BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

JOSEPH MOYER, Claimant, vs. INTERSTATE POWER & LIGHT COMPANY, Employer, Self-Insured, and SECOND INJURY FUND OF IOWA, Defendants.	File No. 5047944 ARBITRATION DECISION Head Note Nos.: 1803; 1803.1; 3200

FILED
MAR 16 2017
WORKERS' COMPENSATION

STATEMENT OF THE CASE

Claimant, Joseph Moyer, filed a petition in arbitration seeking workers' compensation benefits from Interstate Power & Light Company, self-insured employer, and the Second Injury Fund of Iowa (Fund), both as defendants, as a result of a stipulated injury sustained on March 20, 2012. This matter came on for hearing before Deputy Workers' Compensation Commissioner Erica J. Fitch, on August 8, 2016, in Des Moines, Iowa. The record in this case consists of claimant's exhibits 1 through 22, defendant-employers' exhibits A through B, the Fund's exhibits AA through BB, and the testimony of the claimant. The parties submitted post-hearing briefs, the matter being fully submitted on October 7, 2016.

ISSUES

The parties submitted the following issues for determination:

1. The extent of claimant's permanent disability resulting from the stipulated work injury, as to defendant-employer, including whether the disability is a scheduled member disability to the right foot or leg, or an industrial disability;
2. Whether defendant-employer is responsible for claimed medical expenses and medical mileage;
3. Whether claimant is entitled to an award of alternate medical care pursuant to Iowa Code section 85.27;
4. Whether claimant is entitled to Second Injury Fund benefits and, if so, the amount of benefits; and
5. Specific taxation of costs.

The parties filed a hearing report at the commencement of the arbitration hearing. On the hearing report, the parties entered into various stipulations. All of those stipulations were accepted and are hereby incorporated into this arbitration decision and no factual or legal issues relative to the parties' stipulations will be raised or discussed in this decision. The parties are now bound by their stipulations.

FINDINGS OF FACT

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

Claimant's testimony was clear and consistent as compared to the evidentiary record. His demeanor at the time of evidentiary hearing was excellent and gave the undersigned no reason to doubt claimant's veracity. Claimant is found credible.

Claimant was 48 years of age on the date of evidentiary hearing. (Claimant's testimony) He graduated high school in 1986; he lacks postsecondary education. (Claimant's testimony; Ex. AA, p. 3) Claimant worked as a laborer consistently following graduation from high school; such positions included loading and unloading moving trucks, mixing and applying mortar and plaster, or loading and unloading barges. He began employment with defendant-employer in 1998 and remained so employed at the time of evidentiary hearing. (Claimant's testimony; Ex. AA, p. 4)

On July 2006, claimant presented to Steven Rock, M.D. with complaints of left knee pain of approximately three-weeks' duration. Dr. Rock prescribed medication and physical therapy; he also ordered an MRI. (Ex. 11, pp. 1-2) Claimant underwent the MRI, which yielded normal results. (Ex. 11, p. 6) Claimant participated in physical therapy from July 19, 2006 through August 10, 2006. (Ex. 12, pp. 1-16) Dr. Rock ultimately referred claimant to Scott Schemmel, M.D., for evaluation. (Ex. 11, pp. 7-8)

Dr. Schemmel examined claimant and outlined treatment options, including: observation, injections, anti-inflammatories, physical therapy, and arthroscopy. Due to a history of similar symptoms and treatment of his opposite knee, claimant elected to proceed with arthroscopy. (Ex. 11, p. 12) Dr. Schemmel performed arthroscopic chondroplasty of claimant's left patella on August 29, 2006. He issued a postoperative diagnosis of left knee grade three articular surface lesion of the undersurface of the patella. (Ex. 11, pp. 15-16) Following surgery, claimant participated in physical therapy from September 1, 2006 through October 3, 2006. (Ex. 12, pp. 17-33) On October 31, 2006, Dr. Schemmel noted claimant expressed no complaints and had returned to work without restrictions. He described claimant's recovery as an excellent one and released claimant to return as needed. (Ex. 11, p. 25)

Following release by Dr. Schemmel, claimant did not experience significant problems with his left knee. He testified to continued soreness and stiffness with kneeling, squatting, and stair use. Claimant testified he attempts to use a knee pad with kneeling and utilizes an elevator, as opposed to the stairs, whenever possible.

Claimant testified he also ceased playing sports due to increased pain. (Claimant's testimony)

Claimant held a number of positions at defendant-employer over his years of employment. He began as an apprentice conveyor and relief tractor/crane operator at the Dubuque power plant. Claimant held this position for approximately one year. The job description for this position required heavy lifting and climbing of ladders and rails. (Ex. 21, pp. 1, 3; Ex. BB, p. 8) Claimant spent the next three years as a relief assistant plant operator. The job description for this position required claimant to perform multiple positions on an as-needed basis: assistant plant operator, plant maintenance, and conveyor operator. The job description also noted a physical demand of lifting a minimum of 50 pounds. (Ex. 21, pp. 1, 6) In 2002, claimant began work as a truck driver/groundman/operator. The job description noted requirements of climbing and heavy lifting. (Ex. 21, pp. 1, 8; Ex. BB, pp. 9-10) In 2004, claimant moved to a mechanical maintenance position which required lifting a minimum of 50 pounds. He proceeded through the apprenticeship program and ultimately obtained journeyman status in 2006; he earned $27.75 per hour as a journeyman. (Ex. 21, pp. 1, 10; Ex. BB, pp. 13-17)

In March 2011, claimant began the apprenticeship program for the position of line mechanic. The job description for a line mechanic described very heavy work, climbing, balancing, stooping, crawling, standing, and work in weather extremes. Claimant was paid by a step scale in the apprenticeship program. (Ex. 21, pp. 1, 12; Ex. BB, p. 18)

On March 20, 2012, claimant suffered a stipulated work-related injury. Claimant testified he was working on a three-man crew, when a coworker lowered the outriggers from a boom truck. One of these outriggers, designed to support the truck, came down on claimant's right foot. Claimant reported the incident and a coworker transported claimant to the emergency room. (Claimant's testimony)

In the Mercy Medical Center emergency room, claimant was evaluated by Anna Lorence, M.D. Dr. Lorence opined claimant's x-rays showed crush fractures of the 2nd, 3rd, 4th and 5th distal phalanges, but the great toe and bones of the foot "were otherwise spared." (Ex. 2, p. 30) Claimant received an injection of Dilaudid and his wounds were cleaned and dressed. An orthopedic shoe was fitted and claimant was advised to only stand for bathroom breaks, otherwise leaving his foot elevated above heart-level. Dr. Lorence assessed open crush injuries and fractures to toes 2 through 5 of the right foot. (Ex. 2, pp. 22, 30) Dr. Lorence removed claimant from work, prescribed Percocet, and issued an orthopedic referral. (Ex. 2, pp. 31, 35)

Per Dr. Lorence's orders, on March 22, 2012, claimant presented to Michael Chapman, M.D., for evaluation. Following examination, Dr. Chapman issued prescriptions for Percocet and Keflex. He also removed claimant from work pending recheck and provided claimant crutches to use with weight-bearing on his heel. (Ex. 3, pp. 1-4) Dr. Chapman noted claimant suffered from multiple open wounds due to skin splitting and referred claimant to physical therapy for pulse lavage treatment of his

wounds. Claimant completed four sessions of lavage treatment between March 23 and March 28, 2012. (Ex. 2, pp. 44-46; Ex. 3, p. 1)

Claimant followed up with Dr. Chapman in March and April 2012. (Ex. 3, pp. 5-9) At an appointment on April 12, 2012, Dr. Chapman noted the tissue of claimant's foot was healing, but he continued to experience swelling. As a result, Dr. Chapman continued claimant's off-work restriction and directed claimant to elevate his right foot the majority of the day. (Ex. 3, pp. 7-9) Following an appointment on April 26, 2012, Dr. Chapman released claimant to return to work regular duty, without restrictions, on May 7, 2012. (Ex. 3, pp. 10-11)

Claimant testified he returned to work at this time. He further testified defendant-employer allowed him to perform lighter-natured work, such as cleaning the warehouse and he was permitted to take frequent breaks. Despite these accommodations, claimant testified he continued to experience problems. (Claimant's testimony)

