BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

DAVID ARNOLD,

Claimant,

vs.

TYCO INTERNATIONAL MANAGEMENT COMPANY,

Employer,

and

NEW HAMPSHIRE INSURANCE COMPANY,

Insurance Carrier,
Defendants.

File No. 5042195

ARBITRATION DECISION

Head Note Nos.: 1108, 1803

STATEMENT OF THE CASE

The claimant, David Arnold, filed a petition for arbitration and seeks workers' compensation benefits from Tyco International Management Company, employer, and New Hampshire Insurance Company, insurance carrier. The claimant was represented by Tom Currie. The defendants were represented by Lee Hook.

The matter came on for hearing on May 26, 2017, before deputy workers' compensation commissioner, Joe Walsh in Des Moines, Iowa. The record in the case consists of Joint Exhibits 1 through 8, Claimant's Exhibits 1 through 14 and 16, and Defense Exhibits A through D. The claimant testified under oath at hearing. Emily Maiers was appointed the official reporter for the proceeding. The matter was fully submitted on June 26, 2017, after helpful briefing by the parties.

ISSUES

The parties submitted the following issues for determination:

1. Whether the stipulated April 16, 2010, work injury is a cause of any temporary or permanent disability, and if so, the nature and extent of the disability.

2. Whether the claimant is entitled to healing period benefits from January 10, 2014, through May 12, 2014, and December 23, 2015, through November 10, 2016.

3. Whether the claimant is entitled to permanent disability benefits, including permanent total disability benefits under the odd-lot doctrine.

4. Whether the claimant is entitled to medical expenses as outlined in Claimant's Exhibits 3 and 4.

STIPULATIONS

Through the hearing report and order, the parties stipulated to a number of issues. Those stipulations are accepted by the agency through the order and are deemed binding at this time.

FINDINGS OF FACT

Claimant, David Arnold, was born in 1950 and was 66 years old as of the date of hearing. He resides in Waterville, Minnesota and has been married to his wife, Barbara for 43 years. He graduated from Medford High School in 1969, and has some vocational training in auto mechanics. He served in the military in 1969 to 1970. Most of his work history is in the area of sales and management. In particular, he worked for Schwan's as a salesperson and manager for a number of years.

Mr. Arnold testified live and under oath at hearing. I find his testimony to be generally credible.

Mr. Arnold began working for Tyco in 2007 as a sales representative. He sold residential and small business security systems. (Claimant's Exhibit 1, page 5) His job description is in the record and it describes light physical activities: "Exerting up to 20 pounds of force occasionally, and/or up to 10 pounds of force frequently, and/or a negligible amount of force constantly." (Cl. Ex. 6, p. 2) Mr. Arnold did testify that he was required to carry a bag, which weighed upwards of 40 pounds, to each customer visit. It is undisputed that he had not carried this bag to the visit on April 16, 2010. (Tr., pp. 67-68)

Prior to April 16, 2010, Mr. Arnold was in reasonably good physical health, although he had received active medical treatment for a variety of ailments relevant to this claim. Prior to April 16, 2010, he was under no work restrictions. He had received regular chiropractic care from William Tweeton, D.C., as a result of ongoing, intermittent back pain. He began receiving such treatment in at least 1996. (Jt. Ex. 2, p. 1) The records are somewhat difficult to decipher, but it appears the treatment involved claimant's entire back and spine. Mr. Arnold testified that his back condition had never interfered with his ability to work.

Mr. Arnold also had some right shoulder problems prior to 2010. (Jt. Ex. 4, p. 1) His symptoms culminated in a right shoulder hemioarthroplasty surgery in April 2009. (Jt. Ex. 5, pp. 1-3) He recovered well and had returned to work without incident. It is undeniable, however, the condition never fully healed. (Jt. Ex. 4, p. 7)

On April 16, 2010, Mr. Arnold was working at a customer's home. At this time, claimant lived in Washington, Iowa and was working in Davenport, Iowa. While outside at the customer's home, he fell. The incident is documented in an accident/incident report.

> AS I WAS LEAVING THE HOME OF MY CLIENT, HE WAS OUTSIDE WITH ME AND WE WERE LOOKING AT THE OUTSIDE OF THE UPSTAIRS WINDOWS. I FELL ON RIGHT SIDE HITTING SHOULDER, HIP, LEG AND FOOT AND TWISTED BACK. THERE WAS A STEP UP TO THE STREET AND I FELL UP THE STEP.

(Cl. Ex. 5, p. 1)

The following day, claimant saw Dr. Tweeton who documented the fall and appears to have provided standard treatment which was not significantly different than the type of routine adjustments he had prior to the injury. (Jt. Ex. 2, p. 99) On April 28, 2010, Mr. Arnold sought evaluation from Matthew Prihoda, M.D. He documented the following:

> This is a 59-year-old white male pt who presents with rt shoulder and hip pain after a fall that occurred on 4/16/10. He works for ADT Company. He was in Davenport looking at a project and he tripped over a sidewalk and fell to the ground landing primarily on his rt shoulder where he has had previous rt shoulder replacement done in '09 and then his rt hip. He has also banged up his knee a little bit but that is doing much better. He continues to have pain in the shoulder and hip area and was kind of worried about it.

