BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

BILL J. GROUETTE SR.,	
Claimant,	
vs.	
	File No. 5044473
GILBANE BUILDING COMPANY OCIP/MIDWEST STEEL, INC.,	APPEAL
Employer,	DECISION
and	
ZURICH NA INSURANCE,	
Insurance Carrier, Defendants.	Head Note No.: 1803

FILED
AUG 14 2017
WORKERS' COMPENSATION

Defendants Gilbane Building Company OCIP/Midwest Steel, Inc., employer and its insurer, Zurich NA Insurance, appeal from an arbitration decision filed on December 16, 2015. Claimant Bill Grouette Sr., responds to the appeal. The case was heard on September 23, 2015, and it was considered fully submitted in front of the deputy workers' compensation commissioner on October 27, 2015.

The deputy workers' compensation commissioner found claimant carried his burden of proof he sustained temporary and permanent disability arising out of and in the course of his employment on August 31, 2012. The deputy commissioner concluded claimant established he is permanently and totally disabled under the odd-lot doctrine. The deputy commissioner also awarded claimant medical expenses and the cost of an independent medical evaluation (IME) performed by Marc Hines, M.D., on June 13, 2014.

Defendants assert on appeal that the deputy commissioner erred in finding the alleged injury caused temporary and permanent disability and in finding claimant is permanently and totally disabled under the odd-lot doctrine.

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. Having performed a de novo review of the evidentiary record and the detailed arguments of the parties, I find the deputy commissioner erred in finding claimant sustained permanent disability as a result of the work injury and I find the deputy commissioner erred in finding claimant is permanently and totally disabled. I provide the following analysis:

FINDINGS OF FACT

Claimant is married and lives in Mason City, Iowa. (Transcript page 5; Exhibit 2, p. 1; Ex. 4, p. 1; Ex. A, p. 2) At the time of the hearing, claimant was fifty-eight years old. (Tr. p. 5) Claimant is left-hand dominant. (Ex. 9, p. 1) He smokes a pack of cigarettes per day and has smoked since he was eight. (Tr. pp. 91-92, 130)

Claimant attended school through the eighth grade in Mason City and received mostly "D" grades. (Tr. pp. 6, 78; Ex. 2, p. 1; Ex. A, p. 5) Claimant testified he has difficulties with reading and math. (Tr. pp. 6-7) In 1995 or 1996, claimant obtained a Class A CDL endorsement. (Ex. 14, p. 2; Tr. pp. 78-79) Claimant passed the CDL test the first time he took it and he continued to hold a CDL license at the time of the hearing. (Tr. p. 79) Claimant is certified to operate a forklift. (Ex. A, p. 4)

After leaving school, claimant initially worked in the concrete business as a laborer installing driveways, curbs, gutters and roads. (Tr. pp. 7-8) When he was seventeen, he joined the United States Marines. He testified he was discharged due to poor academic performance. (Tr. pp. 8-9)

After leaving the Marines, claimant worked as a sheet metal worker for his father's commercial heating, ventilation and air conditioning (HVAC) company installing HVAC units and ductwork. (Tr. pp. 9-10; Ex. A, p. 2) Claimant got married and went to work for the railroad changing rails, installing ties, packing around ties, and knocking in railroad spikes into plates for a few years. (Tr. p. 11) Claimant left the railroad and returned to his father's business as a sheet metal worker. (Tr. p. 11) After a year or two, claimant left his father's business and joined the union, installing HVAC systems. (Tr. pp. 13, 16; Ex. A, p. 3) For a period of time between union jobs, claimant worked as a long-distance flatbed tractor trailer driver where he was responsible for chaining down equipment and heavy tarping. (Tr. p. 17; Ex. A, p. 3)

After several years of sheet metal work, claimant accepted a position as a pipeline oiler, checking the oil levels of machinery and cleaning the machinery. (Tr. pp. 19-20) He later worked as a telehandler operator for a power plant operating mechanical equipment similar to a forklift with a boom. (Tr. pp. 21-22)

In June 2012, defendant-employer hired claimant as a forklift driver and oiler. (Ex. 3, p. 1; Ex. A, p. 3; Tr. p. 24) The union position description states the position requires being able to lift up to seventy-five pounds, lift, bend, sit, and stand for a period

of time, tug and pull cable, withstand jarring motions, walk on rough terrain, load and unload trucks, sort and stock material, check and maintain machinery, assist the crane operator, work outside in the elements, and climb on machinery. (Ex. 3, p. 1) Claimant testified he fueled the crane, checked the fluids, greased the Zerks in the movable parts, threaded the cable through the pulleys, watched the movable parts for the operator, and operated a forklift. (Tr. pp. 25-27)

In his petition, claimant alleges he sustained injuries to his neck, back, both shoulders, both upper extremities, his hip, and both hands on August 31, 2012, just before the Labor Day weekend. Claimant testified he was walking toward the print table where the general foreman and another employee were standing when his left foot hit something. He stopped and tried to catch himself, but lost his balance and "went down hard," diving into the concrete. (Tr. pp. 30-32). Claimant stated:

> I kind of – I flipped like – like you would do a roll in school, you know, like tumbling. I tumbled over, and then I started into a roll on my side to side to side, trying to break the – break the momentum of the hit. I've already hit. I'm down on the ground. I'm just trying to roll it out. I just – I had so much momentum going when I went down. And I probably rolled – I'm guessing now. It's been three years ago, but it was a good 10 feet, I'm sure.

