BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

RAYE A. BOOKER, Claimant, vs. PARK FAIR ACE HARDWARE, Employer, and FIRST COMP., Insurance Carrier, and SECOND INJURY FUND OF IOWA, Defendants.	File No. 5065816 A P P E A L D E C I S I O N Head Notes: 1108, 1800, 1803.1

Defendants Park Fair Ace Hardware, employer, and First Comp, its insurance carrier, appeal from an arbitration decision filed on December 4, 2018. Claimant Raye Booker cross-appeals. Defendant Second Injury Fund of Iowa (the Fund) responds to the appeal. The case was heard on September 19, 2018, and it was considered fully submitted in front of the deputy workers' compensation commissioner on October 8, 2018.

The deputy commissioner found claimant sustained an industrial loss as a result of his work injury which occurred on August 23, 2014, because of phantom pain following amputation of his left index finger. The deputy commissioner found claimant's degenerative condition in his right knee was temporarily aggravated by the work injury on August 23, 2014, but returned to baseline. The deputy commissioner found claimant reached maximum medical improvement (MMI) for his right knee as of March 9, 2015. The deputy commissioner found the other issues pertaining to temporary benefits and medical benefits for the knee are moot. The deputy commissioner found claimant sustained 35 percent impairment of the whole person due to his industrial loss. The deputy commissioner found the correct weekly benefit rate is $158.06. The deputy commissioner found claimant did not make a claim for penalty benefits in his petition or hearing report, although he did file an amended petition on December 12, 2017,

asserting a claim for penalty benefits. However, because penalty was not an issue identified at the hearing or in the hearing report, it was not properly raised and would be improper to consider.

Defendants assert on appeal that the deputy commissioner erred in finding claimant sustained an industrial loss due to phantom pain. Defendants further assert that in the event his injury is to the body as a whole, he is not entitled to additional permanent partial disability benefits.

Claimant asserts on cross-appeal that the deputy commissioner erred in finding the correct weekly benefit rate to be $158.06. Claimant further asserts the deputy commissioner erred in failing to award additional healing period benefits. Claimant asserts the deputy commissioner correctly determined he sustained industrial disability due to phantom pain, but erred in finding his knee condition was only a temporary aggravation. Claimant further asserts that pursuant to Iowa Code section 85.34(2)(t), he is entitled to industrial disability by nature of sustaining two scheduled member injuries arising from the same incident.[1] Claimant asserts the deputy commissioner erred in awarding only 35 percent industrial disability, and claimant asserts the award for industrial disability should be increased substantially. Claimant asserts the deputy commissioner erred in failing to award him control of the medical care. Claimant asserts the deputy erred in failing to award penalty benefits, and in failing to order defendants to pay the lien asserted by the Veteran's Administration (VA) for claimant's medical care related to the knee. Finally, claimant asserts that in the event the left hand injury is not found to be an industrial disability, he is entitled to benefits from the Fund.

The Fund does not appeal, but asserts the deputy commissioner was correct in finding claimant sustained an industrial loss due to phantom pain. The Fund further asserts that in the event the left hand injury is not found to be an industrial disability, claimant is not entitled to Fund benefits because he failed to prove he sustained a qualifying first injury.

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

I have performed a de novo review of the evidentiary record and the detailed arguments of the parties. Pursuant to Iowa Code section 86.24 and 17A.15, those portions of the proposed arbitration decision filed on December 4, 2018, that relate to issues properly raised on intra-agency appeal and cross-appeal are affirmed in part, modified in part, and respectfully reversed in part, with the following additional findings, conclusions, and analysis:

[1] At the time of claimant's injury, this code section was numbered as 85.34(2)(s).

Right Knee

The deputy commissioner found claimant's degenerative condition in his right knee was temporarily aggravated by the work injury, but returned to baseline. In reaching that conclusion, the deputy commissioner noted there were two significant gaps in treatment following the aggravation, which suggest the knee returned to baseline, and flared up again following an incident unrelated to work. (Arbitration Decision, p. 10) Claimant argues that the fact that he now wears a knee brace every day, which he did not wear prior to the injury, supports his claim that the injury caused a permanent aggravation. Claimant also asserts the reason for claimant's gaps in treatment was due to the defendants' refusal to authorize care.

Prior to the work injury, claimant had at least two instances of knee pain resulting in X-rays. (Exhibit M, p. 2) Claimant had X-rays of the right knee for "chronic pain" on January 2, 2013, which the note indicates were compared to X-rays taken on April 23, 2012. (Ex. M, p. 2; Ex. N, p. 7) Following the work injury, claimant reported to the emergency room at the VA Hospital on August 25, 2015, with complaints of right knee pain, noting he "may have twisted knee a few days ago when he lost his R index finger." (Joint Exhibit 7, p. 3-5) He saw Robert Winchell, D.O. On exam, claimant was noted to have no ligamentous instability, and changes in joint were consistent with degenerative joint disease. (JE 7, p. 3) He was provided with an injection of Toradol and prescription Naprosyn, and it appears he was also provided with a knee brace at that time, as he had the brace at his next appointment with Steven Lilla, D.O., his primary care physician. (JE 7, pp. 28-29) At that appointment on August 29, 2014, Dr. Lilla noted claimant was there regarding prostate surgery, as he had recently been diagnosed with prostate cancer. (JE 7, p. 28) The note goes on to state claimant had injured his knee when he twisted it after cutting his finger, and that it is better with a brace but still painful with walking. Id. On physical exam, Dr. Lilla noted "right knee – mild effusion and edema with no erythema." (JE 7, p. 29) Under his assessment and plan, he noted claimant should "continue with the knee brace and if not better by time of surgery he may need an X-ray and MRI as he likely has ligamentous damage." Id. He was given a note to stay off work until after his prostate surgery. Id.