(Jt. Ex. 3, p. 5) Dr. Prihoda diagnosed right shoulder and hip contusions, prescribed Celebrex and told him to return in two to three weeks if the condition had not improved. (Jt. Ex. 3, p. 6) The symptoms did not resolve. He had some diagnostic tests and attempted some physical therapy in July 2010. He was also treated for a hernia condition. (Jt. Ex. 3, pp. 7-9) During this period of time, Dr. Prihoda did not diagnose any back condition or even document ongoing low back pain. He did diagnose ongoing hip pain which was felt to be related to the work-related hernia condition. Claimant had no specific recollection of whether he was specifically complaining of low back pain between April and October 2010. (Tr., pp. 70-72)

By October 2010, his right shoulder symptoms had not improved at all. "He was able to pick himself up but he had continued shoulder and hip discomfort subsequent.

He says the shoulder pain is most notable with ROM activities and he feels like it 'clunks' and 'shifts' at times and wakes him up at night when he sleeps." (Jt. Ex. 3, p. 11) Dr. Prihoda also noted that there is "no low back sx or related to speak of." (Jt. Ex. 3, p. 11)

After having a hernia surgery at the University of Iowa Hospitals and Clinics, claimant was finally referred to James Nepola, M.D., at the same hospital for his right shoulder. He first saw Dr. Nepola on January 3, 2011. (Jt. Ex. 6, p. 7) Dr. Nepola ordered diagnostic tests including a shoulder arthrogram. (Jt. Ex. 6, p. 14) He performed a Lidocaine injection which provided no relief. (Jt. Ex. 6, p. 16) Dr. Nepola opined the current difficulties were unrelated to his previous shoulder replacement. "He has had no relief at all with intra-articular glenohumeral anesthetic injection. Therefore, this rules out any type of pathology regarding the implant or within the joint space." (Jt. Ex. 6, p. 18)

In March 2011, claimant was evaluated by Steindler Clinic orthopedic surgeon Cory Christiansen, M.D. Dr. Christiansen documented the following:

> He has recently begun complaining of some right hip pain and has had no treatment for this, as of yet. He was referred to my clinic for further evaluation.
>
> He feels an intermittent pain in his right hip. He feels pain in the groin, as well as pain over the lateral aspect of the hip that radiates down the thigh to the level of his mid-calf. The pain is very unpredictable. It can happen almost at any time. It happens usually several times per day. The pain is sharp and often times goes away quite quickly but sometimes it will last for 20 minutes. It occasionally causes him to limp, and then as he walks, it improves. He states he initially had some pain in his hip shortly after his fall. It was felt to be related to a hernia. He actually underwent a hernia repair, but this did not take care of the pain that he was feeling in his groin and lateral thigh.

(Jt. Ex. 4, p. 8) In April 2011, he was sent for some physical therapy on the right hip. Dr. Christiansen was not certain what was causing his symptoms. (Jt. Ex. 4, p. 10)

Dr. Nepola performed shoulder surgery on June 16, 2011. (Jt. Ex. 6, p. 23) Thereafter, Mr. Arnold continued follow up treatment with Dr. Nepola. The defendants authorized the surgery and indemnity benefits for his time off work. On December 12, 2011, Dr. Nepola opined that Mr. Arnold suffered a 13 percent whole person impairment. He released claimant to return to work with no repetitive reaching above shoulder height or away from his body. "Future treatment for this injury could include periodic corticosteroid injections, physical therapy and non-steroidal anti-inflammatory medications." (Jt. Ex. 6, p. 38) During this same period of time, Mr. Arnold continued to treat with Dr. Christiansen for his right hip. Dr. Christiansen continued to be uncertain of

an exact diagnosis or etiology. Dr. Christiansen did, however, begin considering hip replacement surgery after conservative treatment failed. (Jt. Ex. 4, p. 13) In October 2011, Dr. Christiansen recommended an MRI of the low back in an effort to determine whether there was disc involvement. (Jt. Ex. 4, pp. 14-16)

An MRI was performed at the University of Iowa on November 1, 2012. The MRI demonstrated a number of abnormalities. (Jt. Ex. 6, pp. 30-31)

In January 2012, Mr. Arnold was evaluated at Steindler Clinic by Brent Overton, M.D. He diagnosed right hip osteoarthritis "which I believe is the primary pain generator in this instance." (Jt. Ex. 4, p. 17) Dr. Overton also diagnosed degenerative disk disease, and spinal stenosis.

> PLAN: At this point I feel that his primary pain generator is his right hip. I think most of his pain can be explained by this right hip, and I think it is steadily getting worse. Certainly even if he had overlapping lumbar radicular-type pain, which is possible in this instance and could be present, I would definitely treat the right hip first and see what pain was left over at that time. If it was pain after the total hip, and it seemed to be in the lumbar radicular pattern, then that could be treated, but certainly I would wait on that until I had appropriately treated his right hip osteoarthritis and I am recommending that he go ahead and have a right total hip arthroplasty with Dr. Christiansen.