(Tr. p. 32)

Claimant testified he was embarrassed when he fell and after he stopped rolling the general foreman asked him if he was okay and he responded he thought he was. (Tr., p. 33) Claimant left for the holiday weekend and testified his neck was stiff, his shoulders were sore, and his symptoms became worse. (Tr. pp. 33-34) Claimant did not seek medical treatment that weekend.

Claimant has a preexisting history of left knee pain, chronic low back pain, tension headaches, knots in his neck, difficulty sleeping, and anxiety. (Ex. H, pp. 1, 11-14) In 2006, claimant attended a series of appointments with Stephanie Seemuth, D.O., family practice physician, claiming he injured his neck after slipping and falling at work. (Ex. H, pp. 16-17) Dr. Seemuth documented "[h]e fell principally striking his right knee, right shoulder, and his head snapped back. Ever since then, he has had pain in the left side of his neck. He feels a cracking or grinding when he turns his head." (Ex. H, p. 17) Dr. Seemuth assessed claimant with neck pain, and ordered a MRI. (Ex. H, p. 17) Dr. Seemuth noted the radiologist called her "with concerns about the MRI as it showed at C6, a subchondral edema section and some impingement on the left. He also felt there was a bone contusion there." (Ex. H, p. 19) Dr. Seemuth referred the claimant to a neurosurgeon, and prescribed Relafen and Lortab. (Ex. H, p. 19)

On May 25, 2006, claimant was evaluated by David Beck, M.D., neurosurgeon, complaining of pain at the base of his neck down into the scapula, and a clicking or

popping sound when turning his head, but he denied weakness and pain down his arms. (Ex. H, p. 20) Dr. Beck noted claimant's MRI demonstrated mild degenerative changes and he released claimant to return to work without restrictions. (Ex. H, pp. 20-21) During a follow-up appointment with Dr. Beck's partner, Darren Lovick, M.D., claimant complained of tightness and burning along his left trapezius muscle. Dr. Lovick prescribed Tramadol and Flexeril. (Ex H, p. 22)

On November 8, 2011, claimant attended an appointment with Stephen Holmes, M.D., family medicine practitioner, complaining of chest pain, left shoulder pain, and left arm pain. (Ex. H, p. 25) Dr. Holmes assessed claimant with a neck strain, left shoulder inflammation, and fleeting chest pain, and documented on examination claimant could move his neck in all four directions, but "he has some discomfort with moving toward the left shoulder and a little bit toward extension of the left neck, back." (Ex, H, pp. 25-26) Dr. Holmes prescribed Naprosyn and noted claimant was seeing a chiropractor for treatment. (Ex. H, p. 26) Claimant testified he never missed a day of work before his August 2012 work injury and he was able to perform his job duties. (Tr. pp. 23-24, 107)

Claimant returned to work after the work injury on the Tuesday following the Labor Day holiday in 2012. Claimant reported his work injury to the safety manager for Midwest Steel. (Tr. pp. 34-35) Claimant testified the safety manager refused to document the work injury, told him to use his own insurance to receive medical care, and to report the injury did not occur at work. (Tr. pp. 34-35) Claimant stated he reported the injury again, this time to Jim Free, safety manager for Gilbane, and eventually Mr. Free documented the injury and provided him with medical care. (Tr. pp. 34-36; Ex. M)

On October 8, 2012, claimant attended his first medical appointment following the work injury with Mark Haganman, D.O., a family medicine physician with Mitchell County Regional Health Center. Claimant complained of bilateral shoulder, neck, and back pain. (Ex. 5, p. 1) Mr. Free also attended that appointment. (Ex. 5, p. 1) Dr. Haganman documented he did not believe claimant "had a significant neuromuscular injury from the fall that occurred on 08/31/12 over five weeks ago." Dr. Haganman prescribed anti-inflammatory medication and he ordered claimant to increase his motion and to stretch. (Ex. 5, p. 1) Dr. Haganman did not impose any work restrictions.