Claimant followed up with Patricia Kallemeier, M.D., for his hand injury on September 9, 2014, and mentioned his knee injury to her during that visit. (JE 3, p. 3) Claimant had an MRI of the right knee on September 29, 2014. (JE 5, pp. 3-4) It is not clear from the record who ordered the MRI, but it was read as showing a possible subtle ACL tear. (JE 5, p. 4) It was recommended that claimant follow up with an orthopedic consultation for further evaluation and to check the stability of the ACL. Id. Claimant had another follow-up with Dr. Kallemeier for his hand on October 21, 2014, at which time Dr. Kallemeier noted claimant continued to struggle with right knee pain from the injury and that he had not had treatment for it yet. (JE 3, p. 6) Dr. Kallemeier later noted claimant recently had further testing for his knee and "will follow-up with another doctor regarding this issue." Id.

Claimant saw Timothy Rankin, M.D., at Broadlawns Orthopedic Clinic on November 13, 2014, on referral from the VA Hospital. (JE 4) Dr. Rankin's note indicates claimant had surgery for prostate cancer on October 22, 2014. (JE 4, p. 2) Dr. Rankin noted claimant indicated he has had "injury and pain to the knee on and off for many years." Id. Claimant further indicated he "was having pretty good use of his right knee recently until the recent injury." Id. Dr. Rankin reviewed the MRI, and his assessment was chondromalacia of the right knee, lateral tibial bone contusion, and partial ACL tear/sprain. (JE 4, p. 3) He recommended an ACL control brace to stabilize the knee, and physical therapy for four weeks, after which he would see claimant back. Id.

Claimant began physical therapy at the VA Hospital on November 26, 2014. (JE 7, p. 24-26) It was noted at that time that claimant was using a knee brace with a 90-degree extension stop. Claimant complained that the knee brace was "sliding down," so he was provided with tubagrip to place under the brace. (JE 7, p. 25) Claimant was also using a cane that day due to snow outside, but stated he was otherwise able to ambulate independently. Id. The plan at that time was to continue physical therapy with the extension brace for four weeks, and then progress out of the brace to work on increasing knee flexion. (JE 7, p. 26) Claimant continued with physical therapy until December 29, 2014. (JE 7, p. 17-18) Over the course of physical therapy, claimant noted several times he was doing well, getting better, and also independently exercising his lower extremities at the YMCA. (JE 7, pp. 17-26) He continued to complain that the extension knee brace was sliding down, so the physical therapist ordered him a smaller, hinged knee brace. (JE 7, p. 22) By December 22, 2014, claimant was reporting he was doing great and had no pain since his prior visit. (JE 7, pp. 18-19)

There is no physical therapy discharge note in the records, and no indication claimant ever followed up with Dr. Rankin as recommended. The next record related to claimant's knee is his appointment with Kary Schulte, M.D. on March 9, 2015. (JE 3, p. 9) The record notes claimant was seen at the request of First Comp. Id. Dr. Schulte noted claimant reported pain over the anterior and lateral knee, and subjective instability and crepitus with range of motion. Id. Claimant also reported swelling of the knee and stiffness after prolonged sitting. Id. Claimant reported wearing a brace with "very good relief of symptoms." Id. He was not taking any pain medications and had not had any injections. Id. He reported his physical therapy resulted in "minimal changes in his symptoms. Id.

On physical examination, Dr. Schulte noted knee range of motion was from 0 to 130 degrees of flexion bilaterally. (JE 3, p. 10) Claimant had 5/5 strength with flexion and extension of both knees. Id. He had no instability to varus or valgus stress, and posterior drawer testing and Lachman testing were within normal limits bilaterally. Id. Dr. Schulte also ordered X-rays, which showed moderate medial compartment joint space narrowing bilaterally, and marked lateral compartment joint space narrowing of the right knee. Id. Dr. Schulte also reviewed the MRI report, but the actual MRI films were not available for his review. Id.

Dr. Schulte's assessment was right knee sprain, work related, and right knee degenerative arthritis, non-work related. Id. Dr. Schulte advised claimant that the majority of his residual symptoms are related to degenerative arthritis, which is not a work-related condition. (JE 3, p. 11) Dr. Schulte stated claimant's work injury was a temporary aggravation of claimant's pre-existing arthritis. Id. Dr. Schulte recommended claimant continue to wear the brace as needed, and ice the area and use ibuprofen or Tylenol as needed. Id. He released claimant with no restrictions, and placed him at MMI. (JE 3, p. 11-13)

