BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

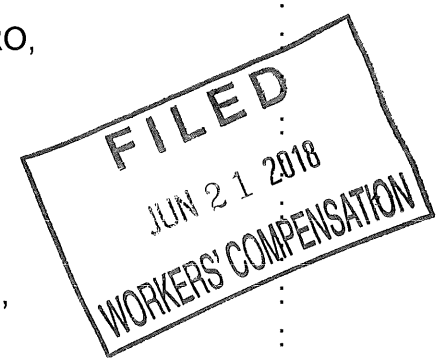
JOSEPHINE F. PEDRO,

Claimant,

vs.

TYSON FOODS, INC.,

Employer,
Self-Insured,
Defendant.



File No. 5056938

A R B I T R A T I O N

D E C I S I O N

Head Note Nos.: 1108, 1803, 2500

STATEMENT OF THE CASE

Claimant, Josephine Pedro, filed a petition in arbitration seeking workers' compensation benefits from Tyson Foods, Inc., self-insured employer, as defendant, as a result of a stipulated injury sustained on October 18, 2015. This matter came on for hearing before Deputy Workers' Compensation Commissioner Erica J. Fitch, on July 25, 2017, in Waterloo, Iowa. The record in this case consists of Joint Exhibits 1 through 8, Claimant's Exhibits 1 through 5, Defendant's Exhibits A and C through E, and the testimony of the claimant. The parties submitted post-hearing briefs, the matter being fully submitted on September 14, 2017.

ISSUES

The parties submitted the following issues for determination:

1. Whether claimant is entitled to temporary disability benefits from July 14, 2016 through July 7, 2017;

2. The extent of claimant's permanent disability;

3. Whether any permanent disability is a scheduled member disability or an unscheduled disability;

4. The commencement date for permanent partial disability benefits;

5. Whether defendant is responsible for claimed medical expenses;

6. Whether claimant is entitled to an award of alternate medical care under Iowa Code section 85.27; and

7. Specific taxation of costs.

The parties filed a hearing report at the commencement of the arbitration hearing. On the hearing report, the parties entered into various stipulations. All of those stipulations were accepted and are hereby incorporated into this arbitration decision and no factual or legal issues relative to the parties' stipulations will be raised or discussed in this decision. The parties are now bound by their stipulations.

FINDINGS OF FACT

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

Claimant's testimony was largely consistent compared to the evidentiary record and her deposition testimony. Her demeanor at the time of evidentiary hearing gave the undersigned no reason to doubt claimant's veracity. The undersigned observed claimant move her right upper extremity during the course of hearing, although she moved the right arm less freely than she moved the left arm. Claimant generally held her right shoulder down at her body. Claimant is found credible.

Claimant was 37 years of age at the time of hearing. She is left-hand dominant. Claimant is a native of Liberia, West Africa. Claimant is fluent in English; she was educated in English, although she also studied French. In Liberia, claimant graduated high school and obtained an associate's degree in business management and sociology. Following graduation from college, claimant obtained a position in the finance and procurement department for the Liberian government. In this office-based role, claimant's duties included: speaking with vendors; evaluating receipts, purchase orders, and contracts; and reviewing claims for reimbursement. Claimant testified her duties almost exclusively involved paperwork; she denied more than occasional use of a computer. This employment is the first formal job of claimant's lifetime. Her duties were completed entirely in English. Claimant held this job from October 2012 through August 2014. At that time, claimant immigrated to the United States and took up residence in Waterloo, Iowa. She continues to reside in Waterloo. Claimant denies suffering any left hand or right shoulder injuries prior to the injuries she allegedly sustained on October 18, 2015. (Claimant's testimony)

In May 2015, claimant applied for employment with defendant. Prior to beginning employment at defendant, claimant participated in a post-offer physical examination. The assessment noted no limitations on claimant's abilities. (Claimant's testimony; JE1, pp. 1-3) Defendant placed claimant in the position of separate black gut. Claimant testified this position is repetitive in nature and required her to reach onto a conveyor belt, grab the guts, and place the guts on a table. She would then hold the guts in both hands and pull the sides apart. Her duties were done in front or to the side of her body,

below head level. Claimant performed these separating tasks for two hours and then rotated to a piping position, when she would hold the guts under running water. Claimant performed piping for two hours; she continued on this two-hour rotation throughout her shift. Claimant worked 8 to 10 hours per day, 5 to 6 days per week. (Claimant's testimony) Review of supplied video of the separate black gut position reveals activities consistent with claimant's testimony. (*See* DEE)

While performing separate black gut duties, claimant testified she began to suffer with symptoms throughout the upper half of her torso and upper extremities. Specifically, claimant complained of numbness and pain of her left hand, with radiation up the left arm into her bilateral shoulders, neck, and back; symptoms then radiated down her right arm to the right elbow. (Claimant's testimony)

On October 19, 2015, claimant presented to defendant's medical clinic (medical clinic). Renee Brown, RN noted complaints of pain of the left wrist, left shoulder, bilateral upper extremities, and left middle finger, as well as tingling of the fingertips of the right hand. Claimant also complained of popping at the third joint of her left middle finger. She was advised to use over the counter ibuprofen. Claimant had been performing the separate black gut job; she was placed on a light duty assignment of set black gut count. However, after attempting this assignment, claimant's supervisor felt claimant continued to overuse her left hand. As a result, she was given a new light duty assignment of monitor fecals. (JE1, p. 4)

That same date, October 19, 2015, claimant completed an injury report. Claimant identified a date of injury of September 18, 2015, at which time she performed the separate black gut position. She noted complaints of popping, locking, and pain of her left middle finger, as well as right finger numbness, shoulder pain, left arm pain, and neck pain. (CE2, p. 15)

Claimant returned to the medical clinic on October 22, 2015, at which time Dyanna Buhrman, RN, noted complaints of pain of the left middle finger, left wrist, left shoulder, and bilateral upper extremities. Ms. Buhrman noted resolution of prior complaints of tingling digits and neck pain. Claimant was assigned to light duty on the monitor fecals at trim/neck job. (JE1, p. 4)

Claimant returned to Ms. Buhrman on October 27, 2015; conservative care continued. (JE1, p. 5)

On November 2, 2015, claimant returned to Ms. Buhrman with complaints of pain, popping, and locking of the left middle finger. Claimant denied pain of her upper extremities. Claimant requested evaluation by a physician. (JE1, p. 5) Ms. Buhrman subsequently arranged for claimant to be evaluated by MOHA. (JE1, p. 6) Claimant testified the plant nurses, Ms. Brown and Ms. Buhrman informed her the scheduled appointment was to address her hand complaints only, as her shoulder pain simply reflected muscle pain. (Claimant's testimony)

Defendant arranged for claimant to be evaluated at MOHA by Robert Gordon, M.D. At an appointment on November 10, 2015, Dr. Gordon noted claimant's complaint as triggering of her left long finger, with associated pain of the third volar metacarpal region. Claimant also reported that in mid-September 2015, she began to notice pain of her neck and down her arms bilaterally; however, Dr. Gordon noted these complaints had since resolved. Dr. Gordon performed a physical examination, noting full range of motion of the bilateral shoulders, without tenderness; and pain of the left third metacarpal, with nodularity over the A1 pulley and triggering over the long finger. Dr. Gordon assessed a history of cervical and bilateral upper extremity pain, resolved; and left long digit stenosis tenosynovitis. He performed a left long digit trigger finger corticosteroid injury and provided a finger splint for nocturnal use. Dr. Gordon imposed work restrictions of no grasping with the left hand on more than an occasional basis; he specifically opined claimant should not return to the separate black gut job. (JE2, pp. 22-23)

Claimant testified at the time of the initial evaluation with Dr. Gordon, she experienced left hand and right shoulder problems. However, she did not discuss her shoulder complaints due to the nurses' direction that the appointment was designed only to address her hand complaints. (Claimant's testimony)

Claimant returned to Dr. Gordon on November 24, 2015 and noted improvement, but some continued triggering. Dr. Gordon ordered a course of physical therapy and imposed light duty restrictions of no grasping or pinching with the left hand while working. (JE2, p. 24)

On December 8, 2015, claimant presented to Dr. Gordon with complaints of continued triggering. Dr. Gordon ordered continued physical therapy and performed a repeat injection. He imposed restrictions of limited grasping and no gripping or pinching with the left hand. Dr. Gordon spoke with claimant about potentially bidding into another position. He noted the separate black gut job required notable forceful grasping and expressed belief that such a job was not in claimant's best interest. (JE2, pp. 26-27)

