that it was "not bad," and improving. (JE 4:23). He also mentioned improvement in his left-sided neck pain, and left shoulder pain. (JE 4:23). He had no pain in his left elbow or wrist while resting. (JE 4:23). His left wrist caused him increased pain while moving or using it, but he wore a splint during the day. (JE 4:23). Ms. Armstrong diagnosed Mr. Odobasic as follows: abrasion of the left elbow, acute cervical myofascial strain, acute

exacerbation of chronic low back pain, acute pain of the left shoulder, acute pain of the left wrist, acute posttraumatic headache, thoracic back pain, contusion of the left hip, left retinoschisis, partial retinal detachment of the right eye. (JE 4:24). Ms. Armstrong released Mr. Odobasic to return to work with a restriction of lifting/pushing/pulling a maximum of 25 pounds, only occasional bending and twisting of the neck and back, no climbing, and using a left wrist splint at all times. (JE 4:24). Ms. Armstrong ordered physical therapy and anticipated an average healing time of four to six weeks in general. (JE 4:24). She noted that Mr. Odobasic may have a longer course of recovery due to his previous chronic back pain. (JE 4:24).

Mr. Odobasic testified that he was allowed to return to work with restrictions largely due to his desire to return to his job and his enjoyment of his work. (Testimony).

Stephen Russell, M.D., wrote a letter to Dr. Baumann on March 8, 2018. (JE 6:81). Dr. Russell noted an inferotemporal area of detachment in the right eye with "excellent laser photocoagulation demarcation around the detachment." (JE 6:81). Dr. Russell found an area of retinoschisis. (JE 6:81). Dr. Russell asked Mr. Odobasic to return in four to six weeks for an additional examination of the right eye. (JE 6:81). Dr. Russell opined that if the demarcation was "fully matured" at that time, he would discharge the claimant from the University of Iowa. (JE 6:81).

On March 20, 2018, Mr. Odobasic returned to visit Ms. Armstrong. (JE 4:27-30). Mr. Odobasic told Ms. Armstrong that he was "doing good" since his last visit, that physical therapy was helping, and that his left wrist bothered him the most. (JE 4:27). Ms. Armstrong discovered that Mr. Odobasic was working full duty at ARC, and that he was told to call someone if he needed assistance. (JE 4:27). He reported that he continued to have a "global mild headache," felt mentally foggy, and felt mentally slower than his baseline. (JE 4:27). He had left-sided back pain which he told Ms. Armstrong was not bad. (JE 4:27). He continued to have left hip soreness. (JE 4:27). Due to the continued left wrist complaints, Ms. Armstrong ordered additional left wrist x-rays. (JE 4:28-29). The x-rays were negative. (JE 4:28-29). Mr. Odobasic felt that he was lifting/pushing/pulling more than 25 pounds at work. (JE 4:28). By the end of his workdays, his left wrist was more sore and his headaches were worse. (JE 4:28). Ms. Armstrong released Mr. Odobasic to work with his previous restrictions, including a lifting/pushing/pulling restriction of 25 pounds. (JE 4:28). His additional restrictions included only occasional bending of his back, no climbing, and using his left wrist splint at all times. (JE 4:28). Ms. Armstrong indicated that if Mr. Odobasic did not show satisfactory improvement by the next visit, she would provide more stringent restrictions. (JE 4:28). Ms. Armstrong further recommended that Mr. Odobasic continue formal physical therapy. (JE 4:28).

On April 11, 2018, Mr. Odobasic returned to the retina clinic at the University of Iowa, where Dr. Russell examined him. (JE 6:82-85). Mr. Odobasic denied new floaters, but had occasional itching. (JE 6:83). Dr. Russell also noted that Mr. Odobasic had age-related nuclear cataracts in both of his eyes. (JE 6:83). After examining the claimant, Dr. Russell indicated he would continue to observe him, and discussed symptoms of retinal detachment. (JE 6:85). Dr. Russell also discussed referring Mr. Odobasic to a neurologist for his migraines. (JE 6:85). Dr. Russell

released Mr. Odobasic to care with Dr. Baumann. (JE 6:85). Dr. Russell followed this visit up with a letter to Ms. Armstrong on April 18, 2018. (JE 6:86).

Ms. Armstrong examined Mr. Odobasic again on April 13, 2018, regarding his work injury. (JE 4:31-34). He reported that he did his regular job duties by himself, and that he had not improved much since his last visit. (JE 4:31). He complained that physical therapy was not helping. (JE 4:32). His physical therapist corroborated that his progress in physical therapy was slow. (JE 4:32). He told Ms. Armstrong that he had headaches in the left side of his head on a daily basis along with a "buzzing" sensation in his left ear. (JE 4:32). He complained of mental slowness and fog. (JE 4:32). He also described an aversion to loud noises. (JE 4:32). His neck hurt on both sides, which radiated into both of his shoulders. (JE 4:32). His left shoulder also was not improved. (JE 4:32). His left wrist felt "a little bit better," and he continued to wear a brace when working. (JE 4:32). Mr. Odobasic told Ms. Armstrong that his low back pain was worse on the left than the right, and increased with sitting, standing, walking, and bending. (JE 4:32). He also complained of radicular pain. (JE 4:32). His left hip hurt only "a little bit." (JE 4:32). Certain aspects of his physical examination elicited pain to some of the above body parts. (JE 4:32). Ms. Armstrong opined that the claimant worsened since his last visit. (JE 4:33).

She told Mr. Odobasic that he was doing too much at work, and that he required more strict restrictions. (JE 4:33). Accordingly, she provided restrictions of no lifting, carrying, pushing, or pulling more than 10 pounds. (JE 4:33). She also indicated that Mr. Odobasic should only occasionally bend his spine. (JE 4:33). He also could not climb ladders and could only work a maximum of 40 hours per week. (JE 4:33). He could sit, stand, and walk as tolerated, and should avoid noisy environments. (JE 4:33). Mr. Odobasic expressed some hesitancy to working within these increased restrictions, as he enjoyed his job; however, Ms. Armstrong indicated that increasing his restrictions was necessary since he reported no progress over the last month. (JE 4:33). Ms. Armstrong recommended that Mr. Odobasic continue formal physical therapy. (JE 4:33).

On April 23, 2018, Mr. Odobasic returned to visit Ms. Armstrong at Tri-State Occupational Health. (JE 4:35-39). He complained of worsening back pain and headaches. (JE 4:35). He did not tolerate physical therapy due to increased pain with simple stretching. (JE 4:35). He had increasing photophobia and phonophobia along with a "beeping" on his left side. (JE 4:35). Upon physical examination, Ms. Armstrong found that Mr. Odobasic had increased pain with lateral flexing to both sides in the lower back. (JE 4:35). Ms. Armstrong completed a concussion evaluation form with the claimant. (JE 4:37-38). Mr. Odobasic scored a 15 out of 22 based upon his reported symptoms. (JE 4:38). Ms. Armstrong consulted with an attending physician, Dr. Kennedy, regarding Mr. Odobasic's condition. (JE 4:36). Both Dr. Kennedy and Ms. Armstrong agreed that Mr. Odobasic should have a brain MRI and lumbar MRI, as well as a referral back to ophthalmology for his retinal injuries. (JE 4:36). Ms. Armstrong continued the 10-pound restriction from the prior appointment. (JE 4:36). She also advised Mr. Odobasic that he should not drive, nor should he bend or twist his back. (JE 4:36). He also should avoid loud environments and be allowed to change from

sitting to standing or walking at will. (JE 4:36). Finally, Ms. Armstrong noted that Mr. Odobasic should reschedule his planned vacation. (JE 4:36).

Dr. Baumann examined the claimant again on April 24, 2018. (JE 5:63-68). He reported blurry vision. (JE 5:63).

In late April of 2018, Mr. Odobasic took paid time off. (Testimony). He initially testified that this was to feel better; however, when pressed on cross-examination, he admitted that this time off was for a vacation to Miami with his wife. (Testimony). This vacation was planned one year prior to the trip occurring. (Testimony). While in Miami, he went to the beach with his wife and walked around. (Testimony).

Ms. Armstrong ordered an MRI of the brain and lumbar spine. (JE 3:9-11). The MRI of the brain showed mild chronic sinus disease, but was otherwise a normal MRI. (JE 3:9). The MRI of the lumbar spine showed mild to moderate multilevel degenerative disc and facet disease, and mild central canal stenosis at L4-5 with moderate bilateral neural foraminal narrowing. (JE 3:10-11).

Erin Kennedy, M.D. began seeing Mr. Odobasic on May 9, 2018, as Ms. Armstrong was on maternity leave. (JE 4:40-42). Mr. Odobasic indicated that he was doing well, but still had some back stiffness and pain. (JE 4:40). He also had buzzing in his left ear. (JE 4:40). Dr. Kennedy reviewed Mr. Odobasic's history and imaging. (JE 4:40). Mr. Odobasic continued to have a daily low-grade headache. (JE 4:40). He also had left wrist pain which was eased by stretching. (JE 4:40). Dr. Kennedy diagnosed Mr. Odobasic with concussion, retinal detachment, neck pain, bilateral lumbar radiculopathy, and left wrist pain. (JE 4:41). Dr. Kennedy opined that the claimant was resolving well from his concussion, and that he had expected pain at the "traps" and neck. (JE 4:41). She recommended that he leave his left wrist splint off as much as possible. (JE 4:41). She discontinued physical therapy, as the claimant was not making clear progress. (JE 4:41; Testimony). She recommended an epidural steroid injection to L4-5 to see if the radicular pain would resolve. (JE 4:41). According to the medical record, Mr. Odobasic could return to work full duty based upon his own request. (JE 4:41-42; Testimony). Mr. Odobasic testified that he did not remember requesting a discharge from care; however, he had no reason to argue with the contents of the medical record. (Testimony). Mr. Odobasic also expressed his displeasure with the care provided by Dr. Kennedy. (Testimony). He felt that she was not thorough, and never reviewed the head injury questionnaire previously completed by Ms. Armstrong. (Testimony).

Mr. Odobasic reported to DBF Pain Clinic on June 20, 2018, for an examination by Timothy J. Miller, M.D. (JE 7:87-89). Mr. Odobasic complained of persistent radicular pain with an L4 distribution. (JE 7:87). Dr. Miller noted that Mr. Odobasic "was living with back and right leg pain." (JE 7:87). Based upon his examination of the claimant, Dr. Miller recommended that the claimant proceed with a lumbar epidural steroid injection at L4-5. (JE 7:88).

On July 5, 2018, Mr. Odobasic returned to Tri-State Occupational Health and Dr. Kennedy. (JE 4:43-45). Mr. Odobasic complained of right shoulder and arm pain, low back pain, and right lower extremity pain. (JE 4:43). Mr. Odobasic described his pain

as unchanged since his prior visits. (JE 4:43). He continued to have a headache several times per week; however, the headache does not disrupt his activity. (JE 4:43). He also indicated that he did not feel confusion or a mental fog. (JE 4:43). He had no photophobia or phonophobia. (JE 4:43). He had no improvement after the L5 epidural steroid injection. (JE 4:43). He told Dr. Kennedy that his issues did not functionally limit his activities. (JE 4:43). Upon examination, Dr. Kennedy observed some tenderness in the cervical spine area. (JE 4:44). His left wrist had normal rotation. (JE 4:44). Dr. Kennedy opined that the claimant was resolving well following his concussion. (JE 4:44). Dr. Kennedy recommended continued stretching and activity to improve the claimant's left wrist pain. (JE 4:44). Dr. Kennedy opined that the pain in Mr. Odobasic's lower back was an exacerbation of underlying degenerative issues. (JE 4:44). Dr. Kennedy recommended that Mr. Odobasic remain working full duty despite his discomfort. (JE 4:44). Dr. Kennedy opined that Mr. Odobasic's issues should resolve to his baseline and maximum medical improvement ("MMI") without impairment by August 25, 2018. (JE 4:44).

As of July 25, 2018, Mr. Odobasic was performing the regular functions of his job. (Testimony). He had no changes to his job duties or requirements. (Testimony). He had no complaints during this time about his job performance, and could adequately perform his job functions. (Testimony).

Outside of one planned follow up appointment with Dr. Baumann, Mr. Odobasic had no medical care between July of 2018 and July of 2019. (Testimony). Mr. Odobasic claimed that he was unaware that he could ask for care.

On March 19, 2019, Julie Muenster, A.R.N.P., performed a DOT physical for the City of Dubuque. (JE 4:46-48). Mr. Odobasic denied limitations. (JE 4:46). He marked that he had no health issues. (DE G:6). He ambulated with a steady gait. (JE 4:46). He had normal ranges of motion. (JE 4:47). Ms. Muenster determined that the claimant was physically qualified for the job as a bus driver with the City of Dubuque without accommodations. (JE 4:48; DE G:4).

In 2019, a new resident moved into the group home which Mr. Odobasic supervised. (Testimony). This resident weighed over 250 pounds, and needed assistance with walking and activities of daily living. (Testimony). On July 3, 2019, this new resident fell and needed assistance getting up from the floor. (Testimony). Dr. Kennedy examined Mr. Odobasic following this incident. (JE 4:49-50). The resident was in a narrow space between a piece of furniture and a wall. (Testimony). The claimant had to use a Hoyer lift in order to assist the resident. (Testimony). When Mr. Odobasic assisted the resident, he experienced immediate pain in his lower back and right shoulder. (Testimony; JE 4:49). Dr. Kennedy diagnosed Mr. Odobasic with bilateral lumbar radiculopathy, pectoralis muscle strain, and scapular strain. (JE 4:50). Mr. Odobasic subsequently testified that the July 3, 2019, work injury worsened his low back pain to the extent that his low back pain was constant. (DE H:6).