After seeing Dr. Schulte on March 9, 2015, claimant had no other treatment related to his right knee until March 24, 2017, which is discussed further below. He did have an independent medical evaluation (IME) with Jacqueline Stoken, D.O., on April 5, 2016. (Claimant's Exhibit 3) Dr. Stoken's report is dated April 15, 2016. With respect to claimant's right knee, on physical examination she noted flexion was 110 degrees and extension is 20 degrees. The remainder of the examination was normal, although it was noted claimant ambulated with an antalgic gait. (Cl. Ex. 3, p. 5) Claimant reported pain in his right knee that he described as aching, throbbing, shooting, stabbing, sharp, and continuous. (Cl. Ex. 3, p. 4) He indicated that rest and a knee brace make it better, and walking, standing, and sitting make it worse. Id. Dr. Stoken opined claimant's work injury included a right knee strain that resulted in a partial ACL tear, and that claimant's ongoing complaints of pain are causally related to the work injury. (Cl. Ex. 3, p. 7) Dr. Stoken noted that prior to this time, claimant had periodic pain, while now his knee pain is constant. Id. Dr. Stoken assigned a rating of 20 percent lower extremity, or 8 percent whole person, due to flexion contracture of 10 degrees, and recommended restrictions of avoiding prolonged walking and standing, avoid walking on uneven ground, and avoid repetitive kneeling, stooping, and bending of the knee. Id.

As noted, the next record of treatment for claimant's right knee is dated March 24, 2017, two years after his appointment with Dr. Schulte and about 27 months after his last physical therapy appointment. (JE 7, p. 15) On that date, claimant reported to Dr. Lilla that he had "right knee pain since he was on a cruise. It has given out on him at times." Id. Dr. Lilla noted his previous ACL tear and "known disease there," and ordered an orthopedic consultation, physical therapy, and continued ibuprofen. Id. Dr. Lilla further stated claimant may need an MRI and "likely has some more severe ligament/tendon damage." Id. X-rays taken that day showed mild narrowing in the lateral compartment of both knees, right greater than left, with no acute soft tissue, bone, or joint abnormality in either knee. (JE 5, p. 1) The impression was mild degenerative joint disease involving both knees. (JE 5, p. 2)

Claimant next saw Dr. Lilla on April 6, 2017, for a follow up regarding his prostate cancer. (JE 7, pp. 13-14) At that time, claimant told Dr. Lilla he was working out five to six times per week for about one hour doing weights and cardiovascular exercise without any problems. (JE 7, p. 13) Claimant also reported "his knee is a little better and has yet to start [physical therapy]." Id. Dr. Lilla noted under his assessment and plan that the orthopedic consultation was placed, claimant is awaiting his physical therapy consultation, and his knee had "improved a little." (JE 7, p. 14)

Claimant's physical therapy consultation took place on May 1, 2017. (JE 7, pp. 9-10) At that time claimant stated he wears a knee brace to assist with pain, and had no issues going up and down stairs. Id. The physical therapist quoted claimant as saying "everything is good as long as I have the brace on." Id. The physical therapist further noted claimant lives in a two-story home, and attends the YMCA three times per week to use the bike and do leg curls and knee extensions. Id. On exam, claimant's right knee flexion and extension were both 5/5. (JE 7, p. 11) He had a positive valgus stress test, apprehensive medial knee pain, and positive ACL drawer test. Id. The physical therapist's assessment noted claimant had been wearing the knee brace since the work injury three years prior, which allows him to complete his activities of daily living without pain. (JE 7, p. 12) He noted the special testing on examination showed "instability due to MCL/ACL compromise but strong; again wears hinged knee brace that solves his problem." Id. Claimant advised he was working out at the YMCA three times per week to strengthen his legs, and stated "he does not really need PT and would rather self-exercise at home." Id. As such, claimant was discharged from physical therapy to continue with his independent exercise. Id.

On June 21, 2017, claimant had an orthopedic consultation with Dawn Eastman, ARNP, at the VA Hospital. (JE 7, pp. 6-8) She reviewed claimant's history, noting claimant stated "I don't leave home without it" in reference to his knee brace. (JE 7, p. 6) After examining claimant, ARNP Eastman's impression was right knee degenerative joint disease, right knee instability, and chronic partial ACL tear. (JE 7, p. 8) She noted claimant's laxity was mild, and no surgery would be appropriate, but Ms. Eastman offered a trial steroid injection into the knee. Id. Claimant agreed to the injection. Id. In an addendum dated July 11, 2017, Ms. Eastman noted she spoke to a doctor in the clinic who agreed it was "too early for TKA and ACL repairs not typically done on 64 year old." Id. When Ms. Eastman called to discuss with claimant, he reported "good results with steroid injection and hasn't been wearing his brace unless working out. He is happy with improvements." Id. He was to return in three months, but there is no record of that taking place.

The next record of any medical treatment related to claimant's right knee is a physical therapy consultation that took place about a year later, on July 11, 2018. (JE 7, p. 36) The record notes claimant was referred by Dr. Lilla on June 20, 2018, but the record of Dr. Lilla's appointment is not contained in the exhibits. The physical therapy record notes claimant stated he was going down steps a couple weeks prior and stepped wrong, resulting in right knee pain. Id. He also stated it had "significantly improved" since that incident. Id. He noted a similar issue in 2017, and stated it "feels like the same thing." Id. Overall, claimant reported feeling "pretty close to normal," but also inquired about replacing his current knee brace as he wears it all the time. Id. He reported no issues with going up and down stairs, but said some things are "slightly harder" due to the right knee. Id. He continued to exercise at the YMCA three times per week for lower extremity strengthening. Id.