(Jt. Ex. 4, p. 18)

The surgery was performed on January 13, 2012. Mr. Arnold followed up appropriately with Dr. Christiansen. (Jt. Ex. 4, p. 19) He also received physical therapy during this timeframe. (Jt. Ex. 7) In July 2012, he was referred back to Dr. Overton for the back. Dr. Overton diagnosed painful right total hip arthroplasty and "Lumbar central canal stenosis, L3-4, L4-5 and to some degree L5-S1 with epidural lipomatosis." (Jt. Ex. 4, p. 20) Dr. Overton recommended a transforaminal epidural. (Jt. Ex. 4, p. 20) This was submitted to workers' compensation for approval. There is no record that it was approved at that time. In fact, the record of evidence becomes quite hazy as to exactly what occurred during this period of time. There is no denial letter in evidence. There is no evidence the defendants affirmatively denied the back claim during this period of time. Mr. Arnold sought chiropractic treatment from Bright Futures Chiropractic in Kalona, Iowa, in October 2012, which documented his complaints of pain at that time. (Jt. Ex. 8, p. 1)

Mr. Arnold returned to Dr. Overton in April 2013. Dr. Overton again diagnosed lumbar spinal stenosis with possible right L3 symptomology and recommended the same treatment. "Again, my recommendation is as I stated on my previous visitation with him, and I would recommend a right L3 and L4 transforaminal epidural and we will submit this to his Worker's [*sic*] Compensation insurance for approval." (Jt. Ex. 4, p. 21)

He eventually obtained the epidural in May 2013. In June 2013, Dr. Overton diagnosed "[e]xacerbation of his lumbar spinal stenosis, which is moderately severe at L3-4, severe at L4-5, moderately severe at L5-S1 with epidural lipomatosis." (Jt. Ex. 4, p. 22) "At this point he is failing conservative management. I think that this is likely to come to operative intervention, . . ." (Jt. Ex. 4, p. 22) Since Mr. Arnold had moved to Minnesota, Dr. Overton recommended he follow up with the Mayo Clinic or Twin Cities Orthopedics. A month later, claimant followed up with Dr. Christiansen who noted that Mr. Arnold would be following up regarding his spinal stenosis in Minnesota. "As far as work goes, he is not able to return to work at this time. We will await the opinions of the spine surgeon in Minnesota." (Jt. Ex. 4, p. 23)

The defendants had Mr. Arnold evaluated by John Kuhnlein, D.O. The evaluation actually occurred in January 2013. Dr. Kuhnlein prepared an expert opinion report dated October 1, 2013. The reason for the substantial delay is unclear in the record. Dr. Kuhnlein is a certified independent medical examiner. Dr. Kuhnlein meticulously outlined Mr. Arnold's medical history as documented through the medical file. He performed a thorough evaluation of Mr. Arnold and took a complete medical history. Dr. Kuhnlein reached the following conclusions regarding medical causation:

> Mr. Arnold had a significant right shoulder pathology before the April 16, 2010, injury date with a right shoulder hemiarthroplasty performed on April 15, 2009, by Dr. Lash, with ongoing complaints eight months later (approximately six months before this injury) and after reviewing the records with him, he did recall the pre-existing anterior right shoulder pain with certain over-the-shoulder activities.
>
> In this context, if the stated mechanism of injury is accurate (it was a witnessed accident by the homeowner) he fell directly onto the right shoulder. The records show ongoing complaints of increased right shoulder pain after April 16, 2010, leading to the treatment performed by Dr. Nepola, including the surgery. Differential diagnostic injections led to the acromioclavicular joint being identified as the pain generator, with good response to injections. Even with the pre-existing condition, the pain was anterior, but increased after the April 16, 2010, injury. This injury represents not only a right shoulder contusion, but does represent a material aggravation of the pre-existing acromioclavicular joint osteoarthritis based on the differential pain generator injections performed and the records both before and after the injury.
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> Mr. Arnold sustained a right hip contusion directly and causally related to the April 16, 2010, injury. Bruising was noted by Dr. Prihoda on April 28, 2010. Given the fact that Mr. Arnold was on anticoagulants, this bruising could have been related back to the April 16, 2010, injury, and may have been more pronounced because of the anticoagulation than it might have been in other people. Given the force of the impact, the labral

> tear was also related to the April 16, 2010, work injury. The records suggest that this was a degenerative labral tear, but there is no significant notice of right hip pain or treatment in the currently available records before April 16, 2010. Dr. Prihoda's April 28, 2010, note documents right hip pain after the fall. He complained of right hip catching and a sense of giving way. He also had an inguinal hernia with repair, but says that the inguinal hernia repair did not have any significant effect on his hip pain, which led to further evaluation by Dr. Christiansen. There was an initial confusing picture as to the actual pain generator, but after Dr. Overton's evaluation, it appeared that the right hip was the primary pain generator. Even if the labral tear was present before April 16, 2010, there is no objective evidence in the currently available file to suggest that it was symptomatic before April 16, 2010, and there is afterward. As such, even it was not directly and causally related to the injury, the labral tear would have been aggravated or "lit up" by the April 16, 2010, injury, leading to the procedure performed by Dr. Christiansen on January 13, 2012.