On November 7, 2012, claimant returned to Dr. Haganman complaining of heaviness in his shoulders, reporting moving his neck seemed to enhance his symptoms, and denying he was experiencing paresthesias, numbness or tingling, loss of strength, or weakness. (Ex. 5, p. 2) Dr. Haganman assessed claimant with bilateral shoulder pain, neck pain exacerbating the shoulder pain, obesity. Dr. Haganman documented claimant was able to perform his work as a forklift operator without any difficulty and he noted claimant had not missed any work. (Ex. 5, p. 2) Claimant testified Mr. Free told Dr. Haganman "[n]o restrictions," and Dr. Haganman replied, "[o]kay. No restrictions." (Tr., p. 37) Dr. Haganman did not impose any work restrictions. (Ex. 5, p. 2)

On November 12, 2012, claimant attended an appointment with Jeffrey Nasstrom, D.O., family medicine physician with Mitchell County Regional Health Center. (Ex. 6, p. 1) Dr. Nasstrom documented that claimant was experiencing neck and bilateral shoulder pain extending up over the shoulders, he reviewed the MRI, which he found "showed evidence of diffuse disk bulge at C6-7 and questionable metabolic disease of the C6-7 vertebrae," he ordered a bone scan, and he prescribed a Medrol Dosepak. (Ex. 6, pp. 1-2) The physician who reviewed the bone scan documented the following, in pertinent part:

> Unusual arthritic pattern of uptake without sign of metastatic disease. The edema within the C6-7 vertebral bodies on MRI is more than usually seen, possibly due to trauma or recent alteration in mechanical stresses related to the degenerative disk. Unfortunately the size of the patient makes it more difficult to follow this with plain x-rays, which are partially obscured by overlying shoulders. That would be an option, however, as would MRI in six months if desired. By that time, the edema should be resolved if it was due to benign causes.

(Ex. 6, pp. 3-4)

Claimant returned to Dr. Nasstrom on November 15, 2012, complaining of neck and shoulder pain. (Ex. 6, p. 5) Dr. Nasstrom assessed claimant with a C6-7 disk herniation, continued his Medrol Dosepak, prescribed Mobic and Flexeril, and discussed a possible surgical consultation and physical therapy. (Ex. 6, p. 5) Dr. Nasstrom noted Mr. Free attended the appointment, and discussed "working as a driver would be reasonable." (Ex. 6, p. 6)

On December 3, 2012, claimant returned to Dr. Nasstrom complaining of increasing bilateral wrist pain, numbness and tingling in his fingers "for the last two weeks." (Ex. 6, p. 8) Dr. Nasstrom assessed claimant with "[w]rist pain suspect carpal tunnel," a history of a neck injury "I do not think it is related to this," and bronchitis. (Ex. 6, p. 8) Dr. Nasstrom prescribed Lortab, Aleve, ordered an EMG/NCV, and prescribed bilateral cockup wrist splints. (Ex. 6, pp. 8-9) Claimant testified his hands "went numb about a month into this. Just one day like somebody flipped a switch, and both my hands went numb." (Tr., p. 43)

Claimant was laid off due to a lack of work on December 6, 2012. (Ex. A, p. 9; Ex. K, p. 11; Tr. pp. 39-40) Claimant did not miss any work before the layoff. (Tr. p. 113) Following the layoff, claimant received unemployment insurance benefits. (Ex. K, p. 11; Tr. p. 45)

The insurer sent Dr. Nasstrom a letter asking questions about claimant's work injury. (Ex. 6, p. 7) Dr. Nasstrom documented he diagnosed claimant with neck pain following a fall, and he noted claimant was not at maximum medical improvement (MMI). (Ex. 6, p. 7) The insurer inquired whether claimant has "sustained any residual

impairment (PPI) from the incident," and Dr. Nasstrom replied, "yes." (Ex. 6, p. 7) Dr. Nasstrom opined claimant needed additional medical treatment related to the incident, but not for any preexisting medical conditions, he noted claimant does not have any temporary or permanent restrictions related to the work injury, and he documented claimant's prognosis is fair. (Ex. 6, p. 7)

Sant Hayreh, M.D., the neurologist who conducted the nerve conduction studies, noted the testing was consistent with bilateral carpal tunnel syndrome of moderately severe degree, and the results showed the "MNCV and SNCV are normal in both ulnar nerves except sensory responses are of very small amplitude which may be suggestive of underlying mild sensory polyneuropathy." (Ex. 6, p. 10)

Following the nerve conduction studies, claimant returned to Dr. Nasstrom on January 14, 2013, complaining of neck pain, radiating shoulder pain, and tingling in his fingers. (Ex. 6, p. 11) Dr. Nasstrom assessed claimant with moderate to severe bilateral carpal tunnel syndrome, ongoing neck discomfort secondary to a fall, and degenerative joint disease versus a disk bulge. (Ex. 6, p. 11) Dr. Nasstrom documented he believed the neck and wrist issues "are two separate issues," he noted the "[e]lectromyogram showed no evidence of cervical radiculopathy," he referred claimant to Dr. Richard Rattay for his carpal tunnel syndrome and to Dr. Beck for a neurosurgical consultation, and he prescribed wrist splints, anti-inflammatory medication, and Neurontin. (Ex. 6, pp. 11-12) Following a telephone call from Zurich, Dr. Nasstrom documented the treatment for carpal tunnel syndrome was related to the incident and was not pre-existing. (Ex. 6, p. 14) No medical records were provided by the parties from Dr. Rattay.

