BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

MARIA DELGADO, Claimant, vs. MONSANTO, Employer, and INDEMNITY INSURANCE CO. OF N. AMERICA, Insurance Carrier, Defendants.	File No. 5042707 APPEAL DECISION Head Note No.: 1803

FILED
AUG - 6 2015
WORKERS' COMPENSATION

Defendants Monsanto, employer, and Indemnity Insurance Co. of N. America, insurer, filed a Notice of Appeal on September 24, 2014.

The case was heard on January 24, 2014, in front of the deputy workers' compensation commissioner and was considered fully submitted on March 20, 2014. There was some dispute about chiropractic records that were allowed in late. However, the record was held open for 60 days to allow the defendants to obtain a deposition of the chiropractor. They did not conduct a deposition but instead offered a letter from Mickie J. Schleef, D.C., a letter from Jorge E. Tijmes, M.D., and review of the Hawkeye Chiropractic Clinic records from Jorge E. Tijmes, M.D. (Exhibits O, P and Q).

An arbitration decision was rendered on August 12, 2014, finding the claimant had sustained neck, shoulder, and left upper extremity injuries arising out of a work-related injury. Claimant was given a running award of temporary total disability benefits. On September 15, 2014, a rehearing decision was issued to revise the commencement date of the running award to September 12, 2013.

Defendants assert on appeal that the deputy erred in finding that claimant sustained a neck and shoulder injury and that claimant had an ongoing injury. Defendants also argue that they were prejudiced by the deputy's refusal to grant a motion to continue due to the late production of the chiropractic records.

The detailed arguments of the parties have been considered and the record of evidence has been reviewed de novo.

Pursuant to Iowa Code sections 86.24 and 17A.5, I affirm and adopt as the final agency decision those portions of the proposed arbitration decision filed on August 12, 2014, that relate to issues properly raised on intra-agency appeal with the following additional clarification regarding costs.

The defendants chose to depose the claimant on December 18, 2013. During the deposition, it was revealed that claimant sought treatment at Hawkeye Chiropractic Clinic shortly after the injury date in September 2012. Defendants claimed that they were prejudiced by the late discovery and moved for a continuance. This was denied.

In instances of contested admissibility, the agency applies a prejudice standard. Schoenfeld v. FDL Foods, Inc., 560 N.W.2d 595, 598 (Iowa 1997). Exclusion of evidence is the most severe sanction and is justified only when prejudice would result. The defendants were allowed sixty days following the hearing to depose the chiropractor. Instead, defendants produced a letter from Dr. Schleef and two from Dr. Tijmes. There appears to be no prejudice in admitting the evidence and rather than continuing the hearing, the defendants were allotted additional time to cure any prejudice.

Therefore the deputy did not err in allowing the chiropractic records into evidence or in denying the motion to continue.

The remainder of this case rests on the issue of credibility. The deputy chose to find the claimant credible and the defendants, on appeal, argue that she is not. The deputy concluded claimant sustained a work-related injury to her left wrist, shoulder, arm, and neck. He also determined she was not at maximum medical improvement. The defendants rest their defense on claimant's alleged lack of credibility, the alleged fact that she did not report the injury to her shoulder and neck to her supervisors, and that when she did complain of pain in her left shoulder and neck, it was too remote in time to the injury to be connected.

At the time of her injury claimant was a migrant worker who moved around the United States performing agricultural tasks. She began working for the defendant employer in September 2012. She was hired, among other things, to sort through corn, weeding out the good from the bad. On the date of her injury the claimant fell as she was cleaning up the remains of cornhusks.

There is some confusion about the date of her injury as to whether it occurred on September 11 or September 19. However, the defendants accepted the injury despite the unclear injury date. She reported an injury to her supervisor. The defendants argue that she only reported wrist pain, however claimant recalls informing her supervisor of neck, shoulder, and wrist pain.