On examination, the therapist noted range of motion within normal limits, and strength 5 of 5 bilaterally. (JE 7, p. 37) It was further noted claimant's knee brace was

"visibly tattered" and "should be replaced." Id. The assessment was right knee pain, treated last year for same condition, and symptoms nearly resolved since onset a couple of weeks prior. (JE 7, p. 38) The therapist noted claimant likely had an "acute strain following misstep," and his slight ligamentous instability was unchanged since his 2017 examination. Id. The record also notes claimant was issued a replacement hinged knee brace at that appointment, but at the hearing a few months later he had not received a replacement brace. Id. (See also Hearing Transcript, pp. 13-14) In any event, claimant was advised to continue with his independent exercise regimen at the YMCA, and was again discharged with no formal therapy. (JE 7, p. 38)

On August 8, 2018, claimant returned to Dr. Lilla with complaints of worsening chronic right knee pain. (JE 7, p. 35) He wanted another orthopedic consultation and complained of knee instability. Id. Dr. Lilla noted chronic right knee pain, osteoarthritis, and ACL tear. Id. He advised claimant to continue with the knee brace and physical therapy exercises, prescribed Etodolac, and referred claimant back to orthopedics. Id.

Claimant had an orthopedic consultation on August 17, 2018, with Andrew Olswing, D.O., at the VA Hospital. (JE 7, p. 34) Claimant reported he initially injured his knee at work four years prior. Id. Dr. Olswing noted the 2014 MRI showed a questionable partial tear of the ACL. Id. Claimant also noted he had been using a knee brace that provided him "very good stability" but he does have pain regularly located laterally. Id. He noted he tolerates his work at the hardware store with use of the brace, and his 2017 steroid injection did not provide much relief. Id. Physical exam was essentially normal, other than "minimally increased Lachman's on the right when compared to the left." Id.

Dr. Olswing's impression was right knee osteoarthritis with partial ACL injury. Id. He noted claimant "is symptomatic from his arthritis and partial ACL tear." (JE 7, p. 35) Dr. Olswing offered injections, which claimant declined. Id. Dr. Olswing's recommendation was to continue using anti-inflammatories and the knee brace, and continue his exercise regimen. Id.

Dr. Olswing's record is the last treatment record in evidence regarding claimant's knee. On August 18, 2018, Dr. Lilla signed a checklist letter authored by claimant's attorney, and agreed claimant's right knee condition was causally related to the work injury; that the diagnosis after reading an MRI most likely showed a partial ACL tear; and that claimant needed further treatment including prescription medications, physical therapy, brace, injections, and likely surgery. (Cl. Ex. 4, pp. 2-3) Dr. Lilla agreed claimant was at MMI, but did not indicate what date the claimant reached MMI. Id.

On August 17, 2018, Dr. Olswing signed a similar checklist letter authored by claimant's attorney. (Cl. Ex. 5) Dr. Olswing agreed that the condition of the right knee was causally related to the work injury of August 23, 2014, and that claimant had "more likely than not" sustained a partial ACL tear. (Cl. Ex. 5, p. 2) Dr. Olswing recommended further treatment in the form of medications, injections, physical therapy, and future

surgery should he fail all conservative treatment. Id. Dr. Olswing identified March 9, 2015, as the MMI date, the "date of last visit with Dr. Schulte." Id.

Defense counsel wrote to Dr. Schulte on August 22, 2018. (Ex. E) Dr. Schulte was provided with updated medical records related to claimant's treatment at the VA from January 2013 through July 2017, the 2014 MRI report, and the record from claimant's visit to Broadlawns in 2014. (Ex. E) After reviewing the records, Dr. Schulte reaffirmed his opinion that claimant sustained a temporary aggravation of the preexisting arthritis in his right knee as a result of the work injury on August 23, 2014. (Ex. F) Dr. Schulte further opined claimant's continued use of a brace on the right leg is necessitated by his primary degenerative arthritis, which is a chronic condition, and not the work injury. Id. Finally, Dr. Schulte opined the treatment claimant received at the VA in March 2017, and since that time, for his right knee is related to the primary degenerative arthritis, and not the work injury. Id.

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).

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).

The greater weight of evidence supports the deputy commissioner's finding that claimant sustained a temporary aggravation of his preexisting right knee condition. Claimant reported knee pain shortly after the incident, and received treatment through the VA Hospital until late December, 2014. Over the course of physical therapy, claimant noted several times he was doing well, getting better, and also independently exercising his lower extremities at the YMCA. It does not appear he ever followed up with Dr. Rankin at Broadlawns upon completion of physical therapy. When claimant saw Dr. Schulte in March of 2015, he reported "very good relief of symptoms" from wearing the knee brace, and he was not taking any pain medications and had not had any injections. He reported his physical therapy resulted in "minimal changes in his symptoms," but that statement is not supported by the physical therapy records. On physical examination, he had full strength and nearly full range of motion. Claimant then went two full years without seeking any treatment for his knee, despite access to medical care through the VA Hospital. When he did seek care in March of 2017, he noted knee pain since he had been on a cruise. By the time he had his physical therapy

consultation in May of 2017, he was reporting improvement and indicated he did not need physical therapy as he continued to exercise on his own. He then had another gap in treatment until June of 2018, when he reported stepping wrong while going down stairs. Again, by the time he had a physical therapy consultation about a month later, his symptoms had improved, and he did not believe he needed formal physical therapy.

Claimant's only explanation for the large gaps in treatment is his allegation that defendants refused to authorize treatment. This argument is not persuasive. Claimant was clearly comfortable seeking treatment on his own, and there is no evidence to suggest claimant ever requested treatment from defendants and was denied. Defendants did send claimant for an orthopedic evaluation with Dr. Schulte, who determined the work injury was a temporary aggravation. Defendants have admitted the temporary aggravation, and agree that they are responsible for claimant's treatment related to his right knee from the date of injury until March 9, 2015, when he was placed at MMI.