Claimant returned to Dr. Chapman on May 16, 2012, at which time Dr. Chapman noted claimant was doing poorly, with significant pain and swelling while standing. Claimant reported he was unable to tolerate eight-hour work days. Accordingly, Dr. Chapman imposed work restrictions of a four-hour day for two weeks, then an increase to six-hour days. (Ex. 3, pp. 13-14)

On June 13, 2012, claimant presented to Dr. Chapman and reported he suffered with significant pain and swelling at the end of a six-hour work day. Dr. Chapman imposed restrictions limiting claimant to six-hour work days, with the ability to change positions frequently. Dr. Chapman also issued a referral for podiatric evaluation, with claimant to return to clinic in one month. (Ex. 3, pp. 15, 17)

Pursuant to Dr. Chapman's recommendation, claimant presented for evaluation by Terry Boyle, DPM, on June 21, 2012. Following examination, Dr. Boyle provided claimant with a prefabricated orthotic and prescribed a rocker-bottom sole to apply to claimant's right shoe. (Ex. 3, p. 22) Claimant returned to Dr. Boyle on June 26, 2012 for adjustment of his orthotic. (Ex. 3, p. 23)

Claimant was also evaluated on July 7, 2016 by Jason Keppler, DPM, specifically with respect to skin changes between the digits of claimant's right foot. Dr. Keppler advised claimant on cleaning and padding of the area, but recommended no specific treatment or restrictions. (Ex. 3, p. 24)

On July 11, 2012, claimant returned to Dr. Chapman, who noted healed wounds, but continued pain and swelling. Claimant denied improvement with orthotics and noted he recently received a modified work boot, which he expressed willingness to try. Due to lack of improvement, Dr. Chapman continued claimant's work restrictions and recommended evaluation by a foot and ankle specialist. (Ex. 3, pp. 18-19)

Pursuant to Dr. Chapman's recommendation, on August 16, 2012, claimant presented to Phinit Phisitkul, M.D. (Ex. 4, p. 2) Claimant underwent x-rays, which Dr. Phisitkul opined revealed well-healed distal phalanx fractures in the 2nd through 4th digits, a well-healed 3rd middle phalanx fracture, and no other noted abnormalities. (Ex. 4, pp. 2, 4) Dr. Phisitkul noted examination findings consistent with well-healed fractures, but a finding of great stiffness at the metatarsophalangeal and phalangeal joints of digits 2 through 4, resulting in metatarsal head pain from tenodesis. He related these symptoms as likely due to the position of the gastrocnemius tendon over the preceding six-week period. (Ex. 4, p. 5)

Dr. Phisitkul ordered a specialized physical therapy program. He prescribed a night splint for ankle position, as well as orthotic insoles and a custom insert. Additionally, Dr. Phisitkul ordered an ultrasound study of claimant's right lower extremity veins in order to rule out deep vein thrombosis. (Ex. 4, p. 5)

Claimant returned to Dr. Chapman a final time on September 13, 2012. At that time, Dr. Chapman noted claimant was beginning to see improvement with Dr. Phisitkul's treatment. He noted defendants had designated Dr. Phisitkul to address claimant's work-related complaints and accordingly, scheduled no further appointments. (Ex. 3, pp. 20-21)

On September 27, 2012, claimant returned to Dr. Phisitkul in follow up. Claimant reported his custom shoes had not yet arrived, so he had been unable to utilize that treatment option. (Ex. 4, p. 8) Dr. Phisitkul described slow improvement in claimant's conditions and recommended continued physical therapy and night splinting. He left claimant's six-hour work day restriction in place. (Ex. 4, p. 10)

On November 8, 2012, claimant returned to Dr. Phisitkul. Dr. Phisitkul noted claimant reported improvement with physical therapy and a near return to baseline, with improved pain but continued numbness. Dr. Phisitkul opined claimant was doing well and placed claimant at maximum medical improvement (MMI). He ordered one additional month of physical therapy and released claimant to return as needed. Dr. Phisitkul recommended weight bearing as tolerated and imposed no permanent restrictions. (Ex. 4, pp. 13-14)

Claimant participated in physical therapy sessions from August 21, 2012 through December 27, 2012. (Ex. 5, pp. 3-25)

Subsequently, Dr. Phisitkul authored a letter dated January 31, 2013, whereby he confirmed claimant achieved MMI on November 8, 2012 and required no permanent restrictions. Dr. Phisitkul also opined claimant sustained permanent impairment of 11 percent right lower extremity or 5 percent whole person. He based his rating upon mild loss of metatarsophalangeal extension of the 2nd, 3rd and 4th toes, as well as sensory deficit of the superficial peroneal nerve. (Ex. 4, p. 19)

Due to changes in his gait, claimant testified he experienced soreness of his right low back, hip and knee. Although claimant testified he reported these symptoms to his physicians, no care was provided. (Claimant's testimony) Claimant sought chiropractic care on three occasions in March 2013. Marie Stangl, D.C., of Kobush Chiropractic noted claimant complained of low back, hip and right foot complaints. (Ex. 15, pp. 1-2)

Claimant continued to work for defendant-employer as a line mechanic in the apprenticeship program. In January 2013, claimant progressed to step 4. By June 2013, claimant had passed to step 5 of the program, earning $30.66 per hour. (Ex. BB, pp. 22-23)

On May 30, 2013, claimant returned to Dr. Phisitkul with complaints of persistent and worsening right foot pain. Claimant reported his foot pain caused him to limp, resulting in pain in other parts of his foot, right hip and back, due to altered gait. He reported difficulty tolerating pain on an eight-hour work day and noted he had recently been asked to work ten hours per day. (Ex. 4, p. 20) Dr. Phisitkul ordered x-rays and performed a physical examination. (Ex. 4, pp. 22-23, 26) Following examination, Dr. Phisitkul assessed interdigital neuritis at the 2nd and 3rd web spaces, related to the crushing injury, and contracture of the gastrocnemius tendon. He ordered a course of physical therapy pertaining to the calf muscles, prescribed a night splint and insole, and limited claimant to an eight-hour work day. (Ex. 4, p. 23)

Following this appointment, Dr. Phisitkul authored a letter to defendant-employer dated June 19, 2013. He restated diagnoses of interdigital neuritis of the 2nd and 3rd web spaces and contracture of the gastrocnemius tendon. Dr. Phisitkul causally related the diagnoses to the March 20, 2012 injury, opining claimant's nerve symptoms related to the crushing injury and the gastrocnemius tightness was due to abnormal gait, the use of the foot and ankle, and to the crushing injury itself. He restated treatment recommendations of physical therapy for gastrocnemius stretching, as well as an insert and use of a night splint for gastrocnemius tightness. Dr. Phisitkul also confirmed a restriction limiting claimant to an eight-hour work day. (Ex. 4, pp. 28-29) Claimant participated in physical therapy from June 28, 2013 through July 17, 2013. (Ex. 5, pp. 26-34)

Claimant returned to Dr. Phisitkul on August 1, 2013. Following examination, Dr. Phisitkul assessed 2nd and 3rd interdigital nerve pain, most likely related to varus alignment of claimant's feet. Dr. Phisitkul recommended bilateral custom insoles to use with claimant's current insoles. He left claimant's eight-hour work day restriction in place. (Ex. 4, pp. 33, 37, 38)

On September 19, 2013, claimant returned to Dr. Phisitkul. Dr. Phisitkul examined claimant's orthotics and opined they were made incorrectly, resulting in increased force on the lateral side of claimant's right foot. Dr. Phisitkul opined the orthotics did not relieve claimant's existing pain and in fact, resulted in new pain symptoms. (Ex. 4, p. 40) Dr. Phisitkul noted defendant-employer had not authorized his orders for inserts to be made by "AmPro", instead contracting for inserts with

another provider. Dr. Phisitkul directed claimant not to use the improperly made set of inserts. (Ex. 4, p. 42) Claimant underwent aspiration and injections of the 2nd and 3rd interdigital web spaces. (Ex. 4, pp. 39, 42-43) Dr. Phisitkul imposed a restriction limiting claimant to four-hour work days for three days, followed by a return to eight-hour work days thereafter. (Ex. 4, p. 42)

Claimant returned to Dr. Phisitkul on October 10, 2013 and reported receiving 3 days of relief following the injections, but a subsequent return to prior pain levels. (Ex. 4, p. 45) Dr. Phisitkul assessed failed conservative treatment of Morton's neuroma at the 2nd and 3rd web spaces; he recommended open release of the interdigital nerve at the 2nd and 3rd web spaces, with possible nerve resection. (Ex. 4, p. 47) Dr. Phisitkul left claimant's eight-hour work day restriction in place. (Ex. 4, p. 48)