The defendants repeatedly stated in their brief that the claimant's only early report of neck and shoulder injury is through her chiropractor. Yet the very first medical

record exhibit from the claimant is an emergency room report dated October 1, 2012, in which the claimant reports a strain in her neck and shoulder. (Ex. 1) During the emergency room visit, claimant exhibited limited range of motion in her cervical spine and spasm of the left cervical paraspinal muscles in the left upper trapezius muscle. Those areas were also tender to palpation. She also had diminished strength on the left. (Ex. 1) Claimant was discharged with ibuprofen and Flexeril and ordered to follow up with the company doctor. She was also provided a work release imposing restrictions of no lifting over 10 pounds. (Ex. 1, p. 2)

X-rays indicated that there was no fracture or other significant abnormalities. (Ex. A)

The visit to the emergency room was prompted by claimant's chiropractic visit on the same day. (Ex. 10, p. 66)

Claimant returned to work and her co-workers helped her perform the lifting requirements. Her employment with the defendant employer ended on October 5, 2012, and claimant returned to her home in Texas. She requested additional care from defendant employer but was not provided that care until she retained an attorney. On April 4, 2013, she was authorized to see Dr. Jorge Tijmes in McAllen, Texas. (Ex. 6, p. 51)

She began treatment with Dr. Tijmes on April 12, 2013. (Ex. 2, p. 4) In the narrative portion, claimant reports falling on her left shoulder and arm and that the nurse told her that there was no problem with her left shoulder or arm. (Ex. 2, p. 4) "She refers pain to the left shoulder, left wrist, neck with swelling to the left neck area and left chest area," wrote Dr. Tijmes (Ex. 2, p. 4) On examination her cervical spine revealed mild tenderness to palpation over the left aspect with paravertebral muscle spasms. Her range of motion was normal but she had pain at the extremes. (Ex. 2, p. 5) These were essentially the same symptoms she exhibited at the emergency room months prior. Claimant was placed in a short arm cast for 2 weeks. (Ex. 2, p. 6) She continued to complain of neck and wrist pain on a subsequent visit. (Ex. 2, p. 8) However, by May 30, 2013, claimant was being treated only for left wrist pain. She informed Dr. Tijmes that she would be relocating to Michigan from June to October. (Ex. 2, p. 11)

In a checklist opinion letter, Dr. Tijmes agreed that claimant had sustained injuries to her left wrist, shoulder and neck arising out of the September 11, 2012, injury. (Ex. 2, p 12) In the comment area he wrote: "The majority of complaints are to the forearm-wrist." (Ex. 2, p. 12) He didn't believe that she was at maximum medical improvement and wrote: "More than anything she needs physical therapy to wrist and forearm." (Ex. 2, p. 13) The letter was signed and dated July 18, 2013. In a letter to defendants, Dr. Tijmes wrote: "I have diagnosed a left wrist sprain and recommended treatment. At this time, there are limited objective findings of injury to the shoulder and neck and it is unclear if these conditions are related to the work accident." (Ex. C, p. 2)

Claimant then moved to Michigan and the defendant authorized that she be seen by Patrick Ronan M.D. The letter dated July 2, 2013, it states: "Monsanto has agreed to authorize an examination in order to evaluate the extent of Ms. Delgado's work injury and to determine whether there is a need for further treatment for any injuries sustained." (Ex. B, p. 2) There is some dispute in the briefs as to whether this was an independent medical examination or whether Dr. Ronan was being authorized as a treating physician.

From the letter dated July 2, 2013, it appears that this was an initial evaluation rather than a transfer of treatment. If it had been a transfer of treatment, claimant would have been engaging in physical therapy which had been ordered repeatedly by Dr. Tijmes.

Claimant underwent an MRI on June 24, 2013. The history section of the radiology records indicates claimant sustained injury nine months ago and that the MRI was to include the neck, shoulder, and left upper extremity. (Ex. 3, p. 17) The MRI revealed claimant had sustained a small posterior disc protrusion at T8-T9 and a small paracentral disc protrusion at T12-L1. (Ex. 3, p. 18) At the cervical level, claimant displayed forminal narrowing, greater on the left. It was noted that there was potential for left C6 radiculopathy. (Ex. 3, p. 19) The left shoulder MRI showed degenerative joint changes as well as a full thickness tear in the supraspinatus tendon and a partial thickness tear in the infraspinatus tendon. (Ex. 3, p. 20)

It was also noted that the claimant did not suffer from any neck or shoulder pain prior to the fall in September. (Ex. 3, p. 22)

Claimant was seen by Dr. Ronan on July 30, 2013. (Ex. B, p. 9) She was accompanied by her daughter who served as an interpreter. Claimant's history given to Dr. Ronan was consistent with the history she had given to the emergency room as well as Dr. Tijmes. (Ex. B, p. 9) On examination she exhibited tenderness from the thoracolumbar junction on the left to the flank and upwards into the soft tissues as well as over the chest wall, through the upper limb as well as the shoulder, arm, elbow, forearm and hand. (Ex. B, pp. 9-10) She exhibited normal range of motion.