Claimant attended an appointment with Dr. Beck on January 16, 2013. (Ex. 7, p. 1) Dr. Beck examined claimant, reviewed his imaging, and documented, "I explained to Bill that he has just aggravated some arthritis in his neck. I have shown him neck exercises and sent him to physical therapy as well as a Medrol Dosepak. There is nothing surgical. As far as work he would have no restrictions if there was work for him but I think the therapy and Medrol pack will help his symptoms." (Ex. 7, p. 1) On February 27, 2013, Dr. Beck noted claimant suffers from chronic neck pain, he did not have a surgical problem, he had failed conservative treatment with physical therapy and prednisone, and he referred claimant to a pain clinic. (Ex. 7, p. 2)

Arnold Parenteau, M.D., anesthesiologist specializing in pain management at the McFarland Clinic, provided pain treatment for claimant in March and April 2013. (Ex. 8) Dr. Parenteau ordered and reviewed an MRI, which he found shows "some cervical stenosis but with CSF surrounding the cord throughout." (Ex. 8, p. 3) Dr. Parenteau listed an impression of upper back pain and noted the predominant issue relates to shoulder and cervical spondylosis. (Ex. 8, p. 3) Dr. Parenteau prescribed Norflex, recommended claimant receive an orthopedic evaluation for his shoulders, and referred claimant to Bradley Wargo, D.O., an anesthesiologist practicing in pain management, for cervical facet intervention. (Ex. 8, p. 3)

On April 16, 2013, claimant was evaluated by David Sneller, M.D., orthopedic surgeon. (Ex. 9, p. 1) Dr. Sneller opined "I think his rotator cuff is intact. He does have good range of motion and good strength. I do not think his shoulder is the primary issue. I agree it seems to be coming from his neck and radiating outward." (Ex. 9, p. 1) Dr. Sneller assessed claimant with "[n]eck, bilateral scapulae, and shoulder pain with evidence of carpal tunnel syndrome on nerve conduction studies." Dr. Sneller found surgery was not indicated, he administered a shoulder injection, and he opined claimant could perform regular duty work with respect to his shoulders. (Ex. 9, pp. 1-2) On a form supplied by the insurer, Dr. Sneller wrote claimant's diagnoses are neck pain, bilateral shoulder pain, and carpal tunnel syndrome and he checked a box stating he believed the conditions were work-related. (Ex. 9, p. 3)

During claimant's appointment with Dr. Wargo on May 15, 2013, claimant reported he did not receive any relief from the injection he received from Dr. Sneller. (Ex. 10, p. 1) Dr. Wargo assessed claimant with possible cervical facet joint arthropathy, myofascial pain syndrome, chronic pain post trauma, morbid obesity, and multiple medical comorbidities. Dr. Wargo recommended neck stretching exercises, a trial of bilateral diagnostic cervical medial nerve branch blocks at C3, C4, and C5, and he administered an injection. (Ex. 10, pp. 1-2) Claimant attended a follow-up appointment with Dr. Wargo on June 4, 2013, reporting the injection exacerbated his pain. Dr. Wargo opined there was no indication to proceed with another cervical medial nerve branch block, and he directed claimant to continue his neck stretching exercises. (Ex. 10, p. 6)

Claimant applied for Social Security Disability Insurance ("SSDI") benefits, alleging injuries to his spine, joint pain, shortness of breath, and anxiety. (Tr. pp. 49, 130). The Social Security Administration approved claimant's application on May 21, 2013. (Ex. K) At the time of the hearing, claimant was also receiving retirement benefits through the union. (Tr., pp. 131-32)

On July 10, 2013, claimant returned to Dr. Parenteau, reporting his pain was the same following the medial nerve branch blocks. (Ex. 8, p. 5) During the next appointment on August 6, 2013, Dr. Parenteau found claimant was at MMI with respect to his pain issues. Dr. Parenteau referred claimant to Charles Mooney, M.D., occupational medicine physician with the McFarland Clinic, for an impairment rating. (Ex. 8, p. 6; Ex. H, p. 1)

On October 22, 2013, claimant appeared for an appointment with his primary care provider, Lynne Senty, D.O., complaining of low back pain. (Ex. 11, p. 9)

Claimant underwent a functional capacity evaluation (FCE) on January 15, 2014. (Ex. C) The physical therapist noted claimant provided a valid effort and concluded claimant is able to safely lift 50 pounds waist to floor occasionally, 30 pounds waist to crown occasionally, bilateral carry 40 pounds occasionally, and engage in occasional

elevated work. The therapist concluded claimant met the material handling demands for medium demand employment. (Ex. C, pp. 1, 4)

On January 17, 2014, claimant attended an appointment with Dr. Senty, complaining of neck pain, along with sharp, stabbing and burning pain in both shoulders following the FCE. (Ex. 11, p. 11) Dr. Senty assessed claimant with neck pain, she prescribed a Medrol Dosepak, and she recommended claimant use ice or heat, massage, and physical therapy. (Ex. 11, p. 13)

