BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

MUNIRA BAHIC, Claimant, vs. MERCY MEDICAL CENTER, d/b/a BISHOP DRUMM Employer, INDEMNITY INSURANCE COMPANY, OF NORTH AMERICA, Insurance Carrier, Defendants.	File No. 5047101 A P P E A L D E C I S I O N Head Note No: 1803

Defendants Mercy Medical Center, d/b/a Bishop Drumm, employer, and its insurer, Indemnity Insurance Company of North America, appeal from an arbitration decision filed on July 30, 2015. Claimant Munira Bahic responds to the appeal. The case was heard on April 21, 2015, and it was considered fully submitted in front of the deputy workers' compensation commissioner on May 12, 2015.

The deputy commissioner found claimant carried her burden of proof that her ongoing complaints after February 27, 2014, and her related need for surgery were causally related to the work injury on February 11, 2013. In doing so, the deputy commissioner gave greater weight to the medical opinions of Drs. Woolley, Harris, and Bansal. The deputy disregarded the opinion of Dr. Mendoza as representing a legal opinion, the opinion of Dr. Boarini as premature, and the deputy commissioner expressed the belief both Dr. Mendoza and Dr. Boarini downplayed the work activity claimant was performing at the time of the February 11, 2013, injury. The deputy commissioner adopted the maximum medical improvement (MMI) date proposed by Dr. Bansal and found claimant permanently and totally disabled. The deputy commissioner ordered defendants to pay permanent total disability benefits at the rate of $387.32 per week, commencing February 11, 2013, less any days claimant worked subsequent to

the injury, and continuing during the period claimant remains permanently and totally disabled. The deputy commissioner awarded claimant claimed medical expenses and found defendants responsible for future medical expenses necessitated by the injury. The deputy commissioner also awarded claimant reimbursement for the cost of Dr. Bansal's independent medical evaluation (IME) and the deputy commissioner taxed defendants with the costs of the arbitration proceeding, including the filing fee for claimant's petition, the full cost of a functional capacity evaluation (FCE) and claimant's vocational evaluation. The deputy commissioner declined to award penalty benefits.

While defendants admit the occurrence of the work injury on February 11, 2013, defendants assert on appeal that the deputy commissioner erred in finding claimant's ongoing complaints after February 27, 2014, are causally related to the injury. In the event claimant's ongoing symptoms are found to be work related, defendants assert the deputy commissioner erred in finding claimant achieved MMI and is entitled to permanent total disability benefits. Defendants assert, if the complaints are found to be work-related, claimant has not yet achieved MMI and is entitled to a running award of healing period benefits until her medical treatment is completed. Defendants also argue the deputy commissioner erred in taxing the full costs of the FCE and vocational report to defendants.

Claimant asserts on appeal that the arbitration decision should be affirmed in its entirety.

Those portions of the proposed agency decision pertaining to issues not raised on appeal are adopted as a part of this appeal decision.

Having performed a de novo review of the evidentiary record and the detailed arguments of the parties, pursuant to Iowa Code sections 86.24 and 17A.15, I respectfully disagree with the deputy commissioner's findings and analysis and I reverse the arbitration decision in its entirety.

FINDINGS OF FACT:

Claimant was 55 years of age on the date of arbitration hearing. (Tr. p. 12) She and her husband reside in Grimes, Iowa. (Tr. pp. 11-12) Claimant completed eight years of education in her native Bosnia. (Tr. p. 12; Ex. E, p. 2) While she remained in Bosnia, claimant worked as a homemaker. (Tr. p. 15; Ex. E, p. 3) Upon leaving Bosnia, claimant and her family lived in Germany for a time. During this period, claimant worked very limited part-time hours cleaning offices. (Tr. p. 15) Claimant and her family

subsequently moved to the United States, at which time claimant was hired by defendant-employer, beginning her employment on January 9, 2001. (Ex. E, p. 3)

At the time she was hired by defendant-employer, claimant began working part-time in the dish room. She explained she would serve food and bus dishes in the cafeteria. (Tr. pp. 15-16) Thereafter, claimant was hired as a full-time prep cook, a position she then held for approximately ten years. In this role, claimant prepared food, loaded food and drinks upon a cart, and delivered those items within the facility. She explained her cart would hold all the supplies needed for 160 people during a 24-hour period. (Tr. pp. 17, 19) Claimant earned a base rate of pay of $12.18 per hour, plus an additional $0.25 per hour premium for timeliness and $1.00 extra per hour for working second shift. (Tr. p. 19; Ex. E, p. 3) Defendant-employer's job description for the position of prep cook identifies physical demands of constant standing, lifting, and walking; frequent crouching, stooping, pushing, and pulling; and occasional climbing, kneeling, and lifting. The description lists the position as involving "heavy" work, including pushing and pulling of 65 pounds occasionally and lifting 50 pounds occasionally and 40 pounds frequently. Employees were directed to use assistance with lifting over 50 pounds. (Ex. 5, p. 2)

Claimant testified she completed approximately two semesters of English courses which were provided by defendant-employer early in her employment. Claimant testified her English-language skills are limited, but she was capable of understanding and communicating in her work environment. She also reported an ability to read menu items at work, but she indicated she is a poor speller. Claimant testified that outside of work she can understand approximately five percent of a written newspaper. While she recognizes words, claimant testified she does not always comprehend the words she is reading. (Tr. pp. 13-14)

On February 11, 2013, claimant suffered an admitted work-related injury. Claimant testified she was maneuvering a full cart and was required to lift and twist the rear of the cart to turn a corner. She felt an immediate sharp and stabbing pain in her low back. Claimant reported the injury to a coworker the same day and to her supervisor the following day. (Tr. pp. 20, 22) Claimant denied any prior back injuries. (Tr. p. 21) Photographs of the type of cart used by claimant on February 11, 2013, reveal the cart possessed three levels, with each level at or below waist height. (Ex. 6, pp. 1-2)

