BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

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| TRAVIS JAY,<br><br>Claimant,<br><br>vs.<br><br>ARCHER SKID LOADER SERVICE, LLC,<br><br>Employer,<br><br>and<br><br>GRINNELL MUTUAL REINSURANCE COMPANY,<br><br>Insurance Carrier,<br>Defendants. | File No. 19003586.01<br><br>A P P E A L<br><br>D E C I S I O N<br><br>Head Notes: 1402.40; 1803; 2502; 2907 |

Defendants Archer Skid Loader Service, LLC, employer, and its insurer, Grinnell Mutual Reinsurance Company, appeal from an arbitration decision filed on March 17, 2022. Claimant Travis Jay responds to the appeal. The case was heard on July 15, 2021, and it was considered fully submitted in front of the deputy workers' compensation commissioner on August 12, 2021.

In the arbitration decision, the deputy commissioner found claimant met his burden of proof to establish he sustained 15 percent permanent impairment of his left shoulder caused by the stipulated September 19, 2019, work injury, which entitles claimant to receive 60 weeks of permanent partial disability benefits commencing on June 8, 2020. The deputy commissioner found defendants should reimburse claimant $103.00 for the cost of the filing fee, $14.00 for the cost of service, $285.00 for the cost of the rebuttal report from Mark Taylor, M.D., and $88.15 for the cost of a deposition transcript.

On appeal, defendants allege the deputy erred in finding claimant sustained 15 percent permanent impairment of his left shoulder and in assessing defendants with claimant's costs.

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

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

I performed a de novo review of the evidentiary record and the detailed arguments of the parties. Pursuant to Iowa Code sections 17A.15 and 86.24, with the following additional and substituted analysis, the arbitration decision filed on March 17, 2022, is affirmed in part, modified in part, and reversed in part.

Without further analysis, I affirm the deputy commissioner's finding that defendants should reimburse claimant $103.00 for the cost of the filing fee, $14.00 for the cost of service, $285.00 for the cost of the rebuttal report from Dr. Taylor, and $88.15 for the cost of a deposition transcript.

With the following additional and substituted analysis, I affirm the deputy commissioner's finding that claimant sustained permanent impairment of his left shoulder caused by the work injury, but I modify in part, and I reverse in part, the deputy commissioner's finding that claimant sustained 15 percent permanent impairment.

On September 19, 2019, claimant injured his left shoulder when he fell four feet onto concrete while climbing down from a truck at work. Claimant's boss took claimant to Ottumwa Occupational Health. (JE 1, p. 1) A left shoulder MRI revealed large full-thickness tear of the rotator cuff involving the supraspinatus and infraspinatus tendons. (JE 2, pp. 6-7)

Defendants accepted the claim and referred claimant to Christopher Vincent, M.D., an orthopedic surgeon for treatment. (JE 3) On December 11, 2019, Dr. Vincent performed a left shoulder arthroscopic reconstruction of massive supraspinatus and infraspinatus rotator cuff tear, subacromial decompression, acromioplasty, ligament release, and a distal clavicle excision. (JE 3, p. 11) Claimant received physical therapy and he was released to return to work without restrictions on April 6, 2020. (JE 3, p. 21)

Dr. Vincent found claimant reached maximum medical improvement (MMI) on June 8, 2020, and Dr. Vincent found claimant had normal strength in both shoulders. (Ex. D, p. 7) Dr. Vincent conducted range of motion testing and found claimant had flexion of 160 degrees for the left shoulder and 180 degrees for the right shoulder, abduction of 160 degrees for the left shoulder and 180 degrees for the right shoulder, extension of 45 degrees for both shoulders, external rotation of 90 degrees for both shoulders, and internal rotation of 70 degrees for the left shoulder and 90 degrees for the right shoulder. (Ex. D, p. 7) Using Figures 16-40, 16-43, and 16-46 of the Guides to the Evaluation of Permanent Impairment (AMA Press, 5th Ed. 2001) ("AMA Guides"), Dr. Vincent assigned claimant one percent impairment for loss of flexion, one percent impairment for loss of abduction, and one percent impairment for loss of internal rotation for a combined loss of three percent of the left upper extremity. (Ex. D, p. 7)