Dr. Mooney performed an independent medical evaluation (IME) of claimant for defendants. (Ex. D: Ex. H, pp. 3-5) Dr. Mooney examined claimant and reviewed his medical records. (Ex. D, p. 2; Ex. H, pp. 3-5) Based on the valid FCE, Dr. Mooney found claimant met the material handling demands for medium demand employment. Dr. Mooney also concluded claimant is able to safely lift 50 pounds waist to floor occasionally, 30 pounds waist to crown occasionally, bilateral carry 40 pounds occasionally, and engage in occasional elevated work. (Ex. H, p. 4) Dr. Mooney assessed claimant with cervical spine degenerative disc disease and degenerative facet disease with no radicular findings with EMG testing or examination, pain behavior, hypertension, and a history of COPD. (Ex. H, p. 5)

Using the Guides to the Evaluation of Permanent Impairment (AMA Press, 5th Ed. 2001) ("AMA Guides"), Dr. Mooney opined:

> 1. Complaints of neck pain with preexisting degenerative disc disease at C6-C7, C5-6, and C3-C4, 0% impairment based on table 15-5, page 392 under DRE cervical category 1.
>
> 2. Complaints of bilateral shoulder pain, 0% impairment as there is no evidence of any specific loss of motion, verifiable loss in strength, or neurologic condition to create such impairment.
>
> 3. Complaints of low back pain, 0% impairment based on table 15-3, page 384, under DRE lumbar category 1.
>
> It is my opinion that no impairment can be provided as the examination is dominated by abnormal pain behavior, non-verifiable complaints, and nonphysiologic findings.

(Ex. D, p. 2)

Marc Hines, M.D., neurologist, conducted an IME at claimant's request on June 13, 2014. (Ex. 12) Dr. Hines examined claimant and reviewed his medical records. (Id.) Dr. Hines opined:

> It is my feeling that this patient's fall caused exacerbation of preexisting cervical spinal stenosis and cervical radiculopathy, setting off a patient

> who had preexisting difficulties, that is lighting up or aggravating preexisting difficulties, that have now resulted in persistent cervical nerve root irritation and muscle spasm with a cervical myofascial syndrome. The patient apparently has some element of carpal tunnel syndrome, though I think that this plays little role in the present difficulties. It has aggravated to the point that the patient has developed some biceps tendonitis in addition to this. He also has some direct pain over the lumbosacral spine, but more particularly over the SI joint, though no greater trochanteric tenderness could be elicited that was of any great significance.

(Ex. 12, p. 6)

Using the AMA Guides, Dr. Hines opined,

> I have used cervical category 2 with two level 8% whole person impairment for the patient's impairment as the most significant difficulty for this patient, though he does have some SI joint impairment. I will impair this as well. This original impairment for the cervical area is using table 15-5, page 392. These two impairable areas of 8% each will then be added to bilateral ischial bursitis, which is evaluated using table 17-33, page 546, for 3% impairment on each side. Using combined values tables, 8% plus 8% is 16%, 16% plus 3% is 19%, 19% plus 3% is 21%. This would be the whole person impairment for this person.

(Ex. 12, pp. 6-7)

Dr. Hines recommended restrictions of standing no more than thirty minutes without rest, change positions every thirty minutes, lifting ten pounds, preferably no more than five pounds and not repetitively above shoulder height, lifting from the floor 15 to 20 pounds, no repetitive side bending, twisting, flexing, or extending, flexion or extension of the neck, avoid extreme vibration and temperature, no work with heavy equipment or clutched vehicles, no climbing ladders, avoid repetitive climbing, and climb stairs only for personal convenience. (Ex. 12, p. 7)

Dr. Hines opined claimant did not reach MMI on February 14, 2014, and noted future treatment is indicated. (Ex. 12, p. 7) Dr. Hines recommended sacroiliac joint injections, water therapy for claimant's low back and SI joints, anti-inflammatory medication, a TENs unit for his back and neck, and physical therapy. (Ex. 12, p. 7)

Defendants retained Douglas Martin, M.D., occupational medicine physician, to conduct an IME of claimant in June 2015. (Ex. B) Dr. Martin reviewed claimant's medical records and examined him. (Id.) Dr. Martin assessed claimant with cervical degenerative disk disease/spondylosis, myofascial pain syndrome of the paracervical, parathoracic and parascapular musculature, degenerative spondylosis of the lumbar

spine, obesity, chronic obstructive pulmonary disease, history of gastroesophageal reflux disease, history of anxiety disorder, and hypertension. (Ex. B, p. 8)

Dr. Martin opined:

