BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

PATTI JAY, Claimant, vs. LENNOX INTERNATIONAL, INC., Employer, and INDEMNITY INSURANCE COMPANY OF NORTH AMERICA and ACE AMERICAN INSURANCE, Insurance Carriers, Defendants.	FILED MAY 19 2016 WORKERS COMPENSATION File Nos. 5023886; 5042797 REVIEW-REOPENING AND ARBITRATION DECISION Head Note Nos.: 1108; 1400; 1801; 1803.1; 2403,

STATEMENT OF THE CASE

There are two proceedings before this deputy workers' compensation commissioner. File No. 5023886 is a review-reopening of an agreement for settlement that was approved by the workers' compensation commissioner on September 22, 2008. File No. 5042797 is an arbitration proceeding. The contested case was initiated when claimant, Patti Jay, filed her original notice and petition with the Iowa Division of Workers' Compensation. The petition was filed on September 30, 2014. Claimant alleged she sustained a work-related injury on October 1, 2012. (Original notice and petition.)

For purposes of the review-reopening proceeding, Lennox International, Inc., is insured by ACE American Insurance. In the review-reopening proceeding, defendants filed their answer on October 6, 2011. Defendants denied there had been a substantial change in claimant's condition to warrant a review-reopening.

With respect to the arbitration proceeding, defendants, Lennox International, Inc. and Indemnity Insurance Company of North America, filed their answer on October 17, 2014. They denied the occurrence of a work injury. A first report of injury was filed on March 5, 2013.

The hearing administrator scheduled the cases for hearing on January 26, 2016 at 1:00 p.m. The hearing took place in Des Moines, Iowa at the Iowa Workforce Development Building. The undersigned appointed Ms. Roxann Zuniga, as the certified shorthand reporter. She is the official custodian of the records and notes.

Claimant testified on her own behalf. Defendants elected to call no witnesses.

Claimant offered exhibits marked 1 through 4 in File No. 5023886 and 1 through 13 in File No. 5042797. Defendants, offered exhibits marked A through E. All exhibits were admitted as evidence in the case.

Post-hearing briefs were filed on February 29, 2016. The cases were deemed fully submitted on that date.

With respect to File No. 5023886 the Stipulations and Issues are:

STIPULATIONS

The parties completed the designated hearing report. The various stipulations are:

1. There was the existence of an employer-employee relationship at the time of the alleged injury;

2. Claimant sustained an injury on November 4, 2005 which arose out of and in the course of employment;

3. The injury is a cause of temporary and permanent disability;

4. Temporary benefits have all been paid;

5. The commencement date for permanent partial disability benefits is September 21, 2011;

6. At the time of the work injury, the weekly benefit rate was $412.72 per week;

7. Defendants have waived all affirmative defenses they may have had available to them;

8. Clamant is seeking an independent medical examination pursuant to Iowa Code section 85.39;

9. Prior to the hearing, claimant was paid 85 weeks of permanent partial disability benefits at the rate of $412.72 per week; and

10. The parties agree the costs have been paid by claimant.

ISSUES

The issues presented are:

1. Whether there is a change in condition so as to reopen an agreement for settlement; and

2. If there is a review-reopening, the nature and extent of the review-reopening and

3. Is this a "combined effect" case?

With respect to File No. 5042797, the stipulations and issues are:

STIPULATIONS

1. There was the existence of an employer-employee relationship at the time of the alleged injury;

2. Claimant sustained an injury on October 1, 2012 which arose out of and in the course of her employment;

3. Although entitlement to benefits cannot be stipulated, claimant was off work from June 13, 2013 through October 27, 2013;

4. If permanency benefits are awarded the commencement date is October 28, 2013;

5. Defendants have withdrawn all affirmative defenses;

6. Prior to the hearing, defendants paid unto claimant $5,637.52 in sick pay/disability income and defendants are entitled to a credit for the net amount pursuant to Iowa Code section 85.38 (2); and

7. The parties can stipulate to the costs that were paid by claimant.

ISSUES

1. Whether the injury resulted in a temporary disability;

2. Whether the injury resulted in a permanent disability;

3. Whether claimant is entitled to temporary or healing period benefits;

4. Whether claimant is entitled to permanent partial disability benefits;

5. What is the proper weekly benefits rate to use, if weekly benefits are in order?

6. Is claimant entitled to the payment of medical benefits pursuant to Iowa Code section 85.27?

7. Is claimant entitled to an independent medical examination pursuant to Iowa Code section 85.27? and;

8. Is this a "combined effect" case?

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This deputy, after listening to the testimony of claimant, after judging the credibility of claimant, and after reading the evidence, and the post-hearing briefs, makes the following findings of fact and conclusions of law:

The party who would suffer loss if an issue were not established has the burden of proving the issue by a preponderance of the evidence. Iowa Rule of Appellate Procedure 6.14(6).

Claimant is 50 years old and right-hand dominant. She is single with 3 adult children. Claimant has an associate of arts degree in liberal arts from Marshalltown Community College. She testified she is able to use such computer programs as Excel, PowerPoint, Office, and Word for Windows. (Transcript, page 11)

Claimant commenced employment with Lennox International, Inc. on February 10, 2003. She started working on an assembly line. Later, claimant was transferred to a forklift position. She estimated she worked as a forklift driver for eight years.

FILE NO. 5023886 REVIEW-REOPENING

On September 22, 2008, the Iowa Workers' Compensation Commissioner approved an agreement for settlement in File No. 5023886. Some of the terms of the settlement provided that:

> 1. Claimant sustained an injury arising out of and in the course of employment with Employer on 11-04-05.
>
> . . . .
>
> 4(b) Permanent partial disability for 17% loss of earning capacity resulting in 85 weeks of compensation under Iowa Code Section 85.34 (2)(u) payable commencing 10-01-07.
>
> . . . .
>
> 7. This settlement waives a hearing, decision, and resulting statutory benefits. It is subject to review-reopening for three years following the last date that weekly compensation is paid. Iowa Code sections 85.26(2) and 85.27.
>
> . . . .
>
> 9. Evidence that corroborates this settlement is attached. . . .

