BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

MICHAEL PARIS,

Claimant,

vs.

ABF NORTH AMERICA d/b/a TONE'S BROTHERS, INC.,

Employer,

and

UNITED HEARTLAND, INC.,

Insurance Carrier,
Defendants.

File No. 5022472

ARBITRATION

DECISION

Head Note No.: 1402, 1803, 1803.1

STATEMENT OF THE CASE

Michael Paris, claimant, filed a petition in arbitration seeking workers' compensation benefits from ABF North America d/b/a Tone's Brothers, Inc., employer and United Heartland, Inc., insurance carrier, both as defendants. Hearing was held on April 21, 2016.

Claimant, Michael Paris, and Joshua Eners testified live at trial. The evidentiary record also includes claimant's exhibits 1-7 and defendant's exhibits A-D. The parties submitted a hearing report at the commencement of the evidentiary hearing. On the hearing report, the parties entered into certain stipulations. Those stipulations are accepted and relied upon in this decision. No findings of fact or conclusions of law will be made with respect to the parties' stipulations.

The parties requested the opportunity for post-hearing briefs which were submitted on May 16, 2016.

ISSUES

The parties submitted the following issues for resolution:

1. Whether claimant's injury is confined to his left upper extremity or whether the injury extends to the body as a whole.

2. The extent of claimant's entitlement to permanent partial disability benefits.

FINDINGS OF FACT

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

At the time of hearing claimant, Michael Paris (Paris) was 51 years of age and was a long-time employee of ABF North America d/b/a Tone's Brothers, Inc. (Tone's). The parties have stipulated that he sustained a compensable injury to his left arm when a steel tube dislodged from its housing and struck the distal portion of his left forearm on May 23, 2005. The central dispute in this case is whether the work injury also caused Complex Regional Pain Syndrome (CRPS) and if so, whether claimant should be compensated on an industrial disability basis.

Following the injury, Paris initially treated with Richard McCaughey, D.O. He was assessed as having a contusion of the distal left forearm and possibly wrist with concurrent laceration over the ulnar aspect of his distal left forearm. Dr. McCaughey cleaned and sutured the laceration and placed work restrictions on his activities. (Ex. 1, pp. 1-3; Ex. 2) Paris continued to follow-up with Dr. McCaughey. By June 1, 2005, Paris reported only occasional tingling in his fourth and fifth digits of his left hand. Paris was allowed to return to his usual duties. He was told to follow-up if the tingling did not subside in the next few weeks. (Ex. 1, pp. 4-5) The record is void of any such follow-up with Dr. McCaughey.

On November 13, 2007, Paris was seen by Kenneth L. Pollack, M.D., at the request of the defense attorney for an Independent Medical Evaluation. In addition to examining Paris, Dr. Pollack reviewed the medical records and claimant's answers to interrogatories. The notes indicate that in preparation for the appointment Paris had completed a general health history form, upper body pain questionnaire, and pain diagram.

At the exam, Paris reported that prior to the injury he had no upper extremity tingling. His tingling began immediately after the injury and had persisted; his tingling sensation extended up to the elbow. He also reported some left upper extremity weakness, particularly when gripping. He had to frequently shift work to his right hand to avoid pain at his left elbow and tingling in the distal upper extremity. Paris experienced annoying nocturnal symptoms. The notes reflect Dr. Pollack's findings upon physical examination. Dr. Pollack felt the clinical examination at that time was most consistent with a diagnosis of cubital tunnel syndrome and perhaps ulnar compression at the wrist. However, he felt it was doubtful that there was significant direct injury to the ulnar nerve from the original impact of the injury. Dr. Pollack recommended that Paris be evaluated by an upper extremity surgeon. (Ex. 3, pp. 1-6)