On February 21, 2013, claimant presented to her personal physician, Rebecca Bollin, D.O., in follow up of personal medical conditions of hyperlipidemia and hypertension. At that evaluation, claimant noted a one-week history of back pain with

radiation to the bilateral lower extremities. Claimant related the symptoms to a work-related injury. The record notes claimant, per her employer's instructions, was to seek any evaluation and care for related symptoms at the Mercy Workers' Compensation Clinic. (Ex. D, p. 12)

Following the injury on February 11, 2013, claimant continued to work full time in her regular prep cook position. Claimant testified that during this period she used ibuprofen and medicated patches to treat her symptoms, but she hoped the complaints would resolve. Pain then spread to her right hip and leg, resulting in limping and difficulty bearing weight on her foot. Approximately two months following the injury, claimant discussed her concerns with a supervisor and a medical evaluation was arranged. (Tr. pp. 23-24)

At defendant-employer's referral, claimant presented to Mercy Clinic for evaluation of back pain on April 11, 2013. The corresponding records are largely illegible, but note claimant complained of low back and right leg pain beginning two months prior and progressively worsening. (Ex. 1A, p. 1) Claimant began light duty work in defendant-employer's laundry room. (Tr. 25)

Claimant underwent a lumbar spine MRI on May 1, 2013. The radiologist read the results as revealing moderate single-level degenerative spinal stenosis at L4-L5 due to thickening and overgrowth of the ligamenta flava, and facet arthritis exacerbated by a broad based right paracentral disc herniation. The radiologist recommended evaluation for potential correction to right L5 radiculopathy. (Ex. 1A, p. 2)

Defendants arranged for claimant to be evaluated by Cassim Igram, M.D., on May 17, 2013. Claimant reported low back and radiating right leg pain. Dr. Igram noted claimant suffered an injury at work on February 11, 2013, while "pulling a cart," in the "context" of lifting a heavy object with pushing and twisting movements. He noted claimant did not seek medical treatment for two months. (Ex. 1B, p. 1)

On examination, Dr. Igram noted claimant utilized a wheelchair and stood with great difficulty; he observed claimant ambulate with a very antalgic and unsteady gait. Dr. Igram also noted numbness of the right leg, as well as breakaway weakness in a seated position, right greater than left. Dr. Igram reviewed claimant's MRI and opined it revealed some disc bulging with lateral recess stenosis at L4-L5 on the right, a finding he noted could cause right L5 nerve root impingement. Dr. Igram ultimately assessed lumbar radiculopathy and radiographic evidence of a herniated disc at right L4-L5. He removed claimant from work and issued a pain management referral. (Ex. 1B, p. 3)

Pursuant to Dr. Igram's referral, claimant was seen on May 28, 2013, at Pain Specialists of Iowa by Clinton Harris, M.D. Claimant reported she suffered an injury on February 11, 2013, when she lifted and twisted a cart and developed immediate low back pain. Dr. Harris further noted that after 1 ½ months, this pain progressed into claimant's right leg. (Ex. 1C, p. 1) Dr. Harris recommended a right L5-S1 transforaminal epidural steroid injection (TESI). (Ex. 1C, p. 2)

The recommended L5 TESI was performed by Dr. Harris on June 12, 2013. (Ex. 1D, pp. 1-9) Thereafter, claimant returned to Dr. Harris on June 28, 2013, and reported no relief with the TESI. Claimant reported she was bedridden for seven days following the injection and subsequently developed a sensation of heaviness in the right leg. Claimant also denied relief with nabumetone. (Ex. 1C, p. 3) Dr. Harris opined a right lower extremity EMG would be reasonable to evaluate for potential nerve damage and he recommended claimant follow up with Dr. Igram. Dr. Harris issued prescriptions for Baclofen and Gabapentin and he imposed a 10-pound lifting restriction with no bending or twisting. (Ex. 1C, p. 4)

Claimant returned to Dr. Igram on July 15, 2013, and reported worsening low back pain with radiation to the right lower extremity. She denied relief with the injection performed by Dr. Harris. Dr. Igram noted claimant's examination was essentially unchanged and she continued to utilize a wheelchair. (Ex. 1B, p. 4) Dr. Igram described claimant as "quite symptomatic" and further commented that claimant's symptoms were "much more than I would expect" given her radiographic findings. Accordingly, Dr. Igram restricted claimant from performing any work and recommended a right lower extremity EMG. (Ex. 1B, p. 5)

Claimant underwent the recommended EMG/nerve condition studies on August 2, 2013, with Kurt Smith, D.O., who opined both studies were normal, with no evidence of right lumbar radiculopathy. (Ex. D, pp. 15-16)

Claimant returned to Dr. Harris on August 5, 2013. Dr. Harris noted claimant's EMG was normal. Claimant reported a poor reaction to Gabapentin. As a result, Dr. Harris discontinued the prescription. (Ex. 1C, p. 5) Dr. Harris recommended a repeat right L5 TESI. (Ex. 1C, p. 6) Claimant underwent the recommended injection on August 7, 2013. (Ex. 1D, pp. 10-18)

On August 12, 2013, claimant returned to Dr. Igram. Dr. Igram reviewed claimant's electrodiagnostic studies and opined the results were normal. Dr. Igram noted claimant utilized a crutch with ambulation. Dr. Igram assessed back pain and lumbar radicular pain. He opined claimant's condition was non-surgical and issued a

referral for evaluation by a physical medicine and rehabilitation physician. Dr. Igram maintained claimant's no-work restriction and recommended claimant return as needed. (Ex. 1B, pp. 6-7)

Pursuant to Dr. Igram's referral, on September 9, 2013, claimant presented to Anthony Stark, D.O. Claimant complained of pain of the right sacroiliac (SI) joint and buttock, with radiation to the right lower extremity. (Ex. 1B, p. 8) Dr. Stark performed a physical examination, during which he noted claimant utilized crutches. He also reviewed claimant's EMG and MRI results. (Ex. 1B, pp. 9-10) Dr. Stark assessed low back pain, sacroilitis, sciatica, and right-sided piriformis syndrome. He removed claimant from work, ordered a course of physical therapy, and prescribed a Medrol Dosepak to decrease inflammation around the Si joint and piriformis. (Ex. 1B, p. 10)