On July 10, 2019, Dr. Kennedy examined Mr. Odobasic again. (JE 4:51). The claimant complained of right pectoralis and scapular strain, along with a right low back strain with radicular leg pain. (JE 4:51). His pain was 7 out of 10. (JE 4:51). He had

chronic low back pain in his right lower back for "many years." (JE 4:51). His back pain worsened following the July of 2019 incident. (JE 4:51). The back pain radiated to his right buttock and posterior thigh and calf. (JE 4:51). Dr. Kennedy ordered physical therapy and an MRI for the lumbar spine. (JE 4:51). She also issued restrictions, but those are not listed in the record. (JE 4:51).

The MRI of the lumbar spine was performed on July 15, 2019. (JE 4:52). The MRI showed chronic findings, diffuse disc bulging at L4-5, and milder disc bulging at L5-S1, L3-4, and L2-3. (JE 4:52). Finally, the MRI noted multilevel degenerative disc disease, central stenosis, facet arthropathy, and neural foraminal encroachment. (JE 4:52).

Dr. Kennedy examined Mr. Odobasic again on July 22, 2019. (JE 4:53-54). Mr. Odobasic presented following his lower back injury in early July of 2019. (JE 4:53). His back was improving, but he had additional pain in his right hip and leg. (JE 4:53). Dr. Kennedy noted that Mr. Odobasic's low back pain was chronic and present "for many years." (JE 4:53). He found that being active and running helped alleviate his pain. (JE 4:53). Upon physical examination, Mr. Odobasic displayed no tenderness to his neck. (JE 4:54). He did, however, display tenderness in the low back. (JE 4:54). Dr. Kennedy recommended that Mr. Odobasic continue physical therapy and have an evaluation for an epidural steroid injection. (JE 4:54). Dr. Kennedy wanted the claimant to return in two weeks after the possible epidural steroid injection. (JE 4:54).

As a result of this incident, Mr. Odobasic had additional care and used paid time off for most of the month of July and August of 2019. (Testimony). Mr. Odobasic is not claiming that the July 3, 2019, incident exacerbated his previous injuries, but that they are new and/or distinct injuries. (Testimony).

Dr. Miller performed another lumbar epidural steroid injection on Mr. Odobasic on August 7, 2019, due to his continued complaints of lumbar radiculopathy. (JE 7:90). The injection was to the L4-5 area. (JE 7:90).

On August 21, 2019, Mr. Odobasic returned to Tri-State Occupational Health, where Dr. Kennedy re-examined him for lower back pain stemming from the July 3, 2019, injury. (JE 5:55). The epidural steroid injection alleviated his lower back pain somewhat. (JE 5:55). He displayed tenderness in the right shoulder area. (JE 5:55). Dr. Kennedy recommended an evaluation for a second epidural steroid injection. (JE 5:55). Pending the second injection, Dr. Kennedy placed a hold on physical therapy. (JE 5:55).

Dr. Kennedy examined the claimant again on August 27, 2019, due to his continued complaints of pain. (JE 4:56-57). Mr. Odobasic reported relief from his first epidural steroid injection, but elaborated that the relief did not last long. (JE 4:56). He noted that his pain gradually increased since immediately following the epidural steroid injection. (JE 4:56). He told Dr. Kennedy that his shoulders were still sore, but not severe. (JE 4:56). He also continued to have tenderness in the right low back and right piriformis area. (JE 4:56). Dr. Kennedy diagnosed the claimant with a scapular muscle strain and bilateral lumbar radiculopathy. (JE 4:57). Dr. Kennedy requested that Mr. Odobasic return to her clinic two weeks following the scheduled injection. (JE 4:57).

After that, Dr. Kennedy recommended a consultation with an orthopedic physician or a neurosurgeon. (JE 4:57). Dr. Kennedy provided restrictions limiting the claimant to working in a seated or standing position without lifting, carrying, bending at the waist, squatting, or kneeling. (JE 4:57). Dr. Kennedy allowed the claimant to continue in his role as a bus driver with the City of Dubuque without concern. (JE 4:57).

Dr. Miller administered another lumbar epidural steroid injection to Mr. Odobasic on September 11, 2019. (JE 7:91). Dr. Miller diagnosed Mr. Odobasic with lumbar disorder and right leg radicular pain. (JE 7:91). Dr. Miller provided the injection to the right L4-5 lumbar spine. (JE 7:91).

On September 25, 2019, Dr. Kennedy re-examined the claimant for his July 3, 2019, injury. (JE 4:58-59). Dr. Kennedy noted her diagnoses of a right trapezius strain and lumbar disc bulge. (JE 4:58). Mr. Odobasic reported that his pain worsened and now involved his legs. (JE 4:58). Dr. Kennedy noted that Mr. Odobasic appeared uncomfortable. (JE 4:59). Dr. Kennedy restricted Mr. Odobasic to working in a seated or standing position without lifting, carrying, bending at the waist, squatting, or kneeling. (JE 4:59). Dr. Kennedy limited Mr. Odobasic's driving to 4 hours. (JE 4:59).

When Mr. Odobasic returned to work with ARC, he was placed in a workshop. (Testimony). He worked in the workshop from September of 2019 to February 18, 2021, when he returned to the group home setting. (Testimony). In the workshop, Mr. Odobasic and the residents worked on seals that needed to be smoothed with a grinder, scraper, and brush. (Testimony). Mr. Odobasic claims that this work caused dust and metal burs to enter his eyes and cause an infection. (Testimony). Mr. Odobasic testified that he did not like working in the workshop, as it was a more physically demanding job. (Testimony).

Mr. Odobasic reported to Medical Associates Clinic on October 14, 2019, where Michael Chapman, M.D. examined him. (JE 8:95). Mr. Odobasic complained of low back pain, especially on the right side. (JE 8:95). Mr. Odobasic claimed that the epidural steroid injections provided no relief. (JE 8:95). He told Dr. Chapman that his pain worsened throughout the day. (JE 8:95). He felt some weakness in his right leg, along with a pins and needles sensation. (JE 8:95). Dr. Chapman noted that the imaging done to date showed mild spondylosis, but "no compressive pathology." (JE 8:95). Dr. Chapman recommended a right SI joint injection for both therapeutic and diagnostic purposes. (JE 8:95). If the injection provided relief within several days of the injection, he was to call the doctor's office, at which time they would prescribe pelvic stabilization exercises. (JE 8:95).

On October 30, 2019, Dr. Miller visited with Mr. Odobasic again. (JE 7:92-94). Mr. Odobasic complained about residual back pain in the right buttock that was "now thought to be SI [*sic*]." (JE 7:92). After the epidural, Mr. Odobasic had no radicular pain. (JE 7:92). Dr. Miller administered a diagnostic "and hopefully therapeutic" SI joint injection on the right side. (JE 7:93-94).

Dr. Chapman saw Mr. Odobasic again on November 15, 2019, for Mr. Odobasic's continued low back pain after the right SI joint injection. (JE 8:96). Mr. Odobasic was "doing poorly." (JE 8:96). He looked uncomfortable and had an antalgic

gait which favored the right side. (JE 8:96). Dr. Chapman opined, "I do not see anything on imaging studies or find anything on exam or anything on response to injections that would make me think surgery would predictably help." (JE 8:96). Dr. Chapman prescribed an MRI to rule out any other issues. (JE 8:96). If the MRI was negative, then Dr. Chapman opined that there was nothing further for him to offer. (JE 8:96).

Mr. Odobasic had an MRI of the pelvis at Westside Orthopaedics on December 9, 2019. (JE 9:97). The MRI showed mild bilateral sacroiliitis, degenerative changes and disc bulging in the lower lumbar spine, and mild enlargement of the prostate. (JE 9:97).

On January 23, 2020, Mr. Odobasic underwent a functional capacity evaluation ("FCE") at E3 Work Therapy Services. (DE F:1-12). The examiner opined that Mr. Odobasic's FCE was invalid due to inconsistent performance during a repeated measures protocol. (DE F:1). Based upon the invalid examination, the examiner opined that Mr. Odobasic met the material handling demands for a medium demand vocation. (DE F:1). The examiner could not provide an opinion as to the claimant's maximum lifting capabilities and/or other functional capabilities due to the claimant's failure to give maximum voluntary effort during the examination. (DE F:1). The examiner opined that benign testing showed possible over-reporting of symptoms. (DE F:2). Even with the invalid results, Mr. Odobasic could lift 30.38 pounds from 10 inches to his waist and from 20 inches to his waist. (DE F:3). He could lift 15.91 pounds above his shoulders. (DE F:3). He could carry 19.34 pounds bilaterally. (DE F:3). The FCE took measurements of active and passive ranges of motion as part of the FCE. (DE F:10-11).

Joseph J. Chen, M.D., examined Mr. Odobasic on July 13, 2020, for the purposes of an IME. (DE E:1-7). Dr. Chen is board certified in physical medicine and rehabilitation and in spinal cord injury medicine. (DE E:6). Dr. Chen documented Mr. Odobasic's medical treatment following his July 3, 2019, work injury. (DE E:1-2). Mr. Odobasic told Dr. Chen that he was working light duty for six hours per day. (DE E:2). He indicated that he liked his job, but that he had to lay down at the end of his workday to alleviate his pain. (DE E:2). Upon physical examination, Mr. Odobasic displayed diffuse tenderness to light tactile stimulation of the cervical spine. (DE E:3). He also showed tenderness over the left trapezius and scapular borders. (DE E:3). Dr. Chen found diffuse tenderness to light tactile stimulation of the thoracic spine. (DE E:3). Mr. Odobasic also displayed diffuse tenderness to light tactile stimulation of the midline lower lumbar spine and paraspinal muscle mass. (DE E:3). Dr. Chen found normal reflexes and muscle strength in the lumbar spine. (DE E:3). Mr. Odobasic's responses to questionnaires about fear avoidance beliefs for physical activity and work activities were abnormal. (DE E:4). His pain catastrophizing scale responses, as well as his anxiety scale responses were abnormal. (DE E:4).

Dr. Chen opined that Mr. Odobasic had a history of chronic back pain including pre-existing lumbar spondylosis and facet arthritis. (DE E:4). An MRI also showed sacroiliitis. (DE E:4). Dr. Chen opined that Mr. Odobasic's July 3, 2019, work incident led to a permanent aggravation of pre-existing lumbar spondylosis and sacroiliitis. (DE

E:4). Dr. Chen further opined that Mr. Odobasic received appropriate diagnostic and therapeutic injections. (DE E:4). Mr. Odobasic displayed a chronic myofascial pain condition "due to a combination of multiple personal factors including misunderstanding about pain and injury, fear avoidance beliefs, pain catastrophization, anxiety and depression." (DE E:5). Dr. Chen recommended that Mr. Odobasic undertake gentle stretching, strengthening and exercise. (DE E:5). Dr. Chen would allow Mr. Odobasic to return to full work duties at ARC. (DE E:5). Dr. Chen also indicated that Mr. Odobasic expressed a desire to continue employment "as long as possible." (DE E:5). Dr. Chen placed Mr. Odobasic at MMI effective January 31, 2020. (DE E:6). Dr. Chen provided a permanent impairment rating based upon the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition. (DE E:6). Dr. Chen used Table 15-3 to arrive at a DRE Category II impairment rating of 5 percent of the whole person. (DE E:6).

On September 21, 2020, the claimant reported to the office of Chad Abernathey, M.D., for an examination. (JE 11:100-101). Mr. Odobasic noted a chronic history of low back pain since lifting a patient on July 3, 2019. (JE 11:100). Mr. Odobasic told Dr. Abernathey that he underwent "extensive conservative management" under the care of various doctors with no positive results. (JE 11:100). Dr. Abernathey reviewed the MRIs, which he opined showed mild degenerative changes consistent with Mr. Odobasic's age. (JE 11:100). Due to a lack of radiographic or clinical findings, Dr. Abernathey did not recommend "an aggressive neurosurgical stance." (JE 11:100). Dr. Abernathey recommended further conservative care. (JE 11:100). Mr. Odobasic expressed a desire to return to his normal job activities rather than light duty. (JE 11:100). Dr. Abernathey agreed with this plan "from a neurosurgical standpoint." (JE 11:100).

Dr. Baumann re-examined Mr. Odobasic on December 22, 2020. (JE 5:69-72). Mr. Odobasic told the doctor that he had soreness and redness in his eyes since April. (JE 5:69). Dr. Baumann observed that Mr. Odobasic had eye irritation or conjunctivitis. (JE 5:72). Dr. Baumann prescribed eye drops and a re-examination in April of 2021. (JE 5:72).

Mr. Odobasic visited Matthew Kraciun, D.O., on December 28, 2020, to establish care as a primary care physician. (JE 10:98-99). Dr. Kraciun informed the claimant that he needed to work through his workers' compensation claim if the treatment was for injuries incurred therefrom. (JE 10:98). The claimant largely complained of back pain and issues. (JE 10:98). Dr. Kraciun indicated that he would not discuss certain issues with the claimant if they were related to the workers' compensation claim. (JE 10:99). Dr. Kraciun diagnosed Mr. Odobasic with right-sided piriformis syndrome, right-sided sacroiliac joint dysfunction, and bilateral lumbar radiculopathy. (JE 10:99). Dr. Kraciun prescribed a "burst" of prednisone to help alleviate his symptoms, but noted that it was difficult to establish care with Mr. Odobasic, as he continued to discuss his work comp issues. (JE 10:99).