On January 8, 2008, Paris saw Delwin E. Quenzer, M.D., who recommended EMG testing. The testing was completed and demonstrated ulnar neuropathy distal to the midforearm, possibly including Guyon's canal. Dr. Quenzer recommended surgery. (Ex. 3, pp. 7-9) On January 25, 2008, Dr. Quenzer performed a left ulnar neurolysis at the forearm and at the wrist and hand. (Ex. 7, p. 3) Paris continued to follow-up with Dr. Quenzer and reported some improvement with only residual numbness in his ring and small fingers and mild tenderness over his wrist. (Ex. 3, pp. 10-11) On April 15, 2008, Paris was released back to full-duty work. (Ex. 3, p. 11) Dr. Quenzer placed Paris at maximum medical improvement (MMI) on August 20, 2008. (Ex. 3, pp. 12-13) Dr. Quenzer assigned 14 percent left upper extremity impairment. (Ex. 3, pp. 13-16)

Paris continued to experience persistent numbness in his ring and small finger. He was re-evaluated by Dr. Quenzer on October 20, 2009. Repeat EMGs were recommended. The repeat studies demonstrated residual ulnar neuropathy at or near the wrist. Dr. Quenzer prescribed Neurontin. Dr. Quenzer noted that if Paris had relief of dysesthesias with the anticonvulsant then he recommended that he stay on the mediation for three to four months. Dr. Quenzer stated he could continue his regular work duties without restriction. (Ex. 3, pp. 17-19)

The next note in evidence is dated November 4, 2010. Paris returned to see Dr. Quenzer and reported having dysesthesias in the ring and small fingers. He also reported that he was awakened at night with worse numbness and tingling. Additionally, he noted weakness of his hand which seemed to be worse than what he had before. The patient associated his increased symptoms to his increased work. Dr. Quenzer requested updated EMG/NCS testing. Dr. Quenzer noted that this was the same condition he treated the patient for in the past. Because Paris had not contacted Dr. Quenzer, the doctor assumed he was at maximum medical improvement. However, he seemed to now have an aggravation. Dr. Quenzer limited his work to five days per week. (Ex. 3, p. 22)

Paris underwent the additional testing and returned to Dr. Quenzer on January 11, 2011. Even though the testing did not confirm ulnar neuropathy at the elbow, the clinical exam was suggestive so Dr. Quenzer recommended decompression of the nerve at the elbow. (Ex. 3, pp. 24-25)

On January 17, 2011, Dr. Quenzer sent a letter with his opinions to the United Heartland insurance. He was unable to state within a reasonable degree of medical certainty that the laceration of the left forearm on May 23, 2005, was the material causative factor regarding the need for the treatment and surgery which was currently recommended. United Heartland asked Dr. Quenzer if the left upper extremity neuropathy was related to a new injury that Paris may have sustained after United Heartland's policy period ended in July of 2006. Dr. Quenzer noted that the work injury did not include an injury to the elbow or hand. Dr. Quenzer stated that the ulnar neuropathy may or may not be related to any injury. He felt that it was of indeterminate origin. He stated that they are most likely related to ergonomic risk factors. (Ex. 3, pp.

26-27) Based on his opinion the worker's compensation claim was denied and the proposed procedure was not authorized. (Ex. 3, p. 28)

On September 16, 2011, Paris saw Teri S. Formanek, M.D., for an independent medical evaluation. Dr. Formanek felt the patient had ulnar nerve paresthesias in his left hand and also by exam had altered circulation in the ulnar artery. He recommended ultrasound studies and/or an arteriogram. (Ex. 5)

At the request of the defendants, Paris saw John D. Kuhnlein, D.O., for an IME on September 19, 2011. After his examination of Paris and his records review, Dr. Kuhnlein issued a report on October 3, 2011. Dr. Kuhnlein diagnoses included: crush injury left forearm, cubital tunnel syndrome, left carpal tunnel syndrome, and possible ulnar artery pathology. He opined that the original left ulnar neuropathy was directly and causally related to the May 23, 2005, injury. (Ex. 4)

On October 17, 2011, Dr. Quenzer authored a letter to the defense counsel after he had a chance to review Dr. Formanek's report. He found Dr. Formanek's evaluation to be credible. He agreed that vascular testing can determine the status of the ulnar artery. Dr. Quenzer recommended that Paris have noninvasive testing of his left upper extremity, with attention to the ulnar artery at his forearm and hand. Dr. Quenzer also agreed with Dr. Formanek that there was not sufficient evidence to suggest that there was a material aggravation of the left ulnar neuropathy at the left upper extremity since the August 20, 2008, MMI date. Dr. Quenzer felt that Paris did not have carpal tunnel syndrome; rather, he had ulnar neuropathy at the level of his previous injury in the forearm and was related to the injury of May of 2005. (Ex. 3, pp. 29-31)