(Jt. Ex. 10, pp. 18-19)

Dr. Kuhnlein went on to opine he could not state within a reasonable degree of medical certainty that the hernia, the neck complaints or the back were causally connected to the work injury. While the hernia causation issue is insignificant at this point, the back condition is one of the primary fighting issues in the case. Dr. Kuhnlein stated the following:

> I am also not able to state, within a reasonable degree of medical certainty, that his current back pain is related to the April 16, 2010, injury at this time. There was no back pain documented initially in the record. He says that he is not sure if he had back pain or leg symptoms initially, because his primary focus was reasonably on his right shoulder, and he says that he had backaches before and he is not certain if they were different. He says that he noticed increased leg symptoms while he was doing volunteer work. Dr. Overton's January 4, 2012, note initially thought that the hip was the primary pain generator, and Mr. Arnold says that his pain did improve after the hip arthroplasty, although he says that it was not completely eliminated. The MRI did show degenerative changes and neural foraminal stenosis, and with the persistent pain after the hip arthroplasty, Dr. Christiansen was not sure if his ongoing symptoms were related to the hip, his back, or another source.
>
> On July 18, 2012, Dr. Overton suggested an L3-L4 epidural as both a diagnostic and therapeutic maneuver, but this has not been done at this point. At times back pain can develop in relation to altered gain, such as noted after his hip arthroplasty, but at this time the diagnosis has not been more clearly defined. As such, I am uncertain if his lumbar spine is part of

> his pain picture here, and so cannot opine at this time, within a reasonable degree of medical certainty, that his back pain is related to the April 16, 2010, work injury. If more information becomes available I'd be happy to review it.

(Jt. Ex. 10, p. 19)

Dr. Kuhnlein, however, went on to assign a 5 percent whole person impairment assessed for the left shoulder condition and a 20 percent whole person impairment for the right hip arthroplasty. Combining the impairments resulted in a total 24 percent whole person impairment as assessed at that time. (Jt. Ex. 10, p. 20) He assigned rather significant restrictions as well.

> With respect to permanent restrictions, with respect to the shoulder and hip, Mr. Arnold could lift 10 pounds occasionally from floor to waist, 20 pounds occasionally from waist to shoulder, and 10 pounds occasionally over the shoulder.
>
> With respect to nonmaterial handling functions, he could sit, stand or walk on an as needed basis. I would suggest that he not squat in the workplace. He could bend occasionally. I would suggest that he not work off ground level. The combination of the shoulder condition and the hip condition would potentially affect his safety on ladders and his ability to maintain a 3-point safety stance. He can go up and down stairs, but would use a tandem gait. He could work occasionally at or above shoulder height. I would suggest that he not work away from the axial plane of his body, or over shoulder height on more than an occasional basis. I would suggest that he not operate foot-operated machinery.
>
> There are no vision, hearing or communication restrictions. If traveling, he should change positions on an as needed basis, and should be able to stretch every couple of hours when driving. I would suggest that he not use vibratory or power tools. There are no environmental restrictions. He should not work at height where he would require a fall protection harness.

(Jt. Ex. 10, p. 21)

Through the summer of 2013, Mr. Arnold began treating with a chiropractor, William Beschnett, D.C., in Waseca, Minnesota. At claimant's request, Dr. Beschnett referred Mr. Arnold to Sunny Kim, M.D., in July 2013. (Jt. Ex. 9, p. 1) Mr. Arnold established treatment with Dr. Kim in October 2013. Dr. Kim recorded the following history from Mr. Arnold:

> He has had low back pain prior to the fall but since the fall he has developed persistent low back pain with some radiation into the right posterolateral thigh usually up to the knee. There is some weakness in the right leg. There is some numbness and tingling in the groin and anterior thigh.

(Jt. Ex. 11, p. 1) Dr. Kim quickly ordered a CT myelogram of Mr. Arnold's entire spine. After review, Dr. Kim diagnosed severe spinal stenosis with foraminal disc herniation right L4-L5. (Jt. Ex. 11, p. 7) He recommended L1 to L5 decompression and posterolateral fusion. "Most likely the disc herniation arose as a result of the work related injury." (Jt. Ex. 11, p. 8) Surgery was performed January 10, 2014. (Jt. Ex. 12) Upon follow up, Dr. Kim noted Mr. Arnold's "severe preop right groin pain is gone." Some right lateral thigh pain continued. (Jt. Ex. 11, p. 9)

After surgery, Dr. Kim provided a medical opinion to claimant's attorney that the work injury caused Mr. Arnold to develop radicular pain. (Jt. Ex. 11, p. 12) Dr. Kim specifically opined that the fall caused Mr. Arnold to develop the herniated disc.

> It is my professional opinion that this patient's fall in 2010 resulted in the large foraminal disc herniation which was missed on the initial MRI scan but clearly delineated on the CT scan as the latter shows the foraminal disc herniations much better than MRI scans. The herniation was discovered during the surgery and after the resection and fusion patient achieved complete relief of his sciatica.