On February 18, 2021, Dr. Kennedy wrote a letter to a claim representative from United Heartland providing her opinions as they related to Mr. Odobasic's care and condition following the July 3, 2019, work incident. (DE D:1-5). At the time of his examination by Dr. Kennedy on February 2, 2020, Mr. Odobasic complained of pain

"fairly diffusely through the body." (DE D:1). Mr. Odobasic explained that not all of his pain was related to the July 3, 2019, incident. (DE D:1). The pain that he related to the July 3, 2019, incident specifically was in the right side of the low back. (DE D:1). The pain extended from the right SI area to the gluteus to the posterior thigh and calf. (DE D:1). He also experienced pain in the left gluteus and posterior thigh. (DE D:1). Mr. Odobasic told Dr. Kennedy that his right calf also cramped at times. (DE D:1). Things like physical therapy, stretching, yoga, walking, and changing positions, alleviated his pain. (DE D:1-2). Injections, as previously provided, were not helpful. (DE D:2). Mr. Odobasic indicated that he would stand and walk for 45 to 60 minutes continuously before back pain forces him to stretch or sit. (DE D:2). He also could lift or carry 20 pounds comfortably. (DE D:2). He had difficulty bending at the waist. (DE D:2). Mr. Odobasic would stretch every two hours during the day and through most of the night. (DE D:2). Mr. Odobasic told Dr. Kennedy that he worked about 30 hours per week between his jobs at ARC and the City of Dubuque. (DE D:2). Dr. Kennedy noted that the Oswestry Low Back Index scored 60 out of 100, which is the "perception of crippling low back pain." (DE D:2). The fear avoidance beliefs questionnaire results were considered abnormal. (DE D:2). Dr. Kennedy opined:

> My interpretation of these tools is that Mr. Odobasic's responses to these health status measures indicate high levels of self-reporting of pain severity and intensity, perception of being severely limited by pain, and fear avoidance beliefs and pain catastrophization. These are each known risk factors for the development of chronic pain syndrome in the absence of musculoskeletal trauma or injury.

(DE D:2). Upon physical examination, Mr. Odobasic displayed tenderness to palpation over the bilateral trapezius and scapular borders in the cervical spine. (DE D:3). Dr. Kennedy found Mr. Odobasic to have a normal range of motion in his cervical spine. (DE D:3). There was diffuse tenderness to the perithoracic musculature including the bilateral trapezius attachments at the thoracic spine. (DE D:3). Dr. Kennedy also observed diffuse tenderness over the paralumbar muscles and SI joints. (DE D:3).

Dr. Kennedy opined that Mr. Odobasic had pre-existing degenerative spine issues, "specifically lumbar spondylosis." (DE D:4). She also indicated that Mr. Odobasic had "longstanding sacroiliitis." (DE D:4). Dr. Kennedy stated, "[i]t is my opinion that he experienced a work-related aggravation of these two conditions in the work place on July 3, 2019, when he attempted to lift a resident from the floor to her bed." (DE D:4). Dr. Kennedy further indicated that Mr. Odobasic sustained a muscular injury to the bilateral upper back which resolved. (DE D:4). Dr. Kennedy opined that Mr. Odobasic achieved MMI on January 3, 2020. (DE D:4). She recommended no further treatment. (DE D:4). Dr. Kennedy would allow Mr. Odobasic to work full duty based upon his diagnoses and current physical capacity. (DE D:4). Dr. Kennedy used the DRE method for rating Mr. Odobasic's impairment. (DE D:5). Dr. Kennedy opined that Mr. Odobasic sustained a category 2 impairment, which was equal to a 5 percent whole person impairment rating. (DE D:5). This was due to Mr. Odobasic's clinical history and examination findings that were compatible with a specific injury. (DE D:5).

Dr. Baumann signed a letter on April 1, 2021, drafted by defendants' counsel indicating agreement with the following statements:

1. Mr. Odobasic's left eye condition attained 'maximum medical improvement' (MMI) by the time you saw him on 4/24/18.

2. Mr. Odobasic's left eye condition sustained 0% permanent impairment pursuant to the AMA Guide [*sic*] 5th ed., as it is causally related to the 2/25/18 work injury.

3. Mr. Odobasic requires no further medical care for his left eye condition, as it is causally related to the 2/25/18 work injury.

(DE C:1-2).

On April 30, 2021, Jonathan Citow, M.D., reviewed Mr. Odobasic's medical records, including the results of a March 2021 MRI, and drafted a letter to claimant's counsel. (JE 12:103). The letter mentions the July 3, 2019, lower back injury while Mr. Odobasic moved a resident. (JE 12:103). Dr. Citow opined that Mr. Odobasic suffered from lumbar spondylosis and stenosis with radiculopathy. (JE 12:103). Based upon his symptoms and diagnoses, Dr. Citow recommended that Mr. Odobasic undergo a right sided L4-5 hemilaminotomy with a bilateral medial facetectomy. (JE 12:103). Dr. Citow opined that Mr. Odobasic had a 90 percent chance of improvement from the surgery. (JE 12:103). Dr. Citow also opined that Mr. Odobasic suffered an exacerbation of his preexisting lumbar spondylosis and stenosis as a result of a June 30, 2019, or July 3, 2019, incident. (JE 12:103).

Dr. Abernathey wrote a letter to defendants' counsel, dated June 18, 2021. (DE B:1). Dr. Abernathey confirmed his opinion that Mr. Odobasic required no further neurosurgical intervention. (DE B:1). He also confirmed that there was "no contraindication to full duty work activities." (DE B:1). Dr. Abernathey also confirmed that he did not believe that Mr. Odobasic required surgical intervention based on clinical and radiographic findings. (DE B:1). Dr. Abernathey noted, "[p]erhaps an additional opinion with another qualified neurosurgeon would help, since you have two diametrically opposed opinions." (DE B:1). Dr. Abernathey agreed with Dr. Kennedy's assessment, and went further by indicating that Mr. Odobasic had no specific impairment, and required no additional pain management treatment. (DE B:1).

Mr. Odobasic visited with Dr. Citow in the Chicago area. (Testimony). Dr. Citow recommended an L4-5 hemilaminotomy with bilateral medial facetectomies, and proximal foraminotomies with microdissection, and performed the same on August 13, 2021. (Testimony; CE 4:93). Mr. Odobasic testified that he was off work for a bit and felt that the surgery helped his pain. (Testimony). While he was off work, he had a hernia surgery in September of 2021. (Testimony). Mr. Odobasic testified that this surgery was not related to his work injuries. (Testimony).

Mr. Odobasic testified at an evidentiary deposition on October 27, 2021. (DE I). He testified that the ringing and noises in his ears were "almost all gone." (DE I:9). He

also could lift more after the surgery performed by Dr. Citow. (DE I:9). At the time of his deposition, he had lower back pain, right leg pain, and right shoulder pain. (DE I:10). He had no issues with his left leg at the time of the deposition. (DE I:10).

Included in an IME medical records review were records from an FCE conducted by WorkWell/Short Physical Therapy on November 15, 2021. (CE 4:85-90). The examiner determined that Mr. Odobasic gave a consistent effort and performance on all test items. (CE 4:86). Mr. Odobasic reported pain to his low back, right leg, neck and right shoulder/arm. (CE 4:86). Mr. Odobasic had slight limitations with sitting, standing work, and walking. (CE 4:86). He had "some to slight" limitations with lifting up to 25 pounds to the waist from the floor, and front carrying up to 25 pounds up to 50 feet. (CE 4:86). He had some limitations with elevated work, forward bent standing, crouching, kneeling/half-kneeling, reaching, stairs, lifting up to 35 pounds to the waist from the floor, lifting up to 10 pounds from the waist up to the crown, and front carrying 35 pounds up to 50 feet. (CE 4:86). He had significant limitations lifting to the waist from the floor up to 45 pounds, lifting to the crown from the waist up to 20 pounds, and front carrying 45 pounds up to 50 feet. (CE 4:86). The examiner noted a primary diagnosis of low back pain. (CE 4:88).

The FCE included measurements of range of motion and muscle strength for various parts of Mr. Odobasic's body. (CE 4:88). Mr. Odobasic had flexion, extension, right lateral flexion, and left lateral flexion within normal limits. (CE 4:88). He had reduced right and left cervical rotation with pain. (CE 4:88). His cervical muscle strength was within normal limits. (CE 4:88). His trunk showed reduced range of motion and muscle strength. (CE 4:89). Mr. Odobasic had mildly reduced forward flexion and abduction in his left shoulder. (CE 4:89). Mr. Odobasic's left shoulder extension, internal rotation and external rotation were within normal limits. (CE 4:89). The strength of his left shoulder was measured within normal limits. (CE 4:89). He had some reduced forward flexion and abduction in his right shoulder, as well. (CE 4:89). He also displayed reduced muscle strength with forward flexion and abduction in his right shoulder. (CE 4:89). Mr. Odobasic displayed range of motion and muscle strength within normal limits in both his right and left elbows. (CE 4:89). The examiner found Mr. Odobasic to have bilateral upper extremity and wrist range of motion and muscle strength within normal limits. (CE 4:89-90). Mr. Odobasic had gross motion and muscle strength in his bilateral hands that were within normal limits. (CE 4:90). Mr. Odobasic had reduced range of motion with flexion in both the right and left hips; however, the remainder of the measurements of range of motion and muscle strength in Mr. Odobasic's hips were within normal limits. (CE 4:90).

David H. Segal, M.D., J.D., examined the claimant for purposes of an IME on December 11, 2021. (Testimony; CE 4:8-109). Mr. Odobasic testified that Dr. Segal spent 2 hours with him, and performed a thorough physical examination. (Testimony). Dr. Segal also used measuring tools during the examination. (Testimony). Dr. Segal is a board certified neurosurgeon with Eastern Iowa Brain & Spine Surgery in Cedar Rapids, Iowa. (CE 5:110). He is also a licensed attorney in the states of Nevada and California. (CE 5:110). Of note, Dr. Segal entered into a settlement agreement with the Iowa Board of Medicine in 2016. (DE J:1-12). Dr. Segal denied certain allegations that

he violated various rules and laws governing the practice of medicine in Iowa. (DE J:1-12). Specifically, Dr. Segal failed to provide appropriate neurosurgical care. (DE J:1-12). Dr. Segal agreed to pay a five thousand and 00/100 dollar ($5,000.00) civil penalty, reimburse for certain overpayments for medical services, stop performing surgery under his Iowa license, and complete a professional ethics program. (DE J:1-12). The relevance of this information to this decision is debatable, but noted.

Mr. Odobasic recounted his slip and fall on ice on February 25, 2018. (CE 4:11). At the time of the examination, he expressed neck, left shoulder, left lower back, left leg, left hip, and left arm/wrist pain. (CE 4:11, 14). He described his pain as stable, but constant in all areas. (CE 4:11). He characterized his pain as aching, sharp, shooting in the neck and elbow, stiffness in the neck, and numbness and tingling in the left fingers and hand. (CE 4:11). He listed a variety of factors that aggravated his pain areas. (CE 4:11). He found that rest, physical therapy, stretching, heat, ice and medications, alleviated his pain. (CE 4:11). Chiropractic care and physical therapy helped alleviate his neck pain the most. (CE 4:11). Mr. Odobasic told Dr. Segal that his right shoulder also began to hurt, which the claimant attributed to overuse from compensation for his left shoulder issues. (CE 4:12). During his examination, Dr. Segal observed that Mr. Odobasic had pain bilaterally at T11-12. (CE 4:12). Mr. Odobasic reported to Dr. Segal that he felt that his cognitive abilities were slower than prior to the incident. (CE 4:12). He provided the example of difficulties calculating his family's finances. (CE 4:12). His cognitive difficulties also included issues with concentration, judgment, dizziness, personality change, mood issues, and finding words while speaking. (CE 4:12-13). Mr. Odobasic also told Dr. Segal that he had memory issues and vision issues. (CE 4:13). Mr. Odobasic recounted a humming or buzzing sound in his left ear that began after his fall. (CE 4:13). The claimant continued by noting that he had headaches from the back of his head to the top of his head, along with photophobia and phonophobia. (CE 4:13). He also noted issues with sleeping, in that he woke several times per night, "usually feeling like something is wrong." (CE 4:13). Mr. Odobasic recounted his surgery with Dr. Citow, and opined that it worked well for his right-sided pain. (CE 4:15) However, the surgery did not alleviate his left-sided pain. (CE 4:15).

Dr. Segal reviewed Mr. Odobasic's treatment history with him. (CE 4:15-17). Mr. Odobasic told Dr. Segal that he could frequently lift 25 pounds, and could carry 20 pounds. (CE 4:17). Dr. Segal conducted a "mini mental state exam" in which Mr. Odobasic scored 24 out of 30, with noted deficits in memory, calculation, and dates. (CE 4:17). Upon physical examination, Mr. Odobasic displayed tenderness to palpation in the neck, back, left hip, left shoulder, and left arm. (CE 4:18). Mr. Odobasic also displayed issues with adduction of the left eye, and a "dysconjugate gaze." (CE 4:18). Dr. Segal also took various measurements of Mr. Odobasic's shoulders. (CE 4:18-19). Some of these measurements showed a decrease in range of motion. (CE 4:18-19). Mr. Odobasic's bilateral lower extremities also showed deficits in range of motion. (CE 4:19). Dr. Segal performed bilateral grip strength testing. (CE 4:19).