Dr. Quenzer also had the chance to review the report of Dr. Kuhnlein. Dr. Quenzer agreed that the prognosis for complete symptom resolution appeared to be fairly poor. He also agreed that vascular studies of the left ulnar artery should be conducted. Dr. Quenzer felt that only the ulnar neuropathy at the level of the previous injury was related to the work injury. He was not certain that further surgery regarding the ulnar nerve would improve Paris's condition. (Ex. 3, pp. 29-31)

On January 13, 2012, Dr. Quenzer issued another letter to defense counsel. Dr. Quenzer agreed with Dr. Formanek in that the left forearm injury was the most likely explanation for the left ulnar artery vascular difference. (Ex. 3, pp. 32-33)

On February 29, 2012, Paris returned to see Dr. Quenzer. The doctor recommended arteriogram of the left upper extremity to determine the level of the ulnar artery injury. (Ex. 3, pp. 34-36) On March 27, 2012, Paris returned to Dr. Quenzer who reviewed the arteriogram report. Dr. Quenzer's impression was ulnar neuropathy and ulnar artery occlusion of the left arm, related to the work injury. Repeat EMG/NCS were once again recommended. (Ex. 3, p. 37)

Evidently, it took multiple requests for the EMG/NCS testing Dr. Quenzer recommended in March of 2012 to be approved. Paris saw Dr. Quenzer on August 21, 2012, to go over the testing result. The testing was positive for left carpal tunnel and left ulnar neuropathy at the wrist. The physical examination noted that color, temperature, hidrosis, and ranges of motion of the hand were all normal. Dr. Quenzer felt he was a surgical candidate and that the surgery was related to the work injury. (Ex. 3, pp. 38-41) Paris was given time to decide if he wanted to proceed with the surgical treatment.

On November 16, 2012, Dr. Quenzer sent a letter to the worker's compensation carrier. He indicated that he had sent a letter to Paris asking him to clarify whether he intended to proceed with the authorized surgery. He also provided the carrier with an impairment rating if the claimant decided not to proceed with surgery. (Ex. 3, pp. 42-43)

On March 11, 2013, Dr. Quenzer performed an excision of the ulnar nerve and artery vein graft. (Ex. 3-52) Following the procedures, Paris continued to follow-up with Dr. Quenzer. Dr. Quenzer's May 8, 2013, notes states that Paris was doing very well. Paris indicated he wanted to return to full duty. Dr. Quenzer released him to full duty as of May 13, 2013. (Ex. 3, pp. 44-51) On June 11, 2013, Paris returned to Dr. Quenzer. Dr. Quenzer conducted a physical examination and placed him at MMI. (Ex. 3, pp. 53-53) On July 10, 2013, Dr. Quenzer issued his impairment rating. Dr. Quenzer assigned 6 percent permanent impairment of the left upper extremity. (Ex. 3, p. 54-56) In that report, Dr. Quenzer stated, "[h]e does not have objective evidence of chronic regional pain syndrome. *There is no impairment relating to sensation.*" (Ex. 3, p. 55)

At his attorney's request, Paris underwent an independent medical evaluation with Sunil Bansal, M.D., on December 4, 2015. As a result of Dr. Bansal's evaluation and records review he issued a report dated January 4, 2016. At that time, he had continued swelling of his left arm and hand. He also reported that this hand locked up when he was driving or gripping something for a prolonged period of time. Paris also reported constant aching pain from about the middle of his forearm to his hand which was exacerbated by activity. He had constant numbness or tingling of his hand which involved his third, fourth, and fifth fingers; occasionally all of his fingers were involved. Paris reported that he had noted a temperature change of the left hand and a reddish discoloration. The doctor noted that there was no difference of hair distribution from hand to hand. Paris felt that he also had a loss of range of motion in his hand.