Claimant presented for surgical intervention with Dr. Phisitkul on October 16, 2013. Dr. Phisitkul ultimately performed an excision of Morton's neuroma. Following surgery, Dr. Phisitkul removed claimant from work, with no weight-bearing for two weeks. (Ex. 4, pp. 49-50, 52, 54)

Following surgery, claimant continued to follow up with Dr. Phisitkul. On October 30, 2013, Dr. Phisitkul removed claimant's sutures and ordered a course of physical therapy. He ordered claimant to remain off work, pending a six-week postsurgical check up on December 5, 2013. Dr. Phisitkul allowed claimant to perform progressive weight bearing in a post-operative shoe for two weeks and then transition to regular footwear. (Ex. 4, pp. 55, 58) However, on November 1, 2013, Dr. Phisitkul authored a "medical excuse" which limited claimant to sedentary duty, with an allowance of time for claimant to ice his leg. Dr. Phisitkul also restricted claimant from driving. (Ex. 4, p. 59)

Claimant returned to Dr. Phisitkul on December 5, 2013. At that time, claimant reported he had recently taken a new position at defendant-employer, which involved greater office duties. Dr. Phisitkul opined this change in position would be very beneficial given the status of claimant's foot. Dr. Phisitkul recommended continued physical therapy and imposed work restrictions of light-duty work, with limited walking and standing, as well as avoidance of stairs, ladders, and uneven ground. (Ex. 4, p. 60)

Claimant testified the surgery performed by Dr. Phisitkul provided little relief of his symptoms. When the surgery failed to help, claimant testified he looked for work at defendant-employer which was less physically demanding. Claimant testified he did not believe he was physically capable of continuing work as a line mechanic, despite a desire to remain in one of the higher-paying positions at defendant-employer. As a result, he applied for a position as a relief plant operator at the power plant; he described this work as physically easier, lighter in nature, and it allowed for seated work. (Claimant's testimony) Claimant was awarded the position and in January 2014, claimant began work as a relief plant operator. In this position, claimant was responsible for performance of four positions on an as-needed basis: plant operator, plant operator-boiler, assistant plant operator, and plant maintenance. The job

description noted physical demands including climbing and lifting a minimum of 50 pounds. He earned $34.40 per hour. (Ex. 21, pp. 1, 14; Ex. BB, p. 24)

Claimant participated in physical therapy sessions from November 6, 2013 through January 7, 2014. (Ex. 5, pp. 35-44)

On January 9, 2014, claimant returned to Dr. Phisitkul for follow up. Claimant reported he had begun work in his new position, a position requiring less activity. Dr. Phisitkul imposed no work restrictions and recommended claimant continue utilizing a night splint. Dr. Phisitkul also raised the possibility of a 2nd web space nerve transection surgery in order to bury the interdigital nerve into the muscle of the foot. (Ex. 4, p. 68)

At the arranging of claimant's counsel, on January 22, 2014, claimant presented to board certified occupational and environmental medicine physician, Robin Sassman, M.D., for independent medical examination (IME) with respect to claimant's right foot crush injury. Dr. Sassman authored a report containing her findings and opinions dated March 7, 2014. (Ex. 7, p. 1) As elements of the IME, Dr. Sassman interviewed claimant and reviewed relevant medical records. (Ex. 7, pp. 1-5) During the interview, claimant complained of burning pain in the ball of his foot, worse while on his feet; swelling of his foot and calf; hypersensitivity over his scar; and right hip and knee pain due to altered gait. (Ex. 7, p. 5) Dr. Sassman ordered x-rays of claimant's right foot and performed a physical examination. (Ex. 7, pp. 6-7)

Following records review, interview and examination, Dr. Sassman assessed a right foot crush injury with 2nd through 5th open distal phalanx fractures, status post excision of Morton's neuroma, with continued pain and neuritis; as well as right hip and knee pain secondary to gait change caused by the crush injury. (Ex. 7, p. 7) Dr. Sassman opined claimant had not achieved MMI and recommended a second opinion by a podiatrist to determine if any treatment options were available with respect to claimant's right foot. Dr. Sassman opined claimant's right hip and knee pain were likely to decrease with improvement of the right foot and altered gait. In the absence of further care, Dr. Sassman opined claimant achieved MMI as of the date of examination, January 22, 2014. (Ex. 7, pp. 7-8)

Dr. Sassman opined claimant sustained permanent impairment as a result of the crush injury: 10 percent lower extremity for fractures and subsequent deformity of the foot; 4 percent lower extremity for neuritis; 4 percent lower extremity for hypersensitivity over claimant's scar in the distribution of the superficial peroneal nerve; and 4 percent lower extremity for hypersensitivity over claimant's scar in the distribution of the sural nerve. Dr. Sassman opined claimant suffered no ratable impairment to his right knee or hip. She found a combined total impairment of 16 percent lower extremity or 6 percent whole person. (Ex. 7, pp. 8-9) Dr. Sassman recommended permanent restrictions of occasional sitting, standing, walking or use of stairs, and rare use of ladders or walking on uneven surfaces. (Ex. 7, p. 9)

Claimant followed up with Dr. Phisitkul on February 27, 2014. Following examination, Dr. Phisitkul assessed a painful neuroma, equinus contracture and related metatarsalgia. He ordered a course of physical therapy, continued splinting, a new insert, and advised claimant to work on gastrocnemius stretching. (Ex. 4, p. 71)

Claimant participated in physical therapy sessions from March 12, 2014 through March 25, 2014, at which time claimant was discharged due to lack of progress. (Ex. 5, pp. 45-50)

Following examination of claimant on March 28, 2014, Dr. Phisitkul opined claimant had failed conservative treatment measures and the prior simple neurolysis procedure. He assessed interdigital neuroma at the 2nd and 3rd web spaces with tightness of the gastrocnemius tendon, and recommended surgical intervention. Specifically, Dr. Phisitkul recommended an open interdigital neuroma excision at the 2nd and 3rd web space, implantation of the proximal nerve stump into the muscle of the foot, and partial endoscopic gastrocnemius recession. (Ex. 4, p. 80)

Claimant underwent surgery with Dr. Phisitkul on April 11, 2014, consisting of excision of the interdigital neuroma and gastrocnemius recession. Dr. Phisitkul issued postoperative diagnoses of right Morton metatarsalgia and acquired equinus deformity of the right foot. (Ex. 4, p. 89) Claimant was removed from work and placed in non-weight bearing status. (Ex. 4, pp. 88, 91)

Following surgery, claimant continued to follow up with Dr. Phisitkul. (Ex. 4, pp. 96-98) On June 5, 2014, Dr. Phisitkul ordered a course of physical therapy and recommended claimant wean himself from use of a boot. He released claimant to return to work on sedentary duty. (Ex. 4, pp. 101-103)

Claimant returned to Dr. Phisitkul on July 24, 2014 and reported no improvement in symptoms following surgery. (Ex. 4, p. 105) Dr. Phisitkul assessed minimal improvement from the prior visit, but opined claimant would "likely improve over the course of the next several months." (Ex. 4, p. 107) Dr. Phisitkul noted claimant's hypersensitivity had improved with desensitization therapy and recommended further physical therapy. He maintained claimant's sedentary work restriction. (Ex. 4, pp. 107, 109)

Claimant participated in physical therapy sessions from June 9, 2014 through August 28, 2014. (Ex. 5, pp. 51-68)

On October 23, 2014, claimant returned to Dr. Phisitkul and reported slight improvement since surgery, but significant pain on the bottom of his foot. (Ex. 4, p. 111) Dr. Phisitkul assessed residual nerve pain, six months post-surgery. He expressed belief claimant demonstrated nerve-related symptoms, despite successful neurotomy, and ordered a pain service consultation. Dr. Phisitkul also ordered new orthotics and imposed restrictions, allowing for light-duty work with a 20-pound lift and 10-minute breaks after each hour of being on his feet. (Ex. 4, pp. 112-113, 115, 119-120)

Defendant-employer subsequently provided the job description for claimant's position of relief plant operator to Dr. Phisitkul for review. (Ex. 4, pp. 124, 126-130) On December 4, 2014, Dr. Phisitkul authored a statement expressing belief that claimant's current restrictions were adequate and no additional restrictions were necessary with respect to claimant's ability to perform the position. (Ex. 4, p. 125)

