BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

MARIA PAREDES,	:	
Claimant,	:	File No. 5022049
vs.	:	A R B I T R A T I O N
TYSON FOODS,	:	D E C I S I O N
Employer, Self-Insured, Defendant.	:	Head Note No.: 1803

STATEMENT OF THE CASE

Maria Paredes filed a petition in arbitration seeking workers' compensation benefits from the above-named self-insured defendant as a result of an injury she sustained on November 3, 2006, which arose out of and in the course of her employment. The case was heard and fully submitted in Des Moines, Iowa, on June 3, 2009. The evidence in the case consists of the testimony of claimant and David Duncan, as well as, claimant's exhibits 1 through 8 and joint exhibits A through J.

ISSUES

The issue presented in the case is whether the injury is the cause of permanent disability. The parties stipulated that if permanent disability is found to have occurred as a result of the injury it will be evaluated industrially and that the commencement date for any permanent partial disability benefits awarded would be December 5, 2006.

The parties also stipulated claimant's gross weekly earnings at the time of the injury were $447.47, she was married and entitled to 4 exemptions. Based upon the applicable rate book claimant's correct weekly rate of compensation on the claim is $317.02.

FINDINGS OF FACT

The deputy workers' compensation commissioner having heard the testimony of the witnesses and considered the evidence in the record finds that:

Maria Paredes, claimant, was 60 years old at the time of the hearing. Claimant was born in Mexico and testified that she received no education in Mexico or in the United States. She stated that she speaks little English and does not read and write

English. Although she does speak Spanish she testified that she is not able to do much reading and writing in Spanish.

Claimant's employment history has involved her working in food processing line work. She began working for Tyson Foods on September 16, 2003.

Claimant testified she passed a pre-employment physical and she had no physical problems or work restrictions at the time she began working for the employer. Claimant's job involved working on a line.

On July 30, 2004, claimant was seen by Charles Buck, M.D., at which time she described the gradual onset of pain on the right side of her neck extending over her lateral shoulder. Dr. Buck indicated claimant associated her pain to moving to a new position at her job which involved reaching and pulling heavy amounts of meat toward her. She also described reaching overhead with both arms and pulling forward. Dr. Buck assessed claimant as having mild cervical and trapeziual strain which was getting worse and he started her on physical therapy. He released claimant to work with no bending and twisting of her neck, lifting 10 to 20 pounds occasionally, no over the shoulder use of her right arm and limited pushing and pulling. (Exhibit B, page 1)

Claimant saw her family physician, Debbie Gibbs, M.D., on August 2, 2004, for continued severe headaches. Dr. Gibbs noted claimant having fallen and hitting her head five months before. Dr. Gibbs also noted a CT scan of claimant's head had been done and the results were normal. She then ordered a head and neck MRI. (Ex. A, p. 1)

Claimant underwent an MRI of her cervical spine on August 4, 2004, which showed a mild diffuse narrowing of the AP diameter of the cervical canal which was deemed probably to be a congenital situation. The MRI was otherwise negative. (Ex. F, p. 2)

Claimant was seen by Brian Johns, M.D., an associate of Dr. Buck, on September 30, 2004. Dr. Johns' physical examination of claimant found normal right shoulder range of motion without pain. Dr. Johns stated claimant needed no further medical care and that she was at maximum medical improvement without impairment. (Ex. B, p. 2)

Claimant returned to Dr. Johns on October 28, 2004, indicating that the day before she had pushed and pulled 30 pound pieces of product and had developed left shoulder pain. Dr. Johns assessed claimant as having left shoulder pain and a left proximal bicep strain. (Ex. B, p. 3)

Dr. Johns saw claimant on December 2, 2004, with claimant reporting her left shoulder pain was no better. Dr. Johns indicated that he found claimant to have inconsistent findings on his examination of her, as well as the history she provided. Dr. Johns indicated that he wanted claimant to be evaluated by an orthopedist. (Ex. B, p. 4)