The parties stipulate that the Claimant has returned to work, with significant restrictions, has not received or needed medical treatment for

> her myofascial/degenerative conditions since May 12, 2008, that she is stable albeit symptomatic in her neck, shoulders, arms and hands; and that no additional medical treatment is foreseen. Claimant has underlying degenerative conditions that occasionally produce myofascial type symptoms as described in the medical records attached thereto. The symptoms have had a permanent and adverse effect on Claimant's employment and she is unable, within her restrictions, to perform certain activities required of various jobs with this employer. The employer agrees to use its best efforts to accommodate claimant's restrictions but makes no guarantee of continued employment.
>
> The parties represent that this agreement was reached as a result of the parties [*sic*] desire to avoid litigation, and to resolve complicated issues of causation, nature and extent.

(Exhibit 4, pp. 20-22)

A number of medical records were attached to the settlement documents. There was a report from Charles Mooney, M.D. It was dated, May 14, 2008. In the report, Dr. Mooney found claimant's left arm had normal range of motion. (Ex. 4, p. 23) She was mildly tender over the sternoclavicular joint but did not demonstrate any swelling or erythema. There was normal cervical range of motion. (Ex. 4, p. 23) Dr. Mooney was prepared to recommend a second opinion to an orthopedist. Dr. Mooney wrote, "I feel that she can return to work to her permanent restrictions and be reevaluated here p.r.n." (Ex. 4, p. 23)

There was a June 16, 2008 clinical note from Kary R. Schulte, M.D. He diagnosed claimant with "Nonspecific left shoulder pain." The physical findings were mild and nonspecific. (Ex. 4, p. 25) Dr. Schulte recommended claimant continue a home exercise program and she return to full activity as tolerated. (Ex. 4, p. 25)

Also attached to the agreement for settlement was the report of Robert C. Jones, M.D., claimant's independent medical evaluator. Dr. Jones examined claimant on October 29, 2007. (Ex. 4, pp. 26-32) Dr. Jones diagnosed claimant with:

> **IMPRESSION:**
>
> 1. Bilateral carpal tunnel syndrome, mild.
>
> 2. Chronic cervical strain with headaches, mild radiculopathy, left.
>
> 3. Status post right lateral elbow release.
>
> 4. Chronic left shoulder and trapezius myofascial pain syndrome.
>
> 5. History of right shoulder pain, essentially resolved.

(Ex. 4, p. 29)

Dr. Jones attributed the conditions to claimant's work at Lennox. The evaluating physician related the conditions to either overuse or a combination of overuse and traumatic aggravation. (Ex. 4, p. 29) Because of claimant's short stature, Dr. Jones opined claimant had to work with her arms in an elevated position. As a result, she developed pain in her shoulders and neck. (Ex. 4, p. 29) Dr. Jones found irritation of a nerve originating in claimant's cervical spine. Dr. Jones opined the left shoulder and trapezius symptoms were essentially myofascial in nature. (Ex. 4, p. 30)

Dr. Jones opined claimant had permanent functional impairments. The physician rated claimant in the following manner:

> **PERMANENT FUNCTIONAL IMPAIRMENT:** I have used the AMA Guides to the Evaluation of Permanent Impairment, fifth edition, as a resource. The following ratings, unless otherwise indicated, are causally related to the patient's work duties as explained in **CAUSAL CONNECTION.**
>
> 1. Left shoulder and trapezius. The myofascial syndrome involving the left shoulder and trapezius is not ratable under the Guides. There is at present insufficient medical evidence of pathology involving the shoulder joint with corresponding loss of motion to merit a rating based on loss of range of motion.
>
> 2. Left carpal tunnel. 5% of the right upper extremity. See table 16-15, page 492 and discussion appearing at page 495. The rating considers the abnormal NCV and clinical signs noted in the medical record and upon examination.
>
> 3. Right carpal tunnel. 5% of the right upper extremity. See table 16-15, page 492 and discussion appearing at page 495. The rating considers the clinical signs noted in the medical record and upon examination.
>
> 4. Right elbow. 5% of the right upper extremity. See table 16-15, page 492 and discussion appearing at page 495. While the discussion refers to carpal tunnel syndrome, there is no reason that I can see that it should not just as well apply to the entrapment that gave rise to the release. The rating considers the clinical signs noted in the medical record and upon examination. It does not factor diminished strength because I found her grip to be nearly within normal limits for a person of her sex and age.
>
> 5. Cervical strain with radiculopathy. 5% of the whole person. DRE Cervical Category II, table 15-5, page 392. There are some early degenerative changes in the cervical spine with positive EMG. She has a positive Spurling-Jones sign to the left which satisfies the criteria of nonverifiable radicular complaints since the test actually verifies her complaints.