Pursuant to Dr. Phisitkul's order, on December 3, 2014, claimant presented to Foad Elahi, M.D., for evaluation of nerve pain. (Ex. 4, p. 131) Dr. Elahi opined the characteristics of claimant's symptoms were most consistent with neuropathic pain. Dr. Elahi recommended pain medication, which claimant declined. Claimant agreed to undergo a recommended corticosteroid injection; Dr. Elahi indicated he would seek authorization for the procedure. (Ex. 4, pp. 134-135)

On December 15, 2014, claimant presented to Michael Pyevich, M.D., for a second opinion evaluation at the request of defendant-employer. (Ex. 8, p. 5) Dr. Pyevich performed a medical records review, ordered x-rays, and physically examined claimant. He ultimately assessed right cavovarus foot deformity with chronic metatarsalgia and decreased sensation. (Ex. 8, p. 6)

Dr. Pyevich recommended an MRI of claimant's right foot to rule out a stress reaction or soft tissue abnormality. He noted he would craft treatment recommendations following this test, which may include surgery designed to change the shape of claimant's foot in order to unload the metatarsal heads. (Ex. 8, p. 6) Dr. Pyevich recommended continued light-duty work. (Ex. 8, pp. 7-8) He subsequently clarified restrictions allowing claimant to work as tolerated with respect to a combination of sitting, standing and walking tasks. (Ex. 8, pp. 10-11)

Claimant underwent the MRI recommended by Dr. Pyevich on January 19, 2015. The radiologist read the results as revealing mild degenerative changes of the 1st metatarsophalangeal joint, but an otherwise unremarkable study. (Ex. 8, p. 12)

Following the MRI, claimant returned to Dr. Pyevich on January 23, 2015. Dr. Pyevich opined claimant's MRI was relativity normal. He assessed a right cavovarus foot deformity with chronic metatarsalgia, possibly neuritic from autonomic nerve function. (Ex. 8, p. 13) Dr. Pyevich recommended evaluation by Tim Miller, M.D., for a ganglion block. In the event claimant did not receive relief, Dr. Pyevich noted he would consider surgery. (Ex. 8, pp. 13-14)

On February 9, 2015, claimant returned to Dr. Sassman for an IME at the arranging of his counsel; on this occasion, the subject of evaluation was claimant's left knee. Dr. Sassman authored a report of her findings and opinions dated March 2, 2015. (Ex. 13, p. 1) Dr. Sassman performed a medical records review, interviewed claimant and performed a physical examination. (Ex. 13, pp. 1-3) On interview, claimant complained of continued left knee pain "at times," particularly with kneeling. He localized the pain to the outside of his knee following prolonged kneeling; he similarly reported short-term stiffness with prolonged kneeling. (Ex. 13, p. 2) Claimant also

described difficulty climbing stairs and walking. (Ex. 13, p. 3) Dr. Sassman performed a physical examination and ordered an x-ray of claimant's knee to assess cartilage interval. (Ex. 13, pp. 3-4)

Following records review, interview and examination, Dr. Sassman assessed left knee pain status post arthroscopic chondroplasty of the patella on August 29, 2006. Dr. Sassman opined claimant achieved MMI on August 29, 2007 and sustained permanent impairment of 10 percent left lower extremity for degenerative changes, based upon patellofemoral cartilage interval. She recommended permanent restrictions of rare kneeling and squatting; she further recommended use of a knee pad with kneeling. (Ex. 13, p. 4)

Dr. Miller performed a diagnostic lumbar sympathetic nerve block on February 12, 2015. (Ex. 9, pp. 3-4)

On February 23, 2015, claimant returned to Dr. Pyevich and reported no relief with the nerve block. As the block provided no relief, Dr. Pyevich opined claimant's symptoms were not likely to be nerve-related. Dr. Pyevich assessed right cavovarus foot deformity with chronic 2nd, 3rd, and 4th metatarsalgia. He recommended claimant either learn to live with his symptoms, undergo repeat evaluation by Dr. Miller to determine if any treatment options were available, or undergo surgery, consisting of partial calcanectomy, tarsal tunnel release and plantar fascial release. (Ex. 8, p. 17)

Claimant returned to Dr. Pyevich on March 24, 2015 and discussed treatment options. Dr. Pyevich recommended exhausting all conservative treatment options prior to considering surgery. Dr. Pyevich noted surgery would consist of calcaneal osteotomy, tarsal tunnel release, plantar fascial release, and "1-2-3 TMT" joint fusion. He cautioned there was no guarantee surgery would alleviate claimant's symptoms. (Ex. 8, p. 20) Dr. Pyevich noted claimant would consider his options; he left claimant's work restrictions in place. (Ex. 8, pp. 21-22)

Claimant continued to work as a relief plant operator until April 2015, at which time he earned $36.16 per hour. Claimant then sought to transfer into the position of engineering coordinator, due to an impending plant closure. The job description notes physical demands of standing, prolonged walking and lifting. (Claimant's testimony; Ex. 21, pp. 1, 16) Claimant testified his duties are split between office work, performing computer mapping, and work in the field. He is able to change positions frequently, allowing him to mix sitting, standing and walking. Claimant testified he continues to experience difficulty with extended walking and ambulation on uneven ground. (Claimant's testimony)

On April 1, 2015, Dr. Pyevich provided responses to questions posed by defendant-employer. Dr. Pyevich opined claimant was capable of performing the position of engineering coordinator, without restrictions. He highlighted claimant's belief he was capable of performing the related duties. (Ex. 8, p. 23)

Claimant returned to Dr. Miller on April 8, 2015 for consideration of a medication regimen. Dr. Miller prescribed meloxicam and Ultram. (Ex. 9, p. 11) Claimant again presented to Dr. Miller on June 16, 2015. At this time, Dr. Miller opined claimant received no benefit with nonsteroidal medications, tramadol or topical gel. He issued a prescription for Butrans. (Ex. 9, p. 13)

Claimant returned to Dr. Phisitkul on June 26, 2015 for a second opinion with respect to Dr. Pyevich's surgical recommendations. (Ex. 4, p. 136) Following examination, Dr. Phisitkul assessed residual metatarsalgia after a failed Morton's neuroma excision. (Ex. 4, p. 136) Dr. Phisitkul opined it was unlikely the surgery recommended by Dr. Pyevich would result in relief, as claimant's symptoms were not caused by claimant's cavovarus deformity. He further opined surgery might exacerbate claimant's metatarsalgia pain. Instead, Dr. Phisitkul recommended an ultrasound guided injection of the residual nerve stump; claimant expressed desire to proceed. (Ex. 4, pp. 136-137) Dr. Phisitkul imposed work restrictions of a 20-pound lift and 10-minute breaks following each hour claimant spent on his feet. (Ex. 4, pp. 137, 140)

At Dr. Phisitkul's orders, on August 5, 2015, claimant underwent an ultrasound-guided corticosteroid injection of the 2nd and 3rd web spaces. (Ex. 4, pp. 141-142)

The following day, August 6, 2015, claimant returned to Dr. Phisitkul and reported no relief with the injections. (Ex. 4, p. 146) Based upon this diagnostic tool, Dr. Phisitkul opined claimant was not a surgical candidate. Dr. Phisitkul, instead, recommended treatment modalities designed to control claimant's pain, including a pain clinic referral and either insoles or rocker-bottom shoes. Dr. Phisitkul opined claimant had achieved MMI and recommended he follow up as needed. With respect to activities, Dr. Phisitkul advised claimant that pain was not indicative of additional damage and advised him to perform activities as tolerated. Dr. Phisitkul left claimant's work restrictions in place and recommended a functional capacity evaluation (FCE) to determine permanent restrictions. (Ex. 4, pp. 146, 148)

Claimant returned to Dr. Stangl for chiropractic care on September 8, 2015. (Ex. 15, p. 2)

At the arranging of claimant's attorney, on September 22, 2015, claimant underwent an FCE with Charles Goodhue, M.S. Mr. Goodhue opined claimant gave maximal, consistent effort throughout the examination; he described the evaluation as valid in nature. (Ex. 14, p. 3) Mr. Goodhue noted claimant demonstrated significant abilities in performance of certain tasks, including, but not limited to: elevated work; crawling; kneeling; and gross dynamic balance. (Ex. 14, p. 4) Mr. Goodhue also observed certain significant deficits: deep static crouching; repetitive squatting; standing tolerance; walking; stair climbing; and step ladder climbing. He opined claimant's greatest functional limitations were demonstrated in prolonged weight bearing activities of standing and walking; step ladder and stair climbing; repetitive squatting; and prolonged deep static crouching. He noted the deficits were primarily due to claimant's

right forefoot symptoms and the resulting altered mechanics in progressive weight-bearing tasks. (Ex. 14, p. 5)