At a follow up appointment with Dr. Gordon on December 22, 2015, claimant reported experiencing very intermittent triggering. Claimant reported she was performing an inspection position to full capacity, but was uncertain if she was permitted to own the job. While this question was investigated and physical therapy was completed, Dr. Gordon imposed a work restriction of no gripping or pinching with the left hand on a more than occasional basis. In the event the inspection job assignment was permanent, Dr. Gordon opined he would release claimant to full duty. He opined claimant had achieved maximum medical improvement (MMI) and remained under restrictions until completion of physical therapy, but was released to full duty thereafter. (JE2, pp. 28-29)

At the referral of defendant, on January 20, 2016, claimant presented to Cedar Valley Medical Specialists for evaluation with Thomas Gorsche, M.D. Dr. Gorsche

noted a four-month history of triggering of the left long finger, with only temporary relief following two cortisone injections by Dr. Gordon. On examination, Dr. Gorsche noted tenderness and pain of the A1 pulley of the left long finger, with some clicking. Due to lack of relief with injections, Dr. Gorsche recommended surgical release. In the interim, he recommended continued light duty work. (JE3, p. 47)

Dr. Gorsche performed a release of the A1 pulley of claimant's left long finger on January 28, 2016. He issued a postoperative diagnosis of trigger finger of the left long finger. (JE4, p. 58)

Post-surgery, Dr. Gorsche imposed a restriction of right-handed only work. (JE3, p. 48) On February 6, 2016, claimant was assigned to light duty in the box shop at defendant. (JE1, p. 11)

Claimant returned to Dr. Gorsche on February 9, 2016. Dr. Gorsche left in place a light duty restriction of no work with the left hand. He ordered a course of physical therapy. (JE3, pp. 48-49)

Claimant testified while on light duty, she was assigned to monitoring for contamination. In this role, she performed "audit split," where she would check the split hogs for contamination. She performed her duties utilizing only her right hand and was required to touch 4,000 to 5,000 hogs per day to examine the carcasses. Claimant also testified she was required to inspect about the hog heads for contamination and to do so, would have to lift the hog head from about her chest level to shoulder level to check for any potential contamination about the head or neck. (Claimant's testimony)

At evidentiary hearing, claimant testified her right shoulder symptoms did not resolve after she was removed from the separate black gut job. Claimant testified while performing her inspection duties, the pain in her right shoulder began to radiate into her neck and face, as well as down to her right elbow and into her mid-back. She also began to experience popping and catching of the right shoulder. (Claimant's testimony)

At her deposition, claimant testified she initially felt right shoulder pain while performing the separate black gut position, but her symptoms later worsened during performance of one-handed light duty. (CE3, p. 8)

On February 24, 2016, Ms. Buhrman telephoned claimant to inform her of a follow up appointment with Dr. Gorsche, scheduled for March 1, 2016. Ms. Buhrman noted claimant had left work for personal reasons, but expressed complaints of right shoulder pain. Ms. Buhrman advised claimant to complete paperwork upon her return to work. (JE1, p. 12) Upon claimant's return on February 25, 2016, she was assigned to a light duty position of audit splits. (JE1, p. 12)

On February 26, 2016, claimant returned to the medical clinic and was examined

by Ms. Brown. Ms. Brown noted complaints of right shoulder, right scapular, and right-sided neck with radiation to the elbow. Claimant also expressed complaints of pain and swelling of her left hand. (JE1, p. 12)

On March 1, 2016, claimant returned to Dr. Gorsche in follow up. Dr. Gorsche recommended continued physical therapy and imposed work restrictions of no repetitive gripping or grasping with the left hand. (JE3, pp. 50-51)

Also on March 1, 2016, claimant presented to Dr. Gordon for evaluation of right shoulder complaints. Claimant reported an onset of pain approximately two weeks prior while performing light duty. Claimant denied problems during her assignment in the box shop. Instead, claimant testified her problems began while performing the monitoring for contamination job. In this job, claimant testified she was required to, at times, raise her right hand above shoulder or head height, and also may move the position of a carcass to allow for proper monitoring. Dr. Gordon commented he had personally performed this job. (JE2, p. 30)

Dr. Gordon noted that approximately four months prior, claimant had experienced pain, numbness, and tingling of her right shoulder and right upper extremity. He noted these complaints resolved with treatment in defendant's medical clinic. Dr. Gordon also noted claimant had not previously expressed any right shoulder complaints to him during prior treatment visits. (JE2, p. 30)

On examination, Dr. Gordon noted decreased range of motion and tenderness of the right shoulder. He assessed right shoulder pain of an insidious onset. He opined the monitoring for contamination job was low intensity and required minimal force, with no sustained awkward positions of the right shoulder. Accordingly, he opined this job would not precipitate, aggravate, or accelerate a right shoulder condition. Dr. Gordon recommended continued physical therapy and use of medication per Dr. Gorsche, and imposed restrictions of no right upper extremity activity over chest height and no lifting over five pounds with the right upper extremity. (JE2, pp. 31-32)

On March 22, 2016, claimant returned to Dr. Gorsche with some continued symptoms of her left long finger. Dr. Gorsche recommended continued light duty and advised claimant of treatment options, including an injection or repeat surgery. (JE3, pp. 52-53)

Claimant returned to Dr. Gorsche on April 19, 2016 with complaints of persistent clicking and catching of the left long finger. Dr. Gorsche recommended surgical intervention. He left claimant's light duty restrictions in place. (JE3, pp. 54-55)

On May 5, 2016, Dr. Gorsche performed a repeat release of the A1 pulley of the left long finger. He denoted a postoperative diagnosis of scarring of the A1 pulley. (JE4, p. 59)

Due to defendant's denial of liability for her right shoulder condition, claimant sought care with board certified orthopedic surgeon, Arnold Delbridge, M.D., for complaints of right shoulder, thoracic, and cervical symptoms. (JE5, p. 62; CE2, p. 1) Claimant presented to Dr. Delbridge on May 6, 2016. She related her symptoms to an October 2015 work injury and use of her non-dominant right hand. (JE5, p. 62) Claimant complained of limited range of shoulder motion and severe pain. She reported development of symptoms upon increased use of her non-dominant right hand after experiencing left trigger finger. Dr. Delbridge noted defendant had denied liability for these expressed symptoms by a letter dated March 24, 2016. Following x-rays, Dr. Delbridge ordered a right shoulder MRI. (JE5, p. 64)

In response to inquiry from defendant regarding claimant's cervical and bilateral upper extremity pain, Dr. Gordon offered opinions dated May 10, 2016. He opined claimant achieved MMI for the cervical and bilateral upper extremity symptoms arising from the October 19, 2015 injury on November 10, 2015. He found no permanent impairment associated with these conditions. (JE2, p. 34)

On May 11, 2016, claimant completed defendant's injury report. Thereby, claimant noted an injury date of December 2015, with an onset of right shoulder pain she attributed to overcompensating for use of her left hand. (JE1, p. 14)

On May 16, 2016, claimant returned to Dr. Gorsche for post-surgical follow up. At that time, claimant reported improvement over her preoperative symptoms. Dr. Gorsche ordered physical therapy and imposed a restriction of no work with the left hand. (JE3, pp. 56-57)

Claimant returned to the medical clinic on June 2, 2016. Ms. Brown noted complaints of pain of the cervical spine down to the low back, and right shoulder pain radiating down to the right forearm. Claimant reported the pain was present prior to her current light duty assignment in the box shop. (JE1, p. 15)

On June 3, 2016, claimant returned to Dr. Delbridge. Dr. Delbridge noted in claimant's light duty job, she checked 3,500 hogs with one hand. Dr. Delbridge reviewed claimant's MRI and opined it revealed a large SLAP tear extending into the anchor involving the labrum, tendinopathy of the supraspinatus tendon, and degenerative changes of the AC joint. Dr. Delbridge opined the SLAP tear was the probable source of claimant's pain and recommended surgical fixation. (JE5, p. 65)

On June 7, 2016, claimant returned to Dr. Gordon in follow up. Claimant completed a pain diagram, noting symptoms of the cervical region, thoracic region, right shoulder girdle region, and right upper arm. Dr. Gordon noted at the time of claimant's March 1, 2016 evaluation, claimant related these symptoms to the monitoring for contamination job; he opined such a proposition was not biomechanically plausible. Claimant reported she related her symptoms to the separate black gut job. She also reported the symptoms were worsening, despite not performing this job for eight

months. Dr. Gordon noted that by the time of his first evaluation of claimant on November 10, 2015, claimant no longer complained of bilateral shoulder or cervical symptoms attributable to the October 19, 2015 work injury. Claimant did not report any such complaints at visits on November 24, 2015, December 8, 2015, or December 22, 2015. Dr. Gordon opined it was not medically plausible to relate claimant's current symptoms to the separate black gut job, given this chronology. (JE2, p. 35) Upon receipt of this opinion, claimant subsequently related her symptoms to the monitoring for contamination job. Dr. Gordon again opined such a job would not cause or aggravate any of the expressed conditions. (JE2, p. 36)