(Jt. Ex. 11, p. 12)

Dr. Kim's causation opinion is undoubtedly based upon two important factual assumptions. First, it is based upon the assumption that Mr. Arnold's radicular pain developed shortly after the injury. Second, it is based upon the assumption that the disc herniation was not picked up on the MRI scan. In other words, the herniation pre-existed the scan but was not identified because a CT scan is better at demonstrating foraminal disc herniations. In 2014, claimant's counsel sent two follow up letters to Dr. Kim ensuring that he had a full picture of claimant's preexisting back condition. (Jt. Ex. 11, pp. 14-16) Dr. Kim affirmed his opinion. (Jt. Ex. 11, p. 17)

For his part, Mr. Arnold continued to follow up with Dr. Kim through 2014 and into 2015. In November 2014, he also established further treatment for his right shoulder at the Mayo Clinic in Rochester, Minnesota. (Jt. Ex. 1, p. 2) J.W. Sperling, M.D., diagnosed hemiarthroplasty with significant cartilage and glenoid bone loss. (Jt. Ex. 1, p. 4) A revision surgery was performed in December 2014, and the diagnosis was changed to "[f]ailed right shoulder hemiarthroplasty." (Jt. Ex. 1, p. 6)

Mr. Arnold continued to experience symptoms and significant additional diagnostic testing was performed. A second lumbar spine surgery was performed on

September 25, 2015. This surgery was described as tranforaminal interbody fusion, posterolateral fusion, L2-L3, L3-L4. (Jt. Ex. 14)

For the right shoulder, Dr. Sperling placed Mr. Arnold at maximum medical improvement on December 23, 2015. (Jt. Ex. 1, p. 21) He assigned an impairment rating of 18 percent of the whole body and recommended some permanent restrictions. (Jt. Ex. 1, pp. 23, 25) Dr. Sperling never provided any medical causation opinion as to whether this surgery was causally connected to the April 16, 2010, work injury.

In April 2016, Dr. Kim authored a report clarifying that Mr. Arnold was still not at maximum medical improvement (MMI) following his September 2015, surgery. In May 2016, following a conference with defense counsel, Dr. Kim signed off on an opinion letter (authored by defense counsel) wherein he modified his opinions to some degree. He signed off that he agreed with the following statements.

> You note that the November 1, 2011 MRI occurred approximately 1-1/2 years after the work injury. If the October 1, 2011 MRI shows a herniated disc at L4-5, and if Mr. Arnold's radicular symptoms began at or about the time of his work injury, it remains your opinion that the herniated disc surgically treated on January 10, 2014 was a direct result of the work injury. If Mr. Arnold did not have a herniated disc based on review of the November 2011 MRI, or if the history provided by Mr. Arnold to you was not accurate and he was not having radicular pain temporal to the slip and fall injury, then low back symptoms and his need for surgery are likely not a result of the work incident.

(Jt. Ex. 11, p. 30) Dr. Kim further opined that the second fusion surgery he performed in September 2015, was in no way related to the work injury. (Jt. Ex. 11, p. 30)

In May 2016, defense counsel sought a medical opinion from the physician who initially read the November 2011 MRI at the University of Iowa, Aristides Capizzano, M.D. Dr. Capizzano re-reviewed the MRI film of Mr. Arnold's lumbar spine. He disputed that it showed any herniated disc. He further indicated that the MRI is "more accurate and more sensitive than a CT myelogram." (Jt. Ex. 6, p. 43)

Dr. Kim authored a final report directed to claimant's counsel following his November 16, 2016, evaluation with Mr. Arnold. Dr. Kim noted that a CT scan had been performed recently demonstrating a solid fusion from L2 to L4 above his solid fusion at L4-L5. (Jt. Ex. 11, p. 34) He clarified that the main reason for the first surgery was the disc herniation, which he still felt was work-related. He went on to note that the second surgery was necessitated by the first surgery. "The fusion at L4 L5 put further stress on the stenosis at the levels above eventuating in the 2nd surgery." (Jt. Ex. 11, p. 34) He assigned a 22 percent whole body impairment rating and recommended a 10 pound lifting restriction. He did also clarify that his opinion is that the "stenosis from L1 to L5 was not permanently aggravated by the work related injury of 2010 as I stated

to [*sic*] my handwritten response to Mr. Lee Hook." (Jt. Ex. 11, p. 34)

In February 2017, at the request of defense counsel, Dr. Kuhnlein updated his opinions. He reviewed some additional medical records, including the report of Dr. Capizzano, the Tweeton chiropractic records and a Mayo Clinic record from 1969. (Jt. Ex. 10, p. 35) Dr. Kuhnlein did not change any of his prior opinions. (Jt. Ex. 10, pp. 26-28) Claimant's counsel points out that the defendants did not provide additional records from Dr. Kim wherein he expressed that the November 2011 MRI missed the herniated disc.