Mr. Goodhue found claimant demonstrated the ability to work in the lower end of the medium physical demand category. (Ex. 14, p. 5) He offered recommendations with respect to limitations upon claimant's activities: limiting prolonged standing in one spot and walking to an occasional basis; sitting, standing and walking as needed; rare ambulation on uneven surfaces and inclines; and occasional stair climbing, step ladder climbing, prolonged deep static crouching, repetitive squatting, and standing tolerance. (Ex. 14, pp. 5-6) Mr. Goodhue noted claimant progressively relied more upon his left leg than right with testing. (Ex. 14, p. 8) Mr. Goodhue also noted maximum lifting abilities as follows: horizontal lift of 70 pounds rarely, 60 pounds occasionally, 45 pounds frequently and 30 pounds constantly; and front carry of 65 pounds rarely, 55 pounds occasionally, 40 pounds frequently and 25 pounds constantly. (Ex. 14, p. 7) He noted claimant also demonstrated the following abilities: constant crawling or kneeling; occasional walking, with walking resulting in a progressive right lower extremity limp; and occasional stair climbing or step ladder climbing, with a caveat regarding potential balance concerns and specific placement of claimant's right foot. (Ex. 14, pp. 8-9)

Defendant-employer authored a letter to Dr. Phisitkul requesting his opinions on claimant's MMI status, need for future medical treatment, and whether or not claimant sustained permanent impairment "beyond the previously assigned rating." (Ex. 4, p. 152) Dr. Phisitkul authored a responsive letter to defendant-employer on September 28, 2015. Dr. Phisitkul confirmed claimant achieved MMI as of his last appointment on August 6, 2015. He opined future treatment of claimant's condition could include anti-inflammatory or nerve pain medication, custom orthotics and/or bracing, physical therapy, and revision surgery. Dr. Phisitkul opined claimant sustained permanent impairment of 6 percent right foot or 4 percent right lower extremity, based upon metatarsal fracture with metatarsalgia of the 3rd and 4th metatarsal heads. He assigned no permanent impairment ratings with respect to gait derangement. (Ex. 4, p. 153) Dr. Phisitkul further stated:

> I understand [claimant] was previously assigned 17% lower extremity impairment. The 6% assigned above DOES NOT represent additional impairment, but instead is an evaluation of his overall level of impairment on August 6, 2015.

(Ex. 4, p. 153)

Claimant's counsel supplied Dr. Phisitkul with a copy of claimant's FCE results for review. Following review, on October 14, 2015, Dr. Phisitkul drafted a letter to claimant's counsel whereby he adopted the restrictions set forth in the FCE, which placed claimant in the medium physical demand category. (Ex. 4, pp. 155-156)

Claimant continued to seek sporadic chiropractic treatment, presenting to Dr. Stangl for one visit in each of the months of November 2015, December 2015, and January 2016. (Ex. 15, pp. 2-3)

At the arranging of claimant's counsel, claimant returned to Dr. Sassman on February 3, 2016 for another IME. Dr. Sassman authored a report containing her findings and opinions dated May 26, 2016. The subject of this IME was claimant's right foot crush injury with continued pain and neuritis, as well as right hip and right knee pain secondary to altered gait. (Ex. 16, p. 1) Dr. Sassman performed a records review. (Ex. 16, pp. 2-6) She also interviewed claimant, at which time claimant reported burning pain in the ball of his right foot which worsened with increased time on his feet, daily swelling and redness, hypersensitivity over his scar, and right knee and hip pain due to gait changes. (Ex. 16, p. 6) Dr. Sassman ordered an x-ray of claimant's right foot and performed a physical examination. (Ex. 16, pp. 7-8)

Following records review, interview, and examination, Dr. Sassman issued diagnoses of: right foot crush injury with 2nd through 5th open distal phalanx fractures, status post excision of Morton's neuroma, with continued pain and neuritis; and right hip and right knee pain secondary to gait change due to the right foot crush injury. Dr. Sassman expressed agreement with Dr. Phisitkul's MMI date of August 6, 2015 and offered no further specific treatment recommendations. (Ex. 16, p. 8) Dr. Sassman recommended permanent restrictions of occasional sitting, standing and walking; an ability to change positions frequently; rare use of ladders or walking on uneven surfaces; and occasional use of stairs. (Ex. 16, p. 10)

With respect to permanent impairment, Dr. Sassman opined claimant sustained the following ratable impairments: 10 percent lower extremity for fractures and subsequent deformity of the foot; 4 percent lower extremity for neuritis in the distribution of the medial plantar nerve; 4 percent lower extremity for hypersensitivity in the distribution of the superficial peroneal nerve; and 4 percent lower extremity for hypersensitivity in the distribution of the sural nerve. She found a combined permanent impairment of 16 percent lower extremity, which equated to 6 percent whole person impairment. However, Dr. Sassman opined this functional rating was insufficient to reflect the impact of claimant's symptoms upon his activities of daily living. As a result, she opined claimant sustained additional impairment of 3 percent whole person due to pain. In total, she opined a combined impairment of 9 percent whole person. (Ex. 16, p. 9)

On June 9, 2016, Dr. Sassman authored a letter to claimant's attorney, seeking to correct a typographical error in her IME report. Dr. Sassman authored a substitute impairment rating to insert in the report of May 26, 2016. Dr. Sassman computed claimant's impairment rating as follows: 10 percent lower extremity for fractures, metatarsalgia and subsequent deformity of the foot; 4 percent lower extremity for neuritis in the distribution of the medial plantar nerve; 4 percent lower extremity for hypersensitivity in the distribution of the superficial peroneal nerve; and 4 percent lower extremity for hypersensitivity in the distribution of the sural nerve. She found a

combined lower extremity rating of 20 percent, which equated to 8 percent whole person impairment. Dr. Sassman opined claimant demonstrated no ratable impairment to the right knee or hip, but sustained an additional 3 percent whole person impairment due to pain. In total, Dr. Sassman opined claimant sustained a combined impairment of 11 percent whole person as a result of the work injury of March 20, 2012. (Ex. 17, pp. 1-2)

At the arranging of defendant-employer, on June 20, 2016, claimant presented for IME with Erin Kennedy, M.D., with respect to his right foot, right knee, right hip and right low back conditions. (Ex. 18, p. 4) Dr. Kennedy performed a medical records review and physically examined claimant. (Ex. 18, pp. 5, 8-11) She also interviewed claimant, who complained of constant pain while pressure is placed on his foot and which worsened with time on his feet, on uneven ground, or with wearing rigid shoes. Claimant reported his pain could reach a level 8 on a 10-point scale. Claimant also reported scar sensitivity, with uncomfortable numbness with contact of the 2nd through 4th toes. Claimant also complained of right hip pain with external rotation of the hip, right knee pain ranging from a level 2 to level 4, and right low back pain ranging from a level 2 to level 6. (Ex. 18, pp. 6-7)

Following records review, interview and examination, Dr. Kennedy assessed a crush injury to the right foot, resulting in open distal phalanx fractures of digits 2 through 5 and open middle phalanx fractures of digits 2 and 3, with chronic neuropathic foot and toe pain. She indicated the fractures were without intraarticular involvement and no metatarsal fractures were sustained. Dr. Kennedy noted claimant underwent neurolysis of the 2nd and 3rd interdigital nerves of the right foot and subsequently, Morton's neuroma excision of the 2nd and 3rd web spaces and gastrocnemius resection. Dr. Kennedy noted claimant continued to suffer with pain and had exhausted conservative care measures. (Ex. 18, pp. 11-12)

Dr. Kennedy also assessed right medial knee pain, lateral hip pain and low back myofascial pain secondary to poor gait body mechanics, representing myofascial discomfort without injury. Dr. Kennedy opined claimant's right low back, hip and knee pain developed secondary to claimant's self-imposed gait change designed to avoid right foot pain. She causally related the symptoms to claimant's gait derangement due to foot pain. Dr. Kennedy further opined these pains represented "stress and fatiguing," as opposed to injury to or derangement of the pain sites. (Ex. 18, p. 12)