(Ex. 4, pp. 30-31)

Dr. Jones imposed the following permanent restrictions:

> The FCE appears to be reasonable subject to the following recommendations. Lifting is limited to no more than 30 pounds and this only occasionally. She may be able to tolerate lifting of up 15 pounds on a more frequent basis but this will depend upon the way in which the object is being lifted. Any lifting or use of the upper extremities should be to no higher than the level of the chest. No lifting or use of the upper extremities above the level of the chest. All lifting should be in close proximity to the trunk of the body. There should be no frequent or constant lifting, carrying, pushing, or pulling with either upper extremity. Avoid frequent rotation, flexion, or extension of the neck and head. The reason I differ from the FCE is that it does not appear to consider injuries other than the chronic left shoulder and trapezius myofascial pain syndrome.
>
> She should not engage in repetitive, forceful pinching (no more than 10 pounds of force) and grasping (no more than 20 pounds of force) with either hand. Avoid repetitive flexion and extension of the wrists. She is limited to performing fine movements with the digits of both hand [*sic*] on an occasional basis. Grasping and holding onto the object with either hand will be a problem with most any weight, even 4 or 5 pounds. It would be better to lift using the hands in a fashion whereby they cup under the object to lift rather than to grasp the object. No use of vibratory tools. I do not give much credence to the X-RTS hand assessment. The carpal tunnel syndrome and the radiculopathy is [*sic*] likely to impair the application of the forces necessary to engage in the consistency of exercise demanded by the testing. The FCE contains no reference to submaximal effort. I saw no evidence of submaximal effort during the examination and I see no such suggestion in the other medical records.
>
> The pace at which she will be able to work must be considered. At present, I think the [*sic*] she needs to be in a work environment where she is able to take rest breaks as symptoms and fatigue require. The need to rest will depend upon the type of work being performed. The closer the demands of the work approach the upper limits of what I recommend, the greater will be the need for longer and more frequent rest breaks.

(Ex. 4, pp. 31-32)

After the settlement agreement was approved, claimant found it necessary to continue medical treatment for her upper extremities. On April 24, 2009, claimant presented to Juan Acosta, M.D., at the McFarland Clinic, P.C. with complaints of right hand numbness and intermittent tingling in the right arm. (Ex. 1, p. 1) Nerve conduction studies and electromyography of selected muscles showed Dr. Acosta:

IMPRESSION:

Abnormal study. There is electrophysiologic evidence for a mild median neuropathy at the left wrist (as in carpal tunnel syndrome) and for a mild, chronic and ongoing, median neuropathy at the right wrist (as in carpal tunnel syndrome). In addition, the electrophysiologic evidence suggests a mild, chronic, C6 radiculopathy on the right.

(Ex. 1, p. 1)

Dr. Mooney examined claimant on October 31, 2012. Claimant complained of left shoulder girdle problems and symptoms of carpal tunnel syndrome. Dr. Mooney opined there was no significant change in claimant's overall physical condition related to the neck, shoulders, arms or hands. (Ex. A1-iii, p. 7) The physician would not authorize new EMG studies at the time. (Ex. A-1-iii, p. 7)

On April 15, 2013, claimant underwent new nerve conduction and electromyography studies with Dr. Acosta at McFarland Clinic. The physician found:

Impression

Abnormal study. There is electrophysiologic evidence for bilateral, mild, chronic, median neuropathies at the wrists (as in carpal tunnel syndrome). There is evidence for a mild ulnar neuropathy at the right elbow. There is no evidence for a cervical radiculopathy on the right side or lower cervical radiculopathy on the left.

In comparison to study from 4/2009, there has been some mild progression of the right carpal tunnel syndrome and the presence of new left carpal tunnel syndrome and ulnar neuropathy at the right elbow. Patient will follow-up with Dr. Mooney to discuss results of the test and further management. I would suggest trying carpal tunnel injection [*sic*] to see if her symptoms improve or surgical consultation.

(Ex. 1, p. 3)

On January 13, 2014, James A. Friederich, M.D., performed a right submuscular ulnar nerve transposition and open carpal tunnel release. (Ex. 2, p. 8) A left open carpal tunnel release was performed on April 17, 2014. (Ex. 2, p. 11) Dr. Friederich opined the left carpal tunnel condition was **"occupationally related carpal tunnel syndrome as established previously."** (Emphasis added.) (Ex. 2, p. 10)

Dr. Friederich last examined claimant on October 22, 2014. Claimant reported she had some pain in her left wrist but she was performing a less vigorous job than she had been doing. Dr. Friederich found:

PHYSICAL EXAMINATION: She has well-healed surgical scars consistent with her previous surgery. She has full motion of her elbows,

forearms, wrists, fingers, and thumbs. There is a small nodule present over the left wrist volarly that may be consistent with an early ganglion cyst. She is able to appose her thumbs to the small fingers and has no intrinsic or thenar atrophy or weakness. Maximum grip strength on the right is 20 kg and on the left is 17 kg. Average pinch strength on the right is 6.5 kg, on the left is 7 kg.

Based on her evaluation today, she has a 5% impairment of the left upper extremity. This is based on the Guides to Evaluation of Permanent Impairment by the American Medical Association, 5th Edition and is expected to be a permanent impairment. It is based on comparison of her right to left sides and strength tables on page 509, table 1632 and 1633. This is expected to be a permanent impairment and she has previously been released for full duty at work. She may require additional treatment for her possible trigger finger or cyst in the future, but at this time no intervention is required.

(Exhibit A1-iv, p. 10)

On October 1, 2015, Dr. Mooney provided a checklist summary of his opinions. The summary was prepared by defense counsel. It stated:

1. You evaluated and treated Patti Jay beginning in 2007 through 2013 for issues surrounding her neck, arms, hands, and shoulders.

____√____ Agree _____ Disagree

2. In the course of your treatment of Ms. Jay, you came to understand that beginning in October 2008, she was working under restrictions issued by Dr. Robert Jones. You also came to understand the various requirements of the jobs she held at Lennox over the period of time of your treatment.

____√____ Agree _____ Disagree

3. The opinions you issued by Medical Opinion Letter of October 26, 2012, to attorney William Schwarz, have not changed.

____√____ Agree _____ Disagree

4. Ms. Jay's presentation and EMG tests of April 15, 2013, did not present a change to her bilateral carpal tunnel issues that could be attributed to any workplace activity.

____√____ Agree _____ Disagree

5. The lack of cervical radiculopathy evinced in the April 15, 2013, EMG test, is indicia of the myofascial, temporary complaints associated

with Claimant's neck, such complaints being driven by issues personal to Claimant, and not materially driven by any workplace activity.