Claimant returned to Dr. Stark in follow up on September 24, 2013. At that time, she reported approximately 30 percent relief with use of the Medrol Dosepak. (Ex. 1B, p. 12) Claimant continued to utilize crutches and continued to report significant pain located to the right SI joint, which Dr. Stark noted radiated to the right lower extremity in an L5 distribution. Dr. Stark continued claimant's prescription for nabumetone and referred claimant to a pain management specialist for right SI joint injection. (Ex. 1B, pp. 13-14)

On October 23, 2013, defendant-employer terminated claimant's employment. Associated documentation indicates claimant was eligible for rehire. (Ex. 8, p. 1)

Pursuant to Dr. Stark's referral, claimant returned to Dr. Harris on October 28, 2013. Claimant denied any pain relief with the TESI, but reported resolution of right lower extremity numbness and tingling. Dr. Harris opined it was reasonable to attempt a right SI joint injection, but cautioned that if claimant received no relief, he did not believe repeat injections would be beneficial. (Ex. 1C, p. 7) Dr. Harris performed the right SI joint injection on November 1, 2013. (Ex. 1D, pp. 19-27)

On or about November 4, 2013, claimant's daughter-in-law telephoned the surgery center at which Dr. Harris performed the SI joint injection. She claimed claimant suffered a negative reaction to the injection, resulting in significant swelling of the right thigh. The nurse advised claimant to contact Dr. Harris. (Ex. 1D, p. 26)

Claimant returned to Dr. Harris on November 8, 2013. Claimant complained of essentially unchanged symptoms, with continued low back pain, right lower extremity pain, and numbness and tingling of the right lower extremity. She also complained of

right knee pain. She reported minimal relief with the SI joint injection. At the time of the evaluation, claimant utilized a crutch with ambulation. (Ex. 1C, p. 10)

Dr. Harris performed a physical examination. He opined claimant's findings on examination were "somewhat inconsistent at times." He highlighted the impact of distraction on claimant's examination. Dr. Harris noted claimant complained of some pain symptoms on examination, but not during manipulation of the body part. He also noted claimant demonstrated difficulty with full extension of her legs on examination, but no difficulty with full extension while distracted. He further described claimant's complaint of leg tenderness as inconsistent. (Ex. 1C, p. 11) Dr. Harris also opined claimant's examination and subjective complaints were "somewhat inconsistent" with claimant's MRI and EMG findings. He further indicated he saw no reason why claimant required a crutch or other assistive device, given the MRI and EMG findings. Dr. Harris opined he saw no reason claimant would be prohibited from performing seated work. (Ex. 1C, p. 10)

On December 3, 2013, claimant returned to Dr. Stark. Dr. Stark noted claimant complained of continued low back pain which appeared to originate from about the right SI joint, as well as radicular symptoms of the entire right lower extremity. Claimant denied relief with the right SI joint injection and reported receiving some minimal relief with nabumetone. Dr. Stark noted little progress with physical therapy. Claimant reported therapy resulted in worsened pain. (Ex. 1B, p. 15)

At the December 3, 2013, appointment, Dr. Stark observed claimant's continued use of a crutch for ambulation. (Ex. 1B, p. 15) However, during physical examination, Dr. Stark noted claimant sat in a chair and then travelled to the exam table without assistance and with minimal observed symptoms. Dr. Stark noted claimant exhibited quite a bit of pain with very light palpation of the right-sided paraspinals, SI joint, gluteal muscles, thigh, and lateral foot. He also noted the pressure of sitting in a chair or lying on the examination table did not appear to cause pain to claimant. Dr. Stark noted claimant did sit with her right lower extremity slightly extended. (Ex. 1B, p. 16)

Dr. Stark noted claimant continued to experience significant right low back pain with radicular-type symptoms of the right lower extremity. He opined the findings were most consistent with right SI joint dysfunction and sciatica. However, Dr. Stark opined claimant's examination revealed some inconsistencies and likely symptom magnification. After considering claimant's EMG and MRI findings and given the lack of neuropathy or lumbosacral radiculopathy present, Dr. Stark indicated he lacked a clear explanation for the severity of claimant's pain symptoms. (Ex. 1B, p. 17)

Dr. Stark opined that, from a medical standpoint, claimant should reasonably be capable of performing light duty work. He further indicated claimant could resume working without restrictions within one month. Dr. Stark also noted he failed to see a reason claimant required an assistive device with ambulation. He refilled claimant's nabumetone and recommended claimant complete the existing course of physical therapy. Dr. Stark otherwise released claimant from care as he lacked any additional treatment options. Instead, Dr. Stark referred claimant to the Des Moines University Clinic for evaluation and possible manipulation treatments. In the event Des Moines University refused care, he advised claimant to follow up with her personal medical provider. (Ex. 1B, p. 17)

At the referral of defendants, on February 19, 2014, claimant presented for independent medical examination (IME) with neurosurgeon, David Boarini, M.D. (Ex. A, p. 3) Dr. Boarini issued a 1 ½ page narrative report containing his findings and opinions dated February 27, 2014. Dr. Boarini noted claimant suffered an injury while pushing, turning and twisting a cart, which resulted in low back pain. He noted claimant thereafter continued working for a period of two months, without seeking medical treatment. At the time of the IME, claimant complained of constant low back pain with burning and weakness into her right leg. (Ex. A, p. 1)

In completing his IME, Dr. Boarini noted he reviewed relevant records; he did not summarize or identify all records reviewed. Dr. Boarini opined claimant's MRI revealed some degenerative changes, primarily at L4-L5, with a small bulge and mild stenosis. Dr. Boarini attempted to physically examine claimant; however, he described the examination as "essentially impossible" due to "obvious pain exaggeration and symptom magnification." Dr. Boarini described claimant's testing as inconsistent, with demonstrated breakaway and clearly non-physiologic findings. He noted he was unable to utilize straight leg raise testing in evaluating claimant's condition, due to "massive symptom exaggeration." Dr. Boarini also noted claimant complained of numbness of her entire right leg, a finding he identified as non-physiologic. Additionally, Dr. Boarini opined claimant's tuning fork testing demonstrated clear indications of malingering. (Ex. A, p. 1)