With respect to future care, Dr. Kennedy expressed belief that invasive care was not warranted and recommended claimant work to normalize his gait. She, accordingly, recommended physical therapy for claimant's gait and to strengthen the low back and right leg. Dr. Kennedy also recommended a podiatry or dermatology consult with respect to the condition of claimant's skin in the right foot web spaces. Additionally, Dr. Kennedy recommended evaluation by a pain clinic, should claimant seek additional medication management in the future. She specifically declined to recommend chiropractic care and expressed belief that if claimant desired such treatment, he should seek the treatments through his personal health insurance. (Ex. 18, pp. 12-13)

Dr. Kennedy opined claimant achieved MMI with respect to the right foot and toe injuries on August 6, 2015. She opined the low back, knee and hip complaints did not require assignment of an MMI date, as they did not reflect injuries and should resolve quickly with improved gait. (Ex. 18, p. 13)

In consideration of the extent of permanent impairment sustained by claimant, Dr. Kennedy provided detailed analysis of the prior ratings issued by Drs. Phisitkul and Sassman. With respect to Dr. Phisitkul's January 31, 2013 rating of 11 percent lower extremity, Dr. Kennedy opined she considered the rating invalid. She explained that the report lacked the range of motion measurements which would allow for independent reproduction of a rating and also did not apply a grade modifier with respect to sensory deficit. (Ex. 18, pp. 13-14) With respect to Dr. Sassman's March 17, 2014 rating of 16 percent lower extremity, Dr. Kennedy opined the methodology was improper. She explained that Dr. Sassman rated in part based on fractures; however, the referenced section of the AMA Guides to the Evaluation of Permanent Impairment pertained to metatarsal fractures. Dr. Kennedy stated claimant was diagnosed with metatarsalgia, but not with metatarsal fracture. (Ex. 18, p. 14) Dr. Kennedy also commented that Dr. Sassman incorrectly combined the ratings she did issue. (Ex. 18, p. 15) With respect to Dr. Phisitkul's September 28, 2015 rating of 6 percent foot or 4 percent lower extremity, Dr. Kennedy disagreed with the underlying methodology of rating based upon metatarsal fractures, when no such fracture occurred. With respect to Dr. Sassman's May 26, 2016 rating, Dr. Kennedy maintained disagreement with rating based upon metatarsal fracture. (Ex. 18, p. 15) She further opined Dr. Sassman's 3 percent whole person rating for pain was improper as it should have been limited to a lower extremity rating, as opposed to a whole person impairment. Dr. Kennedy also expressed belief the separate rating for pain was redundant, given Dr. Sassman had previously rated for neuritis and scar sensitivity. (Ex. 18, p. 16)

Dr. Kennedy also authored an opinion by which she computed claimant's impairment rating. Dr. Kennedy provided a detailed analysis of various rating methodologies. She ultimately opined claimant sustained no ratable impairment to his spine, right hip, right thigh, right knee, right calf, right ankle, right foot, or right toes; she also found no ratable impairment for gait derangement. (Ex. 18, pp. 17-19) Dr. Kennedy opined claimant did sustain ratable permanent impairment to his peripheral nervous system: 3 percent lower extremity for motor dysfunction; 4 percent lower extremity for sensory dysfunction of the superficial peroneal nerve; 4 percent lower extremity for sensory dysfunction of the medial plantar nerve; and 4 percent lower extremity for dysesthesia of the superficial peroneal nerve. In total, Dr. Kennedy found a combined lower extremity impairment of 15 percent, due to peripheral nerve dysfunction of the right foot and toes. (Ex. 18, p. 20) Dr. Kennedy also recommended permanent restrictions allowing for ambulation up to 50 percent of an eight-hour workday or four hours maximum, regardless of shift length; ambulation on uneven surfaces up to 25 percent of an eight-hour shift or two hours maximum; and occasional crouching, squatting, stair use and step ladder use, but no use of ladders taller than step ladders. (Ex. 18, p. 21)

Claimant's counsel provided Dr. Sassman with a copy of Dr. Kennedy's IME report. Following review thereof, Dr. Sassman authored a letter dated June 14, 2016. Dr. Sassman opined claimant sustained a significant crush injury to his right foot, resulting in deformity and significant ongoing symptoms. She opined the AMA Guides do not address every type of injury and as a result, she utilized her clinical experience and chose an impairment rating consistent with claimant's status. Dr. Sassman opined the AMA Guides allow discretion and are not strictly formulaic in nature, or else there would be no need for a physician to compute impairment levels. Dr. Sassman further commented that the AMA Guides allowed the examining physician discretion to add additional impairment due to pain symptoms, in the event the examiner believes the calculated impairment rating fails to adequately reflect claimant's true level of impairment. Dr. Sassman expressed belief that claimant's impairment level was not adequately reflected by the base impairment rating, thus warranting additional rating based on pain. Dr. Sassman stood by her opinions as stated in the May 26, 2016 IME report and subsequent letter of June 9, 2016. (Ex. 19, p. 2)

Claimant continued his sporadic chiropractic treatment dating up to the evidentiary hearing, visiting Dr. Stangl on one occasion in February 2016, one occasion in May 2016, and one occasion in July 2016. (Ex. 15, p. 3) Claimant testified chiropractic care provides him with temporary relief of his symptoms. (Claimant's testimony)

Claimant testified he continues to suffer with symptoms of his right foot and toes, right knee, low back, and right hip. His most significant symptom is a constant burning pain of the ball of his right foot. At best, his pain level is a 3 on a 10-point scale. With being on his feet, standing, walking and weight bearing, his pain worsens and can reach a level 8. Each night, claimant rests and elevates his foot in order to reduce pain levels. Claimant also described pain of three digits of his toes, hypersensitivity of the toes and scar site, and swelling and redness of the right foot and calf. He reported constant pain, varying from a level 1 to 6. Due to altered gait, claimant also reported pain of the right knee, low back, and right hip. Claimant relayed difficulty and worsened symptoms with walking, stair climbing, carrying weight, standing, squatting, and crawling. (Claimant's testimony)

Claimant testified he is limited in his ability to perform household chores and maintenance. He has forgone certain recreational and familial activities. Claimant also testified to interrupted sleep patterns. (Claimant's testimony)

Claimant's symptoms led him to inquire with Dr. Pyevich regarding amputation of his right foot; however, Dr. Pyevich informed claimant he may develop phantom pain following an amputation. Claimant testified his symptoms have resulted in seeking chiropractic care; he indicated he would seek such care more frequently, but his personal health insurance limits the number of sessions which are covered. Claimant does not utilize medication to treat symptoms due to stomach side effects. (Claimant's testimony)

As of the date of evidentiary hearing, claimant remained employed at defendant-employer on a full time basis as an engineering coordinator. Claimant earned $30.78 per hour; the journeyman rate of pay is $34.20 per hour. Claimant has not requested accommodation in performance of his duties. Claimant testified he has not sought work elsewhere and has not applied for Social Security Disability. (Claimant's testimony; Ex. 21, p. 1; Ex. 22, p. 2) Claimant summarized his W2 records from defendant-employer reveal annual earnings of nearly $70,000.00 in 2009 and 2010, approximately $82,000.00 in 2011, $46,659.04 in 2012, approximately $60,000.00 in 2013, approximately $66,500.00 in 2014, and approximately $70,000.00 in 2015. (Claimant's testimony; Ex. 22, p. 1)

CONCLUSIONS OF LAW

The first issue for determination is the extent of claimant's permanent disability resulting from the stipulated work injury, as to defendant-employer, including whether the disability is a scheduled member disability to the right foot or leg, or an industrial disability.

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. 6.14(6).

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

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

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 suffered a stipulated work-related injury on March 20, 2012. Over the course of treatment for the crushing injury of claimant's right foot, claimant required extensive conservative care and two surgical procedures. One procedure involved an incision and intervention in claimant's right calf; Dr. Phisitkul causally related the precipitating contracture of the gastrocnemius tendon to the March 20, 2012 injury. Dr. Sassman causally related complaints of right knee and hip pain to resulting gait change; Dr. Kennedy opined claimant developed right knee, hip and low back pain secondary to the gait change. It is therefore determined that the work injury of March 20, 2012 necessitated treatment and/or caused pain of claimant's right foot, right leg, right hip and low back.