____√____ Agree _____ Disagree

6. I have reached these opinions within a reasonable degree of medical certainty.

____√____ Agree _____ Disagree

(Ex. A1-v, pp. 14-15)

Dr. Jones prepared an independent medical examination report on November 18, 2015 after he had examined claimant. Dr. Jones causally connected claimant's conditions to her 2005 work injuries which were the subjects of claimant's agreement for settlement. (Ex. 3) Dr. Jones wrote in his report:

PHYSICAL EXAMINATION: She is a well-developed, well-nourished, right-handed white female.

1. Examination of the right hand: Signs of atrophy are negative. Phalen's sign is negative. Tinel's sign is negative. Sensory findings are normal. Abductor pollicis brevis strength is normal. Grip strength is 16kg on 3 tries with the Jamar dynamometer (normal about 22 kg) which represents an 18% grip strength loss index as explained in Table 16-34, page 509, AMA Guides to the Evaluation of Permanent Impairment, fifth edition. She is tender over the radial tendon at the wrist. Finklestein test is positive. This tenderness over the radial tendon and positive Finklestein suggests a condition known as de Quervain's tenosynovitis.

2. Examination of the left hand: Signs of atrophy are negative. Phalen's sign is negative. Tinel's sign is negative. Sensory findings are normal. Abductor pollicis brevis strength is normal. Grip strength is 13kg on 3 tries with the Jamar dynamometer (normal about 18) which represents an 18% grip strength loss index as explained in Table 16-34, page 509. She is tender over the radial tendon at the wrist. Finklestein test is positive.

3. Examination of the right arm: She has a scar from the cubital tunnel surgery. She is tender over the lateral epicondyle. She has good range of motion at the right elbow except with extension which is to about 75 degrees.

4. Examination of the left shoulder: She has a good range of motion of the left shoulder. There is tenderness of the left shoulder and tenderness over the left AC joint. The findings are similar to the findings in 2007.

5. Examination of the neck: She has good range of motion. There is tenderness in the lower neck on the left and in the trapezius. The findings are similar to the findings in 2007 except I was unable to detect a positive Spurling-Jones sign to the left.

(Ex. 3, p. 15)

Dr. Jones diagnosed claimant with the following conditions:

1. Bilateral carpal tunnel syndrome; status-post bilateral open carpal tunnel release.

2. Bilateral de Quervain's tenosynovitis.

3. Right cubital tunnel syndrome; status-post cubital tunnel release. status-post right lateral elbow release.

4. Chronic left shoulder and trapezius myofascial pain syndrome.

5. Chronic cervical strain with headaches.

(Ex. 3, p. 15)

This same evaluating physician provided permanent impairment ratings for the conditions addressed in the 2008 agreement for settlement. Dr. Jones opined:

The ratings for the neck and left shoulder are unchanged from 2007.

1. Left carpal tunnel. 5% of the left upper extremity. See table 16-15, page 492 and discussion appearing at page 495. The rating considers the abnormal NCV and ensuing surgery. The loss of strength should now be considered because the loss of strength represents an impairing factor that has not been considered adequately by the method under table 16-15. An 18% strength index loss converts to a 14% impairment of the upper extremity. The 5% and 14% combine for 18% of the upper extremity.

2. Right carpal tunnel. 5% of the right upper extremity. See table 16-5, page 492 and discussion appearing at page 495. The rating considers the abnormal NCV and ensuing surgery. The loss of strength should now be considered because the loss of strength represents an impairing factor that has not been considered adequately by the method under table 16-15. An 18% strength index loss converts to a 14% impairment of the upper extremity. The 5% and 14 % combine for 18% of the upper extremity.

3. Right arm. The rating for the lateral release remains at 5% of the right upper extremity. I would add 5% of the upper extremity for the

cubital tunnel syndrome for the same reasoning as previously discussed considering table 16-15, page 492 and discussion appearing at page 495.

4. De Quervain's tenosynovitis: I see no good way [to] rate impairment for this condition under the Guides even though normal function of the hand is impaired by this condition.

(Ex. 3, pp. 16-17)

With regard to the matter of permanent restrictions, Dr. Jones opined the 2007 restrictions he previously recommended were still valid. However, he acknowledged the same restrictions did not prevent a worsening of claimant's carpal tunnel syndrome or the advancement of the tenosynovitis. (Ex. 3, p. 17)

Defendants sought an independent medical evaluation at about the same time claimant sought the opinion from Dr. Jones. Thomas A. Carlstrom, M.D., performed a records review of claimant's medical treatment for her upper extremities and Dr. Carlstrom had a telephone conversation with defense counsel. Dr. Carlstrom did not personally evaluate claimant. Dr. Carlstrom authored a report bearing the date of November 18, 2015. In the report, the physician opined in relevant portion:

I believe the diagnosis of carpal tunnel syndrome is appropriate. In addition, the treatment for this disorder has been appropriate.

I do not see that there has been any significant change, as I read particularly Dr. Mooney's office notes and Dr. Jones' independent medical exam.

You ask about work activities after September 2008 and its relation to causation. I do not see that the work activities after 2008, particularly with the severe restrictions that had been imposed, created an increase in her symptomatology, or could have created an increase in her symptoms.

You ask about work restrictions and impairment. I do not see that her work activity, since 2008, could have caused an increase in her impairment or work restrictions, and it appears that the office visits to Dr. Mooney would corroborate that. In fact, since the carpal tunnel syndrome has been repaired, it might be possible to lift some of her restrictions as her problem should be less significant now than prior to surgery.

I note that Dr. Jones gave her a diagnosis of cervical radiculopathy back in 2008. An impairment was suggested for that disorder. I don't see that there has been any change in that symptomatology noted in the chart anywhere. Likely, she has some cervical spondylitic symptoms that seemed to be fairly mild and do not constitute reason to assign a greater impairment to either the shoulder of [*sic*] the hand.