Dr. Gordon performed a physical examination. He noted decreased range of motion of claimant's shoulder on examination, but free movement of the shoulder during observation. Dr. Gordon opined there was no physiological explanation for this lack of congruency. He also noted tenderness to palpation throughout the right shoulder girdle area. Dr. Gordon noted claimant complained of diffuse tenderness of the right upper arm; however, no such complaints were noted when claimant was distracted. (JE2, p. 36)

Dr. Gordon assessed cervical and thoracic pain. He opined it was not plausible to relate this condition to the separate black gut job and further, that the monitoring for contamination job would not cause, aggravate or accelerate this condition. Dr. Gordon also assessed right shoulder girdle region pain and right proximal upper extremity pain. He opined claimant's examination revealed nonphysiologic findings and further opined it was not plausible to relate these complaints to the separate black gut position. Dr. Gordon also opined the monitoring for contamination job would not cause, aggravate, or accelerate such disorders, due to a lack of biomechanical risks to the right shoulder and upper extremity. Dr. Gordon prescribed ibuprofen 800 mg, imposed restrictions of no activity above shoulder level with the right upper extremity, and recommended performance of an independent job site evaluation to assess the monitoring for contamination job. (JE2, pp. 36-37)

Defendant retained John Kruzich, MS, OTR/L of ARC Physical Therapy, to complete a job analysis of the monitor for contamination light duty positions, including inspect for fecal at viscera and inspect head/neck for fecal. Mr. Kruzich presented to defendant's plant on June 27, 2016, with the task of identifying the biomechanical stressors on the cervical and thoracic spine, right shoulder girdle, proximal right upper extremity, and distal right upper extremity. Mr. Kruzich reviewed the job descriptions and physical demands for each position. (DEA, pp. 1-2) He also performed range of motion measurements for the cervical spine, right shoulder, right elbow, right forearm, and right wrist. (DEA, p. 3)

Based upon the observed demonstration, Mr. Kruzich opined the positions fell within the light physical exertion level. Mr. Kruzich concluded that, as demonstrated, the positions lacked risk factors for shoulder disorders, such as sustained awkward posture, force in combination with repetition, or force in combination with certain

postures. Mr. Kruzich also concluded that the positions lacked significant risk factors for a neck disorder, including limited cervical motion required, a lack of sustained awkward postures, and a lack of forceful movements. With respect to the thoracic spine, Mr. Kruzich identified negligible amounts of bending and/or twisting, and an absence of compressive forces. Finally, in considering stressors upon the hand, wrist, and elbow, Mr. Kruzich concluded the positions were safe by the Moore-Greg Strain Index, given factors of intensity, duration of exertion and tasks, efforts per minute, hand/wrist posture, and speed. Following completion of his analysis, Mr. Kruzich opined it was not "biomechanically/medically plausible" that these positions caused, precipitated, aggravated, or accelerated a pathological disorder of the cervical spine, thoracic spine, right shoulder girdle, or right upper extremity. (DEA, p. 4)

On July 12, 2016, claimant returned to Dr. Gordon. Claimant reported a primary complaint of right shoulder girdle region pain. She reported improvement in the cervical and thoracic regions, as well as resolution of numbness and tingling of the right upper extremity. Dr. Gordon reviewed Mr. Kruzich's job site evaluation of June 27, 2016 and summarized that Mr. Kruzich concluded the monitoring for contamination positions would not cause, precipitate, aggravate, or accelerate pathological disorders of the cervical spine, thoracic spine, right shoulder girdle, or proximal and distal right upper extremity. Dr. Gordon also reviewed the job analyses for monitoring for contamination positions of inspect for fecal at viscera and inspect head/neck for fecal. (JE2, p. 38)

Dr. Gordon noted he discussed the job site evaluation results, as well as his own opinions, with claimant. Specifically, he opined the monitoring for contamination positions lacked sufficient biomechanical stressors to cause, aggravate, or light up disorders of the cervical spine, thoracic spine, or right shoulder girdle. After he expressed this opinion, Dr. Gordon noted claimant then relayed that her symptoms may have come on while working in the box shop. To this, Dr. Gordon indicated he had evaluated the light duty jobs available in the box shop, and those jobs would not precipitate, cause, or aggravate disorders of the right shoulder, even if claimant was precluded from use of her left upper extremity. He described the positions as extremely light in nature, with minimal use of either upper extremity. (JE2, p. 38-39)

Following expression of this opinion, Dr. Gordon noted claimant then indicated she related her symptoms to the monitoring for contamination – inspect head/neck for fecal job, as she was required to use her right hand to inspect 4,000 to 5,000 hogs per day. Dr. Gordon indicated knowledge of the frequency with which claimant performed her tasks, but replied that repetition alone did not make the job "deleterious" to the right shoulder, cervical spine, or thoracic spine. He opined the performed tasks must be kinematically relevant and these activities were not, as her problematic regions are not placed in positions of compromise or used in ways which would stress or strain the rotator cuff, labrum, discs, or surrounding tissues. Dr. Gordon opined the force involved in the positions was negligible and less than that to which people are exposed in daily activities. (JE2, p. 39)

Dr. Gordon performed a records review, including the evaluation of Dr. Delbridge; he noted claimant had not otherwise informed him of her evaluation with Dr. Delbridge. Dr. Gordon opined claimant's MRI revealed a large SLAP tear, tendinopathy of the supraspinatus tendon, and degenerative changes of the AC joint. He opined these findings were "definitely" not related to any of claimant's job duties, including monitoring or contamination or in the box shop. Dr. Gordon specifically opined the monitoring for contamination – inspection position would not cause rotator cuff tendinopathy or a labral tear. He also opined the separate black gut job would not cause, precipitate, or otherwise aggravate a labral disorder, as the position lacks the necessary biomechanical risk factors. (JE2, p. 29) Dr. Gordon performed a physical examination. He noted findings of diffuse tenderness of the right scapular region, tenderness of the right shoulder girdle, very guarded movement of the right shoulder, and cog-wheeling of the right shoulder with strength testing, during which Dr. Gordon indicated he was unable to obtain an accurate examination. Following interview, records review and examination, Dr. Gordon issued assessments of cervical and thoracic pain, as well as right shoulder girdle region and proximal right upper extremity pain. (JE2, pp. 39-40)

With respect to the cervical and thoracic pain, Dr. Gordon noted claimant reported improvement. Dr. Gordon noted claimant related these symptoms to performance of monitoring for contamination jobs. Dr. Gordon indicated he was personally familiar with these positions and opined it was not "remotely plausible" for these jobs to cause, aggravate, or accelerate any disorders of the cervical or thoracic regions. Dr. Gordon also cited Mr. Kruzich's evaluation results in support of his opinion. (JE2, p. 40)

With respect to the right shoulder girdle region and proximal right upper extremity pain, Dr. Gordon expressed some agreement with Dr. Delbridge insofar as he believed the SLAP tear might be causing at least part of claimant's symptomatology. However, Dr. Gordon cautioned that claimant's symptoms were quite diffuse and her examination yielded nonphysiologic findings. Dr. Gordon opined the monitoring for contamination positions would not cause, precipitate, or aggravate disorders about the right shoulder, including a SLAP tear, supraspinatus tendinopathy, or AC joint arthrosis. He reasoned the positions lacked biomechanical stressors incurred on the right shoulder, even under the condition of using only the right upper extremity to perform the job. Dr. Gordon again noted Mr. Kruzich reached the same conclusion. Dr. Gordon also noted claimant related her symptoms to her duties in the box shop. Dr. Gordon indicated he was familiar with these positions and opined it was not remotely plausible for such work to cause a right shoulder disorder, even if one were limited to use of only the right upper extremity. (JE2, p. 40)

Dr. Gordon discharged claimant from care with respect to any work-related condition, without restrictions. He recommended claimant follow up with Dr. Delbridge for the non-work related cervical, thoracic, and right shoulder girdle conditions. For these conditions, Dr. Gordon recommended interim restrictions of no activities above chest height and no lifting over 10 pounds with the right upper extremity. (JE2, p. 40)