Dr. Segal then undertook his own independent review of the various imaging studies. (CE 4:20-22). Dr. Segal opined that the brain MRI in May of 2018 showed "punctate white matter hyperintensities" on the flair images and T2 axial images. (CE

4:20). Dr. Segal opined that the pattern of white matter changes can be consistent with diffuse axonal injuries. (CE 4:20). It should be noted that Dr. Segal arrived at this opinion based upon "the severity of the head trauma" while admitting that "it may be difficult to completely differentiate between DAI [*sic*] and age-related changes." (CE 4:20). Dr. Segal further noted that there was a pattern of white matter changes in the frontal regions of Mr. Odobasic's brain that indicated a traumatic brain injury. (CE 4:21).

Dr. Segal opined that Mr. Odobasic suffered a concussion and resulting post-concussive syndrome as a result of the February 25, 2018, fall. (CE 4:22). His symptoms included: cognitive deficits, word-finding difficulty, short term and long term memory deficits, vision disturbance, headaches, migraines, fatigue, vestibular dysfunction, hearing loss, tinnitus, sleep disturbance, and psychiatric sequelae. (CE 4:22). He also suffered injuries to his eyes, cervical spine, lumbar spine, left hip, left shoulder, right shoulder, and left upper extremity. (CE 4:22). Dr. Segal opined that Mr. Odobasic's post concussive syndrome is permanent, and that the wiring of his brain is "forever changed" and does not function as it should. (CE 4:22-23). Dr. Segal further opined that Mr. Odobasic permanently aggravated his pre-existing lumbar condition and cervical condition as a result of the February 25, 2018, work injury. (CE 4:23). Of note, Dr. Segal did not include any increased impairment from the July of 2019, work injury in his impairment analysis. (CE 4:23). Dr. Segal opined that Mr. Odobasic had not received adequate evaluation or treatment for his cervical, shoulder, and arm injuries. (CE 4:23).

Dr. Segal provided the following diagnoses that he opined were causally related to the February 25, 2018, work injury: closed head injury with traumatic brain injury and concussion; post-concussion syndrome with cognitive deficits, memory deficits, visual deficits, vestibular dysfunction, tinnitus with decreased hearing, sleeping disturbance, fatigue; retinal detachment and tears of the left eye; left-sided cervical radiculopathy; permanent aggravation of degenerative cervical spine disease and spondylolisthesis; traumatic cervical and thoracic facet arthropathy; left shoulder AC joint injury; left shoulder rotator cuff and biceps pathology; left shoulder subdeltoid bursitis; right shoulder overuse syndrome; right shoulder impingement syndrome; left ulnar neuropathy; left grip weakness; left wrist arthropathy; and, left hip trochanteric bursitis. (CE 4:23-24). Dr. Segal opined that Mr. Odobasic had moderately impaired cognitive function. (CE 4:26). Based upon this impairment, Dr. Segal concluded that it was unlikely that Mr. Odobasic could function in the workforce at his prior level of function. (CE 4:26). Dr. Segal diagnosed Mr. Odobasic with a "mild to moderate traumatic brain injury." (CE 4:27). Dr. Segal cited to certain studies that indicate that migraines after a concussion indicate a worse potential outcome. (CE 4:28). Dr. Segal continued by noting that Mr. Odobasic had vestibular dysfunction in that he described periodic dizziness. (CE 4:30). Dr. Segal then engaged in an extended discussion as to why every diagnosis listed above is causally connected to the work injury of February 25, 2018. (CE 4:24-36).

Dr. Segal opined that Mr. Odobasic reached MMI for his traumatic brain injury and right shoulder issues on February 25, 2020. (CE 4:42). He continued by noting that Mr. Odobasic achieved MMI for his cervical, thoracic, retinal detachment, left

shoulder, left elbow, left wrist, and left hip injuries, on February 25, 2019. (CE 4:42). Finally, Dr. Segal placed Mr. Odobasic at MMI for the lumbar issues related to the February 25, 2018, work issue on August 2, 2018. (CE 4:42).

Dr. Segal then endeavored to assign permanent impairment ratings based upon the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition. (CE 4:43-49). Dr. Segal used Table 13-5 to evaluate the claimant's cognitive impairment rating. (CE 4:43). Using a variety of factors listed in Table 13-5 and Table 13-6, Dr. Segal opined that Mr. Odobasic suffered a 7 percent impairment to the whole person based upon his cognitive impairment. (CE 4:44). Dr. Segal then provided opinions based upon Mr. Odobasic's post-concussive migraines and trigeminal nerve dysfunction. (CE 4:44). Page 331 of the Guides provides guidance as it relates to permanent impairment due to trigeminal nerve issues. (CE 4:44). The report stated, "[b]oth atypical, episodic facial pain and typical, neuralgic pain may be evaluated . . . . if they have occurred for months and interfere with daily activities." (CE 4:44). Dr. Segal opined that Mr. Odobasic's headaches "with migrainous and trigeminal features independently restrict and diminish Mr. Odobasic's ability to work. . . .," which entitle Mr. Odobasic to an additional 5 percent permanent impairment based upon Table 13-11. (CE 4:44). Dr. Segal then utilized Table 13-8 to provide an impairment rating based upon Mr. Odobasic's emotional lability and depression. (CE 4:45). Based upon his evaluation, Dr. Segal placed a 3 percent impairment of the whole person on Mr. Odobasic for his emotional and behavioral impairment. (CE 4:45). Dr. Segal continues his evaluation in discussing Mr. Odobasic's claim of vestibular dysfunction. (CE 4:45). Dr. Segal cites Mr. Odobasic's claim that he "loses his balance frequently." (CE 4:45). Further Mr. Odobasic told Dr. Segal that if he closes his eyes in the shower, he gets dizzy or feels off balance. (CE 4:45). Due to his gait and station impairment, Dr. Segal assigned Mr. Odobasic a 5 percent impairment of the whole person. (CE 4:45). Dr. Segal adds on an additional 3 percent due to alleged tinnitus for an 8 percent whole person impairment due to Mr. Odobasic's alleged vestibular dysfunction. (CE 4:45).

Moving on to the alleged visual impairment, Dr. Segal provided an interesting statement. (CE 4:45). Dr. Segal noted that the impairment from the retinal detachment would be assessed "within the context of visual disturbance from the brain injury." (CE 4:45). Specifically, Dr. Segal noted that there was not a specific rating for retinal detachment, only that functional impairment may result in terms of acuity and visual field defects. (CE 4:45). Dr. Segal provided his visual impairment ratings largely based upon nerve issues. (CE 4:45-46). Based upon Mr. Odobasic's claimed blurry/double vision, convergence insufficiency, and inability to focus, Dr. Segal provided Mr. Odobasic with a 5 percent whole person impairment. (CE 4:46).

Dr. Segal proceeded to provide an impairment rating based upon Mr. Odobasic's "arousal and sleep disorders." (CE 4:46). As Dr. Segal previously connected Mr. Odobasic's sleep issues to his brain injury, he noted that Mr. Odobasic awoke two times per night. (CE 4:46). Mr. Odobasic also complained about constant fatigue due to his interrupted sleep. (CE 4:46). Based upon Dr. Segal's examination and Table 13-4, he provided Mr. Odobasic with a 3 percent impairment of the whole person. (CE 4:46).

Dr. Segal combined the impairment ratings provided for the traumatic brain injury and post concussive syndrome using the combined values chart on page 604 of the Guides, to arrive at a 26 percent whole person impairment. (CE 4:46).

Dr. Segal then moved on to evaluating permanent impairment based upon the claimant's cervical issues. (CE 4:46). Dr. Segal noted that his impairment rating was based upon Mr. Odobasic's symptoms of radicular and mechanical cervical pain. (CE 4:46). Dr. Segal opined that Mr. Odobasic met the criteria for cervical DRE Category II. (CE 4:46). Based upon his evaluation, Dr. Segal provided the claimant a 7 percent whole person impairment. (CE 4:46). Considering there was no palpable spasm in the thoracic spine or radicular complaints, Dr. Segal opined that Mr. Odobasic had a 0 percent impairment. (CE 4:47).

Dr. Segal continued his IME report by analyzing Mr. Odobasic's bilateral shoulder impairment. (CE 4:47). Using the Guides, Dr. Segal opined that Mr. Odobasic had a 9 percent impairment to his left shoulder and a 7 percent impairment to his right shoulder due to issues with range of motion. (CE 4:47). These impairments converted to 5 percent whole person impairment and 4 percent whole person impairment, respectively. (CE 4:47). Dr. Segal combined these ratings to a 15 percent combined upper extremity impairment, or a 9 percent whole person impairment rating. (CE 4:47). Based upon strength deficits as measured by Dr. Segal, he provided Mr. Odobasic with a 12 percent combined upper extremity impairment rating. (CE 4:47). This converted to a 7 percent whole person impairment rating. (CE 4:47). For motor strength deficits, Dr. Segal assessed Mr. Odobasic with a 15 percent whole person impairment. (CE 4:47-48).

With regard to the left ulnar neuropathy, Dr. Segal assigned Mr. Odobasic an 18 percent upper extremity impairment. (CE 4:48). Dr. Segal converted this to an 11 percent whole person impairment based upon Table 16-3. (CE 4:48). Dr. Segal continued by assigning a 3 percent upper extremity impairment due to deficits in Mr. Odobasic's left wrist range of motion. (CE 4:48). This converted to a 2 percent whole person impairment. (CE 4:48). Based upon Table 17-33, Dr. Segal assigned the claimant with a 3 percent whole person impairment, and 7 percent lower extremity impairment for the claimant's alleged left trochanteric bursitis. (CE 4:48).

Dr. Segal took all of the whole person impairment ratings discussed above and arrived at a 51 percent whole person impairment related to the February 25, 2018, date of injury. (CE 4:48-49).

Dr. Segal reiterated his belief that Mr. Odobasic had yet to receive adequate evaluation or treatment for his areas of work injury. (CE 4:49). Specifically, Dr. Segal recommended that Mr. Odobasic have a neurology consultation for headaches, a neuropsychological evaluation, a neuro ophthalmologic evaluation, a vestibular evaluation, and a psychiatric evaluation. (CE 4:49). Dr. Segal also recommended that Vision in Motion in Cedar Rapids, Iowa, evaluate Mr. Odobasic. (CE 4:49). Dr. Segal further recommended additional MRIs and surgical evaluations for Mr. Odobasic's ongoing cervical, thoracic, and extremity issues. (CE 4:49). He also recommended potential injections, occupational therapy, and pain medication. (CE 4:49). Dr. Segal

then provided a laundry list of potential future treatments that Mr. Odobasic may need. (CE 4:49-50).

Dr. Segal provided permanent work restrictions for Mr. Odobasic. (CE 4:51-54). He divided these restrictions between those that are due to his cognitive impairment, and those that are due to his spine and extremities. (CE 4:51-54). Dr. Segal noted that Mr. Odobasic had a "much shorter" attention span than prior to the injury, and also that Mr. Odobasic had short-term memory issues. (CE 4:51). With regard to Mr. Odobasic's cognitive impairment, Dr. Segal recommended the following restrictions:

- Work hours limited to 8 hours consecutively with breaks as needed.
- Work environment needs to be free of loud noise or 'busy' atmosphere.
- Tasks involving intense concentration (paperwork, calculations, computer work) limited to 30 minutes per day.
- Prolonged static neck position up to 10 minutes (such as looking down to do paperwork), then must take a break.
- Operating complex and/or very loud machinery: Never
- Driving: Occasionally (due to cognitive deficit and dizziness)
- Avoid noisy and/or busy environments where possible
- Ability to use whiteboard, note taking, etc. to assist with memory impairment
- Fellow workers assigned to assist with memory and complex tasks
- Ladders: never (due to balance)
- Stairs: Occasionally holding onto handrail (due to balance)
- Uneven surfaces or heights: Never (due to balance)
- Rest periods as needed
- Return home as needed

(CE 4:51). Dr. Segal continued by noting that Mr. Odobasic's ability to function declined with prolonged activity. (CE 4:51). The permanent work restrictions related to Mr. Odobasic's spine and extremities recommended by Dr. Segal were:

- Sitting/Standing/Walking: Frequently
- Reaching Overhead: Occasionally
- Working with neck extended or flexed: Rarely
- Fine Motor, repetitive: Rarely with left
- Lifting/Carrying: 35 pounds, Rarely, 20 pounds Occasionally
- Pushing/Pulling: 20 pounds, Rarely, 10 pounds Occasionally
- Stairs: Needs handrail (balance issue)
- Ladders: Never (balance issue)
- Crawling/kneeling/crouching: Rarely

(CE 4:52).

Dr. Kennedy responded to a "check-box" type letter from defendants' counsel on November 23, 2021. (DE A:1-3). She agreed that Mr. Odobasic sustained 0 percent permanent impairment regarding his head, low back, left hip, left arm, left ear, and

vision, as it related to the February 25, 2018, work injury. (DE A:2). Dr. Kennedy also agreed that Mr. Odobasic required no permanent work restrictions, and that he could return to work full duty with regard to the February 25, 2018, incident. (DE A:2). Dr. Kennedy related any lumbar pain and lumbar radicular symptoms to degenerative spine issues and the July 3, 2019, work injury. (DE A:3). Finally, Dr. Kennedy opined that Mr. Odobasic required no additional medical care as it related to the February 25, 2018, work injury. (DE A:3).