Dr. Bansal diagnosed Paris with a contusion of the distal left forearm with a concurrent laceration over the ulnar aspect of the distal left forearm and ulnar artery occlusion of the left forearm. Dr. Bansal also diagnosed Paris with left upper extremity complex regional pain syndrome (CRPS). Dr. Bansal related both diagnoses to the work injury. He placed Paris at MMI as of December 4, 2015, the date of his exam. Dr. Bansal assigned 9 percent whole person impairment. He restricted Paris to no lifting greater than 10 pounds occasionally and no sustained gripping or grasping with his left hand. He recommended management with a pain physician for his CRPS. (Ex. 6, pp. 1-16)

On March 8, 2016, Paris underwent an IME with Michael Jacoby, M.D., at Iowa Neurology Research. Dr. Jacoby did not agree with Dr. Bansal's diagnosis of CRPS. He felt that the signs and symptoms were not adequate to make a definitive diagnosis. Dr. Jacoby stated that at best Paris had only one, maybe two of the necessary three symptom categories for a CRPS diagnosis. With regard to impairment, Dr. Jacoby agreed with Dr. Quenzer's rating of 6 percent of the upper extremity. With regard to restrictions, Dr. Jacoby stated that he could continue at his current job duty. With regard to future treatment, Dr. Jacoby recommended multiple trial and error efforts at neuromodulating medications which could be provided to the patient by a pain specialist. (Ex. 7)

On April 20, 2016, Dr. Bansal issued a letter to claimant's counsel. He indicated that he had recently reviewed the IME of Dr. Jacoby. Dr. Bansal disagreed with Dr. Jacoby's conclusions and findings. Dr. Bansal stood by his diagnosis of CRPS. (Ex. 6, pp. 17-20)

The central dispute in this case is whether claimant has CRPS. Since the time of the work injury, Paris has seen at least six doctors, including Dr. McCaughey, Dr. Pollack, Dr. Formanek, Dr. Kuhnlein, Dr. Jacoby, and Dr. Bansal. Of those doctors, only one, Dr. Bansal, has diagnosed Paris with CRPS. Dr. Quenzer stated that Paris did not have any objective evidence of chronic regional pain syndrome. (Ex. 3, p. 55) Dr. Jacoby specifically opined that Paris did not have CRPS. His examination did not reveal hyperesthesia and/or allodynia, only paresthesias with no indication of a centralized pain syndrome. Dr. Jacoby also noted that there was a lack of motor or trophic changes or hyperalgesia. Additionally, he disagreed with Dr. Bansal's assessment of Paris having hyperesthesia or allodynia. Ultimately, Dr. Jacoby stated that "at best only one arguably two of the needed three symptom categories and only one of the needed two sign categories" and that "based on the Butapest criteria used by Dr. Bansal, I do not find a definitive diagnosis of Complex Regional Pain Syndrome, Type 1." (Ex. 7, p. 7)

Paris testified that he continues to experience swelling in his left upper extremity. He experiences numbness in his pinky and ring finger. He has difficulty holding onto objects. He wakes at night because he feels like his left upper extremity is asleep. He testified it is difficult for him to work but he continues because he has been there for 21 years.

Ultimately, it is the claimant who has the burden of proof to show by a preponderance of the evidence that he has CRPS as a result of the work injury. Although claimant has had pain and limitations with his left upper extremity since 2005 and has not had a great result from his surgeries, this does not necessarily mean he has CRPS. I find the opinions of Dr. Jacoby and Dr. Quenzer to be more persuasive than that of Dr. Bansal. The opinions of Dr. Jacoby and Dr. Quenzer are consistent with the clinical treatment notes throughout this case. Dr. Jacoby specifically opined that the claimant's condition does not meet the necessary criteria for a diagnosis of CRPS under the Butapest criteria. In the present case, the greater weight of the evidence does not

support claimant's contention. None of the medical providers who treated Paris from the time of the May 23, 2005 work injury through the date of last treatment, June of 2013, diagnosed CRPS. The clinical treatment notes during this timeframe do not support a diagnosis of CRPS. I find the opinions of Dr. Jacoby and Dr. Quenzer to be more persuasive. Thus, I find that claimant has failed to carry his burden of proof to show that his work injury extends beyond the left upper extremity and into the body as a whole.