Dr. Boarini ultimately opined claimant sustained "an extremely minimal, if any, injury" on February 11, 2013. In discussion of claimant's MRI findings, Dr. Boarini found no sign of a related structural lesion and opined it would be "impossible" to attribute any finding of structural significance in claimant's back to the reported February 11, 2013, injury. Dr. Boarini expressed belief his conclusion was supported by claimant's lack of

pursuit of medical care for approximately two months. He found no basis upon which to assign a permanent impairment rating or activity restrictions. (Ex. A, p. 2)

Dr. Boarini further opined he was unable to state whether claimant continued to suffer with symptoms, given demonstration of malingering and symptom exaggeration. Dr. Boarini opined claimant did present with degenerative disease of her back and noted this condition might benefit from use of over-the-counter medications and conditioning exercises. However, he was unable to offer an opinion as to claimant's need for activity restrictions due to symptom exaggeration. Dr. Boarini again cautioned that any potential need for restrictions would not be causally related to the February 11, 2013, work injury. (Ex. A, p. 2)

Pursuant to Dr. Stark's recommendation, defendants scheduled three appointments for claimant at Des Moines University. (Ex. 16, p. 1) On February 27, 2014, claimant presented to Des Moines University Osteopathic Medical Center and was examined by Adrian Woolley, D.O. In her handwritten notes, Dr. Woolley noted claimant sustained an injury on February 11, 2013, while moving a cart weighing 50 to 60 pounds. Claimant reported when she lifted and twisted the cart she felt immediate right back pain and, later, she felt right lower extremity symptoms. (Ex. 1E, pp. 1, 3) Dr. Woolley performed osteopathic manual medicine (OMM) and issued prescriptions for lidocaine patches and nabumetone. (Ex. 1E, p. 5)

Claimant returned to Dr. Woolley on March 26, 2014. In her handwritten notes, Dr. Woolley noted claimant walked slowly, without placing her full body weight upon the right lower extremity. Dr. Woolley also noted that while seated, claimant did not place her full weight upon her right buttocks. On examination, claimant expressed complaints regarding the limited scope of the examination performed by Dr. Boarini. Dr. Woolley indicated the interpreter had also been present at Dr. Boarini's evaluation and "corroborated" claimant's statements. (Ex. 1E, p. 7) Dr. Woolley then stated claimant's version of events did not correlated with Dr. Boarini's report. (Ex. 1E, p. 7) Dr. Woolley again performed OMM and altered claimant's medications to include Vicodin and Lyrica. (Ex. 1E, p. 9)

On April 23, 2014, claimant returned to Dr. Woolley. At that time, claimant reported some improvement with use of Lyrica. Dr. Woolley's handwritten notes indicate that on examination, claimant claimed to have not seen a tuning fork before, despite Dr. Boarini's report indicating claimant failed a tuning fork test. Dr. Woolley indicated claimant's statement was corroborated by the interpreter. Dr. Woolley recommended a repeat surgical evaluation. (Ex. 1E, p. 14)

Following claimant's April 23, 2014, appointment, Dr. Woolley authored a letter regarding claimant's care to date. She noted at that day's evaluation, claimant complained of low back pain with radiation down her leg. Dr. Woolley noted claimant was receiving relief with use of Lyrica, Vicodin and Lidoderm patches. Claimant also reportedly informed Dr. Woolley that OMM felt good at the time of the treatment, but resulted in later flares of symptoms. As a result, Dr. Woolley opined she did not recommend further OMM. (Ex. 1E, p. 19)

Based upon her three appointments with claimant, Dr. Woolley expressed belief claimant's current symptoms and presentation were consistent with L5 nerve root entrapment. However, she cautioned her findings were "diametrically opposite" of findings and observations of a number of other examining physicians. (Ex. 1E, p. 19) Dr. Woolley also expressed concern regarding the scope of Dr. Boarini's IME examination, noting conflict between his report and claimant's statements. (Ex. 1E, pp. 20-21) Specifically, Dr. Woolley commented on Dr. Boarini's reference to a tuning fork test, while claimant, her husband, and the interpreter denied seeing such a device. (Ex. 1E, p. 19)

Accordingly, Dr. Woolley recommended a repeat surgical opinion. Dr. Woolley recommended this second opinion be performed outside of the Des Moines metropolitan area. She based this recommendation upon the local familiarity between surgeons and a potential for "strong bias" against claimant. Dr. Woolley therefore recommended evaluation by Dr. Mary Hlavin. (Ex. 1E, p. 21)

On May 6, 2014, defendants' counsel authored a letter to claimant's attorney, providing notice claimant's indemnity benefits would cease on May 30, 2014. Counsel noted Dr. Boarini had opined claimant sustained no impairment and required no restrictions. He also noted an opinion had been requested from Dr. Harris. (Ex. 18, p. 3) Claimant's counsel authored a responsive letter dated May 7, 2014. He noted that while Dr. Boarini had issued such opinions, claimant remained under the care of authorized physician, Dr. Woolley. Claimant's counsel indicated that penalty benefits would be sought, should defendants terminate claimant's indemnity benefits on May 30, 2014. (Ex. 18, p. 2)

Claimant continued to follow up with Dr. Woolley for medication management. Such appointments took place on May 7, May 21, and June 26, 2014. (Ex. 1E, pp. 22-29, 34-37) At the appointment on May 21, 2014, Dr. Woolley commented she found the insurer's delay in authorizing claimant's medications to be "inappropriate" and "unethical." (Ex. 1E, p. 29)

In lieu of a referral to Dr. Hlavin, the parties jointly agreed to refer claimant to orthopedic surgeon, Sergio Mendoza, M.D., at the University of Iowa Hospitals and Clinics (UIHC) (Ex. 18, p. 5; Ex. B, pp. 5-6)

On July 29, 2014, claimant underwent a CT of her lumbar spine. The radiologist read the results as revealing moderate spinal stenosis at L4-L5 due to disc bulging /right paracentral disc herniation, associated ligamentum flavum thickening and facet arthropathy. The radiologist also noted moderate right-sided neural foraminal stenosis. (Ex. 1A, p. 4)