On July 14, 2016, claimant underwent right shoulder arthroscopy with Dr. Delbridge. The procedure included SLAP tear repair and debridement of the posterior glenoid rim. Dr. Delbridge noted a postoperative diagnosis of right shoulder SLAP tear. (JE4, pp. 60-61)

Following surgery, claimant followed up periodically with Dr. Delbridge. In August 2016, Dr. Delbridge ordered a course of physical therapy. (JE5, pp. 66, 68) Following an appointment on September 16, 2016, Dr. Delbridge ordered claimant to cease use of the shoulder immobilizer and continue physical therapy. Dr. Delbridge removed claimant from work for another four weeks. (JE5, p. 70)

At defendant's referral, on September 22, 2016, claimant presented to Peter Pardubsky, M.D. for a second opinion regarding claimant's left long finger. Claimant complained of severe constant pain over the palmar aspect of her left hand which radiated into the long finger and forearm, as well as sharp and burning pain, numbness, and tingling. (JE7, p. 82) Dr. Pardubsky performed a physical examination. (JE7, pp. 83-84) Thereafter, he assessed left hand pain following long finger release; possible early chronic regional pain syndrome (CRPS) versus contribution of carpal tunnel syndrome to hand and forearm pain; and minimal residual flexor tenosynovitis without mechanical triggering. Dr. Pardubsky indicated he was left without a definitive surgical recommendation, as claimant lacked significant mechanical triggering that would benefit from release or partial tendon excision. He expressed concern regarding the possibility of CRPS and recommended evaluation in a pain clinic. Dr. Pardubsky indicated electrodiagnostic studies might also be warranted to evaluate potential carpal tunnel syndrome. (JE7, p. 84)

Given Dr. Pardubsky's concern regarding potential CRPS, on September 29, 2016, claimant presented to pain management physician, Frank Hawkins, M.D. Claimant complained of pain of her left hand, from the long finger up into the forearm, as well as sharp and burning pain, stiffness, clicking, numbness, and tingling. Dr. Hawkins performed a physical examination. (JE8, pp. 89-90) Thereafter, Dr. Hawkins assessed nociceptive left hand pain, status post trigger finger releases. He opined claimant did not meet the Budapest criteria for a diagnosis of CRPS. Rather, Dr. Hawkins opined claimant continued to self-limit her recovery post-surgery and noted a potential tie to a recent increase in use of the left hand following right shoulder surgery. Dr. Hawkins indicated the reported clicking symptom may not resolve, but opined this symptom was not worrisome unless claimant also developed restricted range of motion. Dr. Hawkins noted claimant did not demonstrate restricted motion; however, she was welcome to return for care in the event her condition changed. Due to acceptable range of motion, Dr. Hawkins opined claimant was capable of performing work functions. (JE8, p. 91)

Claimant drafted answers to interrogatories on October 5, 2016. At that time, claimant related her left hand pain to the duties involved in the separate black gut job. Claimant further represented that while on light duty, she began experiencing right shoulder pain. (DEC, p. 8)

At a follow up appointment on October 7, 2016, Dr. Delbridge continued claimant's off-work restriction for an additional six weeks, ordered additional physical therapy, and scheduled a right shoulder injection. The injection was performed on October 12, 2016. (JE5, pp. 71-73)

On October 11, 2016, Dr. Gordon performed a records review. He recommended claimant undergo electrodiagnostic studies of her left upper extremity. He recommended claimant follow up with him thereafter. (JE2, p. 41)

On October 25, 2016, claimant presented to Dr. Gordon in follow up of left upper extremity symptoms. Dr. Gordon noted he reviewed the records of Drs. Gorsche, Pardubsky, and Hawkins, including the EMG of October 21, 2016, which revealed mild carpal tunnel syndrome. Claimant complained of clicking of the left long digit with flexion; Dr. Gordon noted good range of motion. Claimant also reported at times experiencing a burning sensation into the left forearm, which claimant believed originated in the left long digit. (JE2, p. 42)

Following examination, Dr. Gordon assessed left hand pain, primarily in the left long digit with radiation to the forearm. Dr. Gordon noted claimant's EMG showed mild carpal tunnel syndrome, but opined claimant's complaints and examination were inconsistent with carpal tunnel syndrome. Dr. Gordon also expressed agreement with Dr. Hawkins' opinion that claimant did not have CRPS by the Budapest criteria. Dr. Gordon imposed no restrictions with respect to claimant's left upper extremity. He noted claimant would be in contact in the event she intended to seek further treatment of her left arm. (JE2, p. 43)

On November 30, 2016, claimant returned to Dr. Pardubsky for evaluation related to her left hand complaints. He noted Dr. Hawkins did not find evidence of CRPS and had not recommended specific treatment. Dr. Pardubsky also reviewed claimant's EMG, which he opined was normal, with mild left carpal tunnel syndrome. (JE7, pp. 86-87) Following physical examination, Dr. Pardubsky assessed left hand pain after long digit trigger finger release with continued subjective symptoms and limited objective findings. Despite claimant's EMG findings, Dr. Pardubsky opined claimant's clinical examination did not suggest median nerve compression as the cause of claimant's diffuse hand and long finger complaints. Dr. Pardubsky indicated he was unable to identify objective evidence of median nerve compression at the wrist or ongoing triggering. He described claimant's EMG findings as mild in nature. Dr. Pardubsky opined claimant was not a surgical candidate and was free to utilize her hand without suffering further injury. (JE7, p. 87) As claimant was non-surgical, Dr. Pardubsky recommended claimant return to Dr. Gordon for consideration of MMI and permanent restrictions. (JE7, p. 88)

Claimant continued to follow up with Dr. Delbridge for her right shoulder complaints. (JE5, p. 74) At an appointment on December 2, 2016, claimant reported some continued shoulder pain, which Dr. Delbridge described as understandable. Dr.

Delbridge noted fairly good, but incomplete, shoulder range of motion. Claimant reported she had exceeded the physical therapy sessions allowed under her health insurance; Dr. Delbridge advised claimant she needed to continue exercising the shoulder. Dr. Delbridge advised claimant to return in three weeks; he expressed belief that at that time, claimant could return to work under restrictions, provided it would be allowed by defendant. (JE5, p. 75)

Claimant returned to Dr. Gordon on December 20, 2016 with complaints of some triggering of the left long digit and left hand pain, at times radiating to the left shoulder. Dr. Gordon performed a physical examination, including grip strength measurements. He thereafter opined claimant's grip strength results were not physiological and did not demonstrate valid effort. Dr. Gordon assessed left hand pain, primarily of the left long digit with radiation into the forearm and, at times, into the left shoulder. Dr. Gordon placed claimant at MMI and imposed no permanent restrictions on the left upper extremity. Dr. Gordon opined claimant sustained permanent impairment due to mild constrictive tenosynovitis, totaling 20 percent of the left long digit, which converted to 4 percent of the left hand and 4 percent of the left upper extremity. (JE2, pp. 44-46)

On January 6, 2017, claimant returned to Dr. Delbridge. He excused claimant from work until February 5, 2017. In the meantime, Dr. Delbridge indicated he would attempt to identify restrictions which would be acceptable to defendant. (JE5, p. 76)

Defendant provided Dr. Delbridge with a job analysis of claimant's owned position, separate black gut, for review. Dr. Delbridge reviewed the provided information and, on January 30, 2017, identified claimant's work restrictions as no above shoulder level work with the right upper extremity and work with the left upper extremity as tolerated. Dr. Delbridge opined claimant could not perform the position of separate black gut within these restrictions, as the duties were too repetitive and required too much strength to perform on a repetitious basis. (JE5, p. 77)

Claimant returned to Dr. Delbridge on February 3, 2017. Dr. Delbridge opined claimant was unable to perform the separate black gut job, as the position required too much repetitive pulling and fairly hard pulling was involved. Dr. Delbridge imposed restrictions of no overhead work with the right arm, no repetitive reaching, and no hard pulling. (JE5, pp. 78-79)

At the arranging of claimant's counsel, on February 28, 2017, claimant presented to board certified physiatrist, Farid Manshadi, M.D., for an independent medical examination (IME). Dr. Manshadi performed an examination, interview, and records review, summarizing claimant's medical care and the positions she held at defendant. Thereafter, Dr. Manshadi authored a report containing his findings and opinions dated March 22, 2017. (CE1, pp. 7-10, 15) In his report, Dr. Manshadi addressed claimant's left hand and right shoulder complaints separately.