In April 2017, an expert vocational assessment was prepared by James Carroll, M.Ed., C.R.C., C.C.M., A.B.D.A. He reviewed Dr. Kuhnlein's reports and summarized those reports in his opinion. Based upon Dr. Kuhnlein's restrictions, he concluded that Mr. Arnold has an 8 to 12 percent loss of access to employment with no loss of earning capacity. (Jt. Ex. 16, pp. 10-11) In his eleven page report, Mr. Carroll devotes nine full pages to re-summarizing Dr. Kuhnlein's medical summary. (Jt. Ex. 16, pp. 1-9) His one and a half page analysis is superficial and extraordinarily limited. For example, he provided no explanation whatsoever of the effect of Mr. Arnold's nonmaterial handling restrictions on standing, sitting, walking and driving. Those restrictions are an enormous impediment to obtaining employment in the field of sales and management. He provides no explanation as to how he arrived at the occupations for which he contends Mr. Arnold is still capable of performing. For these reasons, I give no weight to the opinion of Mr. Carroll.

Having reviewed all of the evidence in the record as a whole, I conclude that Mr. Arnold suffered a serious fall while working on April 16, 2010. The injury is a substantial cause of permanent impairments in his right shoulder and right hip. It is possible that the injury also aggravated his low back, however, I find that the claimant has failed to meet his burden of proof in this regard. I find that the most convincing expert medical opinion in the record is that of Dr. Kuhnlein. To be clear, I find that Mr. Arnold is credible. I believe him that he believes his ongoing groin, back and leg difficulties began with the fall. The defendants have questioned his credibility, pointing out that there is little contemporaneous documentation in the medical records to show he was having back problems immediately after the injury. I give little weight to this for several reasons.

First, Mr. Arnold did report his back was injured immediately after the fall in the injury reports. His most concerning and immediate problem was his right shoulder, which had been surgically repaired in 2009. In particular, Dr. Prihoda paid little attention to any issues other than the shoulder, documenting very little regarding any of his other problems. Moreover, his groin, right leg and right hip pain were contemporaneously documented in the early medical records. There was some confusion about what the pain generator for these symptoms was exactly. For example, a hernia surgery was performed early on which, in hindsight, appears to have been unnecessary. It seems likely that his groin symptoms, which were thought related to the hernia, actually

stemmed from either his right hip or his low back. Therefore, I do not see this as a credibility issue whatsoever. The defendants are correct though, generally, that it is somewhat unclear when precisely Mr. Arnold developed true radicular symptoms. At a minimum, the record is hazy as to exactly when radicular symptoms began.

The more concerning issue, and the primary reason the claimant has failed to meet his burden of proof, is the November 2011 MRI, which showed degenerative changes, but no acute disc herniation. Dr. Capizzano stood by these results and insisted that the MRI is superior for identification of a herniated disc. Dr. Kim, the treating surgeon, opined that the 2011 MRI missed the disc herniation. He suggested that the CT scan is superior for identifying the specific type of disc herniation claimant suffered. I am not convinced. While this is certainly possible, having viewed the entire record as a whole, I cannot find this is probable. Based upon the record before the agency, it is more likely that the disc herniation developed sometime later.

As I have stated, Dr. Kuhnlein has provided the most comprehensive and believable medical causation opinions in this file. His causation opinions would have been even clearer if he had been provided a full explanation of Dr. Kim's theory regarding the MRI and CT scan. In any event, Dr. Kuhnlein opined that Mr. Arnold's right shoulder and right hip conditions were both causally connected to his work injury. He assigned a 24 percent whole person impairment associated with his diagnoses. He assigned significant medical restrictions which prevent Mr. Arnold from lifting more than 10 pounds in most instances. He also provided nonmaterial handling restrictions which restrict Mr. Arnold's walking, sitting, standing and driving. These restrictions are devastating for a 66-year-old salesman seeking employment in the competitive job market. The employer was unable to keep Mr. Arnold employed as a salesperson for Tyco, which would have been his best chance to avoid total disability. Mr. Arnold was accepted for Social Security Disability and had not sought employment since going on disability, although it is noted that he continued to receive treatment for his back throughout 2016. Ordinarily, it is difficult for an injured worker to secure permanent total disability benefits without undertaking a good faith work search. In this case, given the claimant's age and limitations, I find that it is so unlikely that a work search would yield positive results, it is unnecessary.

The claimant underwent a three and a half year healing period involving several surgeries, including a significant shoulder surgery, a total hip replacement and a (probably unnecessary) hernia repair. He has been out of the workforce for so long it would be extraordinarily difficult to re-enter it, even with his extensive experience in sales and management. While there may be a sales or management job in the competitive job market that Mr. Arnold could secure if he were to undertake a long an arduous job search, I find it is extremely unlikely that he would ever find this job. Considering all of the factors of industrial disability, I find that the claimant is permanently and totally disabled.

CONCLUSIONS OF LAW

The primary question presented concerns what conditions are causally connected to claimant's stipulated April 2010, work injury. The parties stipulated that claimant fell while working on April 16, 2010. They disagree, however, on the nature of the conditions which are connected to this injury. Claimant alleges a host of medical problems stemming from this work injury, including a substantial aggravation of his prior right shoulder condition, a condition in his right hip and a substantial aggravation of his low back. The defendants concede that claimant injured his right shoulder to some degree, however, deny any causal connection between his injury and his low back condition.