(Ex. A-4-ii, p. 53)

Iowa Code section 86.14(2) provides:

> 2. In a proceeding to reopen an award for payments or agreement for settlement as provided by section 86.13, an inquiry shall be into whether or not the condition of the employee warrants an end to, diminishment of, or increase of compensation so awarded or agreed upon.

Upon review-reopening, the party bringing the action has the burden to show a change in condition related to the original injury since the original award or settlement was made. The change may be either economic or physical. Blacksmith v. All-American, Inc., 290 N.W.2d 348 (Iowa 1980); Hendersen v. Iles, 250 Iowa 787, 96 N.W.2d 321 (1959). A mere difference of opinion of experts as to the percentage of disability arising from an original injury is not sufficient to justify a different determination on a petition for review-reopening. Rather, claimant's condition must have changed in a manner not contemplated at the time of the initial award or settlement before an award on review-reopening is appropriate. Bousfield v. Sisters of Mercy, 249 Iowa 64, 86 N.W.2d 109 (1957).

In Kohlhass v. Hog Slat Inc., 777 N.W. 2d 387, 393 (Iowa 2009). The Iowa Supreme Court wrote:

> Although we do not require the claimant to demonstrate his current condition was not contemplated at the time of the original settlement, we emphasize the principles of res judicata still apply – that the agency in a review-reopening petition, should not reevaluate an employee's level of physical impairment or earning capacity if all of the facts and circumstances were known or knowable at the time of the original action. As this court has explained,
>
> > A contrary view would tend to defeat the intention of the legislature[:] ..."The fundamental reason for the enactment of this legislation is to avoid litigation, lessen the expense thereto, minimize appeals, and afford an efficient and speedy tribunal to determine and award compensation under the terms of this act."

Stice v. Consolidated Ind. Coal Co., 228 Iowa 1038, 291 N.W. 452 (1940) (quoting Flint v. Eldon, 191 Iowa 845, 847; 183 N.W. 344, 345 (1921)).

The commissioner is required to evaluate the "the condition of the employee, which is found to exist subsequent to the date of the award being reviewed." Kohlhaas, 777 N.W.2d at 391.

"Once there has been an agreement or adjudication the commissioner, absent appeal and remand of the case, has no authority on a later review to change the compensation granted on the same or substantially same facts as those previously considered." Kohlhass, 777 N.W.2d at 393. Likewise, section 86.14(2) does not provide a vehicle to re-litigate causation issues that were previously determined in the initial award or settlement agreement.

Even though Dr. Mooney opined the neck condition was not work related, the opinion is in direct conflict with the agreement for settlement and is disregarded. Additionally, Dr. Mooney indicated he was not able to determine the etiology of claimant's bilateral carpal tunnel syndrome. The specialist in occupational medicine deemed claimant's carpal tunnel syndrome to be unrelated to claimant's employment. (Ex. A1-iii, p. 7) Dr. Mooney's opinion is once again contrary to the terms of the settlement agreement. Dr. Mooney's opinion is not accorded any weight.

The treating surgeon, Dr. Friederich, opined the surgery he performed in 2014 on claimant was occupationally related. His opinion deserves appropriate consideration since he was the medical expert who performed the surgery and examined claimant both pre and post-surgery. Dr. Friederich rated claimant as having a five percent permanent impairment to the left upper extremity following the 2014 surgery.

The opinions expressed by Dr. Carlstrom were not based on a personal examination of claimant. Dr. Carlstrom either reviewed medical records or he discussed the case with defense counsel. Dr. Carlstrom did not discuss claimant's job duties with her. Nevertheless, Dr. Carlstrom opined he did not see how claimant's work activities after 2008 could create an increase in her symptoms. The fact Dr. Carlstrom did not speak to claimant about her work duties was a pertinent factor in deciding this case.

At the time of the September 22, 2008 settlement, claimant was working as a forklift operator. She testified she remained in the forklift position until March 2012 when she was removed as a driver because she had run over a co-worker's left foot. (Tr., p. 15) Members of management transferred claimant to the wiring group. (Tr., p. 15) Claimant held a position as a wire harness builder for under 6 months. (Tr., p. 15) The job was too physically demanding with respect to the use of claimant's hands. Claimant made 500 wire harnesses per shift. (Tr., p. 19) She returned to driving a forklift truck for a very brief period. (Tr., p. 16)

Next, management members assigned claimant to an assembly position, "building the top caps" to fit around the chimney of the furnace. The job was labor intensive as far as claimant had to work with her hands. (Tr., p. 17) Claimant held the position until after January 2015. (Tr., p. 20) She testified the job was painful for her to perform. (Tr., p. 25) She experienced numbness and tingling in her hands.

Claimant left "building the top caps "position to become a quality auditor in the cooling area. (Tr., p. 26) Claimant performed the job from January 2015 until June 2015. Claimant testified:

> It was the one job that I knew that I could do without a lot of wear and tear on my hands or my shoulders or neck.

(Tr., p. 26)

Claimant applied for and received a temporary office position that is paid on a salaried basis. (Tr., p. 26) She now is a quality technician and works the day shift. Claimant employs some of the knowledge she acquired during the time she was

obtaining her associate of arts degree. She performs ultrasonic testing on 120 aluminum copper joints per shift. (Tr., pp. 26 and 47) Claimant is required to apply for the job every 6 months, but must work on the plant floor for one week between assignments. (Tr., pp. 26-28) She remains a member of the union and retains her union benefits. (Tr., p. 28) She believes she is making more money now than she made in production jobs. (Tr., p. 47) She enjoys her present position and the job tests her critical thinking skills.