On December 15, 2021, Dr. Citow wrote another letter to claimant's counsel. (JE 12:106). Dr. Citow recounted his previous findings, and noted that he performed the previously recommended right-sided L4-5 hemilaminotomy with a bilateral decompression on August 13, 2021. (JE 12:106). Dr. Citow visited with Mr. Odobasic again on September 1, 2021, at which time he complained of back pain of six out of ten. (JE 12:106). The back pain radiated down his leg. (JE 12:106). At that time, Dr. Citow recommended that Mr. Odobasic complete six weeks of physical therapy before attempting to return to work. (JE 12:106). Dr. Citow opined that Mr. Odobasic had a "relatively" good prognosis since the surgery and that the lifting incidents on June 30, 2019, and July 3, 2019, exacerbated his preexisting issues. (JE 12:106). Dr. Citow recommended that Mr. Odobasic have a functional capacity evaluation in order to determine his permanent restrictions. (JE 12:106).

When Mr. Odobasic returned to work following his time off in September of 2021, ARC transferred him to a new group home. (Testimony). This home had residents who required less physical assistance, and thus the demands on Mr. Odobasic were reduced. (Testimony).

When he started at ARC, Mr. Odobasic made eleven and 39/100 dollars ($11.39) per hour. (Testimony). Mr. Odobasic still works for ARC. (Testimony). As of the time of the hearing, he earns fourteen and 45/100 dollars ($14.45) per hour. (Testimony). He also works overtime. (Testimony). He is required by his union to accept 12 hours of overtime per week, which results in a minimum of a 52-hour workweek. (Testimony). However, Mr. Odobasic testified that he often works more than 52 hours in a week with ARC. (Testimony). He has received no negative reviews or feedback since returning to work. (Testimony).

Mr. Odobasic also obtained another job driving a bus for the City of Dubuque. (Testimony; DE G:1). He started this job in March of 2019. (Testimony). His son-in-law and daughter recommended that he take the job because it was less physically demanding than his work at ARC. (Testimony). He drives a bus that has an air ride seat, so it is comfortable. (Testimony). Prior to his July 3, 2019, injury, Mr. Odobasic drove 30 hours per week. (Testimony). Now, on average, Mr. Odobasic works 15 to 27 hours per week as a bus driver. (Testimony). He makes nineteen and 34/100 dollars ($19.34) per hour. (Testimony).

Before beginning his job as a bus driver, Mr. Odobasic completed a required Department of Transportation physical examination. (Testimony). He passed this examination and was given clearance to drive for two years. (Testimony). He has not

had a repeat examination, and was unsure as to why that had not yet occurred. (Testimony).

Taking both jobs into account, Mr. Odobasic worked between 90 and 100 hours per week prior to the July 3, 2019, injury. (Testimony). Subsequent to the July 3, 2019, injury, Mr. Odobasic works between 72 and 90 hours per week between his job with ARC and his job with the City of Dubuque. (Testimony).

The claimant testified that he would like to continue working for both the City of Dubuque and ARC as long as his health allows him to. (Testimony).

Mr. Odobasic continually testified that he was not referred to a neurologist, and that he continues to experience concussion-like symptoms. (Testimony). He noted that light and noise aggravated his condition and increased his stress levels. (Testimony). Mr. Odobasic also testified that he experienced sadness and difficulty sleeping. (Testimony). Despite these feelings, he had no previous diagnoses of depression or anxiety. (Testimony). He also never went on medications for depression. (Testimony). At times, he has ringing in his ears, and a headache. (Testimony). He noted that he periodically experienced a foggy feeling. (Testimony).

There are portions of the medical records and deposition testimony that directly contradict Mr. Odobasic's testimony. (Testimony). When confronted with items from his medical records and/or deposition testimony which contradicted his arbitration hearing testimony regarding the above-mentioned issues, Mr. Odobasic expressed that he did not remember telling providers certain pieces of information during certain medical visits. (Testimony). While this could be explained by his head injury or a language barrier, it is certainly concerning and/or convenient to Mr. Odobasic's testimony that he had a selective memory when it came to key issues. (Testimony). This gave me concerns regarding the veracity and credibility of aspects of Mr. Odobasic's testimony. (Testimony).

The claimant also testified to issues with maintaining his yard and shoveling snow. (Testimony). Despite being a trained diesel mechanic, he also no longer services his vehicles. (Testimony).

Mr. Odobasic noted that Dr. Segal recommended additional care, and that he was requesting a visit with a neurologist, and potentially a neurosurgeon. (Testimony). He also requested a referral to Dr. Fitzgerald at Vision in Motion and to a mental health practitioner. (Testimony).

CONCLUSIONS OF LAW

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

Permanent Disability

The claimant has the burden of proving by a preponderance of the evidence that the injury is a proximate cause of the disability on which the claim is based. A cause is proximate if it is a substantial factor in bringing about the result; it need not be the only

cause. A preponderance of the evidence exists when the causal connection is probable, rather than merely possible. George A. Hormel & Co. v. Jordan, 569 N.W.2d 148 (Iowa 1997); Frye v. Smith-Doyle Contractors, 569 N.W.2d 154 (Iowa App. 1997); Sanchez v. Blue Bird Midwest, 554 N.W.2d 283 (Iowa App. 1996).

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

Iowa employers take an employee subject to any active or dormant health problems, and must exercise care to avoid injury to both the weak and infirm and the strong and healthy. Hanson v. Dickinson, 188 Iowa 728, 176 N.W. 823 (1920). While a claimant must show that the injury proximately caused the medical condition sought to be compensable, it is well established that a cause is "proximate" when it is a substantial factor, or even the primary or most substantial cause to be compensable under the Iowa workers' compensation system. Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417 (Iowa 1994); Blacksmith v. All-American, Inc., 290 N.W.2d 348 (Iowa 1980).

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

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

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

Iowa Code section 85.34(2)(v) states, in relevant part:

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

In determining whether the above provision of Iowa Code section 85.34(2)(v) applies, there is a comparison between the pre- and post-injury wages and earnings. McCoy v. Menard, Inc., File No. 1651840.01 (App. April 9, 2021). A claimant's hourly wage must be considered in tandem with the actual hours worked by that claimant or offered by the employer. Id.

The parties previously stipulated that the claimant is working for a higher wage post-injury. Additionally, there is no information to indicate that the claimant is working less hours than prior to the injury. Therefore, the claimant should be compensated for his functional impairment only.

Iowa Code section 85.34(2)(x) states:

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

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

The claimant alleges permanent disability to his body as a whole. This rating is based upon alleged permanent disability to the following areas, as evaluated by Dr.

Segal: cognitive, migraines, emotional and behavioral, vestibular dysfunction, tinnitus, visual issues, arousal and sleep disorder, cervical spine, bilateral shoulders, left shoulder, left elbow, left wrist, and left hip. The defendants (and in a less structured way, the claimant) discuss each of these areas in depth in their post-hearing brief. I will divide the analysis of causation, and impairment (if any), by body system. I will then provide a final body as a whole impairment rating, if applicable, at the conclusion of that discussion.

Cognitive Issues

Dr. Segal opined that the claimant's fall on February 25, 2018, caused a concussion and subsequent cognitive impairment. In April of 2018, Mr. Odobasic completed a concussion evaluation form with Ms. Armstrong. That evaluation indicated that Mr. Odobasic had mild to severe issues in 17 of 22 categories. Ms. Armstrong subsequently went on maternity leave, and the claimant's care was transferred to Dr. Kennedy. Of note, Dr. Kennedy's notes indicated that Mr. Odobasic was resolving well from his concussion. There also were no mentions of head issues during Mr. Odobasic's visits with Dr. Kennedy in 2019. Mr. Odobasic testified that he had no recollection of discussing these issues with Dr. Kennedy; however, on cross-examination, he agreed that he had no basis on which to dispute the contents of the medical records. Additionally, this was part of the pattern that I observed in Mr. Odobasic's testimony. He easily recalled portions of medical treatment that would be perceived as "beneficial" to his case, but was unable to recall potentially detrimental issues. This caused me to question his credibility or recall, as noted above.

Further, with regard to his cognitive issues, Mr. Odobasic testified at hearing that he continued to have issues with headaches and/or a mental fog. This contradicted his testimony during two evidentiary depositions to some extent. He was asked in those depositions what issues he continued to have. He did not mention a fog or mental slowness in either of them. He also did not indicate any cognitive concerns during his IME with Dr. Chen.

Dr. Segal provided the most comprehensive discussion and impairment rating of all of the providers with regard to the claimant's alleged cognitive impairment. Dr. Segal opined that the claimant suffered a 7 percent whole person impairment based upon items in Table 13-5 and 13-6 of the Guides. While Dr. Segal only conducted a "mini-mental" examination and not a battery of neuropsychological testing, I would note that the Guides deem this acceptable. See e.g. Guides, pg. 319.

Prior to considering the appropriate impairment for any cognitive issues, I must first consider whether or not the alleged injuries were a cause of permanent disability in the claimant. In this case, there is no question that the claimant fell, and struck his head. However, there are questions as to whether the claimant's fall caused permanent impairment. While Dr. Segal provided a comprehensive report, the claimant did not prove by a preponderance of the evidence that the fall was a cause of permanent disability as it relates to his alleged cognitive issues. The claimant continues to work 72 to 90 hours per week between ARC and the City of Dubuque. He testified that he received no reprimands for sub-par work. He also testified that he must follow plans of

care for residents of the ARC group homes. He further noted that he had to distribute medications to some residents, and make substantive documentation in resident records regarding the residents' care.

The claimant indicated on a DOT physical examination form that he had no issues. He made no mention in two evidentiary depositions that he was experiencing cognitive issues. Dr. Segal performed a mini-mental examination to bolster his causation opinion; however, the Guides note that "[m]ental status tests are used to screen and follow individuals, frequently with repeated testing." Id. Additionally, a mini-mental examination is used to determine whether an individual is severely impaired and whether or not additional neuropsychological testing is needed. Id. Dr. Segal only examined the claimant one time for purposes of an IME. This was not a repeated test, nor was Mr. Odobasic frequently tested or followed for these alleged cognitive issues. Mr. Odobasic made no mention of mental fog or cognitive issues with Dr. Kennedy, and indicated during his testimony that he had no basis to contradict her medical records. Finally, Mr. Odobasic never requested additional mental health care for these issues until his pending arbitration proceeding. If he desired care, or these issues caused him continued concern, he could have requested care. Based upon the foregoing, I conclude that the claimant failed to prove by a preponderance of the evidence that the February 25, 2018, work incident caused a permanent impairment based upon alleged cognitive issues.

Migraines and/or Trigeminal Dysfunction

The claimant relies on the opinions of Dr. Segal again in alleging that he sustained a permanent impairment based upon his migraine headaches, and "atypical" facial pain. Dr. Segal opined that the claimant had "mild uncontrolled facial neuralgic pain that may interfere with activities of daily living" including his ability to work. (CE 4:44). Dr. Segal assigned a 5 percent whole person impairment based upon migraines and trigeminal dysfunction.

Again, it is not disputed that the claimant fell and struck his head on February 25, 2018. After that fall, the claimant experienced headaches for a time. These headaches worsened for some time until May of 2018, when he described them as daily, low-grade headaches. In July of 2018, Mr. Odobasic described a headache multiple times per week; however, he indicated that these headaches did not disrupt his activities of daily living. Imaging studies showed no acute issues in Mr. Odobasic's head or brain. When Mr. Odobasic applied for his job with the City of Dubuque, he made no mention of head issues. Mr. Odobasic also made no mention of headaches while establishing care with Dr. Kraciun.

As noted earlier, the claimant also made no mention of headaches during his evidentiary deposition. The claimant did not make mention of facial pain during his medical care. This appears to only be discussed by Dr. Segal.

Dr. Segal's opinions are flawed as they relate to Mr. Odobasic's alleged migraines and trigeminal dysfunction. Mr. Odobasic described his headaches as low grade. He noted that his headaches did not disrupt his activities of daily living. The rating used by Dr. Segal from the Guides is based upon facial neuralgic pain that

interferes with activities of daily living. Dr. Segal's causation opinion on this does not comport with the evidence in the record, or the Guides. Based upon the foregoing, I conclude that the claimant failed to prove by a preponderance of the evidence that the February 25, 2018, work incident caused a permanent impairment.

Emotional and Behavioral

The claimant alleges that he sustained a permanent impairment based upon emotional lability, anxiety, and depression. Dr. Segal opined that the claimant's emotional issues were causally connected to the February 25, 2018, work injury. Dr. Segal used the Guides to assign the claimant a 3 percent whole person impairment based upon his emotional lability and depression. However, Dr. Segal is not a psychiatrist, psychologist, and/or licensed counselor. His specialty is neurology. Dr. Chen indicated that the claimant had issues with anxiety and depression in catastrophizing his pain. However, Dr. Chen never connects the depression issues to the February 25, 2018, work injury.

The claimant made no mention of depression in his two evidentiary depositions. He missed no time from work due to depression and/or anxiety issues. He complained about feeling sad or depressed. Of note, the claimant did not begin complaining about feeling "miserable" until after his July 3, 2019, work injury, which is unconnected to the February 25, 2018, work incident. As with other issues, the claimant filled out his DOT physical without indicating any issues with depression.