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).

For the reasons set forth in the findings of fact, I conclude that the permanent conditions associated with claimant's April 16, 2010 fall are his right shoulder and right hip. The claimant has failed to meet his burden of proof as it relates to his low back and associated radiculopathy. I adopt Dr. Kuhnlein's expert opinions.

Since claimant has an impairment to the body as a whole, an industrial disability has been sustained. Industrial disability was defined in Diederich v. Tri-City R. Co., 219 Iowa 587, 258 N.W. 899 (1935) as follows: "It is therefore plain that the legislature intended the term 'disability' to mean 'industrial disability' or loss of earning capacity and

not a mere 'functional disability' to be computed in the terms of percentages of the total physical and mental ability of a normal man."

Functional impairment is an element to be considered in determining industrial disability which is the reduction of earning capacity, but consideration must also be given to the injured employee's age, education, qualifications, experience, motivation, loss of earnings, severity and situs of the injury, work restrictions, inability to engage in employment for which the employee is fitted and the employer's offer of work or failure to so offer. McSpadden v. Big Ben Coal Co., 288 N.W.2d 181 (Iowa 1980); Olson v. Goodyear Service Stores, 255 Iowa 1112, 125 N.W.2d 251 (1963); Barton v. Nevada Poultry Co., 253 Iowa 285, 110 N.W.2d 660 (1961).

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. Section 85.34.

Total disability does not mean a state of absolute helplessness. Permanent total disability occurs where the injury wholly disables the employee from performing work that the employee's experience, training, education, intelligence and physical capacities would otherwise permit the employee to perform. See McSpadden v. Big Ben Coal Co., 288 N.W.2d 181 (Iowa 1980); Diederich v. Tri-City R. Co., 219 Iowa 587, 258 N.W. 899 (1935).

A finding that claimant could perform some work despite claimant's physical and educational limitations does not foreclose a finding of permanent total disability, however. See Chamberlin v. Ralston Purina, File No. 661698 (App. October 29, 1987); Eastman v. Westway Trading Corp., II Iowa Industrial Commissioner Report 134 (App. 1982).

In Guyton v. Irving Jensen Co., 373 N.W.2d 101 (Iowa 1985), the Iowa court formally adopted the "odd-lot doctrine." Under that doctrine a worker becomes an odd-lot employee when an injury makes the worker incapable of obtaining employment in any well-known branch of the labor market. An odd-lot worker is thus totally disabled if the only services the worker can perform are "so limited in quality, dependability, or quantity that a reasonably stable market for them does not exist." Id., at 105.

Under the odd-lot doctrine, the burden of persuasion on the issue of industrial disability always remains with the worker. Nevertheless, when a worker makes a prima facie case of total disability by producing substantial evidence that the worker is not employable in the competitive labor market, the burden to produce evidence showing availability of suitable employment shifts to the employer. If the employer fails to produce such evidence and the trier of facts finds the worker does fall in the odd-lot category, the worker is entitled to a finding of total disability. Guyton, 373 N.W.2d at 106. Factors to be considered in determining whether a worker is an odd-lot employee include the worker's reasonable but unsuccessful effort to find steady employment,

vocational or other expert evidence demonstrating suitable work is not available for the worker, the extent of the worker's physical impairment, intelligence, education, age, training, and potential for retraining. No factor is necessarily dispositive on the issue. Second Injury Fund of Iowa v. Nelson, 544 N.W.2d 258 (Iowa 1995). Even under the odd-lot doctrine, the trier of fact is free to determine the weight and credibility of evidence in determining whether the worker's burden of persuasion has been carried, and only in an exceptional case would evidence be sufficiently strong as to compel a finding of total disability as a matter of law. Guyton, 373 N.W.2d at 106.

The refusal of defendant-employer to return claimant to work in any capacity is, by itself, significant evidence of a lack of employability. Pierson v. O'Bryan Brothers, File No. 951206 (App. January 20, 1995). Meeks v. Firestone Tire & Rubber Co., File No. 876894, (App. January 22, 1993); See also, 10-84 Larson's Workers' Compensation Law, section 84.01; Sunbeam Corp. v. Bates, 271 Ark. 609 S.W.2d 102 (1980); Army & Air Force Exchange Service v. Neuman, 278 F. Supp. 865 (W.D. La. 1967); Leonardo v. Uncas Manufacturing Co., 77 R.I. 245, 75 A.2d 188 (1950). An employer who chooses to preclude an injured worker's re-entry into its workforce likely demonstrates by its own action that the worker has incurred a substantial loss of earning capacity. As has previously been explained in numerous decisions of this agency, if the employer in whose employ the disability occurred is unwilling to accommodate the disability, there is no reason to expect some other employer to have more incentive to do so. Estes v. Exide Technologies, File No. 5013809 (App. December 12, 2006).