Dr. Ronan concluded that he could not demonstrate any remarkable findings that were genuine in regard to the claimant's evaluation. He believed that symptomatic complaints were widespread. He found that the loss of sensation to the left upper limb was nonspecific rather than anatomic and that manual muscle testing did not reflect genuine effort. (Ex. B, p. 11) He went on to say that if the claimant had sustained any injury, there were no such residuals at the time of her evaluation of July 2013. After looking at the MRI he concluded that the results revealed only degenerative changes. (Ex. B, p. 13) Defendants did not provide any further medical care for the claimant as it relates to her shoulder pain.

In one follow-up letter dated January 20, 2014, Dr. Ronan indicated that a fall in September 2012 likely related to a contusion and that the MRI revealed only degenerative changes producing impingement and tearing. Further his examination did not demonstrate that this was clinically relevant. (Ex. B, p. 14)

Dr. Ronan's opinions are the outlier when reviewed against the other medical providers. Claimant's historical complaints were consistent from the time she first saw the chiropractor in September 2012, to the emergency room in October 2012, to the first time she saw Dr. Tijmes in the spring of 2013, to the visit with Dr. Ronan.

Further, she exhibited pain and discomfort when Dr. Ronan palpated her during her examination. While she had diffuse pain rather than specific, it was limited to primarily her left side which would be clinically consistent with her radiology records.

Dr. Ronan indicated there were no symptoms and no residuals at the time of his evaluation in July of 2013, but in his January 20, 2014, Addendum, he indicated that she did suffer impingement. It is evident Dr. Ronan did not find the claimant credible and therefore concluded she had no symptomology even though she expressed pain and discomfort with the sole examination he performed.

Dr. Ronan's specific words regarding claimant's left shoulder are as follows: "In regard to the shoulder, there is credence to indicate left shoulder complaints, likely related to a contusion." (Ex. B, p. 14) Thus, he acknowledges that the claimant has a credible left shoulder complaint but, despite the MRI showing tears and disc protrusions, opines that the pain in the left shoulder was related to a contusion because claimant continued to work.

Claimant's complaints of pain and discomfort in her left shoulder, neck, and arm were consistent from at least October 1, 2012, just a couple of weeks following the actual injury date.

While Dr. Tijmes indicated in a post-hearing letter that the lack of mention of wrist pain would indicate that the wrist injury had resolved, Dr. Tijmes had not examined the claimant for over a year. In the intake records for Dr. Stoken claimant clearly complains of left arm pain that is severe at times. (Ex. 4, p. 32) Dr. Stoken notes in the "current status" section that claimant has left arm pain. (Ex. 4, p. 27) Dr. Tijmes' note of March 31, 2014, doesn't accurately reflect Dr. Stoken's reports or medical records but rather sounds as if he is parroting back alleged facts related to him. The medical records of Dr. Tijmes recorded contemporaneously with his treatment are the most reliable.

I find there is sufficient evidence with just Dr. Ronan's conclusion that claimant sustained a left shoulder injury as well as Dr. Tijmes' findings that claimant sustained injury to her left wrist and forearm to fulfill claimant's burden of proof by a preponderance of the evidence. One does not need to rely on Dr. Stoken's opinions. Dr. Stoken's opinions serve only to buttress the opinions of the other doctors.

Finally the defendants argue that the IME reimbursement requested for evaluation is not reasonable. Dr. Ronan, a physician retained by the defendants, did not find any permanent impairment related to the work injury. Dr. Stoken's evaluation and report (December 18, 2013) was conducted after Dr. Ronan's (7/30/2013). (Ex. 4, Ex. B) That Dr. Stoken's evaluation was more exhaustive than Dr. Ronan's does not make it unreasonable.

The elements of Iowa Code section 85.39 are satisfied in this case and claimant is entitled to repayment of Dr. Stoken's IME fees.

Signed and filed this 6th day of August, 2015

JOSEPH S. CORTESE II
WORKERS' COMPENSATION
COMMISSIONER

Copies To:

Eric J. Loney
Attorney at Law
1311 – 50th St.
West Des Moines, IA 50266
eric@loneylaw.com

Caroline M. Westerhold
Attorney at Law
1248 O Street, Suite 600
Lincoln, NE 68508
cwesterhold@baylorevnen.com