Although each of these body parts was affected by the work injury, claimant also bears the burden of proving that the work injury was a cause of permanent disability. Three physicians have offered five opinions regarding the extent of permanent impairment sustained by claimant. No physician has opined claimant sustained ratable permanent impairment as a result of involvement of claimant's low back, right hip or right knee. Similarly, no permanent restrictions were imposed specifically related to these body parts. Therefore, it is determined claimant did not carry his burden to demonstrate the work injury of March 20, 2012 was a cause of permanent disability to claimant's right knee, right hip or low back.

Drs. Phisitkul, Sassman and Kennedy have each offered opinions recommending permanent restrictions specifically as a result of the crush injury. These physicians have also offered a total of five opinions regarding the extent of claimant's permanent impairment attributable to the crush injury. The probative value of each of these opinions must be weighed by the undersigned. As an initial matter, the January 31, 2013 opinion of Dr. Phisitkul and the January 22, 2014 IME of Dr. Sassman are entitled

to little weight, as each occurred prior to completion of claimant's entire course of care. Therefore, neither opinion is reflective of claimant's ultimate level of impairment.

All three physicians opined claimant achieved MMI from the crush injury on August 6, 2015. Dr. Phisitkul, on September 28, 2015, opined claimant sustained permanent impairment of 6 percent right foot or 4 percent right lower extremity for metatarsal fracture with metatarsalgia. Following a February 3, 2016 IME, Dr. Sassman opined claimant sustained permanent impairment of 11 percent whole person. She based her rating upon fractures, deformity, nerve involvement, and pain; she specifically found 20 percent lower extremity impairment and 3 percent whole person impairment due to pain. Dr. Kennedy, following a June 20, 2016 IME, opined claimant sustained permanent impairment of 15 percent lower extremity due to impairment of the peripheral nervous system.

Following review of the entirety of the medical record, I provide the greatest weight to the opinions of Dr. Kennedy with respect to the extent of claimant's permanent functional impairment. Dr. Kennedy performed a detailed rating of permanent impairment which considered multiple rating methodologies. Her process and methodology is clear and has not been questioned by another medical provider.

In addition to providing a rating, Dr. Kennedy also provided critiques of the ratings provided by both Dr. Phisitkul and Dr. Sassman. Primarily, Dr. Kennedy found error in rating based upon metatarsal fractures which were not shown to have occurred. Both Dr. Phisitkul and Dr. Sassman based their ratings, in part, upon metatarsal fracture. Dr. Kennedy also critiqued Dr. Sassman's additional rating of 3 percent whole person for pain, on the grounds the rating was redundant and should have been limited to the lower extremity. Dr. Phisitkul offered no explanation for his methodology; Dr. Sassman highlighted the allowance within the AMA Guides for discretion of the examining physician. I ultimately am left without a clear explanation for the methodology used by Drs. Phisitkul and Sassman in reaching their impairment ratings and thus, find Dr. Kennedy's opinion to be more persuasive.

Dr. Kennedy opined claimant sustained permanent impairment of 15 percent right lower extremity as a result of the work injury of March 20, 2012. Dr. Kennedy specifically rated the impairment to the right lower extremity, as opposed to the right foot. It is therefore determined claimant sustained a 15 percent right lower extremity disability as a result of the stipulated work-related injury of March 20, 2012. Such an award entitles claimant to 33 weeks of permanent partial disability benefits (15 percent x 220 weeks = 33 weeks). The parties stipulated at the time of the work injury, claimant's gross weekly earnings were $1,351.41, and claimant was married and entitled to 4 exemptions. The proper rate of compensation is therefore, $866.74. By the hearing report, the parties stipulated the commencement date for permanent partial disability benefits was November 8, 2012. This stipulation was accepted by the undersigned at the commencement of evidentiary hearing. Pursuant to Evenson v. Winnebago Industries, Inc., 881 N.W.2d 306 (Iowa 2016), permanent partial disability benefits, once

commenced, are not interrupted by subsequent payment of temporary disability benefits.

The next issue for determination is whether defendant-employer is responsible for claimed medical expenses and medical mileage.

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. Section 85.27. Holbert v. Townsend Engineering Co., Thirty-second Biennial Report of the Industrial Commissioner 78 (Review-Reopening October 1975).

Claimant requests defendant-employer be found responsible for chiropractic expenses incurred at Kobush Chiropractic. The evidentiary record demonstrates claimant sought care with Dr. Stangl on 10 occasions between 2013 and 2016. For each session, Kobush Chiropractic charged $50.00, resulting in total charges of $500.00. Of this charge, a portion was paid by claimant's personal health insurance and the remainder was paid by claimant, out-of-pocket. (Ex. 1, pp. 3-9)

Claimant testified he sought chiropractic care due to symptoms which related to alteration of his gait following the stipulated work injury. Dr. Stangl's records support claimant's testimony. The chiropractic care was not authorized by defendant-employer.

When dealing with unauthorized care, to be entitled to payment, claimant must establish the care was rendered on a compensable claim. That being established, claimant must establish that the care provided on the compensable claim was both reasonable and the outcome more beneficial than the care offered by the defendants. Bell Bros. Heating v. Gwinn, 779 N.W.2d 193, 206 (Iowa 2010).

The chiropractic care received by claimant at Kobush Chiropractic was rendered in response to a compensable work-related injury to claimant's right foot and right lower extremity, as claimant's low back and hip complaints developed secondary to claimant's altered gait. Claimant's decision to seek chiropractic care was reasonable in method and frequency; he participated in only 10 sessions over a period of four years following the stipulated work-related injury. Claimant testified he did not routinely avail himself of such services, but rather, waited until his symptoms had become significant. During the period claimant received such services, he remained under care of authorized medical providers, but the provided care did not render relief of claimant's symptoms. Claimant credibly testified the chiropractic treatments provided relief, albeit temporary relief, of his complaints. The chiropractic care was, therefore, beneficial to claimant in that he received some relief of his significant symptoms, symptoms for which he was not receiving relief through authorized treatment.

As the chiropractic care with Kobush Chiropractic was rendered on a compensable claim, the care was reasonable in nature, and the care was more beneficial than that provided by defendant-employer, defendant-employer is properly found responsible for the claimed expenses. Defendant-employer shall hold claimant harmless for such expenses and reimburse claimant for any portion of those expenses he paid out-of-pocket.

Claimant also requests payment of medical mileage expenses incurred in connection with medical treatment, evaluations and/or chiropractic care from 2012 through 2016. Claimant acknowledges certain mileage expenses have been paid, while others remain pending. It is therefore determined that defendant-employer shall pay the claimed medical mileage at the proper annual applicable mileage rate, to the extent the mileage expenses have not already been reimbursed by defendant-employer.

The next issue for determination is whether claimant is entitled to an award of alternate medical care pursuant to Iowa Code section 85.27.

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

> For purposes of this section, the employer is obliged 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.

"Determining what care is reasonable under the statute is a question of fact." Long v. Roberts Dairy Co., 528 N.W.2d 122, 123 (Iowa 1995).

Claimant credibly testified he continues to suffer with symptoms of his right hip and low back. The evidentiary record demonstrates these symptoms are causally related to the stipulated work-related injury of March 20, 2012. Claimant's authorized medical treatment has not resulted in resolution or control of these symptoms. As a result, when symptoms become severe, claimant has sought sporadic chiropractic care and received relief.

As claimant's symptoms persist, no specific treatment for these symptoms has been authorized, and claimant has demonstrated a successful treatment history with Kobush Chiropractic, I find an award of alternate medical care is appropriate. Claimant's request for alternate medical care in the form of authorization of as-needed

chiropractic care for his right hip and low back, under the direction of Dr. Stangl, is granted.

The next issue for determination is whether claimant is entitled to Second Injury Fund benefits and, if so, the amount of benefits.

Section 85.64 governs Second Injury Fund liability. Before liability of the Fund is triggered, three requirements must be met. First, the employee must have lost or lost the use of a hand, arm, foot, leg, or eye. Second, the employee must sustain a loss or loss of use of another specified member or organ through a compensable injury. Third, permanent disability must exist as to both the initial injury and the second injury.

The Second Injury Fund Act exists to encourage the hiring of handicapped persons by making a current employer responsible only for the amount of disability related to an injury occurring while that employer employed the handicapped individual as if the individual had had no preexisting disability. See Anderson v. Second Injury Fund, 262 N.W.2d 789 (Iowa 1978); 15 Iowa Practice, Workers' Compensation, Lawyer, section 17:1, p. 211 (2014-2015).