Claimant underwent an independent medical examination (IME) with Dr. Taylor, an occupational medicine physician, on August 26, 2020. (Ex. 2) Dr. Taylor conducted range of motion testing and found claimant had flexion of 150 degrees for the left

shoulder and 165 degrees for the right shoulder, abduction of 130 degrees for the left shoulder and 170 degrees for the right shoulder, extension of 40 degrees for the left shoulder and 60 degrees for the right shoulder, external rotation of 65 degrees for the left shoulder and 85 degrees for the right shoulder, and internal rotation of 45 degrees for the left shoulder and 65 degrees for the right shoulder. (Ex. 2, p. 8) Using Figures 16-40, 16-43, and 16-46 of the AMA Guides, Dr. Taylor assigned claimant five percent permanent impairment for range of motion deficits, and under Table 16-27, Dr. Taylor assigned claimant an additional 10 percent permanent impairment for the distal clavicle resection, for total impairment of 15 percent of the left upper extremity. (Ex. 2, p. 9) In his report, Dr. Taylor noted:

> I am aware that this rating is significantly higher than the rating assigned by Dr. Vincent. The range of motion values were actually fairly close to each other and only resulted in a minimal difference as far as the rating. The bulk of the difference is related to the distal clavicle excision that was documented as part of the surgery.

(Ex. 2, pp. 9-10)

Defendants shared Dr. Taylor's IME report with Dr. Vincent and asked for his response. (Ex. D, p. 9) Dr. Vincent responded on June 7, 2021, as follows:

> I stand by my original opinion of a 3% upper extremity impairment rating based on the range of motion and functional evaluation performed by myself at the time of final followup. I disagree with an impairment of 10% for the upper extremity impairment due to the distal clavicle excision and will outline my rationale and opinion below.
>
> I would consider myself a specialist in shoulders. I am fellowship-trained in sports medicine specializing in shoulder and knee pathology. I do not award impairment ratings for distal clavicle excisions alone, based on the table 16-27 on page 506. I am well aware of this table in the AMA Guides to the Evaluation of Permanent Impairment. 5th Edition. Many of my colleagues, who are similarly trained, agree with this opinion. Table 16-27 is a table that awards impairment for "arthroplasty procedures". The term "resection arthroplasty" is an old term to describe the distal clavicle excision procedure, or previously known as "Mumford procedure". Resection arthroplasty is really an inaccurate term as this is not a true arthroplasty. This procedure should not be listed in this table. This table is meant for joint replacement surgeries. This includes things like total shoulder arthroplasty, total elbow arthroplasty, radial head replacement, and these procedures do warrant impairment and I agree with the other arthroplasties in this table. However, the distal clavicle excision is not a joint replacement. It is a resection of a small amount of defective bone, much like a cheilectomy or acromioplasty. This is also reflected in the current CPT coding guidelines, which does not refer to the distal clavicle excision as an arthroplasty/joint replacement. Current coding descriptions from CPT

coding states "29824 -arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)." This is further evidence that the terminology of arthroplasty is inaccurate for this procedure. This procedure should not be compared with joint replacement surgeries of the upper extremity, which involves implantation of permanent implants.