Although claimant is close to a normal retirement age, proximity to retirement cannot be considered in assessing the extent of industrial disability. Second Injury Fund v. Nelson, 544 N.W. 2d 258 (Iowa 1995). However, this agency does consider voluntary retirement or withdrawal from the work force unrelated to the injury. Copeland v. Boones Book and Bible Store, File No. 1059319, Appeal Decision (November 6, 1997). Loss of earning capacity due to voluntary choice or lack of motivation is not compensable. Id.

For the reasons set forth in the findings of fact, I conclude that the claimant has made a prima facie showing that claimant is not employable in the competitive labor market. The defendants have failed to produce credible evidence showing the availability of suitable employment. The claimant is entitled to permanent and total disability benefits.

The final issue is medical expenses. The claimant has set forth a number of medical expenses in Claimant's Exhibits 3 and 4, which he alleges are causally connected to his April 16, 2014, work injury.

The employer shall furnish reasonable surgical, medical, dental, osteopathic, chiropractic, podiatric, physical rehabilitation, nursing, ambulance and hospital services and supplies for all conditions compensable under the workers' compensation law. The employer shall also allow reasonable and necessary transportation expenses incurred

for those services. The employer has the right to choose the provider of care, except where the employer has denied liability for the injury. Iowa Code section 85.27 (2013).

Claimant is entitled to an order of reimbursement only if he has paid treatment costs; otherwise, to an order directing the responsible defendants to make payments directly to the provider. See, Krohn v. State, 420 N.W.2d 463 (Iowa 1988). Defendants should also pay any lawful late payment fees imposed by providers. Laughlin v. IBP, Inc., File No. 1020226 (App., February 27, 1995).

Evidence in administrative proceedings is governed by section 17A.14. The agency's experience, technical competence, and specialized knowledge may be utilized in the evaluation of evidence. The rules of evidence followed in the courts are not controlling. Findings are to be based upon the kind of evidence on which reasonably prudent persons customarily rely in the conduct of serious affairs. Health care is a serious affair.

Prudent persons customarily rely upon their physician's recommendation for medical care without expressly asking the physician if that care is reasonable. Proof of reasonableness and necessity of the treatment can be based on the injured person's testimony. Sister M. Benedict v. St. Mary's Corp., 255 Iowa 847, 124 N.W.2d 548 (1963).

It is said that "actions speak louder than words." When a licensed physician prescribes and actually provides a course of treatment, doing so manifests the physician's opinion that the treatment being provided is reasonable. A physician practices medicine under standards of professional competence and ethics. Knowingly providing unreasonable care would likely violate those standards. Actually providing care is a nonverbal manifestation that the physician considers the care actually provided to be reasonable. A verbal expression of that professional opinion is not legally mandated in a workers' compensation proceeding to support a finding that the care provided was reasonable. The success, or lack thereof, of the care provided is evidence that can be considered when deciding the issue of reasonableness of the care. A treating physician's conduct in actually providing care is a manifestation of the physician's opinion that the care provided is reasonable and creates an inference that can support a finding of reasonableness. Jones v. United Gypsum, File No. 1254118 (App. May 2002); Kleinman v. BMS Contract Services, Ltd., File No. 1019099 (App. September 1995); McClellon v. Iowa Southern Utilities, File No. 894090 (App. January 1992). This inference also applies to the reasonableness of the fees actually charged for that treatment.

Claimant's Exhibits 3 and 4 set forth expenses for his low back injury, as well as treatment for a right shoulder revision surgery. The defendants contend claimant has failed to meet his burden of proof that these conditions are causally connected to the April 16, 2010, work injury. I agree with defendants. The claimant is not entitled to any

of the medical expenses set forth in Exhibits 3 and 4. Claimant is entitled to the medical mileage for the treatment which has been found to be causally connected to the work injury set forth in Claimant's Exhibit 8.

ORDER

THEREFORE IT IS ORDERED

The defendants shall pay claimant permanent total disability benefits at the stipulated rate of five hundred thirty-seven and 34/100 dollars ($537.34) commencing April 11, 2010.

Defendants shall receive credit for all workers' compensation benefits paid. Defendants are not required to pay benefits during any period claimant was not working.

Defendants shall pay medical mileage expenses as set forth in Claimant's Exhibit 8 excluding medical treatment which has been found to be not causally-connected to the work injury. The parties are ordered to jointly review Claimant's Exhibit 8 to determine which expenses shall be excluded. If the parties cannot reach an agreement based upon this decision, the claimant may file a new petition to resolve the exact amount of medical mileage owed.

Defendants shall pay any past due amounts in a lump sum with interest.

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

Costs are taxed to defendants.

Signed and filed this 27th day of April, 2018.

JOSEPH L. WALSH
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

Copies to:

Thomas J. Currie
Attorney at Law
1853 – 51st St. NE, Ste. 1
Cedar Rapids, IA 52402-0998
tcurrie@currieliabo.com

Lee P. Hook
Attorney at Law
6800 Lake Dr., Ste. 125
West Des Moines, IA 50266-2504
lee.hook@peddicord-law.com

JLW/srs

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.