> I have no doubt that a trip and fall injury did occur on August 31, 2012. It is difficult for this examiner (and I think this has been borne out by other examiners as well, especially Dr. Mooney) to understand why the gentleman continued to have such significant subjective reports of discomfort after this type of a fall. Unless the gentleman was running, or at an increased pace, it is difficult for this evaluator to understand how that type of fall could have been substantially traumatic. Individuals have trip and falls all the time, and, unless there is something along the lines of a broken bone or significant head trauma, typically, these types of problems lead to soft tissue injuries that recover within weeks.
>
> I therefore, do not understand why this gentleman's situation did not follow that pattern. He definitely does have degeneration with regards to the cervical and the lumbar spine that have been well documented in his medical diagnostics. This was something that was known to exist way back in 2006. These types of degenerative problems sometimes can create symptoms and sometimes can not. It is probably true that they are creating some degree of symptomatology in this individual, but to gauge the severity is somewhat difficult to assess with any degree of surety.
>
> Typically, degenerative conditions of the spine, if they are symptomatic, rarely respond to the medical treatments here that have been entertained. Cervical facet injections, diagnostic blocks, and the types of medications that Mr. Grouette is currently taking usually fail to improve those types of symptoms.
>
> The degenerative changes that you see on the MRI imaging studies in this individual are due to a combination of genetic factors and anthropomorphic factors that have been well borne out in the literature studies published by Dr. Carragee out of Stanford, as well as Dr. Michele Battié out of Canada.
>
> As previously indicated, his carpal tunnel syndrome is not work related, has been there for a considerable number of years, and probably has more to do with his obesity, which is a significant risk factor, as well as possibly his cigarette smoking and hypertension.

(Ex. B, p. 10)

Using the AMA Guides, Dr. Martin found:

> This gentleman's examination is predominated by subjective reports of pain with little, if any, objective abnormalities. He, essentially, has normal range of motion of the cervical spine and the lumbar spine. I see no evidence of any type of muscular spasm or asymmetric range of motion loss on either his cervical or his lumbar spine areas. He is absent any type of radiculopathy. The only conclusion that is reasonable, based upon the AMA Guides, Fifth Edition, is to place him within DRE Category 1 for both his cervical, thoracic and lumbar spines, which would yield a 0 percent impairment rating.
>
> Regarding any type of shoulder issues, he has symmetric range of motion, negative impingement tests, and normal strengths. The minor loss of range of motion that we see in flexion on today's examination and abduction are representative of typical age related changes and is not related to injury. The Upper Extremity section of the AMA Guides indicates this also would yield a 0 percent impairment.
>
> He would not be technically at maximum medical improvement from his carpal tunnel syndrome because I believe that it is a continuing active problem. I think it would improve after he has carpal tunnel release procedures. However, please understand that an impairment rating, in that situation, is not applicable within the workers compensation benefit system because it is not related to work.
>
> The gentleman has reached maximum medical improvement for his claims of work related injury.

(Ex. B, p. 11)

Dr. Martin recommended no permanent physical restrictions. (Ex. B, p. 12) Dr. Martin further stated the results of the FCE which showed claimant is capable of medium physical demand work are probably normal for his age. Dr. Martin did not think the FCE findings were out of character for claimant's age and body habitus, and he noted claimant may have some exertional limitations because of non-musculoskeletal or orthopedic issues, including chronic obstructive pulmonary disease, and a long history of hypertension, which can both be limiting. (Ex. B, p. 12)

Dr. Martin opined within a reasonable degree of medical certainty that claimant's current complaints do not have a causal relationship to the work injury, noting:

> I do believe that his trip and fall injury occurred and I do believe that likely this created a contusion, or perhaps a strain on the cervical spine, the shoulders, and perhaps the low back. However, those issues should have resolved long ago and the current complaints either have a relationship to

> degenerative processes or a relationship of being within the medicolegal context.

(Ex. B, p. 12)

Dr. Martin found claimant reached MMI by the end of November 2012. (Ex. B, p. 13)

CONCLUSIONS OF LAW

To receive workers' compensation benefits, an injured employee must prove, by a preponderance of the evidence, the employee's injuries arose out of and in the course of the employee's employment with the employer. 2800 Corp. v. Fernandez, 528 N.W.2d 124, 128 (Iowa 1995). An injury arises out of employment when a causal relationship exists between the employment and the injury. Quaker Oats Co. v. Ciha, 552 N.W.2d 143, 151 (Iowa 1996). The injury must be a rational consequence of a hazard connected with the employment, and not merely incidental to the employment. Koehler Electric v. Willis, 608 N.W.2d 1, 3 (Iowa 2000). The Iowa Supreme Court has held, an injury occurs "in the course of employment" when:

> It is within the period of employment at a place where the employee reasonably may be in performing his duties, and while he is fulfilling those duties or engaged in doing something incidental thereto. An injury in the course of employment embraces all injuries received while employed in furthering the employer's business and injuries received on the employer's premises, provided that the employee's presence must ordinarily be required at the place of the injury, or, if not so required, employee's departure from the usual place of employment must not amount to an abandonment of employment or be an act wholly foreign to his usual work. An employee does not cease to be in the course of his employment merely because he is not actually engaged in doing some specifically prescribed task, if, in the course of his employment, he does some act which he deems necessary for the benefit or interest of the employer.