In training and during my continuing medical education, I have performed extensive literature review for many procedures and conditions that I treat and particularly have reviewed long-term functional outcome studies after distal clavicle excision. There is good orthopedic literature that supports good long-term function and successful improvements in function after distal clavicle excision. This is based on an extensive body of orthopedic literature demonstrating excellent outcomes and improved function after distal clavicle excision. The table referenced above does award a 10% impairment for acromioclavicular arthroplasty in Table 16-27. Based on articles written in the AMA Guides Newsletter as well as my own training, I do not include this base impairment for distal clavicle excision. I have included the article "Acromioclavicular Joint Arthritis" by Charles Brooks, September 2005, to support my opinion. The AMA Guides to the Evaluation of Permanent Impairment 5th Edition, provides no impairment rating for cheilectomy around the acromioclavicular joint or other joints such as subacromial decompression. During a distal clavicle excision, one is removing a portion of diseased or pathologic bone. Consider the procedure, subacromial decompression, which results in loss of a small portion of the body. The bone that is excised, however, is an abnormality. Similarly, the patient undergoing an appendectomy for a diseased infected tissue does not get a base impairment for removal of the appendix. This is because removal of this defective diseased tissue results in improved function, not diminished function. Excision of an inferiorly projecting spur from the distal clavicle should improve function. Because removal of this liability is beneficial, it should result in no and even perhaps negative impairment. This reasoning is consistent with the prior article in the AMA Guides Newsletter, *Acromioplasty: Is it an impairment*? by Charles Brooks. This article states that uncomplicated acromioplasty results in no impairment. Distal clavicle excision does remove 1 to 1.5 cm of bone from the lateral end of the clavicle; however, this does not result in impairment. I would argue that despite the loss of a small portion of abnormal bone, if done for appropriate indications, the upper extremity function should be improved postoperatively, and like a cheilectomy or decompression results in an even negative impairment. There are other examples in the AMA Guides to Evaluation of Permanent Impairment, 5th Edition, which demonstrates loss of a body part or a portion thereof does not result in impairment. There is, for instance, no impairment due to splenectomy. Even though this is an organ that serves a real physiologic function in the body. This article that I have included has been written after the publication of AMA Guides to

> Evaluation of Permanent Impairment, 5th Edition, (i.e. is more up to date) and I believe it further supports my opinion that no impairment should be awarded based solely on the distal clavicle excision procedures being performed.

(Ex. D, pp. 9-10)

Dr. Taylor received a copy of Dr. Vincent's letter and wrote a response on June 16, 2021. (Ex. 2, pp. 15-16) Dr. Taylor opined, "it could reasonably be argued that most orthopedic procedures serve, in large part, to improve function." (Ex. 2, p. 15) Dr. Taylor acknowledged Dr. Vincent's knowledge, but also noted the authors and reviewers of the AMA Guides were similarly familiar with the procedure when they developed and included the table in the publication, noting:

> Apparently, they decided that, although the procedure may not be a typical arthroplasty-type procedure, such as a shoulder replacement, it was still worth including, and that this Table was a reasonable location in which to place it, a placeholder, if you will. There may also be other procedures in the Table that are not necessarily a true arthroplasty, but were still included. The Table has a column for both implant and resection arthroplasties, and a DCR, as the name implies, is a "resection"-type procedure.

(Ex. 2, p. 15)

Dr. Taylor further noted that the AMA Guides 6th Edition, which was published in 2007, also includes an impairment range between eight and 12 percent for a distal clavicle resection. (Ex. 2, p. 16)

After reviewing the competing opinions of Dr. Vincent and Dr. Taylor and the AMA Guides, the deputy commissioner found:

> Table 16-27 on page 506 of the Guides provides that a ten percent impairment is used for a distal clavicle resection. Dr. Vincent did not assign an impairment rating based on this table because he disagrees with the AMA's decision to include such a table in the Guides and the AMA's conclusion that the procedure merits an impairment rating at all. Dr. Vincent's opinion relates to a policy choice made by the AMA with respect to how this procedure should be treated with respect to permanent impairment. It is not the agency's place to second-guess the AMA on such decisions.
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> Indeed, as noted above, the legislature has mandated that determinations of functional impairment under the Iowa Workers' Compensation Act must be made solely by utilizing the Guides adopted for use by the Commissioner. The Commissioner has adopted the Fifth Edition, with which Dr. Vincent disagrees. Dr. Vincent is entitled to his

> opinion about AMA policy choices as reflected in the Guides, but his opinion does not govern determinations of functional impairment under Iowa law. The Fifth Edition of the Guides does. Consequently, Dr. Vincent's impairment rating is given less weight because he intentionally did not follow the Guides. For this reason, Dr. Taylor's opinion is more credible and is adopted.