Claimant was referred to Everett Law, M.D., who saw claimant on January 10, 2005. Dr. Law stated that claimant said most of her symptoms were located in the lateral and anterior aspects of her left shoulder. Dr. Law ordered a left shoulder MRI. (Ex. D, pp. 1-2)

The left shoulder MRI was performed on February 4, 2005. (Ex. D, p. 3) Dr. Law saw claimant on February 14, 2005, and reviewed the MRI. He stated it showed no evidence of a rotator cuff tear and referred claimant to physical therapy to improve her rotator cuff strength as well as improve the range of motion of her left shoulder. (Ex. D, p. 4)

It was claimant's contention that in March of 2005 she was grabbed by her supervisor by her left arm. (Exhibit 6) Claimant saw Dr. Law on March 10, 2005, making this claim and she stated that she felt her left shoulder had gotten pulled. Dr. Law, however, found on physical examination that claimant had essentially the same left shoulder range of motion she had on February 4, 2005. Dr. Law did recommend that claimant continue on light duty work. (Ex. D, p. 4)

On March 28, 2005, Dr. Law ordered cervical spine and left shoulder MRIs to rule out any new injuries based on the alleged assault. Both MRIs were conducted on March 28, 2005.

The cervical spine MRI at the C6-7 level found a minimal degree of annular disc bulging diffusely. However, no significant neural foraminal narrowing was present. There was no significant bulging or protrusion shown at the C5-6 level and although there were minimal degrees of disc bulging at the C3-4 and C4-6 level, they were not found to compromise the central canal significantly. (Ex. D, p. 6)

Dr. Law determined that the left shoulder MRI was unchanged from the February 4, 2005 MRI and that the cervical spine MRI did not really show anything. Dr. Law did offer claimant an injection to her left shoulder on April 4, 2005. (Ex. D, p. 9)

Claimant reported to Dr. Law, on May 2, 2005, the injection did not make much difference and he did not believe claimant would benefit from continued physical therapy. He also believed that claimant could transition back to her regular work. (Ex. D, p. 10) On August 4, 2005, Dr. Law opined claimant to be at maximum medical improvement without permanent impairment. (Ex. D, p. 12)

On November 3, 2006, claimant testified that a ham weighing approximately 25 to 30 pounds fell on the top of her head. Claimant testified this aggravated her prior right shoulder and neck problems. She saw Dr. Gibbs' physical assistant on November 9, 2006. The incident of November 30, 2006, was noted and that claimant had pain on the left side of her head. The main reason for claimant being seen on November 9, 2006, was in follow-up for her diabetes, hypertension, and hyperlipidemia. The physician assistant noted that claimant had been very noncompliant in taking her medication and that claimant reported being off her medications for at least two months.

It was also noted that claimant's diabetes had typically been poorly controlled. When asked about this notation on cross-examination claimant disagreed with this and testified that she always took her medication.

Claimant saw Dr. Johns on November 17, 2006, reporting to him the incident of the ham hitting her on her head. Dr. Johns offered the impression of claimant having head trauma and ordered a CT scan of her head and brain. (Ex. B, p. 9) The CT scan found no acute findings. (Ex. E)

Claimant went to a hospital emergency room on November 24, 2006, because of the worsening of her symptoms. Claimant was taken off work on that date. (Ex. F, pp. 3, 9)

On November 30, 2006, claimant was seen by Andrew Schaeckenbach, M.D., an associate of Dr. Johns. She reported to Dr. Schaeckenbach having an increase in her headaches and significant muscle spasming in her bilateral trapezius muscle region. She also reported going to the hospital emergency room for additional evaluation and being taken off work. Dr. Schaeckenbach, after examining claimant, assessed her as having postconcussion syndrome post-blunt head trauma. He took claimant off work until December 5, 2006, and referred her to physical therapy. (Ex. B, p. 11)

The physical therapist noted, on December 1, 2006, that claimant's pain report and pain behaviors were so significant that the therapist was not getting a full appreciation for what claimant's actual strengths were. The therapist noted that everything caused claimant pain. (Ex. G, p. 2)