Claimant argues his consistent and ongoing use of a knee brace, which he did not use prior to the injury, supports his claim that the injury caused a permanent aggravation. However, his use of the knee brace alone, which Dr. Schulte opined is related to his arthritis and not the work injury, is not enough to overcome the weight of the other evidence in the record. Because claimant did not meet his burden to prove that the work injury resulted in a permanent aggravation of his preexisting knee condition, he is not entitled to additional temporary disability benefits or medical benefits based on the knee injury, nor is he entitled to penalty benefits.[2] Claimant's argument regarding industrial disability pursuant to section 85.34(3)(t) is also moot.[3]

Further, there are no medical records specifically taking claimant off work related to the knee injury. Dr. Lilla's August 29, 2014 note taking claimant off work until after his prostate surgery is unclear as to the reason why he was taken off work, and in any event, claimant was already off work until October 21, 2014 due to his hand injury. His prostate surgery was October 22, 2014, and there is no indication that claimant needed to remain off work due to his knee following that surgery. As such, claimant is entitled to healing period benefits from August 24, 2014 until October 21, 2014. There is no evidence that claimant was taken off work by any medical provider related to his hand or knee after that date.

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[2] The deputy commissioner correctly determined claimant's claim for penalty benefits was not properly raised before the agency as it was not included on the hearing report. Additionally, the claim is based entirely on the alleged denial of medical care for claimant's knee, which is not a proper basis for penalty benefits. Klein v. Furnas Electric Co., 384 N.W.2d 370, 375 (Iowa 1986).

[3] While claimant's argument regarding industrial disability pursuant to section 85.34(2)(t) is moot, it should be noted that under that section, benefits for permanent partial disability of two members caused by a single accident is a still a scheduled benefit. The degree of disability must be computed on a functional basis with a maximum benefit entitlement of 500 weeks. Simbro v. DeLong's Sportswear, 332 N.W.2d 886 (Iowa 1983).

Left Hand

The deputy commissioner found claimant sustained an industrial loss as a result of the work injury because of phantom pain following amputation of his left index finger. For the reasons that follow, the deputy commissioner's decision with respect to the nature and extent of claimant's left hand injury is respectfully reversed.

The parties agree and the deputy commissioner correctly noted that Dowell v. Wagler, 509 N.W.2d 134 (Iowa App. 1993) is controlling with respect to phantom pain due to the loss of a limb. The court in Dowell reasoned as follows:

> Iowa classifies psychological, mental, and nervous conditions as unscheduled injuries compensable under paragraph (u). Deaver, 170 N.W.2d at 466; Coughlan, 164 N.W.2d at 853; Gosek, 158 N.W.2d at 737. We believe the phantom pain which sometimes occurs after amputation is more akin to these types of injuries than it is to a scheduled physical trauma. At least two other jurisdictions have held phantom pain which is severe enough to require medical treatment may be an independent, unscheduled, compensable injury if it causes disability.
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> The Court of Appeals of New Mexico stated "incapacitating pain can be an impairment separate and distinct so as to remove a disability from the scheduled injury section of the statute." Gordon v. Dennisson Doors, Inc., 114 N.M. 767, 770, 845 P.2d 861, 864 (App.1992). The claimant had an index finger and part of a thumb amputated and suffered from severe, phantom pain. He was awarded scheduled benefits from the amputation and permanent partial disability benefits from the pain. The court noted:
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> > Where, as here, there is evidence that the injury sustained by claimant gave rise to severe pain requiring that he receive medical treatment . . . this evidence is sufficient to permit the [agency] to find that claimant's pain is disabling in nature.
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> Id. at 770, 845 P.2d at 864. The court determined that disabling pain is compensable, but not all pain is sufficient to be a separate and distinct impairment. Id. at 769, 845 P.2d at 863.
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> Pennsylvania also found phantom pain could be disabling. Penn Mar Foundries, Inc. v. Workmen's Compensation Appeal Bd., 76 Pa.Cmwlth. 565, 567, 464 A.2d 670, 671 (1983). The psychological problems and phantom pain from the foot injury were sufficient "to support the findings that claimant is totally disabled as a result of disabling conditions due to the original injury but extending to parts of the body other than the injured [part]." Id. at 567, 464 A.2d at 672. In this case the

> phantom pain and psychological condition were so severe that the claimant was declared totally disabled. Id. at 568, 464 A.2d at 672.
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> We find these cases instructive and their reasoning persuasive. We believe the approach to phantom pain taken by these courts is in line with the language and intent of our statutory workers' compensation scheme. We therefore hold that phantom pain syndrome or phantom limb syndrome may be compensable under Iowa Code section 85.34(2)(u) as an unscheduled disability. . . .

509 N.W.2d at 137–38 (emphasis added).

The holding in Dowell does not mandate an award of industrial disability for phantom pain. Rather, the court stated phantom pain "may" be compensable industrially—not "must" or "shall." Id. at 138. The Dowell court relied on two cases in coming to its decision. In the first case, from New Mexico, the claimant's phantom pain was so severe that the claimant received specific medical treatment for it. See Id. (citing Gordon, 845 P.2d at 864). In the second case, from Pennsylvania, the claimant's symptoms extended "to parts of the body other than the injured [part]." See Id. at 138 (citing Penn Mar Foundries, Inc., 464 A.2d at 671).