(Arb. Dec. p. 11)

Iowa Code section 85.34(2) governs compensation for permanent partial disabilities. The law distinguishes between scheduled and unscheduled disabilities. The Division of Workers Compensation evaluates disability using two methods, functional and industrial. Simbro v. Delong's Sportswear, 332 N.W.2d 886, 887 (Iowa 1983).

This case involves an injury to the shoulder, a scheduled member, which is evaluated functionally based on 400 weeks. Iowa Code section 85.34(2)(n). For functional loss determinations, Iowa Code § 85.34(2)(x) states the following, in pertinent part:

> . . . when determining functional disability and not loss of earning capacity, the extent of loss or percentage of permanent impairment shall be determined solely by utilizing the guides to the evaluation of permanent impairment, published by the American medical association, as adopted by the workers' compensation commissioner by rule pursuant to chapter 17A. Lay testimony or agency expertise shall not be utilized in determining loss or percentage of permanent impairment pursuant to paragraphs "a" through "u", or paragraph "v" when determining functional disability and not loss of earning capacity.

In April 2008, the Iowa Workers' Compensation Commissioner adopted the AMA Guides 5th Edition ("AMA Guides") for determining extent of loss or percentage of impairment for permanent partial disabilities not involving a determination of reduction in an employee's earning capacity. 876 IAC 2.4; Iowa Admin. Code Supp. r. 2.4 (April 28, 2008). It is presumed the legislature was aware of existing decisions and the agency's rules adopting the AMA Guides when it modified the statute to require compensation based on functional loss when an employee returns to work and receives the same or greater salary, wages, or earnings than the employee received at the time of the injury. Roberts Diary v. Billick, 861 N.W.2d 814, 821 (Iowa 2015); Simbo v. Delong's Sportswear, 332 N.S.2d 886, 889 (Iowa 1983); Beier Glass Co. v. Brundige, 329 N.W.2d 280, 285 (Iowa 1983); Lever Bros. v. Erbe, 249 Iowa 454, 87 N.W.2d 469, 474 (1958).

On appeal, defendants assert the deputy erred in finding claimant sustained a five percent permanent impairment for loss of range of motion. As noted by Dr. Taylor in his report, the range of motion findings are similar. Defendants argue the difference

is due to a reinjury. I find the deputy commissioner properly found claimant's reinjury was temporary and did not result in any additional disability.

Defendants next contend the deputy erred in finding claimant sustained ten percent permanent impairment for the distal clavicle excision because the AMA Guides do not allow for assigning an impairment rating for a distal clavicle excision consistent with Dr. Vincent's opinion, and alternatively, Dr. Taylor's opinion should be rejected because he did not apply a modifier to the ten percent rating.

In support of their first contention, Defendants argue Cox v. Bridgestone Americas, Inc., 2021 WL 2624240, File No. 19003499.01 (Iowa Workers' Comp. Comm'n March 9, 2021), supports no rating should be assigned for a distal clavicle excision. The decision does not analyze whether a rating should be assigned for a distal clavicle excision under the AMA Guides. The decision was not appealed. The decision does not support defendants' contention.

Defendants next challenge Dr. Taylor's rating because he did not apply a 25 percent modifier relying on Lemmon v. Nextera Energy Resources, 2021 WL 2624597, File Numbers 5064232, 5064233 (Iowa Workers' Comp. Comm'n April 15, 2021), an arbitration decision, Norstrud v. Snap-On Logistics Co., 2020 WL 5106503, File Number 5061935 (Iowa Workers' Comp. Comm'n Aug. 25, 2020), an appeal decision, and Virden v. City of Des Moines, 2022 WL 1787287, File Numbers 5057949.01, 5053647.01 (Iowa Workers' Comp. Comm'n Feb. 23, 2022), a review-reopening decision. In all three decisions, Dr. Taylor's practice partner, John Kuhnlein, D.O., provided ratings involving shoulder injuries with distal clavicle excisions.