Claimant was seen by Dr. Johns on December 5, 2006, reporting no symptom change and that she had constant pain that was an 8 on a scale of 1 to 10. Dr. Johns noted his physical examination found inconsistencies relating to claimant's neck range of motion, and he also detected submaximal effort on claimant's part. He released claimant to light duty work. (Ex. B, p. 12)

On December 18, 2006, the physical therapist indicated that claimant had been seen for six physical therapy sessions. It was noted that the physical therapy had not benefited the claimant and that she continued to report pain on the level of 8 to 9 on a scale of 1 to 10. The physical therapist reported that claimant's pain exceeded her pain behaviors and the therapist also noted inconsistencies in her cervical spine range of motion measurements. Physical therapy was discontinued as of that date. (Ex. G, p. 4)

On December 19, 2006, Dr. Johns again examined claimant and determined that claimant's subjective pain complaints did not correspond with her objective findings. He also stated that there was evidence of claimant's propensity to amplify her symptoms. (Ex. B, p. 13)

Dr. Gibbs had taken claimant off work from November 27, 2006, through December 14, 2006. (Ex. A, p. 13) Claimant testified that she did not return to work after December 14, 2006.

David Duncan is the employer's human resources manager. He testified that the employer has what is known as a no fault attendance policy and that an employee is subject to discharge if the employee accumulates enough points for absences and tardies. It was his testimony that claimant was granted a leave of absence through December 14, 2006. He did testify as to some uncertainty whether claimant had worked between December 15, 2006 and December 25, 2006. Attendance records indicate that claimant was absent but excused on December 26, 2006 and December 27, 2006. (Ex. J, p. 3) The records reflect that after December 28, 2006 up through January 8, 2007, claimant was deemed to be absent for unexcused reasons. On January 2, 2007, there is a notation that a company nurse informed claimant to provide documentation for her absences after December 15, 2006. (Ex. J, p. 2) Claimant testified she returned to the employer with off work slips from Dr. Gibbs which the employer would not accept. She further testified she was told to leave and she considered that she was fired.

The employer terminated claimant's employment as of January 8, 2007, for being absent five days between December 28, 2006 and January 5, 2007, without calling in. (Ex. J, p. 4) Claimant did apply for unemployment benefits but her claim was denied.

Dr. Johns saw claimant on January 2, 2007, and based on claimant's continuing reports of constant pain he decided that an orthopedic consultation should be done in order to rule out any organic pathology before releasing claimant back to normal activity. (Ex. B, p. 14) As a result claimant was referred to R. T. Garrett, M.D.

Claimant saw Dr. Garrett on February 16, 2007. After examining claimant Dr. Garrett agreed claimant had a postconcussion syndrome that had seemed to resolve. Based on claimant's complaint of neck pain Dr. Garrett ordered another cervical spine MRI. He also indicated that he saw no permanent injury related to the head trauma. (Ex. H, p. 1)

The MRI was performed on April 11, 2007. Minimal disc bulging was found at the C3-4 and C4-5 levels. At the C5-6 level a tiny central protrusion of disc material was seen in the midline and the subarachnoid space was narrowed to approximately 8 millimeters indicating a mild to moderate degree of central stenosis without core compression. The neuroforamina was patent without compromise. At the C6-7 level mild endplate ridging and disc bulging diffusely was found resulting in mild central stenosis. No core compression was found. (Ex. H, p. 4)

Dr. Garrett reviewed the MRI and determined that it was normal for a person of claimant's age. He stated he saw nothing that represented cervical stenosis that was severe or cervical myleopathy or cervical radiculopathy. He determined claimant's neck

pain was more than likely musculoskeletal. His physical examination of claimant was negative. He diagnosed claimant as having primarily a cervical strain. (Ex. H, p. 6)