Dr. Manshadi opined claimant sustained an injury to her left hand, specifically

involving her left middle finger. He recorded claimant's current findings as including moderate triggering of the left middle finger and reduced sensation of the longitudinal aspect of the left middle finger, probably secondary to injury to the ulnar and radial digital nerves. Dr. Manshadi opined claimant achieved MMI as of February 28, 2017 and provided no recommendations for further treatment. With respect to permanent impairment, Dr. Manshadi assessed a 25 percent left middle finger impairment based on loss of digital nerves; he noted this rating corresponded to ratings of 5 percent of the hand and 5 percent of the upper extremity. Dr. Manshadi also assessed a 40 percent impairment of the left middle finger based upon triggering; he noted this rating corresponded to 8 percent of the hand and 7 percent of the upper extremity. Accordingly, he opined claimant sustained a combined permanent impairment of 12 percent of the left upper extremity. Dr. Manshadi recommended permanent restrictions of: avoidance of activities requiring repetitious gripping with the left hand; avoidance of repetitious push or pull with the left hand; and avoidance of use of vibratory tools with the left hand. (CE1, p. 10)

With respect to claimant's right shoulder complaints, Dr. Manshadi opined claimant sustained a right shoulder injury resulting in a SLAP tear and supraspinatus tendinopathy, which required surgery. Dr. Manshadi expressed belief claimant injured her shoulder "while performing her job activities," including the regular separate black gut job and the light duty jobs of inspect for fecal at viscera and feed picnic line box; he reasoned the job descriptions for these positions note stress upon the shoulder related to reaching at or above shoulder level. (CE1, p. 10) Dr. Manshadi opined claimant had achieved MMI as of February 28, 2017 and offered no treatment recommendations. He opined claimant sustained a permanent impairment of 10 percent right upper extremity due to decrements in range of motion. Dr. Manshadi recommended restrictions of: avoidance of activities requiring repetitious reaching, shoulder height or overhead activities with the right upper extremity; and a maximum lift of 20 to 30 pounds with the right upper extremity. (CE1, p. 11)

Dr. Manshadi subsequently reviewed additional medical records from defendant's medical clinic and Dr. Gordon. Following review, Dr. Manshadi authored a supplemental IME report dated March 31, 2017. He confirmed his opinions remained unchanged from those expressed in his prior IME. (CE1, p. 12)

On June 30, 2017, Dr. Manshadi provided deposition testimony. Dr. Manshadi addressed his opinions with respect to causation of claimant's shoulder complaints. He testified he reviewed the job description and video depiction of the separate black gut position, as well as that of light duty assignments. Dr. Manshadi opined claimant probably injured her shoulder as a result of her work performed in separate black gut and while on light duty. Dr. Manshadi opined claimant damaged her shoulder over time in the separate black gut position, as the duties placed claimant's shoulders in abduction on a constant basis in a fast-paced position. He opined claimant's light duty work also played a role and noted the job descriptions for the positions of feeding empty boxes into conveyor, inspect fecal at viscera, and feed picnic all listed stressors placed

on the shoulders. Dr. Manshadi indicated he was aware of the repetitious nature of the inspection positions, but lacked knowledge of the specific number of times claimant needed to move her arm to perform the duties. Dr. Manshadi acknowledged he had not been to defendant's plant nor seen Mr. Kruzich's report. (CE1, pp. 28-31) Dr. Manshadi also opined it was unlikely a SLAP tear such as claimant's developed spontaneously in a 35 year old woman without a prior history of problems. (CE1, p. 36)

On July 20, 2017, Dr. Delbridge provided deposition testimony. Dr. Delbridge opined claimant's performance of the separate black gut position over a period over five months, caused and/or materially aggravated claimant's shoulder condition. He explained the position was repetitive in nature, requiring pulling motions the duration of the day, with these pulling motions requiring some degree of force to accomplish. Dr. Delbridge noted these duties placed claimant's shoulders into abduction. (CE2, p. 3) Dr. Delbridge opined the MRI and visual inspection during surgery lacked sufficient evidence to explain the existence of the labral tear. However, Dr. Delbridge opined the separate black gut duties materially aggravated the SLAP tear because the movements caused the torn area to slip up and down, the movements were repetitive and required a fair amount of force, and the shoulder was unstable. He opined activities involving the shoulders, even below shoulder level, can aggravate a labral tear. Dr. Delbridge indicated it would be normal for a patient with these findings to have symptoms wax and wane based upon activity level. (CE2, p. 11) He therefore opined the separate black gut position materially aggravated claimant's shoulder condition. (CE2, p. 5)

Dr. Delbridge opined claimant's light duty inspection assignment was also a material contributing factor in claimant's shoulder condition. He testified claimant had described performance of a position which required her to lift heads with her right arm many times per day. Dr. Delbridge reasoned this position impacted claimant's shoulder, as it was very repetitive and claimant's shoulder was already compromised. Dr. Delbridge testified Mr. Kruzich's report did not change his own opinions, as claimant arrived in these positions with a compromised shoulder and was required to lift 10 to 12 pound heads repetitively. He opined performance of light duty appeared to aggravate claimant's right shoulder, as her complaints and range of motion steadily worsened thereafter. (CE2, pp. 3, 5, 12)

Dr. Delbridge opined claimant reached MMI as of July 7, 2017 and sustained a permanent impairment of 6 percent right upper extremity due to decrements in range of motion. He recommended permanent restrictions of: no repetitive lifting above shoulder level with the right upper extremity; no work above shoulder level with the right upper extremity; no extreme/far repetitive reaching or hard pulling; a maximum lift of 20 to 30 pounds occasionally to shoulder level with the right arm; and a maximum bilateral lift of 40 pounds. (CE2, pp. 4, 9)

Claimant's original owned position at defendant was that of separate black gut. Following the work injury of October 18, 2015 and through her course of medical treatment, claimant was placed in a number of light duty assignments. (Claimant's

testimony) The dates claimant held each of these light duty positions is not readily available in the evidentiary record. Defendant offered job descriptions[1] for a number of positions.

The description for the position separate black gut describes duties including retrieving the large intestine from a conveyor and pulling the meat to a work station, where the intestine is uncoiled. The job description notes simultaneous use of the bilateral hands, with low to moderate force pulling required to separate black gut and moderate force pulling required to remove glands and fat. The position is noted as typically rotating with the position pipe chitts. (DED, pp. 11-12)

The description for the position set black gut count identifies responsibility for counting the number of black gut sets and controlling flow of sets to the separators. The position is described as a restricted duty position which could be performed one-handed, with the employee working at his own pace. (DED, p. 13)

The description for the position feed empty boxes onto conveyor identifies the job as a light duty position. The employee is tasked with feeding boxes onto the conveyor line leading to the production floor. The boxes are stacked five feet high on pallets, with each box weighing a maximum of three pounds. (DED, p. 15) The job description notes an employee intermittently lifts an empty box above shoulder level. The description also indicates this position would be inappropriate for an individual with "restrictions of limitations of both shoulders which would inhibit the capacity to intermittently reach above shoulder level." (DED, p. 17)

The description for the position feed picnic line box chute notes an employee is tasked with feeding empty box pieces into the appropriate box chute. The box pieces are stacked approximately 5 feet high and weigh approximately 1.3 pounds. The description notes an employee may use one or both hands. The description notes the shoulder as a stressor, as the worker is required to reach at or above shoulder level to obtain box pieces from the tops of stacks. (DED, p. 18) The position also lists a physical demand of reaching above shoulder level. (DED, p. 19) Accordingly, the position is identified as inappropriate for a team member under a restriction of no reaching above shoulder level. (DED, p. 20)

The description for the position inspect head/neck for fecal noted the employee is responsible for visually monitoring the head and neck of each carcass for contamination. The worker may use a lightweight plastic spreader hook to turn the head as necessary. (DED, p. 21)

The record contains two descriptions of similarly titled positions involving inspection of the viscera cavity. The first description, for inspect fecal (viscera), notes

[1] These documents are titled job analysis summary or restricted duty job.

the employee is responsible for inspecting the viscera cavity of each carcass for fecal contamination. The job description notes minimal force is required to perform this position, but an employee must reach outward in the region of one's chest to shoulder height in order to open the cavity for inspection. (DED, p. 10) The second description, for inspect for fecal at viscera, notes the employee is responsible for inspecting the viscera cavity for fecal contamination. To do so, the employee may need to grasp and open the cavity; this reach is located at approximately chest to shoulder height. The "main stressor" is identified as the shoulders due to this contact with carcasses. (DED, p. 23) The position is further identified as inappropriate for team members with limitations to the bilateral shoulders. (DED, p. 24)