Based upon my review of the information in the record, and my reflection on the claimant's credibility, the claimant has not proven by a preponderance of the evidence that the February 25, 2018, work incident caused a permanent impairment due to emotional lability and/or depression issues.

Vestibular Dysfunction

The claimant told Dr. Segal that he frequently had dizziness. He further told him that he would feel as though he was going to fall when he closed his eyes. He also indicated that he felt as though he would fall when he was in the shower. Based upon what Dr. Segal considered as frequent loss of balance and dizziness, Dr. Segal opined that the claimant's February 25, 2018, work injury caused a permanent impairment. Dr. Segal rated the impairment a 5 percent whole person impairment.

Mr. Odobasic reported dizziness on the day of the incident. The claimant denied lightheadedness during visits with Dr. Kennedy. He implied in his hearing testimony that Dr. Kennedy never asked about his dizziness; however, this is contradicted by his hearing testimony wherein he could not dispute the contents of Dr. Kennedy's medical records. Mr. Odobasic had no missed time due to any dizziness. There was no dizziness mentioned during his evidentiary depositions. There was also no dizziness mentioned during his DOT examination. Finally, Mr. Odobasic worked 60 to 100 hours per week at ARC and the City of Dubuque as a bus driver. If Mr. Odobasic was as dizzy as portrayed by Dr. Segal's exam notes, it seems unlikely that he could work that many hours, especially as a bus driver.

Based upon the foregoing, I conclude that the claimant failed to prove by a preponderance of the evidence that the February 25, 2018, work incident caused a permanent impairment due to dizziness or vestibular dysfunction.

Tinnitus

Dr. Segal provided a separate 3 percent impairment rating based upon ringing in the claimant's left ear. He opined that this was caused by the February 25, 2018, work incident. Mr. Odobasic testified in his evidentiary deposition that he felt a little ringing, buzzing, or noise in his left ear.

The Guides provide criteria for rating impairment due to hearing loss, which includes additional impairment for tinnitus. Guides, Section 11.2a, pg. 246. Evaluating hearing impairment is performed using threshold testing. Id. The impairment is based upon the severity of the hearing loss, "which accounts for changes in the ability to perform activities of daily living." Id. "Tinnitus in the presence of unilateral or bilateral hearing impairment may impair speech discrimination." Id. The Guides allow for an additional 5 percent of impairment in the presence of measurable hearing loss, provided the tinnitus impacts the ability to perform activities of daily living. Id.

The problem for Mr. Odobasic and Dr. Segal's causation opinion is that there is no evidence that Mr. Odobasic has a hearing impairment. Mr. Odobasic has not had a hearing test. He does not wear hearing aids. Dr. Segal is not an audiologist. In fact, it appears that Mr. Odobasic never met with an audiologist. His DOT physical indicated that he had no issues with his ears and/or hearing. The DOT physical provides some audiometric testing results. However, there is no indication that these are abnormal, and it does not appear that a qualified provider reviewed these results to provide an opinion. While Mr. Odobasic may have experienced buzzing in his left ear for a time, there is a dearth of evidence that this caused a permanent impairment. Therefore, the claimant failed to carry his burden of proof with regard to tinnitus and his February 25, 2018, work incident.

Visual Disturbance

After Mr. Odobasic fell, he reported flashes of light and floaters, especially in his left eye. Ms. Armstrong sent Mr. Odobasic to Dr. Baumann, an ophthalmologist. Dr. Baumann examined Mr. Odobasic for light sensitivity and new floaters. Dr. Baumann determined that Mr. Odobasic had a left eye retinal tear and detachment. He referred Mr. Odobasic to the University of Iowa Hospital for evaluation and treatment.

Upon arrival at the University of Iowa Hospital, Dr. Feiler determined that the claimant had retinoschisis of the left eye and localized retinal detachment of the left eye. Doctors at the University of Iowa performed a laser barricade surgery to the right eye. Subsequent to his surgery, Mr. Odobasic reported some soreness in his right eye. The flashing resolved by his March 6, 2018, appointment with Ms. Armstrong.

Mr. Odobasic followed-up with Dr. Russell at the University of Iowa. Dr. Russell opined that Mr. Odobasic's right eye was improving, and requested he return in four to six weeks. The claimant returned to Dr. Russell's office, and indicated that he had no

new floaters or issues. Dr. Russell noted the presence of bilateral cataracts, and released Mr. Odobasic to care with Dr. Baumann. Dr. Baumann saw Mr. Odobasic in late April of 2018, wherein Mr. Odobasic complained of blurry vision. Of note, cataracts may cause blurred vision.

Mr. Odobasic then sought no care for his eyes until December of 2020. At that time, he returned to Dr. Baumann's office with complaints of sore, red eyes. Dr. Baumann diagnosed Mr. Odobasic with conjunctivitis. Dr. Baumann provided the claimant with drops and advised him to return in April of 2021. Mr. Odobasic never returned to Dr. Baumann's office.

The claimant testified in evidentiary deposition and at the hearing that his eyes at times become watery and red.

Dr. Baumann replied to a "check box" type letter from counsel for the defendants in which he agreed that the claimant achieved MMI on April 24, 2018. He further agreed that the claimant sustained no permanent impairment that was causally related to the February 25, 2018, work incident. He concluded that the claimant required no further care.

Dr. Segal issued a 5 percent whole person impairment rating based upon "the context of visual disturbance from the brain injury." Dr. Segal did this because there is no specific impairment rating for retinal detachment. Visual impairment ratings are evaluated based upon functional impairment caused by deficits in visual acuity or field defects. Guides, Chapter 12. Dr. Segal opined that he found "Abducens nerve paresis," blurriness, issues with convergence, and focus, upon examination. He then indicates that he based his impairment on the "Individual adjustments" portion of section 12.4b. Guides, pg. 297. It is unclear from the impairment rating provided by Dr. Segal whether his ratings are based upon both eyes or one eye. Based upon his using the alleged brain injury as a basis for his rating, it appears to be based upon issues with both eyes.

The claimant attempted to obtain an impairment rating from ophthalmologists at the University of Iowa, but was not successful in doing so.

I do not find Dr. Segal's opinions as they relate to Mr. Odobasic's alleged vision issues persuasive at all. Dr. Baumann was a treating ophthalmologist in this case. While Mr. Odobasic sustained retinal injuries from his fall, I do not find adequate evidence in the record to support findings that he suffered a permanent disability to his vision as a result of the February 25, 2018, work injury. Based upon the objective medical records, the claimant's testimony, and the opinions of Dr. Baumann, I find that the claimant sustained no permanent disability as a result of his eye injuries.

Arousal and Sleep Disorders

The claimant alleges that he sustained a permanent disability as a result of arousal and sleep disorders. He told Dr. Segal that he woke "on average two times per night." He also testified at hearing that he woke "a couple of times per night" due to pain in his shoulder, neck, left hip, and back. The claimant agreed that he could fall

back to sleep after moving around and walking for a short time. Mr. Odobasic was asked about this during his evidentiary deposition and denied having lingering issues. According to Dr. Segal, Mr. Odobasic was "always fatigued" due to his sleep issues. Dr. Segal used Table 13-4 from the Guides to issue a 3 percent impairment of the whole person.

Dr. Segal issued an impairment rating for Mr. Odobasic's arousal and sleep disorder based upon Mr. Odobasic's claimed brain injury. This directly contradicts Mr. Odobasic's testimony at hearing, wherein he claimed that he woke due to pain in his shoulder, neck, left hip, and back. This is not the only way in which Dr. Segal's opinion is flawed. Mr. Odobasic testified at hearing that he worked between 90 and 100 hours per week at ARC and as a bus driver for the City of Dubuque from March of 2019 until his July 3, 2019, work injury. Subsequent to his July 3, 2019, work injury Mr. Odobasic still worked between 72 and 90 hours between ARC and the City of Dubuque. Even if Mr. Odobasic worked seven days per week, the result would be working between about 10 and 14 hours per day. This is considerably more than a "normal" or "average" work schedule. It does not appear that Dr. Segal took this information into account when he considered Mr. Odobasic's report of constant fatigue. Even the most energetic worker would be fatigued if they constantly worked 10 to 14 hours per day, every day.

Based upon the foregoing, I conclude that the claimant failed to prove by a preponderance of the evidence that the February 25, 2018, work incident caused a permanent impairment due to arousal or sleep disorders.

Cervical Spine

Mr. Odobasic fell on his left side on February 25, 2018. He struck his head. He complained initially of head pain and neck pain. At his initial emergency room visit, he had a CT scan, which showed multilevel degenerative changes, including mild disc space narrowing at C4-5. However, the exam noted no acute abnormalities. At the emergency room, he was diagnosed with a cervical strain. He continued to complain of left neck pain during his first visits with Ms. Armstrong. She eventually diagnosed him with an acute cervical myofascial strain. She provided him with work restrictions including only occasional bending of his neck. Ms. Armstrong also recommended that the claimant seek physical therapy.

By March 20, 2018, Mr. Odobasic returned to full duty work at his own request. He had slow progress in physical therapy during this time, and indicated that his neck hurt on both sides. The pain radiated to his shoulders. Ms. Armstrong increased his restrictions at that time.

During his first visit with Dr. Kennedy, she diagnosed him with neck pain in the "traps." At that time, Mr. Odobasic requested a full duty return to work, which Dr. Kennedy granted. Around that time, his complaints began to shift to his lower back, although he periodically complained about tenderness in his left neck.

The claimant eventually had a DOT physical for his job with the City of Dubuque. There is no mention of neck pain in his record from that examination. Mr. Odobasic also did not make mention of neck or radicular symptoms during his failed FCE. After

his July 3, 2019, work injury, his complaints shifted almost entirely to his lower back issues, and there was no mention of neck pain.

During his IME with Dr. Chen, Mr. Odobasic had diffuse tenderness to light tactile stimulation of the cervical spine. However, Mr. Odobasic displayed full range of motion in his neck. This is the same examination in which Dr. Chen indicated that Mr. Odobasic exhibited abnormal responses and pain catastrophization. Mr. Odobasic indicated aching, pins and needles, and burning pain in his neck. This was placed on the right side of the neck, and not the left side. Dr. Chen provided no impairment rating for the neck, but provided one for the lumbar spine.

During a subsequent evaluation with Dr. Kennedy, Mr. Odobasic displayed tenderness to palpation over the bilateral trapezius and scapular borders in the cervical spine. However, he had normal range of motion. Dr. Kennedy issued opinions based upon the lumbar spine. Dr. Citow then performed a surgery on the lumbar spine that is unrelated to the February 25, 2018, claim.

Mr. Odobasic had another FCE with WorkWell/Short Physical Therapy. That FCE showed some reduced range of motion with pain. The reduction in range of motion was equal on both sides of the neck. The FCE also found normal cervical strength with some pain limitations.

Dr. Segal then performed an IME on the claimant. It is upon this IME which the claimant places the most emphasis. Dr. Segal provided a detailed report after his examination of the claimant. The claimant alleged that he had shooting pain and stiffness in his neck. Chiropractic care and physical therapy helped to alleviate the pain. Upon physical examination, Dr. Segal noted tenderness in the left occipital notch. As a result of the claimant's history, treatment, and examination, Dr. Segal opined that the claimant sustained a permanent aggravation of pre-existing degenerative cervical issues. He assigned the claimant a 7 percent whole person impairment rating using Table 15-5 from the Guides. He further opined that the claimant fell under the cervical DRE II categorization due to radicular and mechanical cervical pain. Dr. Segal recommended additional treatment and imaging, and provided permanent restrictions.

The claimant testified in two evidentiary depositions. When asked about his current complaints in those depositions, he made no mention of cervical complaints. At the arbitration hearing, Mr. Odobasic testified that he woke several times during the evening due to neck pain. He also testified that he had neck pain that radiated into the back of his head, and that he had issues with turning his neck to the left. He also noted that he had missed no time from work due to his neck issues.

His diagnostic testing revealed degenerative issues. The claimant has met his burden of proof as it relates to his neck impairment being caused by his fall on February 25, 2018. It appears that Mr. Odobasic's fall caused a permanent aggravation of his pre-existing degenerative cervical issues. The only impairment rating offered with regard to his cervical spine is from Dr. Segal. I disagree with other aspects of Dr. Segal's report, but adopt his 7 percent whole person impairment rating with regard to Mr. Odobasic's cervical spine. This is in line with observations and complaints of pain during other medical care provided to Mr. Odobasic.

Shoulders

The claimant alleges that the fall on February 25, 2018, caused a permanent injury to his bilateral shoulders. He alleges a specific injury to his left shoulder, and an overuse injury to his right shoulder.

Mr. Odobasic fell on his left side. During his first visit with Ms. Armstrong, he complained of left shoulder pain. He had no improvement in his left shoulder by April of 2018. During Mr. Odobasic's first visit with Dr. Kennedy, he complained of pain in his "traps." He started to have pain in his right shoulder in July of 2018. He had some physical therapy during this time. There is then a dearth of mentions of his left shoulder issues, including at his DOT physical for the City of Dubuque. He had an injury to his right shoulder as a result of the July 3, 2019, work incident, which becomes apparent when he reported tenderness to Dr. Kennedy in August of 2019. At that time, he had some soreness, and was diagnosed with a scapular muscle strain. However, he had no issues with left shoulder range of motion.