We now turn to the issue of claimant's entitlement to permanent partial disability benefits. In this case there are several providers who have provided impairment ratings for claimant's left upper extremity. In September of 2008, Dr. Quenzer assigned 14 percent impairment of the upper extremity. However, since that time claimant has received additional treatment, including surgery. More recently, Dr. Quenzer assigned 6 percent impairment of the left upper extremity. (Ex. 3, pp. 54-56) Dr. Jacoby agreed with Dr. Quenzer's impairment assessment. (Ex. 7, p. 7) Dr. Bansal assigned 9 percent whole person impairment but this rating included the diagnosis of CRPS and therefore, cannot be relied upon. With regard to restrictions, Dr. Quenzer released him to work without restrictions. (Ex. 3, p. 53) Dr. Jacoby continued Paris to work in his current job duty. (Ex. 7, p. 8) Paris testified that he is currently working full-time, full-duties for Tone's, including some overtime work. Dr. Bansal restricted Paris to no lifting greater than 10 pounds occasionally with his left hand and no sustained gripping or grasping with his left hand. (Ex. 6, p. 16) I find that Dr. Bansal's restrictions are not consistent with claimant's testimony regarding his abilities. I find that the release to return to work without restrictions from Dr. Jacoby and Dr. Quenzer to be more persuasive. Therefore, I find that Paris does not have any restrictions placed on his activities as a result of the work injury. I find that Paris has demonstrated that he is entitled to 6 percent permanent partial disability of the left upper extremity; this equates to 15 weeks of permanent partial disability benefits.

Finally, claimant is seeking an assessment of costs. Specifically, claimant is seeking reimbursement for the $100.00 petition filing fee and the cost of service in the amount of $12.96. I find that this is an allowable cost under 876 IAC 4.33(3) & (7). Defendants shall reimburse claimant in the amount of $112.96. Claimant is also seeing reimbursement in the amount of $345.00 for the addendum report from Dr. Bansal. Claimant contends this is permissible as a cost of obtaining a practitioner's report under 876 IAC 4.33(6). In this case, I find that this is an allowable cost under 876 IAC 4.33(6). Defendants shall reimburse claimant in the amount of $345.00 for the report. Thus, defendants shall reimburse claimant costs totaling $457.96.

CONCLUSIONS OF LAW

The party who would suffer loss if an issue were not established ordinarily has the burden of proving that issue by a preponderance of the evidence. Iowa R. App. P. 6.14(6)(e). In the present case, the parties have stipulated that the claimant sustained an injury that arose out of and in the course of his employment with Tone's. The

dispute is whether the injury was contained to the left upper extremity or whether the injury extended to the body as a whole.

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).

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).

Based on the above findings of fact, I concluded that the claimant failed to prove by a preponderance of the evidence that he sustained an injury that extended beyond his left upper extremity. I concluded that the claimant demonstrated that he sustained an injury to his left upper extremity which resulted in 6 percent permanent partial disability. Pursuant to Iowa Code section 85.34(2)(m) the loss of an arm shall be compensated up to 250 weeks. Thus, 6 percent of the upper extremity amounts to 15 weeks of benefits. I conclude that Paris is entitled to payment of 15 weeks of permanent partial disability benefits as a result of the May 23, 2005 work injury. The benefits shall commence on the stipulated date of December 4, 2015.

Finally, claimant is seeking an assessment of costs. Costs are to be assessed at the discretion of the deputy commissioner hearing the case. I exercised my discretion and concluded that defendants shall reimburse claimant costs in the amount of $457.96.

ORDER

THEREFORE, IT IS ORDERED:

All weekly benefits shall be paid at the stipulated rate of four hundred eighty-seven and 28/100 dollars ($487.28).

Defendants shall pay fifteen (15) weeks of permanent partial disability benefits.

Defendants shall be entitled to credit for all weekly benefits paid to date.

Defendants shall reimburse claimant's costs as set forth above.

Defendants shall file subsequent reports of injury (SROI) as required by this agency pursuant to rules 876 IAC 3.1 (2) and 876 IAC 11.7.

Signed and filed this 29th day of July, 2016.

ERIN Q. PALS
DEPUTY WORKERS'
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EQP/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.