Claimant testified credibly and with great detail about the various jobs she performed at Lennox International, Inc., after the agreement for settlement was approved. She discussed the impact each job she performed had on her upper extremities. The position claimant was performing at the time of the review-reopening is not a permanent position. Claimant must re-apply for it every six months. There is no guarantee she will be able to secure the job every time she applies for it. There are fewer jobs claimant is able to handle without putting undue stress on her cervical spine, upper extremities, and hands.

Since the agreement for settlement was approved, claimant has undergone surgery on the left upper extremity. Dr. Friederich has provided a permanent impairment rating for claimant's left upper extremity at 5 percent. Dr. Jones has increased his impairment ratings for each upper extremity to 18 percent. There is also another 5 percent for the right upper extremity for the medial epicondylitis. The bilateral de Quervain's tenosynovitis is not rated. However, it will likely affect claimant's hand use, and impact claimant's employability in a negative fashion.

After considering all of the factors involving industrial disability, it is the determination of the undersigned; claimant now has an industrial disability in the amount of forty (40) percent. Claimant is entitled to a total of two hundred (200) weeks of permanent partial disability benefits less the eighty-five (85) weeks of benefits previously paid to claimant. All benefits shall be paid to claimant at the stipulated weekly benefit rate of $412.72 and benefits shall commence from September 21, 2011. Defendants shall take credit for all benefits previously paid to claimant.

Interest accrues on awards of permanent disability in review-reopening proceedings from a prior award or settlement from the date of the final agency decision awarding further review-reopening benefits. Bousfield v. Sisters of Mercy, 249 Iowa 64, 86 N.W.2d 109 (1957).

FILE NO. 5042797 ARBITRATION

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).

While a claimant is not entitled to compensation for the results of a preexisting injury or disease, its mere existence at the time of a subsequent injury is not a defense. Rose v. John Deere Ottumwa Works, 247 Iowa 900, 76 N.W.2d 756 (1956). If the claimant had a preexisting condition or disability that is materially aggravated, accelerated, worsened or lighted up so that it results in disability, claimant is entitled to recover. Nicks v. Davenport Produce Co., 254 Iowa 130, 115 N.W.2d 812 (1962); Yeager v. Firestone Tire & Rubber Co., 253 Iowa 369, 112 N.W.2d 299 (1961).

Claimant fell at work on October 1, 2012. She was working in the top cap area. A co-worker brought a tub filled with parts to claimant and placed the tub behind her. Claimant turned around and fell over the top of the tubs. Claimant testified:

> Q. What do you remember about the fall and how you felt right after the fall?
>
> A. I just remember the pain in my left shoulder, my low back, my left arm. As I was falling down, there was, what we call, a tree that holds the parts. It's a metal rack that holds the top cap parts, and I remember kind of trying to grab onto that as I fell forward.
>
> Then after I fell, actually one of the guys that was in the area next to mine came over and helped me get up. And it was within an hour I felt just increased pain in my back, sharp shooting, stabbing pain going down my left leg.
>
> Q. Well, that day, October 1, we have Exhibit 3, Page 12, there's a physical therapy note and you'd been in physical therapy that day.
>
> A. Correct.
>
> Q. Do you remember going in that day?
>
> A. Yes.

Q. Why were you in physical therapy that day?

A. I was in there for low back pain.

Q. What kind of low back pain?

A. I have had low back pain on and off, like an aching muscle pain.

Q. On and off for how long?

A. Years. I probably have had low back pain the majority of my life, even as a young kid, teenager.

Q. We have some medical records that say you have a condition called - - it's called a pars defect. Have you seen that word?

A. Yes, I have.

Q. Spondylolysis is another term that they call it.

A. Correct.

(Tr., pp. 29-30)

Numerous medical records were admitted as evidence regarding treatment for claimant's low back. Some of the treatment predated claimant's work injury on October 1, 2012 and other treatment occurred after the work injury.

On July 9, 2009, claimant presented to McFarland Clinic because she had been struck by a forklift truck on the day prior. Claimant was working when she was struck. (Ex. 1, p. 1) Claimant did not fall to the ground. Moulali Shaik, M.D., diagnosed claimant with sustaining a minor incident to her low back. (Ex. 1, p. 1)

Claimant returned to the McFarland Clinic on July 13, 2009 with symptoms of low back pain. (Ex. 1, p. 2) Dr. Mooney opined claimant had been doing fairly well. (Ex. 1, p. 2) Dr. Mooney ordered a brief course of physical therapy. Claimant reached maximum medical improvement on August 31, 2009. (Ex. 1, p. 4)

Claimant presented to the McFarland Clinic on September 23, 2011 with neck and back pain. (Ex. 1, p. 5) Claimant did not complain of radicular symptoms. (Ex. 1, p. 5) Dr. Mooney prescribed a TENS unit for claimant. (Ex. 1, p. 5) On October 25, 2011, claimant reported she was improving with physical therapy and the TENS unit.

On August 23, 2012, claimant returned to Dr. Mooney with low back pain and left lower extremity pain. (Ex. 1, p. 7) Dr. Mooney noted claimant had "anterolisthesis of L5 on S1 with congenital pars defects." (Ex. 1, p. 7) Dr. Mooney diagnosed claimant with:

ASSESSMENT: Symptoms of low back pain with evidence of congenital anterolisthesis L5-S1 with pars defects.

(Ex. 1, p. 7)

CAUSALITY: It is my opinion that her low back symptoms are not related to her current employment or previous work injury. This was discussed with her. Ms. Jay has a congenital condition of the lumbar spine which commonly results in chronic symptoms.

PLAN: I would recommend that she be referred to Physical Therapy for para lumbar muscular conditioning and core strengthening as she has had some significant weight gain over the last couple of years and demonstrates general laxity in her abdominal musculature. This would certainly help stabilize the anterolisthesis.