This agency has addressed the issue of phantom pain on several occasions, and has held both that phantom pain can be an industrial disability, and that the injury is a scheduled injury. It is a case-specific, factual analysis, but the central question in every case is whether the phantom pain is sufficiently disabling to be considered a separate and distinct impairment. See Id. at 137-138.

Specifically, using the Dowell analysis, the agency has often held that when there is no specific medical care related to the phantom pain, and no evidence that the symptoms extend beyond the scheduled member, industrial disability is not appropriate. See Harrell v. Denver Findley & Sons, Inc., File No. 5066742 (Arb. Dec., January 6, 2020) (no specific treatment for phantom pain and no evidence that symptoms extend beyond foot; therefore, scheduled member injury); Pleitez v. Stone House Kitchens & Granite, LLC, File No. 5059473 (Arb. Dec., September 20, 2018; affirmed on agency appeal, January 9, 2020) (no specific treatment for phantom pain and no evidence that symptoms extend beyond foot; therefore, scheduled member injury); Hernandez v. Tyson Foods, Inc., File No. 5051333 (Arb. Dec., January 17, 2017; affirmed on agency appeal, May 30, 2018) (based on available evidence, claimant did not specifically treat for phantom pain or prove disability beyond third and fourth digits); Begley v. Nestle USA, Inc., File No. 5051530 (Arb. Dec., April 12, 2016) (claimant testified to constant ache in hand and intermittent ache where fingers were amputated; needing to rub hand on pant leg for 2 to 10 minutes when in pain; sleep disturbances approximately once per week; and difficulties with hammering and gripping. IME provided additional three percent impairment rating for phantom pain. Deputy commissioner held that claimant did not meet his burden to prove the phantom pain affected his employability, as he had no restrictions related to the phantom pain, the pain was intermittent, and the pain did

not extend beyond the missing fingers and remaining part of the hand); Theppanya v. Alter Trading Corp., File No. 5046632 (Arb. Dec., March 28, 2016) (credible testimony that claimant experienced symptoms of phantom pain, but no evidence that the symptoms resulted in a condition that would justify an award of industrial disability).

Likewise, under the Dowell analysis, the agency has found phantom pain to result in industrial disability in situations where the evidence proves the phantom pain is independently disabling, and often in cases involving another sequelae injury to the body as a whole. See Sparks v. P & J Equipment Corp., File No. 5058524 (Arb. Dec., April 10, 2019) (evidence in the record supports finding that symptoms of phantom pain are independently disabling; claimant also had low back sequelae extending disability to body as a whole); Adams v. M & D Expedited, LLC and Elvis Pajazetovic, File No. 5054637 (Arb. Dec., May 11, 2017) (phantom pain was unscheduled injury where it affected claimant's ability to sleep and prevented him from using his hand, and additional medical treatment was recommended); Nelson v. Schieffer Co. International, File No. 5043321 (Arb. Dec., October 21, 2015) (phantom pain was unscheduled injury when severe enough that psychological treatment was recommended and interfered with claimant's sleep to the point that he was never well-rested); Madsen v. Rembrandt Enterprises, Inc., File No. 5046090 (Arb. Dec., March 4, 2015) (parties had stipulated to industrial disability, as claimant sustained injury resulting in below-the-shoulder amputation, scapular fracture, clavicle fracture, and multiple rib fractures. In considering amount of award, deputy noted that the phantom pain worsened over course of treatment, requiring maximum dose of medication, injections, acupuncture, TENS unit, and mirror therapy. Despite treatment, pain continued, and employer accommodates claimant's need to stop working at times until pain subsides).

In this case, the parties do not dispute claimant experiences phantom pain due to the amputation of his left index finger. Claimant argues the deputy commissioner correctly found claimant cannot undertake many of the tasks he was able to do before the injury as a result of the phantom pain. Given my review of the facts and the applicable law discussed above, I respectfully disagree with the deputy commissioner.

Claimant did report phantom pain at both follow-up appointments with Dr. Kallemeier. At his appointment on September 9, 2014, he reported he "occasionally has some shooting pains and some phantom discomfort." (JE 3, p. 2) Dr. Kallemeier again advised that she could revise the amputation "back to a ray amputation," but claimant was not interested in such treatment at that time. Id. At his next appointment on October 21, 2014, it is again noted "he continues to have issues associated with phantom pains." (JE 3, p. 6) However, claimant was placed at maximum medical improvement "unless he desires ray amputation of the index finger," and released with no restrictions related to his left hand. Id. Following that appointment, there is no evidence in the record of claimant receiving any additional medical treatment with respect to the left hand, or even mentioning the phantom pain or any limitations he experiences as a result to any medical provider.