On August 6, 2014, claimant presented at UIHC for evaluation with Dr. Mendoza. Claimant reported she injured her back on February 11, 2013, while twisting and pushing a snack cart. She reported feeling immediate sharp pain in her back and subsequently, radicular symptoms down the right leg. (Ex. 1F, p. 1) Dr. Mendoza reviewed claimant's MRI and opined it revealed L4-L5 degenerative stenosis with "disc material vs osteophyte vs cyst." (Ex. 1F, p. 3) Dr. Mendoza noted claimant utilized a cane with ambulation. (Ex. 1F, p. 1)

Following examination, Dr. Mendoza outlined treatment options including no further intervention, additional injections, or surgery. The specific surgery recommended by Dr. Mendoza was an L4-L5 posterolateral interbody fusion (PLIF); claimant expressed a desire to proceed with surgery. Dr. Mendoza removed claimant from work and recommended a pre-surgical course of therapy and conditioning. He opined it was likely claimant suffered an exacerbation of her underlying chronic condition. (Ex. 1F, p. 4)

Claimant returned to Dr. Mendoza on September 3, 2014. Dr. Mendoza described claimant's report of injury as twisting her back while pushing a food cart, resulting in immediate back pain and weeks later, radiating pain down the right leg. Claimant reported some relief with water therapy, Lyrica, Lidoderm patches, and hydrocodone. She continued to utilize a cane with ambulation. (Ex. 1F, p. 11)

Dr. Mendoza assessed spinal stenosis of the lumbar region with neurogenic claudication. (Ex. 1F, p. 14) He noted he was awaiting authorization to proceed with PLIF. (Ex. 1F, p. 11) In the interim, he continued to excuse claimant from work and prescribed continued therapy and medications. (Ex. 1F, pp. 13-14) With respect to causation of claimant's condition, Dr. Mendoza opined to the nearest degree of medical certainty, "the causation of this injury is not related to work." (Ex. 1F, p. 14)

On October 1, 2014, claimant returned to Dr. Mendoza. Dr. Mendoza noted claimant's therapy had been stopped, due to the insurer's denial of authorization. (Ex. 1F, p. 18) Dr. Mendoza opined he continued to recommend PLIF, regardless of whether the precipitating condition was work-related. Accordingly, he recommended resumption of pre-surgical physical therapy for endurance and conditioning. (Ex. 1F, p. 21)

Claimant underwent L4-L5 PLIF performed by Dr. Mendoza on October 27, 2014. (Ex. 1F, pp. 24-26, 29-35) Following surgery, claimant remained hospitalized until discharge on October 29, 2014. (Ex. 1F, p. 26)

On November 10, 2014, claimant telephoned Dr. Mendoza's practice, with complaints of development of left lower extremity pain. Dr. Mendoza ordered x-rays and a Medrol Dosepak. (Ex. 1F, p. 37) Following an x-ray, a nurse telephoned claimant on November 14, 2014. At that time, the nurse informed claimant the x-ray was normal. Claimant reported improvement in left lower extremity pain. (Ex. 1F, p. 37)

Counsel for defendants engaged in a telephone conference with Dr. Mendoza. Counsel then posed written questions to Dr. Mendoza, who supplied answers to those questions on November 21, 2014. By his responses to the check-the-box questionnaire, Dr. Mendoza opined claimant's current condition was not related to the February 11, 2013, injury. Rather, he opined claimant's current condition was related to chronic stenosis and underlying degenerative conditions. He further opined the injury of February 11, 2013, was not a substantial or materially aggravating factor in claimant's symptoms and the injury of February 11, 2013, did not cause acceleration, material aggravation, or lighting up of the preexisting condition. (Ex. B, pp. 1-2) Dr. Mendoza opined that, at most, the work injury of February 11, 2013, resulted in a temporary exacerbation of the underlying condition. Dr. Mendoza opined claimant did not sustain permanent impairment as a result of the work injury. He also opined no further treatment was required as a result of the work injury of February 11, 2013, and that any ongoing treatment would be causally related to the preexisting and chronic condition. (Ex. B, pp. 2-3)

Dr. Mendoza provided deposition testimony on December 22, 2014. Dr. Mendoza acknowledged that on August 6, 2014, he diagnosed claimant with a likely exacerbation of an underlying chronic back condition and recommended L4-L5 PLIF. (Ex. 13, p. 5) He further acknowledged that at the time of claimant's second appointment, on September 3, 2014, he opined claimant's symptoms were not related to the work injury. (Ex. 13, p. 7) Dr. Mendoza explained he did not specifically address causation at the time of the first appointment, as his focus is upon the patient. He

indicated he subsequently added his opinion on causation, likely as a result of inquiry from another party. (Ex. 13, p. 7)

Claimant's counsel inquired into opinions purportedly raised by Dr. Mendoza in a prior conference, which Dr. Mendoza did not recall. Claimant's counsel then asked Dr. Mendoza if he believed claimant's condition was not typically aggravated or exacerbated by normal work duties. (Ex. 13, pp. 8-9) Dr. Mendoza replied:

> Well, in particular this type of work duties. It's pushing a snack cart. It's not a major – It's not a fall, it's not a, you know, unloading a truck, or it's not a major mechanical force in the lower back, so that's why I don't see any reason to consider this an injury.