In Lemmon, Dr. Kuhnlein provided multiple ratings for different parts of the body with respect to the work injury. With respect to the shoulder injury, Dr. Kuhnlein noted his rating differed from the rating by James Nepola, M.D., because Dr. Nepola assigned ten percent impairment for the distal clavicle resection without modifying the value by Table 16-18, as indicated by the instructions on page 499. In Virden, Dr. Kuhnlein again applied the modifier for the distal clavicle excision, and assigned three percent impairment for the distal clavicle excision. While the opinions both find Dr. Kuhnlein's opinions persuasive, the deputy commissioners did not analyze the requirement of applying a modifier to a distal clavicle excision under the AMA Guides.

In Norstrud, Dr. Kuhnlein again applied the modifier for the distal clavicle excision, finding three percent impairment for the distal clavicle excision, and Mark Kirkland, D.O., assigned ten percent impairment for the distal clavicle excision. On appeal I found Dr. Kuhnlein's rating more persuasive than Dr. Kirkland's rating because he more accurately applied the AMA Guides by using the modifier for the distal clavicle excision in Table 16-18.

Table 16-27 of the AMA Guides governs impairment of the upper extremities after arthroplasty of specific bones and joints. Under Table 16-27, a distal clavicle excision is assigned ten percent impairment.

Page 498 of the AMA Guides directs the examining physician as follows:

> Conditions not previously described that can contribute to impairments of the hand and upper extremity include bone and joint disorders (Section 16.7a), presence of resection or implant arthroplasty (Section 16.7b), musculotendinous disorders (Section 16.7c) and tendinitis (Section 16.7d), and loss of strength (Section 16.8). The severity of the impairment due to these disorders is rated separately according to Tables 16-19 through 16-30 and then multiplied by the relative maximum value of the unit involved as specified in Table 16-18. . . .

Under Table 16-18, the appropriate multiplier for the acromioclavicular joint is 25 percent.

Claimant underwent a distal clavicle excision. The AMA Guides direct the physician to assign a rating for a distal clavicle excision, contrary to Dr. Vincent's opinion. The AMA Guides also require application of a 25 percent multiplier. This results in a 2.5 percent impairment for a distal clavicle excision under the plain text of the AMA Guides. I find claimant sustained a five percent permanent impairment for loss of range of motion and an additional 2.5 percent impairment for the distal clavicle excision. Using the Combined Values Chart at page 604 of the AMA Guides, claimant has sustained seven percent permanent impairment, and is entitled to 28 weeks of permanent partial disability benefits, commencing on June 8, 2020, at the stipulated weekly rate of $950.24.

## ORDER

IT IS THEREFORE ORDERED that the arbitration decision filed on February 16, 2022, is affirmed in part, modified in part, and reversed in part, with the above-stated additional and substituted analysis.

Defendants shall pay claimant 28 weeks of permanent partial disability benefits, commencing on June 8, 2020, at the stipulated weekly rate of nine hundred fifty and 24/100 dollars ($950.24).

Defendants shall receive credit for all benefits previously paid.

Defendants shall pay accrued weekly benefits in a lump sum together with interest at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two percent.

Pursuant to rule 876 IAC 4.33, defendants shall reimburse claimant one hundred three and 00/100 dollars ($103.00) for the cost of the filing fee, fourteen and 00/100 dollars ($14.00) for the cost of service, two hundred eighty-five and 00/100 dollars ($285.00) for the cost of Dr. Taylor's rebuttal report, eighty-eight and 15/100 dollars

($88.15) for the cost of the deposition transcript, and the parties shall split the cost of the appeal, including the cost of the hearing transcript.

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

Signed and filed on this 23rd day of August, 2022

Joseph S. Cortese II

JOSEPH S. CORTESE II
WORKERS' COMPENSATION
COMMISSIONER

The parties have been served as follows:

Brian Keit (via WCES)

Aaron Oliver (via WCES)