(Ex. 1, pp. 7-8)

Several weeks later, on September 7, 2012, claimant presented to MMSC where she was examined by Sarah Brown, ARNP. The nurse practitioner examined claimant because of complaints of back pain. Claimant described increased pain over the left side of her back and radiating down her left leg with occasional numbness to the left foot and pain to the right side of the low back. (Ex. 2) The nurse practitioner diagnosed claimant with left sciatica and chronic low back pain. (Ex. 2, p. 9)

Claimant attended physical therapy on the afternoon of October 1, 2012. She reported to her therapist the injury she had sustained to her back on the prior evening. Claimant stated she was sore from head to toe. (Ex. 3, p. 12) Claimant was sore from her fall on October 11, 2012. (Ex. 3, p. 13) Claimant did not return to the physical therapist after the October 11, 2012 visit.

With respect to treatment for her low back, claimant began treating with her personal medical providers. She presented to the MMSC Clinic on November 26, 2012 clinic and saw Jamie M. Hooley, PA-C. Mr. Hooley ordered MRI testing. (Ex. 2, p. 10) The physician's assistant diagnosed claimant with:

ASSESSMENT:

1. Left hip pain, questionably due to torn musculature.

2. Chronic low back pain.

3. Left-sided radiculopathy of an ongoing nature.

(Ex. 2, p. 10)

Mr. Hooley referred claimant to Cassim M. Igram, M.D., at Iowa ORTHO, in De Moines. Claimant informed Dr. Igram that her condition had deteriorated in August of 2012 and then on October 1, 2012 when claimant tripped over some tubs at work. Initially, Dr. Igram treated claimant conservatively. Injections were of no benefit. Dr. Igram diagnosed claimant with: "L5-S1 spondylolisthesis with stenosis L5-S1 on the LEFT." (Ex. 2, p. 19) Dr. Igram proposed "a L5-S1 decompression and fusion with facetectomy at L5-S1 on the LEFT."

On June 19, 2013, Dr. Igram performed the following:

1. Transforaminal lumbar interbody fusion at L5-S1 on the left.

2. Percutaneous placement of pedicule screws at L5-S1.

3. Placement of intervertebral fusion cage capstone on the left, L5-S1.

4. Harvesting of local bone spur for purposes of bone grafting.

(Ex. 4, p. 38) "Postoperatively the patient was taken to Recovery, awaken [*sic*] and in good condition at the time of transport from the Operating Room." (Ex. 4, p. 40)

Dr. Igram explained why claimant had pars defects at L5 with a spondylolisthesis of L5 on S1 in his report of March 24, 2014. Dr. Igram opined:

> Thank you for your inquiry regarding Patti Jay. As you know, this patient did have pars defects at L5 with a spondylolisthesis of L5 on S1. In my experience, pars defects typically develop during the teenage years. In fact, a patient with a fairly vertically oriented sacrum, which is probably developmental, probably made it easier for her to develop the pars defects, and over time developed a spondylolisthesis. As I did mention, pars defects typically develop in teenagers when they are most prone to stress fracture and subsequent spondylolisthesis. In other words, it is my opinion that this was a developmental issue that became symptomatic over time with the natural degenerative process with regard to the spondylolisthesis.

(Ex. 4, p. 41)

In a separate report which was also dated March 24, 2014, Dr. Igram opined claimant's grade 2 spondylolisthesis at L5-S1 was likely developmental in nature. (Ex. 4, p. 42) Dr. Igram stated in his report, "It is also my opinion that this was not a work-related injury but merely the natural progression of her spondylolisthesis with resulting symptoms. According to the records, she did have symptoms off and on for quite a period of time." (Ex. 4, p. 42)

Defendants retained an independent medical expert to render an opinion with respect to medical causation. They retained William R. Boulden. M.D., an orthopedic surgeon to examine claimant and to render a report. (Ex. A .3-ii) Dr. Boulden examined claimant on or about November 17, 2015. With respect to medical causation, Dr. Boulden opined:

> With reference to question numbers one and two, the diagnosis is status post spinal fusion, interbody at L5-S1, transverse process fusion of L4 to S1, with percutaneous rodding of L5 to S1. The alleged back symptoms are probably related to mechanical issues in her back. I cannot relate them to any type of traumatic issue based on the alleged injury she

> is claiming. She had pre-existing pathology for which the surgery was done. Dr. Mooney has stated in the past that the spondylolisthesis was not work related. Dr. Igram has also stated that.
>
> With reference to question number three, I do not believe the October 1, 2012, injury caused her the need for surgery. I believe this was all a pre-existing problem with natural progression, as Dr. Igram has stated. It is interesting that she did not really seek any medical care for a significant period of time after the alleged injury. In fact, what sent her to the doctor was left hip pain and not her back as much.

(Ex. A.3-ii, p.32) In short, Dr. Boulden agreed with Dr. Igram, the surgeon, claimant had personally selected to perform her lumbar fusion.

The only physician who disagreed with the issue of medical causation was Dr. Jones. Dr. Jones examined claimant on November 18, 2015, just one day following claimant's examination with Dr. Boulden. (Ex. 7) With respect to the issue of medical causation, Dr. Jones opined:

> **CAUSAL CONNECTION:** It is my opinion that as a result of the fall at work on October 1, 2012, Ms. Jay sustained a material aggravation of the L5-S1 spondylolisthesis. The spondylolisthesis was first diagnosed by Dr. Mooney, I agree with both Dr. Mooney and Dr. Igram that the patient's spondylolisthesis is a condition that she developed and was not caused by her work. However, this begs the question of whether there was a material aggravation of the condition as a result of the fall.
>
> She had intermittent low back pain before the injury. The pain was responsive to treatment or just got better on its own. The pain may have been due to the pars defect or perhaps not. While she at various times reported pain going down into her left leg, there is no mention of any radicular findings in Dr. Mooney's records or the records from MMSC prior to the October 1, 2012 injury. Dr. Mooney's note of August 23, 2012 in fact provides a well detailed record of his examination which was very specific for assessment of the presence of nerve based symptoms in the left leg.
>
> She said that she improved with the PT performed just before the injury. She then discontinued PT shortly after the injury because she was so uncomfortable. What complicated the picture is the left hip condition. I have no way of knowing whether the left hip pain was caused by the dancing incident or just came about on its own. But the pain caused by the left hip condition was clouding the picture when it came to separating out the source of her left leg pain. I think physician's assistant Hooley had it about right as it was stated in the November 26, 2012 office note that there were two conditions of concern, the acute left hip pain and the chronic back pain.