(Ex. 13, p. 9)

Dr. Mendoza further indicated claimant was performing the "natural course of her work" and expressed agreement that he did not believe her employer "should be responsible for an exacerbation of an underlying injury that becomes symptomatic during everyday duties similar" to those described by claimant. (Ex. 13, p. 9) On further questioning by defendants' counsel, Dr. Mendoza reaffirmed his opinions as set forth in his prior letter. (Ex. 13, p. 10)

Following performance of claimant's surgery, Dr. Mendoza relocated and left his medical practice at UIHC. Claimant's care was assumed by Ernest Found, M.D. At a follow up appointment on December 8, 2014, Dr. Found described claimant as doing "quite well." He noted claimant complained of some intermittent right-sided hip and back pain, swelling, and unsteadiness on her feet. As a result, claimant continued to use a walker with ambulation. Dr. Found performed a physical examination and ordered x-rays of claimant's lumbar spine. He ordered a course of physical therapy, imposed restrictions of a maximum lift of 10 to 15 pounds, and issued final prescriptions for hydrocodone and hydroxyzine, with claimant directed to wean herself from these medications. Dr. Found recommended continued use of a back brace, yet noted he would likely wean claimant from its use in the future. (Ex. D, p. 25)

Counsel for claimant conferenced with Dr. Harris and authored a letter requesting Dr. Harris' opinions with respect to claimant. On December 31, 2014, Dr. Harris authored a two-sentence opinion directed to claimant's counsel. Dr. Harris opined:

> [T]he symptoms and conditions [claimant] experienced after her injury dated February 11, 2013 were a material aggravation of that incident.

(Ex. 1C, p. 13)

Claimant returned to Dr. Found on January 15, 2015. Dr. Found noted claimant reported dramatic improvement in her back pain following surgery, although she continued to require a walker for stability. (Ex. D, p. 28) Following x-rays and physical examination, Dr. Found opined claimant was doing "very well." He issued a prescription for Lyrica and lessened claimant's physical restrictions to allow for a 20-pound lift. He imposed no restrictions on bending or twisting. Dr. Found advised claimant to return for follow up evaluation in six weeks. (Ex. D, p. 29)

On January 20, 2015, defendants' counsel authored a letter to claimant's counsel. By this letter, defendants notified claimant that her indemnity benefits would cease in 30 days, based upon Dr. Mendoza's opinion that claimant's condition was not work-related. Defendants further claimed any weekly benefits paid following Dr. Mendoza's letter were to be considered as permanent partial disability benefits. Additionally, defendants offered payment for medical mileage expenses incurred in connection with Dr. Mendoza's evaluations on September 24 and October 1, 2014; however, no medical mileage would be paid on subsequent appointments, as the condition was not work-related. (Ex. 9, p. 1)

Claimant's counsel conferenced with Dr. Woolley on February 2, 2015. Thereafter, Dr. Woolley authored a responsive letter to written inquiry from claimant's counsel. (Ex. 1E, p. 40) Dr. Woolley described claimant's report of injury on February 11, 2013, and briefly summarized her subsequent treatment. (Ex. 1E, p. 41) Dr. Woolley noted she evaluated claimant on February 11, 2015, and recommended the addition of OMM to the course of physical therapy prescribed by claimant's surgeon. (Ex. 1E, p. 40)

With respect to causation, Dr. Woolley noted claimant denied any prior history of back pain and indicated the assigned case manager had described claimant as a model employee. (Ex. 1E, p. 41) She opined:

> Based on this confirmation, I can only believe that [claimant's] presentation to me on February 27, 2014, was due to the work-related trauma the patient states occurred on February 11, 2013.

(Ex. 1E, p. 41)

Dr. Woolley opined claimant demonstrated osteoarthritic changes of the lumbar spine, but had been asymptomatic prior to the work injury. She explained that arthritic symptoms would develop slowly and not in the acute fashion described by claimant. Instead, she opined a sudden disc rupture was consistent with claimant's report of suffering a sharp pain while performing a "strenuous activity of lifting and twisting a heavy object." Dr. Woolley opined such an event could easily cause acute narrowing and compression of the L5 nerve root, resulting in immediate pain and subsequent radicular symptoms. Dr. Woolley opined an acute injury to a disc which demonstrated chronic asymptomatic degeneration could cause claimant's symptoms and examination findings. (Ex. 1E, p. 41)

At the arranging of claimant's counsel, on February 27, 2015, claimant underwent an IME with board certified occupational medicine physician, Sunil Bansal, M.D. Dr. Bansal issued a report containing his findings and opinions dated March 17, 2015. (Ex. 2, pp. 1, 16) In completion of his IME, Dr. Bansal performed a medical records review and summarized claimant's treatment. (Ex. 2, pp. 2-8) Dr. Bansal also interviewed claimant, who described her job duties and the injury of February 11, 2013. Claimant reported she sustained an injury while pushing a cart loaded with supplies weighing an estimated 60 to 80 pounds. She indicated she lifted and twisted to turn a corner when she felt sharp pain in her low back. Claimant denied prior low back problems and indicated she was capable of working without difficulty for years. Claimant informed Dr. Bansal her pain steadily increased, at which point she requested medical care. (Ex. 2, pp. 9-10)

At the time of examination, claimant complained of constant low back pain, radiating to the right hip and entire leg; numbness and tingling of her toes; and instability with walking, resulting in use of a cane. Pain levels were described as reaching a 7 on a 10-point scale. (Ex. 2, pp. 9-10) Dr. Bansal performed a physical examination. (Ex. 2, pp. 10-11)

Following records review, interview and examination, Dr. Basal assessed a herniated disc at L4-L5 on the right, status post-PLIF. He opined claimant had achieved maximum medical improvement for the condition as of the date of examination, February 27, 2015. (Ex. 2, p. 11) He opined claimant presented with failed back syndrome and would benefit from treatment by a pain specialist. Dr. Bansal opined claimant fell within DRE Lumbar Category IV, warranting a permanent impairment of 22 percent whole person, due to surgical arthrodesis and considerable residual pain. He recommended permanent restrictions of a maximum lift of 5 pounds occasionally; no frequent bending, squatting, climbing or twisting; sitting, standing and walking as

tolerated; and avoidance of sitting, standing or walking for over 30 minutes. (Ex. 2, p. 13)

With respect to causation, Dr. Bansal opined the "forceful twisting and lifting" performed by claimant on February 11, 2013, aggravated her underlying lumbar spondylosis and caused an acute L4-L5 disc herniation. (Ex. 2, p. 12) Dr. Bansal highlighted a lack of low back or radicular symptoms immediately preceding the event on February 11, 2013. He opined this event "set off a cascade of neuroregulatory and immunochemical events," leading to sensitization of the L4-L5 disc and chronic pain. Dr. Bansal related claimant's need for surgery to the February 11, 2013, work injury. (Ex. 2, p. 13)