The Fund is responsible for the industrial disability present after the second injury that exceeds the disability attributable to the first and second injuries. Section 85.64. Second Injury Fund of Iowa v. Braden, 459 N.W.2d 467 (Iowa 1990); Second Injury Fund v. Neelans, 436 N.W.2d 335 (Iowa 1989); Second Injury Fund v. Mich. Coal Co., 274 N.W.2d 300 (Iowa 1970).

By this decision, the undersigned found claimant sustained permanent disability to his right leg as a result of the work injury of March 20, 2012. This determination triggers potential liability for benefits from the Fund. However, in order to qualify for Fund benefits, claimant must also establish a first qualifying loss.

In this matter, claimant claims such a loss to his left knee. Claimant underwent left knee surgery on August 29, 2006 by Dr. Schemmel. Approximately three months later, Dr. Schemmel released claimant without restrictions; he did not offer an impairment rating. Claimant thereafter continued to work for defendant-employer, including in physical positions such as the line mechanic job he held at the time of the March 20, 2012 work injury. Claimant testified he experienced soreness and stiffness of the knee with kneeling, squatting and stair use; however, there is no indication these symptoms impacted claimant's ability to work. Claimant sought no medical treatment for ongoing left knee symptoms.

In support of his claim for benefits from the Fund, claimant relies upon the February 9, 2015 IME of Dr. Sassman. Dr. Sassman opined claimant sustained permanent impairment of 10 percent left lower extremity for degenerative changes, based upon patellofemoral cartilage interval. This cartilage interval measurement was computed based upon an x-ray of February 9, 2015. Although such degenerative changes may be causally related to the 2006 injury, Dr. Sassman did not specifically

opine such a connection existed. I am therefore left only with a rating based upon degenerative changes visible on an x-ray taken 9 years following the left knee injury and nearly 3 years following the work related right lower extremity injury. Without more, I am unable to attribute this impairment level to the original 2006 injury.

Dr. Sassman also recommended permanent restrictions as a result of the left knee injury: rare kneeling and squatting. However, the evidentiary record fails to support Dr. Sassman's restrictions. Importantly, it is noted that claimant functioned in physically demanding positions following the 2006 left knee surgery, without permanent restrictions and without ongoing medical care. The results of claimant's September 22, 2015 FCE also contradict these recommended restrictions. Specifically, the FCE noted claimant demonstrated a significant ability to perform kneeling; no limitations were noted with respect to claimant's ability to kneel. The FCE did note deficits in claimant's ability to perform repetitive squatting; however, the limitation was to an occasional basis, as opposed to the rare basis recommended by Dr. Sassman. Furthermore, the FCE noted restrictions with respect to repetitive squatting as contrasted with simple squatting. Finally, the FCE provider related claimant's deficits primarily to right forefoot symptoms and not to involvement of the left knee. I, therefore, find Dr. Sassman's recommendations for permanent restrictions are unconvincing.

Although claimant credibly testified to some ongoing symptomatology following the 2006 left knee surgery, I find claimant failed to prove, by a preponderance of the evidence, that the left knee condition resulted in a loss of use of the left leg. As set forth *supra*, I find the opinions of Dr. Sassman are insufficient to meet claimant's burden. As claimant has failed to prove a first qualifying loss, claimant is not entitled to benefits from the Fund.

The final issue for determination is a specific taxation of costs pursuant to Iowa Code section 86.40 and rule 876 IAC 4.33. Claimant submitted an itemized request for taxation of the costs of: filing fee ($100.00); Dr. Sassman's IME of February 9, 2015, pertaining to claimant's left knee ($641.50); Mr. Goodhue's FCE ($850.00); Dr. Sassman's IME of February 3, 2016 ($626.90); and Dr. Sassman's supplemental letter report of June 20, 2016 ($215.00).

Iowa Code section 86.40 states:

> **Costs.** All costs incurred in the hearing before the commissioner shall be taxed in the discretion of the commissioner.

Iowa Administrative Code Rule 876—4.33(86) states:

> **Costs.** Costs 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, (8) costs of persons reviewing health service disputes. Costs of service of notice and subpoenas shall be paid initially to the serving person or agency by the party utilizing the service. Expenses and fees of witnesses or of obtaining doctors' or practitioners' reports initially shall be paid to the witnesses, doctors or practitioners by the party on whose behalf the witness is called or by whom the report is requested. Witness fees shall be paid in accordance with Iowa Code section 622.74. Proof of payment of any cost shall be filed with the workers' compensation commissioner before it is taxed. The party initially paying the expense shall be reimbursed by the party taxed with the cost. If the expense is unpaid, it shall be paid by the party taxed with the cost. Costs are to be assessed at the discretion of the deputy commissioner or workers' compensation commissioner hearing the case unless otherwise required by the rules of civil procedure governing discovery. This rule is intended to implement Iowa Code section 86.40.

Iowa Administrative Code rule 876—4.17 includes as a practitioner, "persons engaged in physical or vocational rehabilitation or evaluation for rehabilitation." A report or evaluation from a vocational rehabilitation expert constitutes a practitioner report under our administrative rules. Bohr v. Donaldson Company, File No. 5028959 (Arb. November 23, 2010); Muller v. Crouse Transportation, File No. 5026809 (Arb. December 8, 2010) The entire reasonable costs of doctors' and practitioners' reports may be taxed as costs pursuant to 876 IAC 4.33. Caven v. John Deere Dubuque Works, File Nos. 5023051, 5023052 (App. July 21, 2009).

As claimant failed to prevail in his claim against the Fund, none of the claimed costs are taxed to defendant-Fund. Claimant has prevailed in his claim against defendant-employer. It is therefore appropriate to tax defendant-employer with the costs of $100.00 filing fee and two practitioner's reports. I find the FCE expense and Dr. Sassman's IME expense of February 3, 2016 are properly subject to taxation. I find taxation of such expenses warranted, as the FCE was ordered by claimant's authorized physician, Dr. Phisitkul, and Dr. Sassman's opinion regarding the ultimate extent of claimant's permanent impairment provided probative assistance in consideration of the issues presented for determination. Claimant is not permitted, however, to receive reimbursement for the full cost of Mr. Goodhue's FCE or Dr. Sassman's IME as a practitioner's report under rule 4.33. Rather, the Iowa Supreme Court has ruled only the portion of the expenses incurred in preparation of a written report can be taxed. Des Moines Area Regional Transit Authority v. Young, 867 N.W.2d 839 (Iowa 2015).

The FCE invoice fails to specify what portion of the charged expense was incurred in connection with report preparation. Therefore, consistent with the decision of LaGrange v. Nash Finch Co., File No. 5043316 (App. July 1, 2015), defendant-employer is taxed with one-third of the total expense of $850.00. Defendant-employer is taxed with $283.30 of the cost of FCE (33 1/3 percent x $850.00 = $283.30). Dr. Sassman's bill itemization notes a $500.00 charge for the combined examination and report and $126.90 for x-rays. The portion of the IME charge associated with x-rays cannot be considered an element of report preparation. Again consistent with LaGrange, defendant-employer is taxed with one-third of the portion of Dr. Sassman's fee which includes report preparation. Defendant-employer is taxed with $166.65 of Dr. Sassman's IME expense (33 1/3 percent x $500.00 =$166.65).

Defendant-employer is, therefore, taxed with costs totaling $549.95 ($100.00 + $283.30 + $166.65). No costs are taxed to defendant-Fund.

ORDER

THEREFORE, IT IS ORDERED:

The parties are ordered to comply with all stipulations that have been accepted by this agency.

Defendant-employer shall pay unto claimant thirty-three (33) weeks of permanent partial disability benefits commencing November 8, 2012 at the weekly rate of eight hundred sixty-six and 74/100 dollars ($866.74).

Defendant-employer shall pay accrued weekly benefits in a lump sum.

Defendant-employer shall pay interest on unpaid weekly benefits awarded herein as set forth in Iowa Code section 85.30.

Defendant-employer shall pay claimant's prior medical expenses and medical mileage submitted by claimant at the hearing as set forth in the decision.

Defendant-employer shall receive credit for benefits paid.

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

Claimant shall take nothing from defendant-Second Injury Fund of Iowa from these proceedings.

Costs are taxed to defendant-employer pursuant to 876 IAC 4.33 in the amount of five hundred forty-nine and 95/100 ($549.95), as set forth in the decision. No costs are taxed to defendant-Second Injury Fund of Iowa.

Signed and filed this 16th day of March, 2017.

ERICA J. FITCH
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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EJF/kjw

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.