Farmers Elevator Co. v. Manning, 286 N.W.2d 174, 177 (Iowa 1979).

The claimant bears the burden of proving the claimant's work-related injury is a proximate cause of the claimant's disability and need for medical care. Ayers v. D & N Fence Co., Inc., 731 N.W.2d 11, 17 (Iowa 2007); George A. Hormel & Co. v. Jordan, 569 N.W.2d 148, 153 (Iowa 1997). "In order for a cause to be proximate, it must be a 'substantial factor.'" Ayers, 731 N.W.2d at 17. A probability of causation must exist, a mere possibility of causation is insufficient. Frye v. Smith-Doyle Contractors, 569 N.W.2d 154, 156 (Iowa App. 1997).

The question of medical causation is "essentially within the domain of expert testimony." Cedar Rapids Community School v. Pease, 807 N.W.2d 839, 844-45 (Iowa 2011). The commissioner, as the trier of fact, must "weigh the evidence and measure the credibility of witnesses." Id. The trier of fact may accept or reject expert testimony, even if uncontroverted, in whole or in part. Frye, 569 N.W.2d at 156. When considering the weight of an expert opinion, the fact-finder may consider whether the examination occurred shortly after the claimant was injured, the compensation arrangement, the nature and extent of the examination, the expert's education, experience, training, and practice, and "all other factors which bear upon the weight and value" of the opinion. Rockwell Graphic Systems, Inc. v. Prince, 366 N.W.2d 187, 192 (Iowa 1985).

It is well-established in workers' compensation that "if a claimant has a preexisting condition or disability, aggravated, accelerated, worsened, or 'lighted up' by an injury which arose out of and in the course of employment resulting in a disability found to exist," the claimant is entitled to compensation. Dep't of Transp. v. Van Cannon, 459 N.W.2d 900, 904 (Iowa 1990). The Iowa Supreme Court has held,

> [a] disease which under any rational work is likely to progress so as to finally disable an employee does not become a "personal injury" under our Workmen's Compensation Act merely because it reaches a point of disablement while work for an employer is being pursued. It is only when there is a direct causal connection between exertion of the employment and the injury that a compensation award can be made. The question is whether the diseased condition was the cause, or whether the employment was a proximate contributing cause.

Musselman v. Central Telephone Co., 261 Iowa 352, 359-60, 154 N.W.2d 128, 132 (1967).

In his petition and at hearing, claimant alleged he sustained a work injury to his neck, back, right and left shoulders, right and left upper extremities, hip, and right and left hands on August 31, 2012. The deputy commissioner noted claimant had pre-existing neck and shoulder pain, but found claimant's conditions were not symptomatic prior to the work injury and claimant was able to perform his job, which was very strenuous. (Arbitration Decision, p. 10)

The deputy commissioner concluded Dr. Nasstrom, a treating family practice physician, Dr. Sneller, a treating orthopedic surgeon, and Dr. Hines, a neurosurgeon retained for purposes of conducting an IME, found claimant's conditions were related to his work injury, and Drs. Mooney and Martin, both occupational medicine physicians retained to perform IMEs found claimant's conditions were not related to his work injury. The deputy commissioner held claimant's "current neck, bilateral shoulder and CTS [carpal tunnel syndrome] were either caused or aggravated by the work injury on August 31, 2012," giving more weight to the opinions of Drs. Sneller and Hines, concluding Dr. Martin's report contained several erroneous assumptions which the deputy

commissioner did not set forth, and noting Dr. Mooney agreed claimant had ongoing pain and needed pain management. (Arb. Dec. p. 10) The record does not support the deputy commissioner's conclusion. I conclude more weight should be given to the opinions of Dr. Martin and Dr. Mooney.

Dr. Nasstrom, a treating family medicine physician, opined claimant's carpal tunnel syndrome was related to the August 2012 work injury, and he referred claimant to Dr. Richard Rattay for evaluation and treatment. (Ex. 6, pp. 11-12, 14) No medical records were produced from Dr. Rattay. Claimant was referred to Dr. Sneller, orthopedic surgeon, for evaluation and treatment of his claimed shoulder condition. (Ex. 9) On a form supplied by the insurer, Dr. Sneller wrote he diagnosed claimant with neck and bilateral shoulder pain and carpal tunnel syndrome and he checked a box stating, "yes" he believed the conditions were work-related. (Ex. 9, p. 3)

None of the physicians who performed IMEs of claimant, Dr. Hines, Dr. Martin, or Dr. Mooney, causally related claimant's carpal tunnel syndrome or alleged shoulder impairment to the August 31, 2012, work injury. (Ex. B; Ex. D; Ex. 12) Dr. Hines noted claimant had been seen by a Dr. Recinos, who believed the carpal tunnel syndrome was not work-related. (Ex. 12, p. 2) No medical records were produced from Dr. Recinos. No physician has provided a permanent impairment rating for claimant's carpal tunnel syndrome or alleged shoulder impairment. Claimant has failed to meet his burden of proof that he sustained permanent impairment of his shoulders, right and left upper extremities and hands caused by the August 31, 2012, work injury.