On March 10, 2015, claimant participated in a functional capacity evaluation (FCE) at the request of her attorney. The therapist found claimant demonstrated maximum, consistent effort and described the testing results as valid. The therapist opined claimant was capable of functioning in the sedentary physical demand category, with specific restrictions of: occasional lifting and carrying of five pounds, occasional sitting, standing, forward bending, and elevated work, rare walking or squatting, and no crouching. (Ex. 3, pp. 1-5)

Claimant returned to Dr. Woolley on March 16, 2015. At that time, Dr. Woolley provided claimant with a prescription for Tramadol. (Ex. 1E, p. 43)

At the request of claimant's counsel, claimant participated in an interview on March 16, 2015, with vocational specialist Phil Davis. In addition to the interview, Mr. Davis performed a records review. (Ex. 4, p. 1) In his vocational assessment report, Mr. Davis identified transferrable skills possessed by claimant, which he opined were limited to food service activities. Mr. Davis also indicated claimant's lack of English skills represented a significant barrier to her ability to obtain employment in occupations other than unskilled work. (Ex. 4, p. 6)

Mr. Davis described claimant's work for defendant-employer as falling within the medium physical demand category, while the restrictions of the FCE and Dr. Bansal limited claimant to sedentary work. Accordingly, he opined claimant was unable to perform the essential functions of her preinjury position. Mr. Davis further indicated greater than 90 percent of occupations listed in the Dictionary of Occupational Titles fall in the light to very heavy physical demand categories. Given his conclusion claimant only possessed transferrable skills, training, or experience in food service, Mr. Davis opined claimant's restrictions significantly impacted her ability to obtain and maintain employment. (Ex. 4, p. 6) Upon consideration of all relevant factors, Mr. Davis opined

claimant's ability to obtain and maintain employment had been "drastically reduced if not eliminated." (Ex. 4, p. 7)

Dr. Bansal reviewed additional, updated medical records and authored a supplemental report dated March 17, 2015. He opined the opinions expressed in his original IME remained unchanged. Following review of the FCE results, Dr. Bansal adopted the outlined restrictions, which he opined were consistent with his own findings. (Ex. 2, pp. 15-16)

On March 23, 2015, René Haigh, completed a vocational assessment of claimant at the request of defendants. In completion of his assessment, Mr. Haigh completed a records review. By this review, Mr. Haigh concluded claimant's work history demonstrated an ability to function in the medium physical demand category. Assuming Dr. Boarini's full duty work release, Mr. Haigh concluded claimant remained capable of functioning in all physical demand categories. (Ex. C, pp. 1-5) Utilizing Dr. Stark's restrictions, Mr. Haigh concluded claimant remained capable of functioning in the light to select medium physical demand categories. Given the restrictions recommended by Dr. Bansal and found by the FCE, Mr. Haigh concluded claimant could function in selective sedentary positions. (Ex. C, p. 6)

Mr. Haigh performed a job search and located positions available to claimant which fell within the restrictions noted by Drs. Found and Stark. Mr. Haigh opined it was possible claimant might be capable of performing these jobs with reasonable accommodations which would bring the duties into compliance with the restrictions outlined by Dr. Bansal and the FCE. (Ex. C, pp. 7-8) Ultimately, Mr. Haigh opined claimant remained employable, because there were occupations for which claimant remained a viable candidate. (Ex. C, p. 9)

On April 15, 2015, claimant returned to Dr. Woolley in follow up. Dr. Woolley performed OMM and prescribed medication. (Ex. 7, p. 2) Claimant testified such OMM sessions are helpful and she desires to continue with such care. (Tr. 31)

As of the date of arbitration hearing, claimant complained of continued back and right foot pain, as well as numbness of the right foot. (Tr. pp. 41, 63) Claimant testified her leg symptoms improved following surgery, but her back symptoms did not. (Tr. p. 35) At the time of hearing, claimant continued to treat with Dr. Woolley and at UIHC. (Tr. pp. 35-36) Claimant continues to wear a back brace and she ambulates with a cane. (Tr. pp. 37-38) Claimant testified she believed her condition was "improving somewhat but slowly." (Tr. p. 35)

Claimant submitted medical bills incurred in treatment at UIHC from October 23, 2014, through March 4, 2015, and with Des Moines University. (Ex. 10, pp. 6-24; Ex. 14, pp. 1-3) Claimant also submitted an itemized request for medical mileage during the period of September 24 through December 8, 2014. The requested mileage includes visits with Dr. Woolley and UIHC, totaling 989.2 miles. (Ex. 11, pp. 1-3)

As of the date of arbitration hearing, claimant had not sought employment. Claimant believes her back pain precludes a return to work. (Tr. pp. 39-40, 66-67; Ex. E, p. 6) Claimant testified her symptoms limit her to no longer than 30 minutes in any position or posture. (Tr. p. 41) She expressed hope that her condition would improve to a degree as to allow her to work. (Tr. p. 40) Approximately one to two months prior to the arbitration hearing, claimant applied for Social Security Disability benefits; she had received no determination at the time of hearing. (Tr. 43) Review of claimant's W-2s from defendant employer reveal she earned $28,021.91 in 2012 (Ex. 15, p. 5) and $14,597.40 in 2013 (Ex. 15, pp. 6-7).

Claimant's daughter-in-law, Natalia Bahic, testified at evidentiary hearing. She has known claimant for approximately eight years and testified that prior to her injury, claimant loved her job at defendant-employer. (Tr. pp. 73-74) Ms. Natalia Bahic testified she had observed limitations in claimant's abilities following the work injury. Specifically, she testified claimant walks and sits differently, has difficulty rising from seated positions or climbing stairs, and now misses family events. (Tr. pp. 75-76)

CONCLUSIONS OF LAW:

Having performed a de novo review of the evidentiary record and the detailed arguments of the parties, I reverse the proposed arbitration decision as follows, with the following findings and analysis:

The threshold issue for determination is whether the stipulated work injury of February 11, 2013, is a cause of claimant's ongoing disability and symptoms after February 27, 2014.

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).