Claimant and the Fund argue claimant's ongoing phantom pain, still present more than five years after the amputation, combined with his difficulty completing certain tasks, supports the deputy commissioner's finding that claimant's phantom pain is severe enough to qualify as a separate and distinct impairment. Claimant testified his hand is sensitive and it is difficult to grip. (Tr., pp. 16-17) He cannot clap, and he has the feeling that his finger is still there and feels pressure, as though it is constantly being squeezed. Id. However, when asked about his functional abilities, it is the missing finger, not the phantom pain, that causes limitations. For example, claimant noted if hammering he would have to hold a nail with his middle finger and thumb, and noted he is unable to grasp a golf club because "your index finger on your back hand is your first point of contact..." (Tr., pp. 18-19) Later, claimant testified to difficulties with climbing ladders, walking on stairs, and walking on uneven ground, specifically in reference to his right knee. (Tr., pp. 20-21) Still later, when asked about limitations with working in the construction industry, he mentioned he would have issues with his hand if he had to hang drywall, but the remainder of his difficulties are related to his knee. (Tr., pp. 30-31) On cross-examination, he testified he is able to grasp light items with his left hand, but that he tries not to carry a gallon of milk. (Tr., p. 47)

Claimant's testimony at hearing is consistent with his deposition testimony, taken almost three months prior to hearing. At his deposition, claimant testified to his difficulties with grasping items due to the missing finger. (JE 9, p. 13; Deposition Transcript, pp. 46-48) With respect to the phantom pain, the only thing he specifically cannot do is clap his hands. (JE 9, p. 12; Depo Tr., pp. 42-43) Later in the deposition, claimant testified his inability to engage in "flipping houses" or other construction work was due to "a combination of both" the left hand and right knee, because he has difficulty with climbing ladders and walking on uneven surfaces, and "grabbing a - - putting a nail in place or a screw in place, it's just not easy to do anymore." (JE 9, p. 18; Depo Tr., p. 69) This difficulty is not due to the phantom pain, but rather the missing finger. With respect to the pain itself, claimant testified that it "sometimes" keeps him up at night. (JE 9, p. 21; Depo Tr., pp. 78-79)

Despite his ongoing complaints, claimant has not sought any additional medical treatment related to his hand, and he has not been prescribed any medication for pain since Dr. Kallemeier released him. (Tr., pp. 44-46) Claimant further testified multiple times that his pain is limited to the missing finger, as well as the top of his hand and about halfway to the middle of his palm. (Tr., pp. 16-17, 46-47; JE 9, pp. 11-12, 19-20; Depo Tr., pp. 40-43, 71-72, 75-76)

Claimant and the Fund further note that both the treating physician, Dr. Kallemeier, and the IME physician, Dr. Stoken, provided an impairment rating related to the phantom pain. Initially, Dr. Kallemeier provided a 31 percent impairment rating to the left hand, based on loss of sensation, loss of motion, and the amputation level. (Ex. C, p. 2) Dr. Stoken provided the same impairment rating with respect to the level of amputation, which is 19 percent of the hand. (Cl. Ex. 3, p. 10) Dr. Stoken then converted that rating to 17 percent of the upper extremity, or 10 percent of the whole body. Id. Dr. Stoken then used chapter 13 of the AMA Guides to assign an additional

14 percent of the whole person related to "posttraumatic neuralgia (phantom pain)." (Cl. Ex. 3, p. 6) As such, Dr. Stoken's rating with respect to the left finger amputation came to 23 percent of the whole person. Id.

Dr. Kallemeier was provided with Dr. Stoken's IME report, and asked if she agreed that the index finger amputation should be considered an upper extremity injury as opposed to the hand. (Ex. D, p. 1) Dr. Kallemeier opined that the impairment rating for the amputation should be limited to the hand as outlined in the Guides. Id. Next Dr. Kallemeier was asked about Dr. Stoken's rating for the phantom pain, which she termed "posttraumatic neuralgia" and used chapter 13 to address.p Dr. Kallemeier noted that page 444 of the Guides, section 16.2d "Conditions Associated with Amputation," indicates that phantom pain is of neurogenic or central origin and is discussed in chapter 18, pain. Id. Turning to chapter 18, Dr. Kallemeier recommended an additional 3 percent impairment of the hand due to phantom pain. Id. When added to the prior 31 percent rating, total left hand impairment is 34 percent. (Ex. D, p. 2) Dr. Kallemeier then specifically noted that "it is not appropriate in this situation to assign the impairment to the body as a whole." Given that Dr. Kallemeier is a board certified surgeon with a specialty in hand surgery, and that she was the authorized treating physician who performed the surgery, I find her opinions more persuasive than those of Dr. Stoken. Additionally, Dr. Stoken very clearly applied the incorrect chapter of the AMA Guides in assigning her impairment rating, as explained by Dr. Kallemeier.

I find no evidence in the record that claimant received specific treatment for his phantom pain symptoms, and I find no evidence in the record that claimant's symptoms extend beyond his hand. Further, I find Dr. Kallemeier's opinions and ratings more credible and entitled to more weight than those of Dr. Stoken. Thus, while phantom pain may extend an injury into the body as a whole in some cases, in this case it does not. I therefore conclude claimant failed to satisfy his burden to prove his phantom pain extended his injury beyond his hand.

As the injury is to a scheduled member, the deputy commissioner's award of 35 percent industrial disability is respectfully reversed. Where an injury is limited to a scheduled member the loss is measured functionally, not industrially. Graves v. Eagle Iron Works, 331 N.W.2d 116 (Iowa 1983). Functional disability is "limited to the loss of the physiological capacity of the body or body part." Mortimer v. Fruehauf Corp., 502 N.W.2d 12, 15 (Iowa 1993); Sherman v. Pella Corp., 576 N.W.2d 312 (Iowa 1998). The fact finder must consider both medical and lay evidence relating to the extent of the functional loss in determining permanent disability resulting from an injury to a scheduled member. Terwilliger v. Snap-On Tools Corp., 529 N.W.2d 267, 272-273 (Iowa 1995); Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417, 420 (Iowa 1994).