Dr. Hines opined:

> I have used cervical category 2 with two level 8% whole person impairment for the patient's impairment as the most significant difficulty for this patient, though he does have some SI joint impairment. I will impair this as well. This original impairment for the cervical area is using table 15-5, page 392. These two impairable areas of 8% each will then be added to bilateral ischial bursitis, which is evaluated using table 17-33, page 546, for 3% impairment on each side. Using combined values tables, 8% plus 8% is 16%, 16% plus 3% is 19%, 19% plus 3% is 21%. This would be the whole person impairment for this person.

(Ex. 12, p. 6-7)

Dr. Hines's report does not state what criteria he used for his rating of claimant's purported sacroiliac joint impairment. (Ex. 12, pp. 6-7) The deputy commissioner made no finding regarding claimant's purported sacroiliac joint or bilateral ischial bursitis conditions in his decision, but found Dr. Hines rated claimant's permanent partial impairment as twenty-one percent of the body as a whole, which includes Dr. Hines' ratings for the sacroiliac joint and bilateral ischial bursitis. (Arb. Dec. pp. 5, 10)

The record reflects claimant initially complained of bilateral shoulder, neck, and back pain to Dr. Haganman. (Ex. 5, p. 1) Dr. Haganman did not diagnose a lumbar spine or sacroiliac joint condition. (Ex. 5) Claimant complained of low back pain to his primary care provider, Dr. Senty, during his appointment on October 22, 2013, over a year after the work injury. (Ex. 11, p. 9) None of the treating physicians diagnosed claimant with sacroiliac joint or bilateral ischial bursitis conditions or provided any treatment for the purported conditions. Therefore, claimant has not established he sustained permanent impairment to his sacroiliac joint or bilateral ischial bursitis related to the August 31, 2012, work injury.

Dr. Hines also opined the work injury exacerbated claimant's preexisting cervical spinal stenosis and cervical radiculopathy. (Ex. 12, p. 6) The finding of cervical radiculopathy is contrary to the testing and objective finding of Dr. Nasstrom, the treating physician. Dr. Nasstrom noted the "[e]lectromyogram showed no evidence of cervical radiculopathy," which is consistent with Dr. Martin's opinion. (Ex. 6, pp. 11-12) Dr. Hines acknowledged this objective finding based on testing by Dr. Hayreh in his report, but Dr. Hines does not distinguish or explain that finding in reaching his conclusions that claimant has cervical radiculopathy which was aggravated by the work injury. (Ex. 12, p. 6)

Dr. Nasstrom referred claimant to Dr. Beck for a neurosurgical consultation. (Ex. 6, pp. 11-12) Dr. Beck previously treated claimant in 2006, finding claimant's MRI demonstrated mild degenerative changes. (Ex. H, p. 20) Dr. Beck examined claimant in January 2013, reviewed his imaging, and noted, "I explained to Bill that he has just aggravated some arthritis in his neck." Dr. Beck showed claimant neck exercises and ordered physical therapy, but imposed no work restrictions. (Ex. 7, p. 1)

The record supports the finding that claimant's current complaints do not have a causal connection to the work injury. Dr. Martin acknowledged the fall likely "created a contusion, or perhaps a strain on the cervical spine, the shoulders, and perhaps the low back. However, those issues should have resolved long ago and the current complaints either have a relationship to degenerative processes or a relationship of being within the medicolegal context." Dr. Martin concluded claimant reached maximum medical improvement by the end of November 2012. (Ex. B, pp. 12-13) Claimant has failed to carry his burden of proof that he sustained permanent disability as a result the work injury which occurred on August 31, 2012.[1]

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[1] The parties stipulated on the hearing report that the commencement date for permanent partial disability benefits, if any are awarded, is August 31, 2012, the date of the injury. Claimant did not request temporary benefits on the hearing report. The record establishes claimant did not miss any work prior to his layoff in early December 2012.

Because defendants did not appeal the award of medical expenses and costs, defendants shall pay claimant's prior medical expenses submitted by claimant at the hearing, and defendants shall also pay the cost of Dr. Hines' IME along with claimant's costs of the arbitration.

ORDER

IT IS THEREFORE ORDERED that the arbitration decision filed on December 16, 2015, is reversed.

Claimant shall take nothing in the way of weekly benefits in this matter.

Pursuant to Iowa Code section 85.39, Defendants shall pay or reimburse claimant for the cost of Dr. Hines' IME.

Pursuant to rule 876 IAC 4.33, defendants shall pay claimant's costs of the arbitration proceeding, and claimant shall pay the costs of the appeal, including the cost of the hearing transcript.

The petition for partial commutation filed on June 30, 2017, is dismissed.

Signed and filed on this 14th day of August, 2017.

JOSEPH S. CORTESE II
WORKERS' COMPENSATION
COMMISSIONER

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