By September of 2019, Mr. Odobasic was diagnosed with a right trapezius strain. Mr. Odobasic indicated on his IME pain chart with Dr. Chen that he had stabbing pain, and pins and needles in the right shoulder. He also reported Dr. Chen that he had tenderness over his left trapezius and scapular borders. When Dr. Kennedy re-examined him in 2021, she also observed bilateral trapezius tenderness.

There is not much discussion of his left shoulder or right shoulder from his failed FCE. However, there is an extended discussion of the same in his WorkWell/Short Physical Therapy FCE from November 15, 2021. During that FCE, Mr. Odobasic had mildly reduced forward flexion and mildly reduced abduction in both shoulders. He had some reduction in muscle strength in the right shoulder. His left shoulder had strength within normal limits. The FCE found range of motion as follows:

	Normal	Left	Right
Forward Flexion	180	170	150 with pain
Extension	0	Within Normal Limits	Within Normal Limits
Abduction	180	170	130 with pain
Internal Rotation	70	Within Normal Limits	Within Normal Limits
External Rotation	90	Within Normal Limits	Within Normal Limits

The FCE found strength measurements as follows:

	Normal	Left	Right
Forward Flexion	5/5	Within Normal Limits	4/5 with pain
Extension	5/5	Within Normal Limits	Within Normal Limits
Abduction	5/5	Within Normal Limits	4/5 with pain
Internal Rotation	5/5	Within Normal Limits	Within Normal Limits
External Rotation	5/5	Within Normal Limits	Within Normal Limits

The claimant then had an IME with Dr. Segal on December 11, 2021. Dr. Segal diagnosed Mr. Odobasic with an AC joint injury, rotator cuff and biceps pathologies, and

subdeltoid bursitis to the left shoulder. He also diagnosed Mr. Odobasic with overuse syndrome and possible impingement syndrome of the right shoulder. Dr. Segal listed range of motion and strength measurements for Mr. Odobasic's bilateral shoulders. Dr. Segal found Mr. Odobasic to have range of motion in his shoulders as follows:

	Normal	Left	Right
Forward Flexion	180	140	160
Extension	0	40	40
Abduction	180	130	140
Internal Rotation	70	60	50
External Rotation	90	90	90

Dr. Segal assigned an impairment rating based upon his measurements of deficits in range of motion. Dr. Segal assigned Mr. Odobasic a 9 percent impairment to the left shoulder. This equated to a 5 percent whole person impairment rating for the left shoulder. Dr. Segal assigned a 7 percent impairment rating for the right shoulder due to deficits in range of motion. This equated to a 4 percent whole person impairment rating for the right shoulder. These ratings combined to a 15 percent combined upper extremity impairment rating, or a 9 percent whole person impairment.

Dr. Segal then reviewed Mr. Odobasic's strength measurements. Dr. Segal found strength measurements as followed:

	Normal	Left	Right
Forward Flexion	5/5	4+/5	5/5
Extension	5/5	5-/5	5/5
Abduction	5/5	4+/5	5/5
Internal Rotation	5/5	5/5	5/5
External Rotation	5/5	4+/5	5/5
Adduction	5/5	5-/5	5/5

Based upon his strength issues, Dr. Segal provided Mr. Odobasic with a 15 percent whole person impairment rating.

Mr. Odobasic testified at his evidentiary deposition in October of 2021, that he had pain in his right shoulder. He made no mention of his left shoulder in either deposition. During the arbitration hearing, Mr. Odobasic testified that he woke at night due to left shoulder pain. He also acknowledged that he did not miss any time from work due to his shoulder complaints.

There is also a note from a 2003 visit with Dr. Meester, wherein Mr. Odobasic mentioned left shoulder soreness. He also mentioned that he was beaten while he was a prisoner of war in Bosnia, which led to some of his left shoulder pain.

In reviewing the records, I did not find any MRIs or other imaging studies of either shoulder. This calls Dr. Segal's diagnoses into question. Treating doctors diagnosed Mr. Odobasic with muscular strains to his shoulders. They never ordered imaging, and did not find issues with range of motion to his shoulders. Also, Dr. Segal is a

neurosurgeon, and/or neurologist. He is not an orthopedic physician. When the WorkWell FCE was performed, Mr. Odobasic had mild reductions in range of motion in his left shoulder. He had more pronounced reductions in range of motion in his right shoulder, but there are questions as to whether that was aggravated by the July 3, 2019, work incident. I am also concerned by the inconsistencies in the record with regard to the range of motion issues between the WorkWell FCE and Dr. Segal's measurements. Certainly, the fact that Dr. Segal was retained by the claimant hurts his credibility when the range of motion measurements worsened less than one month after the WorkWell FCE measurements. I also was concerned by Dr. Segal's use of loss of strength to add on additional permanent impairment. The Guides note that impairment is largely based upon anatomic impairment, and not functional tests that may be influenced by subjective factors. Guides, pg. 507. The Guides provide that a loss of strength should be considered in rare cases where a loss of strength has not been adequately considered by other methods. Id. at pg. 508. Objective anatomic findings should take precedence. Id. Decreased strength cannot be rated in the presence of decreased motion. Id.

Based upon the foregoing, I conclude that the claimant failed to prove by a preponderance of the evidence that the February 25, 2018, work incident caused a permanent impairment to his bilateral shoulders due to range of motion or strength issues.

Left Elbow

As previously noted, the claimant fell on his left side on February 25, 2018. He reported left elbow pain that he rated 7 to 8 out of 10. Amongst other things, Ms. Armstrong diagnosed Mr. Odobasic with a left arm strain. She provided restrictions for the left arm. By March 6, 2018, Mr. Odobasic had no pain in his left elbow at rest or with movement. His abrasion was healing, and he had mild soreness localized to the area of his abrasion. On March 20, 2018, Mr. Odobasic reported to Ms. Armstrong that his symptoms resolved. He had no swelling or tenderness. He had full range of motion in the left elbow with no pain. His symptoms were not mentioned for some time. In July of 2018, Dr. Kennedy noted that Mr. Odobasic's grip strengths in his hands were equal. No treating physician ordered any EMGs or imaging for the left arm and/or elbow.

There were no mentions of grip strength or left elbow issues in his DOT examination, or the invalid FCE. During his IME with Dr. Chen, Mr. Odobasic filled out a pain chart. There is nothing marked on the claimant's left elbow. There is only numbness, dull and aching issues in the left wrist and hand marked. Mr. Odobasic noted nothing in his evidentiary depositions concerning left elbow symptoms. Mr. Odobasic also missed no time from work due to left elbow issues and/or grip strength issues. Mr. Odobasic wore a left wrist brace at the hearing. He testified that this brace helped with pain in his elbow.

Mr. Odobasic had an FCE with WorkWell/Short Physical Therapy on November 15, 2021. As a part of that FCE, his range of motion and strength was measured. His left elbow displayed range of motion and strength measurements "within normal limits."

His left hand also displayed range of motion and strength measurements "within normal limits."

Dr. Segal performed an IME in December of 2021. He diagnosed Mr. Odobasic with left ulnar neuropathy and grip weakness. The claimant told Dr. Segal that he had numbness, tingling, and shooting pain from his left elbow to his left pinky and ring fingers. This was intermittent, but persistent. He also claimed that his left hand felt weak and that he dropped things "all the time." Dr. Segal found grip strength weakness on evaluation. He opined that the claimant's issues were due to peripheral neuropathy and ulnar neuropathy. He assigned an 18 percent left upper extremity impairment for the diagnosis of left ulnar neuropathy, which equated to an 11 percent whole person impairment.

As with other portions of this case, Dr. Segal's opinions do not match up with the claimant's complaints. The claimant stopped complaining of left elbow pain by March or April of 2018. He made no complaints of issues with grip strength to Dr. Kennedy. He made no mention of left elbow issues or grip strength issues in his depositions. His valid FCE with WorkWell indicated that his left elbow and hand had normal ranges of motion and strength. There is also no objective diagnostic testing to indicate an issue with the ulnar nerve.

Based upon the foregoing, I conclude that the claimant failed to prove by a preponderance of the evidence that the February 25, 2018, work incident caused a permanent impairment to his left elbow.

Left Wrist

As I previously detailed, the claimant fell on his left side on February 25, 2018. He reported left wrist pain. His left wrist was x-rayed twice. The x-ray results were normal. Initially, the claimant was provided with a left wrist brace and restrictions. He continued to wear the brace and had left wrist pain into May of 2018. He noted that stretching his wrist helped to alleviate the pain. Dr. Kennedy found that Mr. Odobasic's left wrist appeared equal to his right wrist, had no swelling, and no decreased range of motion. She also noted that the claimant had a normal forearm range of motion. He exhibited some discomfort on the left carpal bones, but had no focal tenderness over the tendons and muscles. Dr. Kennedy observed that the claimant had equal grip strength in the left and right wrists. She recommended that he leave the provided wrist brace off as much as possible.

By July of 2018, Mr. Odobasic reported little wrist discomfort with physical therapy, exercise, and removing the splint. Eventually, there was no mention of left wrist pain. He made no mention of it during his DOT physical examination in March of 2019. He did note numbness in the left wrist during his IME with Dr. Chen, but there was no additional examination done of the left wrist at that time.

Mr. Odobasic testified at an evidentiary deposition in November of 2020 that he had right wrist issues, but made no mention of any left wrist pain or range of motion issues at that time.

Eventually, Mr. Odobasic had an FCE with WorkWell/Short Physical Therapy. That FCE, on November 15, 2021, measured his left wrist range of motion and strength. These were both found to be within normal limits. The FCE also measured Mr. Odobasic's left hand range of motion and strength. These were also found to be within normal limits.

Less than one month later, Mr. Odobasic attended an IME with Dr. Segal at the arrangement of his counsel. Dr. Segal found that the claimant had a mild loss of extension in his left wrist range of motion measurements. Dr. Segal assessed this as a 3 percent upper extremity impairment, which equated to a 2 percent whole person impairment.

At the time of the hearing, Mr. Odobasic presented wearing a left wrist brace. He testified that the brace helped to "calm down and relieve" his pain. (Testimony).

The records of the treating physicians show that the claimant experienced some pain in his left wrist. By July of 2018, Mr. Odobasic reported little left wrist discomfort. He also made no mention of left wrist issues during his treatment with Dr. Kennedy in 2019. He also made no mention of left wrist issues during his DOT examination. Most importantly, an FCE conducted by WorkWell/Short Physical Therapy in November of 2021, showed no issues with range of motion or strength in the left wrist. It is important to note that the WorkWell FCE indicated in other measurements if the claimant reported increased pain during examination. For example, the claimant reported pain with movement of his lower back and his right shoulder. This was noted in the WorkWell FCE measurements. There is no mention of pain in the wrist range of motion measurement sections. Once again, Dr. Segal is the outlier in his opinions.

Based upon the foregoing, I conclude that the claimant failed to prove by a preponderance of the evidence that the February 25, 2018, work incident caused a permanent impairment to his left wrist.

Left Hip

After the claimant fell on his left side, he immediately reported left hip pain. He rated his pain 7 out of 10 during his first visit with Ms. Armstrong. Pain occurred with ambulation and palpation. However, he still had a normal gait and tender, but good, range of motion and strength in the bilateral hips. On March 6, 2018, Mr. Odobasic returned to Ms. Armstrong's office, where he displayed "soreness" with palpation to the lateral hip. He rated his pain 6 out of 10, but Mr. Odobasic was able to walk with "a little pain" in his left hip. The claimant's gait continued to be normal. On March 20, 2018, Ms. Armstrong again observed that Mr. Odobasic ambulated with a normal gait, despite soreness and pain rated 4 out of 10. Mr. Odobasic returned to Ms. Armstrong's office again on April 13, 2018. He reported soreness and pain 2 out of 10. He told Ms. Armstrong that his left hip was "better" with mild tenderness. Ms. Armstrong observed good range of motion and a normal gait. Mr. Odobasic also was able to fully squat and recover with no pain. On April 23, 2018, Mr. Odobasic continued to show a normal gait.

In late April and early May of 2018, Mr. Odobasic went to Florida, and walked around Miami and various beaches with his wife. Upon return from vacation, he visited

with Dr. Kennedy, who noted that Mr. Odobasic displayed good range of motion without pain. By July 5, 2018, Dr. Kennedy observed that Mr. Odobasic had a normal gait with good range of motion in his hip. In March of 2019, Mr. Odobasic had a DOT physical. There was no abnormality noted with regard to Mr. Odobasic's gait during this DOT physical.

After Mr. Odobasic's July 3, 2019, work injury, Mr. Odobasic had low back and right leg issues.

Dr. Chen performed an IME on Mr. Odobasic, which showed some hip inflexibility. However, Dr. Chen observed that the claimant had a normal gait with a symmetric swing and stance phase. Mr. Odobasic marked buttock pain on the pain diagram provided by Dr. Chen, but did not mark anything on the front of the left hip. Mr. Odobasic attempted to establish care with Dr. Kraciun. During that examination, Dr. Kraciun observed a normal gait and normal strength in the hip.

In February of 2021, Dr. Kennedy examined Mr. Odobasic again. Dr. Kennedy observed that the claimant had normal range of motion in his hip, along with a symmetric swing. Dr. Kennedy found tenderness over the hips, and also found symmetric range of motion.

On November 15, 2021, Mr. Odobasic had an FCE at WorkWell/Short Physical Therapy. There is no mention of hip pain in that FCE report. The report noted that Mr. Odobasic ambulated with a normal gait pattern. There was only an issue with hip flexion on examination of range of motion. This was identical in both the left and right hips. There were also no issues with strength in either hip. Much like I noted with regard to the claimant's left wrist, there is no mention that Mr. Odobasic displayed pain with his range of motion testing.