Claimant remained off work from July 14, 2016 through July 7, 2017, while she treated for her right shoulder condition. (*See* Hearing Report) As of the date of hearing, claimant had not returned to work. Claimant testified she had not been contacted by defendant regarding returning to work; she acknowledged she had not reached out to defendant either. Claimant has not bid into any new positions at defendant, applied for work outside defendant, or requested assistance from a state-run program. Claimant testified she believed she remained in treatment, as she had a follow up appointment scheduled with Dr. Delbridge. (Claimant's testimony)

Claimant incurred medical expenses in treatment of her right shoulder condition. These expenses are detailed in Claimant's Exhibit 4 and include charges at Cedar Valley Medical Specialists and Unity Point Health. (CE4)

Claimant testified she continues to suffer with symptoms of her right shoulder and left hand and long finger. Following right shoulder surgery with Dr. Delbridge, claimant testified her shoulder improved. Prior to surgery, claimant reported significant pain, catching, and limited motion of the shoulder. After surgery, claimant testified her range of motion improved and her residual symptoms were limited to a friction sensation between the bones of her shoulder and pain at the top of the shoulder and shoulder blade. On occasion, claimant testified her shoulder will catch, resulting in pain down her right arm. The shoulder also may become "stuck," as if she is unable to lift her arm; in these instances, she must allow her arm to hang at her side to release. Claimant also testified she continues to experience symptoms of her left hand and finger. She testified her ongoing complaints include: hand shaking and trembling; burning pain and numbness of her palm; inability to straighten her left long finger; and loss of strength in the hand. While claimant is left-hand dominant, following her injury, claimant testified she had to learn to utilize her right as the dominant hand. Claimant testified she continues to perform exercises she learned in physical therapy. She self-treats with ibuprofen. (Claimant's testimony)

CONCLUSIONS OF LAW

The first issue for determination is whether claimant is entitled to temporary disability benefits from July 14, 2016 through July 7, 2017.

The party who would suffer loss if an issue were not established has the burden of proving that issue by a preponderance of the evidence. Iowa R. App. P. 6.14(6).

The claimant has the burden of proving by a preponderance of the evidence that the injury is a proximate cause of the disability on which the claim is based. A cause is proximate if it is a substantial factor in bringing about the result; it need not be the only cause. A preponderance of the evidence exists when the causal connection is probable rather than merely possible. George A. Hormel & Co. v. Jordan, 569 N.W.2d 148 (Iowa 1997); Frye v. Smith-Doyle Contractors, 569 N.W.2d 154 (Iowa App. 1997); Sanchez v. Blue Bird Midwest, 554 N.W.2d 283 (Iowa App. 1996).

The question of causal connection is essentially within the domain of expert testimony. The expert medical evidence must be considered with all other evidence introduced bearing on the causal connection between the injury and the disability. Supportive lay testimony may be used to buttress the expert testimony and, therefore, is also relevant and material to the causation question. The weight to be given to an expert opinion is determined by the finder of fact and may be affected by the accuracy of the facts the expert relied upon as well as other surrounding circumstances. The expert opinion may be accepted or rejected, in whole or in part. St. Luke's Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); IBP, Inc. v. Harpole, 621 N.W.2d 410 (Iowa 2001); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995). Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417 (Iowa 1994). Unrebutted expert medical testimony cannot be summarily rejected. Poula v. Siouxland Wall & Ceiling, Inc., 516 N.W.2d 910 (Iowa App. 1994).

Section 85.34(1) provides that healing period benefits are payable to an injured worker who has suffered permanent partial disability until (1) the worker has returned to work; (2) the worker is medically capable of returning to substantially similar employment; or (3) the worker has achieved maximum medical recovery. The healing period can be considered the period during which there is a reasonable expectation of improvement of the disabling condition. See Armstrong Tire & Rubber Co. v. Kubli, 312 N.W.2d 60 (Iowa App. 1981). Healing period benefits can be interrupted or intermittent. Teel v. McCord, 394 N.W.2d 405 (Iowa 1986).

The parties agreed that claimant was off work and recovering from right shoulder surgery from July 14, 2016 through July 7, 2017. The parties further stipulated that in the event defendant is liable for claimant's right shoulder condition, claimant is entitled to healing period benefits as claimed. As a result, the threshold issue for determination with respect to claimant's entitlement to healing period benefits during this claimed period is whether claimant's right shoulder condition is causally related to the work injury of October 18, 2015.

Claimant testified at deposition and hearing that her right shoulder symptoms began while performing separate black gut, then worsened during her time on light duty. Claimant's testimony is consistent with her ability to pass a pre-employment physical

and physically perform the separate black gut duties for several months prior to development of symptoms, including of the bilateral shoulder. The evidentiary record is devoid of evidence claimant suffered with any prior right shoulder problems. Following development of symptoms, claimant treated in the medical clinic and was placed on light duty. Dr. Delbridge opined it would be reasonable for claimant's symptoms to wax and wane based on activity; therefore, it is entirely plausible claimant's right shoulder symptoms lessened to some degree based upon decreased activity. Claimant also testified that the nurses informed her that the initial referral to Dr. Gordon for evaluation was to address only her left hand symptoms; this testimony is unrebutted.

Claimant subsequently underwent trigger finger release on her left hand and was thereafter placed on a restriction of one-handed duty. Claimant's contention this increased activity on claimant's right arm caused an increase of right shoulder symptoms is entirely reasonable. This testimony is consistent with claimant's report of right shoulder symptoms to the plant nurse within one month of left finger surgery and her completion of an injury report attributing right shoulder pain to overcompensating. Claimant's testimony is also consistent with her contemporaneous report to Dr. Gordon, who noted an onset of right shoulder pain two weeks prior while on light duty. This report is also consistent with the history claimant provided to Dr. Delbridge, who noted claimant related her symptoms to the work injury and subsequent increased use of her right hand.

Multiple medical providers have offered opinions with respect to a potential causal relationship between claimant's work duties and her right shoulder condition. Following review of the entirety of the evidentiary record, I award greatest weight to the opinions of Dr. Delbridge. Dr. Delbridge served as claimant's treating orthopedic surgeon and as such, possesses training and expertise in conditions such as those present in claimant's right shoulder. In this role, Dr. Delbridge also possessed the opportunity to physically observe claimant on multiple occasions, including intraoperatively.

Dr. Delbridge opined the MRI and operative findings were insufficient to allow him to pinpoint the cause of claimant's shoulder pathology. However, following review of a job description and video depiction, Dr. Delbridge opined claimant's separate black gut duties materially aggravated claimant's shoulder condition. He reasoned the position required movements of an unstable shoulder, including repetitive pulling with some degree of force, placing the shoulders in abduction. Dr. Delbridge also opined claimant's subsequent light duty jobs were materially contributing factors which aggravated claimant's right shoulder condition. He specifically highlighted the monitoring for contamination/inspection positions as requiring repetitive movements with a compromised shoulder. Dr. Delbridge disregarded Mr. Kruzich's analysis of the monitoring for contamination positions, as the analysis is premised upon performance of those duties with a stable, uncompromised shoulder. I concur and therefore award very little probative value to Mr. Kruzich's evaluation results. Dr. Delbridge's opinions are

buttressed by the opinions of Dr. Manshadi, who opined claimant damaged her shoulder over time in the separate black gut position due to constant abduction and thereafter worsened in light duty, where the job descriptions listed stressors on the shoulders.

The only contrary opinions are authored by Dr. Gordon, who did possess the benefit of evaluating claimant on multiple occasions, including shortly following the October 18, 2015 work injury. Dr. Gordon repeatedly highlights claimant's attribution of her symptoms to different positions within defendant. I, however, do not believe claimant's layperson inability to pinpoint the cause of her symptomatology is harmful to her credibility. To the contrary, I find claimant's reports are easily reconciled with her testimony that right shoulder symptoms began in separate black gut and later worsened on light duty assignments. I also note that although claimant speaks English, her heavy accent could rather easily lead to instances of miscommunication.