Having found Dr. Kallemeier's rating more credible, and considering the record as a whole, I find claimant is entitled to receive permanent partial disability benefits equal to 34 percent of the hand.

Second Injury Fund

Having determined that the injury to claimant's hand is limited to the scheduled member, I must now address whether claimant is entitled to benefits from the Second Injury Fund of Iowa.

Section 85.64 governs Second Injury Fund liability. Before liability of the Fund is triggered, three requirements must be met. First, the employee must have lost or lost the use of a hand, arm, foot, leg, or eye. Second, the employee must sustain a loss or loss of use of another specified member or organ through a compensable injury. Third, permanent disability must exist as to both the initial injury and the second injury. The Fund is responsible for the industrial disability present after the second injury that exceeds the disability attributable to the first and second injuries. Section 85.64. Second Injury Fund of Iowa v. Braden, 459 N.W.2d 467 (Iowa 1990); Second Injury Fund v. Neelans, 436 N.W.2d 355 (Iowa 1989); Second Injury Fund v. Mich. Coal Co., 274 N.W.2d 300 (Iowa 1970).

For purposes of Fund benefits, claimant has alleged a first injury to his left ankle that occurred approximately 20 years ago while he was playing basketball. (JE 9, p. 16; Depo Tr., pp. 59-60) Claimant testified that at the time of that injury, he was told he had a "severe sprain." (JE 9, p. 17; Depo Tr., p. 62) Claimant asserts he never fully recovered from the ankle sprain, and he asserts his ankle is continually swollen, in pain, and gives out on him. Id. (See also Tr., pp. 37-38) He also testified his ankle limits his physical abilities, but he did not provide any examples. (Tr., p. 38) In fact, claimant's testimony demonstrated he has not sought any treatment for his left ankle after the initial occurrence, and he has successfully worked several physically demanding jobs in the 20-plus years between the ankle injury and the work injury. (Ex. 9, pp. 17-18; Depo Tr., pp. 65-67; Ex. G, p. 2) He testified that when he worked as a security guard, it took approximately one hour to walk the full round of the plant, and he could do that with no pain in his left ankle. (Tr., pp. 51-52) Finally, Dr. Stoken, the only physician to offer an impairment rating for the left ankle, based the rating on a prior ankle fracture with chronic pain, which is inaccurate according to claimant's testimony. (Cl. Ex. 3, p. 6; JE 9, p. 17; Depo Tr., p. 62) Dr. Stoken did not review any medical records related to claimant's ankle, and there are none in the record. (Ex. 3)

Overall, the evidence in the record does not support claimant's contention that he sustained permanent impairment as a result of his first alleged injury to his ankle. In order to obtain benefits from the Fund, claimant has the burden to prove that his first alleged injury resulted in some permanent disability. Second Injury Fund of Iowa v. Shank, 516 N.W.2d 808, 812 (Iowa 1994). As he did not meet his burden of proof in this regard, claimant shall take nothing from the Fund.

Weekly Compensation Rate

Claimant argues on appeal that the proper weekly compensation rate is $209.87, based on defendants' answers to interrogatories. (Cl. Ex. 6) As noted in the arbitration

decision, that rate is clearly based on a mathematical error in calculating the average weekly wage. The proper calculation is set forth in defendants' exhibit H. However, it appears the deputy commissioner inadvertently used average weekly wage as the weekly benefit rate in her decision, which is $158.06. (Arb. Dec., p. 12) As defendants point out, the average weekly wage of $158.06 is below the state minimum at the time, so his compensation rate should actually be $185.49, as defendants asserted on the hearing report. Therefore, the arbitration decision is modified to reflect the correct weekly benefit rate of $185.49.

ORDER

IT IS THEREFORE ORDERED that the arbitration decision filed on December 4, 2018, is affirmed in part, modified in part, and respectfully reversed in part.

With respect to the right knee, claimant shall take nothing.

With respect to the left hand, defendant-employer and insurer shall pay claimant sixty-six point five (66.5) weeks of permanent partial disability benefits at the weekly rate of one hundred eighty-five and 49/100 dollars ($185.49), commencing October 22, 2014.

Defendants shall pay accrued weekly benefits in a lump sum together with interest at the rate of ten percent for all weekly benefits payable and not paid when due which accrued before July 1, 2017, and all interest on past due weekly compensation benefits accruing on or after July 1, 2017, shall be payable at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two percent. See Gamble v. AG Leader Technology, File No. 5054686 (App. Apr. 24, 2018).

Defendants employer and insurer shall receive credit for all benefits previously paid.

Claimant is not entitled to receive benefits from the Second Injury Fund of Iowa.

Pursuant to 876 IAC 4.33, defendants employer and insurer shall pay claimant's costs of the arbitration proceeding as set forth in the arbitration decision. The parties shall pay their own appeal costs. The cost of the transcript shall be divided equally between defendants employer and insurer paying one share and claimant paying one share, pursuant to 876 IAC 4.30.

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

Signed and filed on this 9th day of March, 2020.

Joseph S. Cortese II

JOSEPH S. CORTESE II
WORKERS' COMPENSATION
COMMISSIONER

The parties have been served as follows:

Stephen D. Lombardi	Via WCES
Katrina M. Phillip	Via WCES
Kent Smith	Via WCES
Meredith C. Cooney	Via WCES