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).

The deputy commissioner found claimant carried the burden of showing her ongoing low back condition and need for surgery were causally related to the work injury of February 11, 2013. The deputy commissioner relied upon the opinions of treating physician Dr. Woolley, whose opinions he described as logical. He found additional support in the consistent opinion of Dr. Harris and the thorough opinion of Dr. Bansal. Following review of the entirety of the evidentiary record, I reject the conclusions of the deputy commissioner and I award greater probative value to the opinions of Dr. Mendoza, as buttressed by the opinions of Dr. Boarini.

I award the greatest weight to the opinions of Dr. Mendoza due to his medical expertise, as compared to the remaining opining physicians. Additionally and relatedly, Dr. Mendoza served as claimant's treating surgeon. As claimant's treating surgeon, Dr. Mendoza possessed the unique opportunity to examine claimant on multiple occasions, including intra-operatively. When this knowledge is coupled with Dr. Mendoza's expertise as an orthopedic surgeon, I find his opinion entitled to the greatest weight. The fact that the parties jointly agreed to send claimant to Dr. Mendoza for further evaluation and treatment supports a determination that he is a qualified surgeon.

I believe the presiding deputy was incorrect to disregard Dr. Mendoza's opinions as a legal conclusion. Dr. Mendoza offered clear opinions on the potential bases for a causal relationship between claimant's ongoing symptoms and the stipulated work injury. Dr. Mendoza's opinions were based upon objective physical findings and claimant's reported mechanism of injury. There is documentary evidence to establish that Dr. Mendoza possessed sufficient knowledge of claimant's reported injury and subsequent medical treatment. I find nothing inherently flawed in Dr. Mendoza's description of claimant's work injury which would lead me to disregard his opinion as inaccurate. Dr. Mendoza's deposition testimony is reflective of a physician who is of the

opinion that the injury suffered by claimant was relatively minor and did not give rise to ongoing complaints and the need for surgery. This is an opinion that is well within his purview as a physician, as opposed to an improper legal conclusion.

Dr. Mendoza's opinion is also buttressed by the opinion of Dr. Boarini. Dr. Boarini is a qualified neurosurgeon whose opinion is entirely consistent with the opinion of Dr. Mendoza. Dr. Boarini's examination findings are also consistent with the findings of prior authorized physicians. While claimant attacks the scope of Dr. Boarini's evaluation and by doing so infers Dr. Boarini fabricated certain examination findings, I find no credible basis to support such a conclusion.

I find the opinions of Drs. Woolley, Harris, and Bansal entitled to lesser weight. Dr. Woolley is a physician practicing osteopathic manual manipulation. Dr. Woolley is not a qualified surgeon such as Drs. Mendoza and Boarini. She also, admittedly, noted examination findings "diametrically opposite" of prior treating physicians. This fact is particularly relevant given Dr. Woolley did not examine claimant until over one year following the stipulated work injury, at a point in time after which Dr. Boarini opined claimant's temporary injury had resolved. Dr. Mendoza also opined claimant's work-related condition was, at best, a temporary exacerbation of an underlying degenerative condition. I find Dr. Harris' opinion entitled to little probative weight, given it was cursory in nature and he, too, is not a qualified surgeon. I find Dr. Bansal's opinion, while thorough and logical, is simply not entitled to as much deference as the opinions offered by the opining surgeons.

Given I find the opinions of Dr. Mendoza and Dr. Boarini entitled to greatest weight, it is determined claimant failed to carry her burden of proof that her ongoing condition after February 27, 2014, was causally related to the stipulated work injury of February 11, 2013. Claimant has failed to prove by a preponderance of the evidence that her ongoing condition and need for surgery were causally related to the stipulated work injury of February 11, 2013. Accordingly, claimant is not entitled to temporary disability benefits connected with claimant's ongoing medical treatment. Similarly, defendants are not responsible for medical expenses or mileage incurred in treatment of claimant's ongoing condition. Defendants remain responsible for any claimed medical treatment which was authorized by defendants, as well as related medical mileage.

As claimant suffered a stipulated work-related injury on February 11, 2013, it must be determined if the work injury is a cause of permanent disability. The presiding deputy awarded claimant permanent total disability benefits. This award was predicated upon a causal connection between claimant's ongoing complaints and the work related injury. As I have determined no such causal connection has been proven, claimant is not entitled to an award of permanent total disability benefits.

While is it possible claimant could prove the limited injury of February 11, 2013, was a cause of permanent disability, the evidentiary record contains insufficient support for this proposition. Dr. Mendoza opined claimant did not sustain permanent

impairment as a result of the stipulated work injury. Dr. Boarini opined he found no basis for an assignment of permanent impairment or permanent restrictions related to the February 11, 2013, injury. Only Dr. Bansal opined claimant sustained permanent impairment and required permanent restrictions. His opinion, however, is based upon claimant's ongoing complaints and surgical treatment and, therefore, Dr. Bansal's opinion is entitled to no weight.

It is therefore determined claimant has failed to prove by a preponderance of the evidence that the work injury of February 11, 2013, is a cause of permanent disability. As claimant has not prevailed on the merits of her underlying case, claimant is not entitled to taxation of the costs of the FCE or the vocational report.

ORDER:

IT IS THEREFORE ORDERED that the arbitration decision filed July 30, 2015 is reversed.

Claimant shall take nothing in way of weekly benefits.

Defendants are not responsible for claimed medical expenses, with the exception of any authorized medical expenses and related medical mileage, as set forth in the decision.

The parties shall bear their own costs of the arbitration proceeding and claimant shall pay the costs of the appeal, including the cost of the hearing transcript.

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

Signed and filed this 9th day of February, 2017.

Joseph S. Cortese II

JOSEPH S. CORTESE II
WORKERS' COMPENSATION
COMMISSIONER

Copies To:

Nicholas W. Platt
Attorney at Law
2900 100th Street, Suite 304
Urbandale, IA 50322
plattlawpc@outlook.com

Kent M. Smith
Attorney at Law
P.O. Box 36
Cedar Rapids, IA 52406-0036
ksmith@scheldruplaw.com