I also find attempts to discredit claimant's reports of varied symptoms somewhat disingenuous, given claimant held multiple positions in which defendant-created documents denote stressors on the shoulders or requirements of over shoulder level activity. The light duty position of feed empty boxes denoted intermittent above shoulder level activity and identifies the placement as inappropriate for one with limitations of both shoulders. Given claimant was, for a time, unable to utilize her left hand in performance of activities, the offending tasks would have been performed by claimant's right shoulder only. Dr. Delbridge opined claimant's right shoulder was in a compromised state prior to any light duty assignment; if so, placement in such a light duty position would have been inappropriate. The position of feed picnic line box chute specifically notes the shoulder as a stressor, due to reaching at or above shoulder level. Finally, the position inspect fecal at viscera, and the like-titled position, identifies a main stressor of the shoulder, due to the employee's need to grasp and open the cavity.

Defendant is a sophisticated employer and created the documents outlining these physical guidelines; I find it unlikely defendant listed such physical demands without reason. No medical provider in evidence, including Dr. Gordon, specifically expressed disagreement with these documents or refuted the accuracy of the descriptions. Furthermore, Dr. Gordon never specifically addressed the obvious discrepancies between the descriptions and his opinions.

Additionally, Drs. Delbridge and Manshadi specifically opined the position separate black gut could impact the shoulders due to constant abduction, as well as repetitive pulling movements requiring some degree of force. Dr. Gordon opined it was not medically plausible to relate claimant's right shoulder to her separate black gut duties based on her chronology of complaints; however, Dr. Gordon's opinion is premised upon resolution of claimant's initial right shoulder symptoms, which is contrary to claimant's credible testimony. Dr. Gordon also does not address the possibility for claimant's separate black gut duties to materially aggravate existing shoulder pathology.

Further, Dr. Delbridge opined the monitoring for contamination/inspection duties aggravated claimant's shoulder due to required repetitive movements on an already-

compromised shoulder. Dr. Gordon opined the monitoring jobs lacked the biomechanical stressors to cause, precipitate, aggravate, or light up a right shoulder disorder. However, he fails to address the potential impact of these positions in the event claimant's shoulder was already in a compromised and unstable condition due to a prior injury/aggravation in the separate black gut position.

Finally, I note the evidentiary record is devoid of rebuttal opinions by Dr. Gordon or another medical provider which may have served to counter the opinions offered by Drs. Delbridge and Manshadi.

Given these considerations, I award greatest weight to the opinions of surgeon, Dr. Delbridge, as buttressed by the opinions of Dr. Manshadi. It is therefore found that claimant has proven by a preponderance of the evidence that she sustained a work-related injury to her right shoulder as a result of the work injury of October 18, 2015. Having determined claimant's right shoulder condition is causally related to the October 18, 2015 work injury, claimant is entitled to healing period benefits for the period of July 14, 2016 through July 7, 2017, as claimed. The parties stipulated at the time of the work injury, claimant's gross weekly earnings were $573.00, and claimant was single and entitled to three exemptions. The proper rate of compensation is therefore, $379.11.

The next issue for determination is the extent of claimant's permanent disability. The next issue for determination is whether any permanent disability is a scheduled member disability or an unscheduled disability. The next issue for determination is the commencement date for permanent partial disability benefits. These issues will be considered together.

Under the Iowa Workers' Compensation Act, permanent partial disability is compensated either for a loss or loss of use of a scheduled member under Iowa Code section 85.34(2)(a)-(t) or for loss of earning capacity under section 85.34(2)(u). The extent of scheduled member disability benefits to which an injured worker is entitled is determined by using the functional method. Functional disability is "limited to the loss of the physiological capacity of the body or body part." Mortimer v. Fruehauf Corp., 502 N.W.2d 12, 15 (Iowa 1993); Sherman v. Pella Corp., 576 N.W.2d 312 (Iowa 1998). The fact finder must consider both medical and lay evidence relating to the extent of the functional loss in determining permanent disability resulting from an injury to a scheduled member. Terwilliger v. Snap-On Tools Corp., 529 N.W.2d 267, 272-273 (Iowa 1995); Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417, 420 (Iowa 1994).

When disability is found in the shoulder, a body as a whole situation may exist. Alm v. Morris Barick Cattle Co., 240 Iowa 1174, 38 N.W.2d 161 (1949). In Nazarenus v. Oscar Mayer & Co., II Iowa Industrial Comm'r. Report 281 (App. 1982), a torn rotator cuff was found to cause disability to the body as a whole.

Since claimant has an impairment to the body as a whole, an industrial disability has been sustained. Industrial disability was defined in Diederich v. Tri-City R. Co., 219

Iowa 587, 258 N.W. 899 (1935) as follows: "It is therefore plain that the legislature intended the term 'disability' to mean 'industrial disability' or loss of earning capacity and not a mere 'functional disability' to be computed in the terms of percentages of the total physical and mental ability of a normal man."

Functional impairment is an element to be considered in determining industrial disability which is the reduction of earning capacity, but consideration must also be given to the injured employee's age, education, qualifications, experience, motivation, loss of earnings, severity and situs of the injury, work restrictions, inability to engage in employment for which the employee is fitted and the employer's offer of work or failure to so offer. McSpadden v. Big Ben Coal Co., 288 N.W.2d 181 (Iowa 1980); Olson v. Goodyear Service Stores, 255 Iowa 1112, 125 N.W.2d 251 (1963); Barton v. Nevada Poultry Co., 253 Iowa 285, 110 N.W.2d 660 (1961).

Compensation for permanent partial disability shall begin at the termination of the healing period. Compensation shall be paid in relation to 500 weeks as the disability bears to the body as a whole. Section 85.34.

Having determined *supra*, that claimant's right shoulder condition is causally related to the work injury of October 18, 2015, the extent of claimant's permanent disability is computed industrially. As a result of the work injury of October 18, 2015, claimant suffered left third finger trigger finger, which required two surgical releases, as well as a right shoulder SLAP tear, which also required surgical repair.

With respect to the trigger finger condition requiring two surgeries with Dr. Gorsche, Dr. Gordon recommended no permanent restrictions and opined claimant suffered a 20 percent long digit impairment due to constrictive tenosynovitis; this rating converts to 2 percent whole person. Dr. Manshadi opined claimant sustained permanent impairments of 25 percent long digit due to nerve loss and 40 percent long digit due to triggering. He also recommended restrictions of avoidance of repetitious gripping with the left hand, avoidance of repetitive pushing and pulling with the left hand, and avoidance of vibratory tools with the left hand. Following review of the entirety of the evidentiary record, I award greater weight to the opinions of Dr. Gordon regarding the extent of permanent impairment and need for permanent restrictions as a result of the work injury to claimant's finger. Dr. Manshadi's opinions are rejected as inconsistent with the findings of Dr. Pardubsky, who noted limited objective findings and opined claimant was free to utilize her hand without fear of injury.

With respect to the right shoulder condition, Dr. Delbridge performed surgical SLAP tear repair and debridement. He ultimately opined claimant suffered a 6 percent right upper extremity impairment due to decrements in range of motion; this rating converts to 4 percent whole person. Dr. Delbridge recommended permanent restrictions of no repetitive lifting above shoulder level with the right upper extremity, no work above shoulder level with the right upper extremity, no extreme/far reaching or hard pulling, a maximum lift of 20 to 30 pounds occasionally to shoulder level with the right upper extremity, and a maximum bilateral lift of 40 pounds. Dr. Delbridge

specifically opined claimant was incapable of performing her pre-injury position of separate black gut. Dr. Manshadi opined claimant sustained a permanent impairment of 10 percent right upper extremity due to decrements in range of motion; this rating converts to 6 percent whole person. He recommended restrictions of a maximum lift of 20 to 30 pounds with the right upper extremity and avoidance of repetitive reaching, shoulder height, or overhead activities with the right upper extremity. Dr. Gordon opined claimant sustained no permanent disability with respect to claimant's right shoulder. However, his opinion is premised upon an inaccurate history of claimant's symptoms resolving prior to November 2015; accordingly, Dr. Gordon's opinion is entitled to no weight. Due to Dr. Delbridge's status as claimant's treating surgeon with the opportunity to examine claimant and observe her physical condition on multiple occasions, Dr. Delbridge is in the best position to determine claimant's functional abilities. I therefore adopt Dr. Delbridge's opinions with respect to the extent of claimant's permanent disability and appropriate permanent restrictions.

Claimant was 37 years of age on the date of evidentiary hearing. She is native of Liberia West Africa, where she graduated high school and obtained an associate's degree in business management and sociology. Her primary language is English, in which she is fluent; claimant's speech is heavily accented. In Liberia, claimant's sole employment was in the government finance and procurement office. Claimant's duties involved processing paperwork; specifically, interacting with vendors and handling receipts, purchase orders, contracts, and claims for reimbursement. She only used computers on an occasional basis in this role. Claimant is an educated individual with a background of office work and demonstrated ability to learn skills through further education. Although she may require additional training in computer usage, claimant would very likely be capable of functioning in an office environment, and work in such an environment would generally fall within claimant's permanent restrictions.