> Dr. Igram prudently recommended injection therapy in hopes that the therapy would resolve the patient's discomfort and get her back to her preinjury baseline. The injections did not provide benefit and so he, with the patient's consent, performed the surgery. Spinal fusion is an appropriate surgery in the instance of a patient with grade 2 spondylolisthesis, high grade foraminal stenosis and radicular symptoms. Unfortunately, as is sometimes the case, the intended result was not achieved. The fusion appears solid and yet the patient is still having significant pain. This situation presents an example of failed back surgery syndrome. The source of the pain is difficult to identify. There is the hip condition which is probably contributing to the pain in the general area of the hip but does not explain the low back and pain running into the left leg. I expect the low back and left leg pain is unresolved pain from the injury in combination with pain due to scar tissue and irritation of the facets. Accordingly, I think Dr. Harbach's recommendation for pain management is appropriate.

(Ex. 7, pp. 58-59)

The overwhelming evidence demonstrates claimant had pre-existing conditions known as pars defects at L5 with spondylolisthesis. Claimant testified she had experienced problems with her back dating back to her adolescence, including radiating pain. (Tr., p. 53) Her early back difficulties were totally consistent with the diagnoses provided by Dr. Mooney and claimant's own orthopedic surgeon, Dr. Igram. Claimant's fall on October 1, 2012, by all accounts, seemed to be a minor incident. Prior thereto, claimant was treating for her back condition and under the care of a physical therapist. Claimant reported the fall to her physical therapist on October 1, 2012, but she did not seek treatment from a physician until approximately seven weeks after the injury.

This deputy accords the greatest weight to the opinions of Dr. Igram. He was a surgeon recommended by claimant's personal physician's assistant of many years. Dr. Igram had many occasions to observe and treat claimant for her condition. He was the specialist who performed the fusion. Both Dr. Mooney and Dr. Boulden supported the opinion of Dr. Igram.

The greater weight of the evidence establishes claimant's fall on October 1, 2012 did not cause claimant's back condition or her need for a lumbar fusion.

Claimant is requesting the cost of independent medical examinations in File No. 5023886 and File No. 5042797. Section 85.39 permits an employee to be reimbursed for a subsequent examination by a physician of the employee's choice where an employer-retained physician has previously evaluated "permanent disability" and the employee believes the initial evaluation is too low. The section also permits reimbursement for reasonably necessary transportation expenses incurred and for any wage loss occasioned by the employee attending the subsequent examination.

Defendants are responsible only for reasonable fees associated with claimant's independent medical examination. Claimant has the burden of proving the

reasonableness of the expenses incurred for the examination. See Schintgen v. Economy Fire & Casualty Co., File No. 855298 (App. April 26, 1991). Claimant need not ultimately prove the injury arose out of and in the course of employment to qualify for reimbursement under section 85.39. See Dodd v. Fleetguard, Inc., 759 N.W.2d 133, 140 (Iowa App. 2008).

Firstly, in File No. 5023886, Dr. Friederich rendered his opinion regarding permanent impairment on October 22, 2014. Claimant obtained her independent medical report from Dr. Jones on November 18, 2015. Dr. Jones charged $700.00 for the independent medical examination and $300.00 for the independent medical report. Defendants are liable for both in the total amount of $1,000.00.

Secondly, in File No. 5042797, defendants obtained their independent medical examination and report from Dr. Boulden on November 17, 2015. Claimant received her independent medical examination from Dr. Jones on November 18, 2015. Dr. Jones charged $700.00 for the examination and $300.00 for the report. Defendants are liable for both in the total amount of $1,000.00.

The final issue is the cost to litigate the two files. The deputy workers' compensation commissioner has the discretion to tax costs. Dickenson v. John Deere Products Engineering, 395 N.W.2d 644, 647 (Iowa Ct. App. 1986).

File No. 5023886

Filing fee $100.00

Service Fee

File No. 5042797

Filing Fee $100.00

Service Fee

Dr. Igram's Report $150.00

ORDER

THEREFORE, IT IS ORDERED:

In File No. 5023886, defendants shall pay unto claimant, two hundred (200) weeks of permanent partial disability benefits less the eighty-five (85) weeks of benefits previously paid to claimant and all benefits shall be paid at the stipulated weekly benefit rate of four hundred twelve and 72/100 dollars ($412.72) per week and shall commence from September 21, 2011.

Interest accrues on awards of permanent disability in review-reopening proceedings from a prior award or settlement from the date of the final agency decision

awarding further review-reopening benefits. Bousfield v. Sisters of Mercy, 249 Iowa 64, 86 N.W.2d 109 (1957).

In File No. 5023886, and File No. 5042797, defendants shall pay the costs of the independent medical examinations as addressed in the body of these decisions.

In File No. 5042797, claimant shall take nothing additional from defendants.

Costs, as established in the body of these decisions, are assessed to defendants.

Defendants shall file all reports as required by this division.

Signed and filed this 19th day of May, 2016.

Michelle A. McGovern

MICHELLE A. MCGOVERN
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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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.