The claimant then had an IME with Dr. Segal on December 11, 2021. Dr. Segal opined that the claimant had left hip greater trochanteric bursitis. Dr. Segal described this as pain at the point of the hip which extended to the outside of the thigh area. Dr. Segal further noted that he observed that the claimant had a gait abnormality. Dr. Segal opined that the February 25, 2018, work incident caused the claimant to suffer a permanent disability to his left hip. Based upon his diagnosis of "trochanteric bursitis (chronic) with abnormal gait," Dr. Segal cited to Table 17-33 in the Guides to provide the claimant with a 7 percent lower extremity impairment rating. He equated this to a 3 percent whole person impairment. Dr. Segal noted that this impairment rating would apply whether the bursitis is directly or secondarily caused by the work injury.

In his evidentiary depositions, Mr. Odobasic mentioned no issues with his left hip. He testified at the hearing that he had pain in his left hip if he laid on his left hip. He admitted that his gait disturbance was the result of right leg, hip and low back pain from the July 3, 2019, work injury. He also noted that the July of 2019 incident caused him to limp. He admitted that he had no missed time from work due to any left hip issues. He also admitted that he did not use a cane or crutch.

While Mr. Odobasic experienced hip pain initially after the incident, he never had any gait abnormality. He also indicated that the pain in his right hip was dissipating as

he met with doctors throughout 2018. Dr. Segal was the only doctor that noticed any gait disturbance. In order to have an impairment pursuant to the judgment of Dr. Segal, there would need to be a gait disturbance. No other doctor or provider observed a gait disturbance, including an FCE performed less than one month prior to Dr. Segal's FCE. I do not find Dr. Segal's opinion credible on this issue. From the record, it appears that any gait disturbance may be related to the July 3, 2019, work injury. While Mr. Odobasic may still have pain in his left hip, the record does not show that he sustained a permanent impairment due to the February 25, 2018, work incident.

Conclusion Regarding Permanent Impairment

There is no question that the claimant was injured as a result of his fall. The dispute is whether the injuries caused permanent impairment. Based upon my review of the record, the parties' arguments, and Dr. Segal's impairment ratings above, I find that the claimant has only carried his burden with regard to the neck injury. The only impairment rating provided, which I adopted was a 7 percent whole person impairment due to cervical spine injuries.

Compensation for permanent partial disability shall begin at the termination of the healing period. Compensation shall be paid in relation to 500 weeks as the disability bears to the body as a whole. Iowa Code section 85.34(2)(v).

In this case, the parties stipulated that compensation for permanent partial disability benefits would commence on March 11, 2018. A 7 percent impairment rating is equivalent to 35 weeks. (.07 x 500 weeks = 35 weeks).

Alternate Medical Care Pursuant to Iowa Code section 85.27

The claimant has requested that the undersigned order alternate medical care pursuant to Iowa Code section 85.27.

Iowa Code 85.27(4) provides, in relevant part:

> For purposes of this section, the employer is obligated to furnish reasonable services and supplies to treat an injured employee, and has the right to choose the care…. The treatment must be offered promptly and be reasonably suited to treat the injury without undue inconvenience to the employee. If the employee has reason to be dissatisfied with the care offered, the employee should communicate the basis of such dissatisfaction to the employer, in writing if requested, following which the employer and the employee may agree to alternate care reasonably suited to treat the injury. If the employer and employee cannot agree on such alternate care, the commissioner may, upon application and reasonable proofs of the necessity therefor, allow and order other care.

Iowa Code 85.27(4). See Pirelli-Armstrong Tire Co. v. Reynolds, 562 N.W.2d 433 (Iowa 1997).

"Iowa Code section 85.27(4) affords an employer who does not contest the compensability of a workplace injury a qualified statutory right to control the medical

care provided to an injured employee." Ramirez-Trujillo v. Quality Egg, L.L.C., 878 N.W.2d 759, 769 (Iowa 2016) (citing R.R. Donnelly & Sons v. Barnett, 670 N.W.2d 190, 195, 197 (Iowa 2003)). "In enacting the right-to-choose provision in section 85.27(4), our legislature sought to balance the interests of injured employees against the competing interests of their employers." Ramirez, 878 N.W.2d at 770-71 (citing Bell Bros., 779 N.W.2d at 202, 207; IBP, Inc. v. Harker, 633 N.W.2d 322, 326-27 (Iowa 2001)).

The employer has the right to choose the provider of care, except where the employer has denied liability for the injury. Iowa Code 85.27. Holbert v. Townsend Engineering Co., Thirty-second Biennial Report of the Industrial Commissioner 78 (Review-Reopening, October 16, 1975). An employer's right to select the provider of medical treatment to an injured worker does not include the right to determine how an injured worker should be diagnosed, evaluated, treated, or other matters of professional medical judgment. Assmann v. Blue Star Foods, File No. 866389 (Declaratory Ruling, May 19, 1988). Reasonable care includes care necessary to diagnose the condition, and defendants are not entitled to interfere with the medical judgment of its own treating physician. Pote v. Mickow Corp., File No. 694639 (Review-Reopening Decision, June 17, 1986).

The employer must furnish "reasonable medical services and supplies *and* reasonable and necessary appliances to treat an injured employee." Stone Container Corp. v. Castle, 657 N.W.2d 485, 490 (Iowa 2003)(emphasis in original). Such employer-provided care "must be offered promptly and be reasonably suited to treat the injury without undue inconvenience to the employee." Iowa Code section 85.27(4).

By challenging the employer's choice of treatment - and seeking alternate care – claimant assumes the burden of proving the authorized care is unreasonable. See e.g. Iowa R. App. P. 6.904(3)(e); Bell Bros. Heating and Air Conditioning v. Gwinn, 779 N.W.2d 193, 209 (Iowa 2010); Long v. Roberts Dairy Co., 528 N.W.2d 122 (Iowa 1995). An injured employee dissatisfied with the employer-furnished care (or lack thereof) may share the employee's discontent with the employer and if the parties cannot reach an agreement on alternate care, "the commissioner may, upon application and reasonable proofs of the necessity therefor, allow and order the care." Id. "Determining what care is reasonable under the statute is a question of fact." Long, 528 N.W.2d at 123; Pirelli-Armstrong Tire Co., 562 N.W.2d at 436. As the party seeking relief in the form of alternate care, the employee bears the burden of proving that the authorized care is unreasonable. Id. at 124; Gwinn, 779 N.W.2d at 209; Pirelli-Armstrong Tire Co., 562 N.W.2d at 436. Because "the employer's obligation under the statute turns on the question of reasonable necessity, not desirability," an injured employee's dissatisfaction with employer-provided care, standing alone, is not enough to find such care unreasonable. Id.

Based upon the recommendation of Dr. Segal, the claimant requests alternate medical care. The medical care sought is: referral to a neurologist for ongoing headache issues, referral to a neurosurgeon or orthopedic surgeon for further evaluation of orthopedic injuries, a pain management clinic in Dubuque or Iowa City, neuropsychological evaluation and testing, a neuro-ophthalmologic evaluation, a

vestibular evaluation, and a psychiatric evaluation. The claimant also specifically requested a referral to "Dr. Fitzgerald" in Cedar Rapids, Iowa, at Vision in Motion.

The claimant has not proven that the care offered is unreasonable. The claimant made no requests for additional care until after Dr. Segal's IME findings. The defendants provided the claimant with reasonable care. The claimant's request for alternate medical care is denied.

Reimbursement of IME Expenses of Dr. Segal

Iowa Code 85.39(2) states:

> If an evaluation of permanent disability has been made by a physician retained by the employer and the employee believes this evaluation to be too low, the employee shall, upon application to the commissioner and upon delivery of a copy of the application to the employer and its insurance carrier, be reimbursed by the employer the reasonable fee for a subsequent examination by a physician of the employee's own choice, and reasonably necessary transportation expenses incurred for the examination.
>
> . . .
>
> An employer is only liable to reimburse an employee for the cost of an examination conducted pursuant to this subsection if the injury for which the employee is being examined is determined to be compensable under this chapter or chapter 85A or 85B. An employer is not liable for the cost of such an examination if the injury for which the employee is being examined is determined not to be a compensable injury. A determination of the reasonableness of a fee for an examination made pursuant to this subsection shall be based on the typical fee charged by a medical provider to perform an impairment rating in the local area where the examination is conducted.

Iowa Code section 85.39(2).

Defendants are responsible only for reasonable fees associated with claimant's independent medical examination. The claimant has the burden of proving the reasonableness of the expenses incurred for the examination. See Schintgen v. Economy Fire & Casualty Co., File No. 855298 (App. April 26, 1991). The claimant need not prove that the injury arose out of and in the course of employment to qualify for reimbursement under section 85.39. See Dodd v. Fleetguard, Inc., 759 N.W.2d 133, 140 (Iowa App. 2008). An opinion finding a lack of causation is tantamount to a zero percent impairment rating. Kern v. Fenchel, Doster & Buck, P.L.C., 2021 WL 3890603 (Iowa App. 2021).

The defendants argue that they are only responsible for the fees associated with the examination provided by Dr. Segal, based upon the plain language of Iowa Code section 85.39. The defendants cite to no prior orders or rulings to support their position. I have yet to see a case wherein the statute has been interpreted in such a way.

The claimant contends that Dr. Segal's fees are reasonable. The claimant argues that Dr. Segal spent two hours with the claimant and his daughter, and over one hour reviewing records. Dr. Segal then spent three hours producing his report. The claimant notes that Dr. Segal is a board certified neurosurgeon and an attorney licensed to practice in Nevada and California. I find Dr. Segal's status as a licensed attorney of no relevance whatsoever to this case. Dr. Segal produced medical opinions as a neurosurgeon, not as a lawyer.

Claimant's Exhibit 7 contains Dr. Segal's invoice, which bills four thousand seven hundred fifty and 00/100 dollars ($4,750.00) for about six hours and 20 minutes of work. This equates to about 6.33 hours. Calculating for a per hour basis, it appears that Dr. Segal billed about seven hundred fifty and 00/100 dollars ($750.00) per hour for his IME, record review, and IME report.

The claimant notes that Dr. Chen, in preparing a report in connection with Mr. Odobasic's July 3, 2019, work injury, billed five hundred and 00/100 dollars ($500.00) per hour. (CE 8). The claimant attempts to use this to advance their argument that Dr. Segal's charges are reasonable. I disagree that it proves this point. The defendants did not make any argument or dispute as to the reasonableness of Dr. Segal's fees beyond the statutory argument noted above.

I find that Dr. Segal's charges are reasonable. Additionally, there are several IMEs in the record submitted or arranged by the defendants that indicate 0 percent impairment for various issues alleged to be related to this case by the claimant. Accordingly, I award the claimant four thousand seven hundred fifty and 00/100 dollars ($4,750.00) for the costs of Dr. Segal's IME.

Costs

Claimant seeks the award of costs as outlined in Claimant's Exhibit 1. Costs are to be assessed at the discretion of the deputy commissioner hearing the case. See 876 Iowa Administrative Code 4.33; Iowa Code 86.40. 876 Iowa Administrative Code 4.33(6) provides:

> [c]osts taxed by the workers' compensation commissioner or a deputy commissioner shall be (1) attendance of a certified shorthand reporter or presence of mechanical means at hearings and evidential depositions, (2) transcription costs when appropriate, (3) costs of service of the original notice and subpoenas, (4) witness fees and expenses as provided by Iowa Code sections 622.69 and 622.72, (5) the costs of doctors' and practitioners' deposition testimony, provided that said costs do not exceed the amounts provided by Iowa Code sections 622.69 and 622.72, (6) the reasonable costs of obtaining no more than two doctors' or practitioners' reports, (7) filing fees when appropriate, including convenience fees incurred by using the WCES payment gateway, and (8) costs of persons reviewing health service disputes.

The claimant requests reimbursement for two filing fees. The claimant argues in their post-hearing brief that the first petition had to be dismissed without prejudice "because the case was not yet ready for hearing." I do not find this persuasive.

In my discretion, I award costs for one filing fee in this matter. The defendants shall reimburse the claimant one hundred and 00/100 dollars ($100.00) related to the filing fee.

ORDER

THEREFORE, IT IS ORDERED:

That the defendants are to pay unto claimant thirty-five (35) weeks of permanent partial disability benefits at the rate of four hundred seventy-one and 35/100 dollars ($471.35) per week from the agreed upon commencement date of March 11, 2018.

That the defendants are entitled to a credit as stipulated.

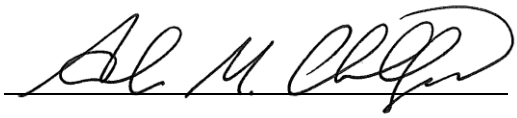
Defendants shall pay accrued weekly benefits in a lump sum together with interest on past due weekly compensation benefits at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two percent. See Gamble v. AG Leader Technology, File No. 5054686 (App. Apr. 24, 2018).

That the defendants shall reimburse the claimant four thousand seven hundred fifty and 00/100 dollars ($4,750.00) for the IME fees of Dr. Segal.

That the defendants shall reimburse the claimant one hundred and 00/100 dollars ($100.00) for costs related to a filing fee.

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

Signed and filed this ___20th___ day of May, 2022.



ANDREW M. PHILLIPS
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served, as follows:

Mark Sullivan (via WCES)

Edward Rose (via WCES)

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