Despite claimant's background and education, her work at defendant represents her only employment since arriving in the United States in 2014. Claimant was able to function in her bid position of separate black gut for several months prior to her work injury; she is now precluded from returning to this position. Claimant showed willingness to continue working during the course of treatment of her left trigger finger, accepting multiple light duty assignments. She only ceased working when restrictions relative to her right shoulder condition were not accommodated by defendant.

As of the date of hearing, claimant had not made efforts to locate alternate employment or return to work at defendant. Admittedly, claimant remained on medical leave until only shortly prior to evidentiary hearing, and defendant had also not made claimant an offer to return to work. Nevertheless, claimant is prevented from returning to her pre-injury position of separate black gut and, if she is to return to work at defendant, it will necessarily be in a new position.

Upon consideration of the above and all other relevant factors of industrial disability, it is determined claimant sustained a 30 percent industrial disability as a result

of the stipulated work-related injury of October 18, 2015. Such an award entitles claimant to 150 weeks of permanent partial disability benefits (30 percent x 500 weeks = 150 weeks). These benefits shall commence on July 8, 2017, the date following the conclusion of claimant's healing period following right shoulder surgery. The parties stipulated at the time of the work injury, claimant's gross weekly earnings were $573.00, and claimant was single and entitled to 3 exemptions. The proper rate of compensation is therefore, $379.11.

The next issue for determination is whether defendant is responsible for claimed medical expenses.

The employer shall furnish reasonable surgical, medical, dental, osteopathic, chiropractic, podiatric, physical rehabilitation, nursing, ambulance, and hospital services and supplies for all conditions compensable under the workers' compensation law. The employer shall also allow reasonable and necessary transportation expenses incurred for those services. The employer has the right to choose the provider of care, except where the employer has denied liability for the injury. Section 85.27. Holbert v. Townsend Engineering Co., Thirty-second Biennial Report of the Industrial Commissioner 78 (Review-Reopening October 1975).

By this decision, the undersigned determined claimant's right shoulder condition was compensable. Defendant denied treatment of claimant's right shoulder condition, resulting in claimant seeking care with Dr. Delbridge. There is no evidence Dr. Delbridge's treatment was unreasonable or unnecessary in treatment of claimant's right shoulder condition. As defendant denied liability for care related to claimant's compensable right shoulder condition, defendant is properly held responsible for the expenses incurred by claimant in seeking treatment of the work-related condition.

The next issue for determination is whether claimant is entitled to an award of alternate medical care under Iowa Code section 85.27.

Claimant seeks an award of alternate medical care, designating Dr. Delbridge as an authorized physician relative to claimant's right shoulder. Defendant argued that should claimant's shoulder condition be found work-related, defendant should be granted the ability to select a physician to treat that condition.

Defendant originally possessed the opportunity to designate a physician to evaluate and treat claimant's right shoulder condition. Defendant subsequently denied liability for claimant's right shoulder condition, in reliance upon the opinion of this authorized physician. Due to the denial of care, claimant subsequently sought care with Dr. Delbridge. Claimant and Dr. Delbridge have established a physician-patient relationship which extends over one year, including surgical intervention, and continued at the time of evidentiary hearing. I was presented with no evidence Dr. Delbridge is unqualified to provide care to claimant. Defendant possessed the opportunity to direct

claimant's care relative to her right shoulder claim, but opted to deny liability and treatment. I see no compelling reason to disrupt an established physician-patient relationship in order to provide defendant the opportunity to designate a new physician to treat claimant's right shoulder. An award of alternate medical care is granted; Dr. Delbridge is hereby designated as an authorized physician relative to claimant's right shoulder condition.

The final issue for determination is a specific taxation of costs pursuant to Iowa Code section 86.40 and rule 876 IAC 4.33. Claimant requests taxation of the costs of: filing fee ($100.00); service fees ($6.46); medical records ($40.00); claimant's deposition transcript ($120.40); Dr. Delbridge's deposition transcript ($313.60); and Dr. Delbridge's deposition fee ($1,000.00).

Iowa Code section 86.40 states:

> **Costs.** All costs incurred in the hearing before the commissioner shall be taxed in the discretion of the commissioner.

Iowa Administrative Code Rule 876—4.33(86) states:

> **Costs.** Costs taxed by the workers' compensation commissioner or a deputy commissioner shall be (1) attendance of a certified shorthand reporter or presence of mechanical means at hearings and evidential depositions, (2) transcription costs when appropriate, (3) costs of service of the original notice and subpoenas, (4) witness fees and expenses as provided by Iowa Code sections 622.69 and 622.72, (5) the costs of doctors' and practitioners' deposition testimony, provided that said costs do not exceed the amounts provided by Iowa Code sections 622.69 and 622.72, (6) the reasonable costs of obtaining no more than two doctors' or practitioners' reports, (7) filing fees when appropriate, (8) costs of persons reviewing health service disputes. Costs of service of notice and subpoenas shall be paid initially to the serving person or agency by the party utilizing the service. Expenses and fees of witnesses or of obtaining doctors' or practitioners' reports initially shall be paid to the witnesses, doctors or practitioners by the party on whose behalf the witness is called or by whom the report is requested. Witness fees shall be paid in accordance with Iowa Code section 622.74. Proof of payment of any cost shall be filed with the workers' compensation commissioner before it is taxed. The party initially paying the expense shall be reimbursed by the party taxed with the cost. If the expense is unpaid, it shall be paid by the party taxed with the cost. Costs are to be assessed at the discretion of the deputy commissioner or workers' compensation commissioner hearing the case unless otherwise required by the rules of civil procedure governing discovery. This rule is intended to implement Iowa Code section 86.40.

The costs of filing fee ($100.00), service fees ($6.46), claimant's deposition transcript ($120.40), and Dr. Delbridge's deposition transcript ($313.60), are allowable

costs and are taxed to defendant. Claimant also seeks taxation of costs associated with medical "reports & records" from Cedar Valley Medical Specialists ($40.00). These charges presumably reflect the costs of medical record copy procurement. Such costs are not delineated as taxable costs under rule 4.33; I, therefore, decline to tax the associated costs to defendant. Claimant also seeks taxation of the cost of Dr. Delbridge's deposition fee ($1,000.00). By rule 4.33(5), the taxable portion of Dr. Delbridge's deposition testimony is capped pursuant to Iowa Code section 622.72 at $150.00. Accordingly, defendant is taxed with $150.00 of Dr. Delbridge's deposition testimony.

Defendant is taxed with total costs of $690.46 ($100.00 + $6.46 + $120.40 + $313.60 + $150.00 = $690.46).

ORDER

THEREFORE, IT IS ORDERED:

The parties are ordered to comply with all stipulations that have been accepted by this agency.

Defendant shall pay unto claimant healing period benefits at the weekly rate of three hundred seventy-nine and 11/100 dollars ($379.11) for the period of July 14, 2016 through July 7, 2017.

Defendant shall pay unto claimant one hundred fifty (150) weeks of permanent partial disability benefits commencing July 8, 2017 at the weekly rate of three hundred seventy-nine and 11/100 dollars ($379.11).

Defendant shall pay claimant's prior medical expenses submitted by claimant at the hearing as set forth in the decision.

Defendant shall pay accrued weekly benefits in a lump sum.

Defendant shall pay interest on unpaid weekly benefits awarded herein as set forth in Iowa Code section 85.30. Defendant shall pay accrued weekly benefits in a lump sum together with interest at the rate of ten (10) 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 (2) percent. See Gamble v. AG Leader Technology, File No. 5054686 (App. Apr. 24, 2018).

Defendant shall receive credit for benefits paid.

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

Costs are taxed to defendant pursuant to 876 IAC 4.33 as set forth in the decision.

Signed and filed this 21st day of June, 2018.

ERICA J. FITCH
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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EJF/sam

Right to Appeal: This decision shall become final unless you or another interested party appeals within 20 days from the date above, pursuant to rule 876-4.27 (17A, 86) of the Iowa Administrative Code. The notice of appeal must be in writing and received by the commissioner's office within 20 days from the date of the decision. The appeal period will be extended to the next business day if the last day to appeal falls on a weekend or a legal holiday. The notice of appeal must be filed at the following address: Workers' Compensation Commissioner, Iowa Division of Workers' Compensation, 1000 E. Grand Avenue, Des Moines, Iowa 50319-0209.