Claimant saw Dr. Johns on June 1, 2007. She reported to Dr. Johns her symptoms were essentially the same but that her pain was a 9 on a scale of 1 to 10. She also reported a 2 week old new symptom of right anterior thigh pain which claimant insisted was related to the November 2, 2006, injury. Dr. Johns again indicated that claimant demonstrated inconsistent findings on her physical examination regarding her cervical spine and shoulder range of motion. He opined claimant to have a 0 percent permanent impairment. (Ex. B, pp. 15-16) He released claimant to return to work without restrictions. (Ex. B, p. 17)

Claimant was seen by Robert Milas, M.D., neurosurgeon, at the request of her attorney on April 24, 2009. Dr. Milas found on his physical examination of claimant that she had cervical motion mildly restricted in all planes and that claimant was unable to elevate her left extremity beyond 90 degrees in any plane. Dr. Milas reviewed the MRIs done in 2004 and 2005 and opined claimant to have cervical radiculopathy secondary to foraminal narrowing at the C6-7 level secondary to a probable disc herniation. He further opined that pursuant to the 5th Edition of the Guides claimant had an 18 percent whole person impairment. He went on to state the following: "I do feel that the event where the patient was struck on the head by the ham accentuated the pre-existing disease in the cervical spine noted at the C6-7 levels with the resultant cervical radiculopathy." (Ex. I, pp. 1-2)

Dr. Milas indicated a repeat MRI should be done and depending on the results of that MRI surgery could be considered. He opined claimant to have a permanent 10 pound lifting restriction with no repetitive cervical motion or work with her upper extremities above a neutral position. (Ex. I, pp. 1-2)

Dr. Milas issued a supplemental report on April 27, 2009. He noted that he reviewed another MRI scan and after doing so determined that claimant had a well defined left C6-7 disc herniation. He indicated his prior opinions remain unchanged. (Ex. I, p. 4)

REASONINGS AND CONCLUSIONS OF LAW

The first issue to be resolved is whether this injury is the cause of 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 causal connection is essentially within the domain of expert testimony. The expert medical evidence must be considered with all other evidence introduced bearing on the causal connection between the injury and the disability. Supportive lay testimony may be used to buttress the expert testimony and, therefore, is also relevant and material to the causation question. The weight to be given to an expert opinion is determined by the finder of fact and may be affected by the accuracy of the facts the expert relied upon as well as other surrounding circumstances. The expert opinion may be accepted or rejected, in whole or in part. St. Luke's Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); IBP, Inc. v. Harpole, 621 N.W.2d 410 (Iowa 2001); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995). Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417 (Iowa 1994). Unrebutted expert medical testimony cannot be summarily rejected. Poula v. Siouxland Wall & Ceiling, Inc., 516 N.W.2d 910 (Iowa App. 1994).

Claimant contends that she has had continuing neck and shoulder pain complaints that were aggravated by the incident of the ham falling on her head on November 3, 2006. She points to the opinion of Dr. Milas that his review of the records reflect claimant having a lesion at the C6-7 level which resulted in his opining her to have an 18 percent whole person impairment and imposed permanent work restrictions. However, the other treating physicians have noted throughout the time that claimant has worked for Tyson, and on the occasions she has had other injuries including the last injury, that claimant has demonstrated inconsistent findings on her physical examination and that her pain complaints did not match the objective findings found during physical examination or the MRIs that had been conducted. The last MRI conducted on April 11, 2007, did not show a disc herniation as discussed by Dr. Milas. It is concluded that claimant has not borne her burden of proof to establish that the injury of November 3, 2006, has resulted in permanent disability based on the opinions of Dr. Johns and Dr. Garrett. Based on this conclusion no other issues need to be discussed.

ORDER

THEREFORE, IT IS ORDERED:

That in File No. 5022049 claimant shall take nothing and her petition is dismissed.

That claimant shall pay the costs of this action pursuant to rule 876 IAC 4.33.

Signed and filed this __9th__ day of July, 2009.

STEVEN C. BEASLEY
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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SCB/dll

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 in writing and received by the commissioner's office 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 a legal holiday. The notice of appeal must be filed at the following address: Workers' Compensation Commissioner, Iowa Division of Workers' Compensation, 1000 E. Grand Avenue, Des Moines, Iowa 50319-0209.