BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

NATEIGA CAMERON, Claimant, vs. PACIFICA HEALTH SERVICES, Employer, and SFM MUTUAL INSURANCE, Insurance Carrier, Defendants.	File No. 5063931 ARBITRATION DECISION Head Note No.: 1108

STATEMENT OF THE CASE

Nateiga Cameron, claimant, filed a petition in arbitration seeking workers' compensation benefits against Pacifica Health Services, LLC, employer, and SFM Mutual Insurance, insurance carrier, both as defendants, for a stipulated work injury date of October 22, 2017.

This case was heard initially by Deputy Workers' Compensation Commissioner Michelle A. McGovern on July 9, 2019, and continued until the October 9, 2019, when a second hearing was held. The record was closed as of October 9, 2019, and the case was considered fully submitted on November 6, 2019, upon the simultaneous filing of briefs. On March 2, 2020, the case was delegated to the undersigned due to the retirement of Deputy McGovern.

The record consists of Joint Exhibits 1-8; Claimant's Exhibits 1-14; Defendants Exhibits A-E and the testimony of Nateiga Cameron, Matt Archibald, Dwala Lehman and Robert Conner.

ISSUES

1. Whether the stipulated injury was the cause of either temporary and/or permanent disability;
2. If there is a permanent disability, the extent of that disability;
3. Rate;
4. The reasonableness of the requested IME;
5. Whether claimant is entitled to alternate medical care;
6. Whether claimant refused suitable work.

STIPULATIONS

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.

The parties stipulate that the claimant sustained an injury on October 22, 2017 which arose out of and in the course of her employment. The parties stipulate to claimant's average weekly earnings and her marital status, but dispute the number exemptions to which she is entitled.

The parties agree that if a permanent disability is found, it is industrial in nature.

FINDINGS OF FACT

At the time of the hearing the claimant was 28 years of age. She was married and under the federal tax return, designated the head of household with four exemptions. (Ex. A:2) Claimant has five minor children.

Her educational background includes graduation from high school followed by three months of courses at William Penn University. She has taken a few classes at DMACC and would like to return and complete a degree program. Currently, she is a certified nurse assistant.

Her past work history has been primarily patient care at adult facilities. (Ex. 6:3) Her work duties vary from position to position. In some of her jobs she was not required to do heavy lifting such as when she worked as a direct support associate helping adults with intellectual disabilities at Mosaic in 2011 through 2013 and as a certified nurse's associate at Ramsey as it was a no lift facility. At others, including the defendant employer, her work duties required heavy lifting, bending, stooping, and twisting.

She began work for the defendant employer on or around June 15, 2016 as a certified nurse's associate. In her position as a CNA, claimant was required to lift over hundred pounds once in a while and over 50 pounds often as well as bend, stoop, crouch. (Ex. D:3)

In February 2017, the claimant was changing a resident and felt a pain in her low back shooting down into her right leg. She was pregnant at the time. After a course of light duty work, physical therapy and pain medication she returned to full duty work with no restrictions. (Joint Exhibit 1:1 to 12) Both parties agree claimant was performing all of her job duties prior to October 22, 2017, the stipulated date of injury.

On October 22, 2017, claimant was assisting a resident getting dressed. The resident grabbed claimant's hand to lift herself up when claimant felt a pop in her back and immediate pain down her right leg. She reported this injury to the on-duty nurse, Kim Jardine who referred claimant to Daniel Miller at Occupational Medicine Plus. (JE 1:17) Dr. Miller had treated claimant previously for the February 2017 injury. (See JE

1:1-12) Claimant rated her pain at an 8 on a 10-scale, beginning on the right side of her back, radiating into the right leg and shooting up into the lower back. (JE 1:13) Dr. Miller documented " numerous positive Waddell sign including facial grimacing, low back pain with high compression, fighting right leg raise, positive heel lift tests in the right, nonanatomic distribution of pain" and pain radiating from the iliac area down her right leg rather than from the sacral area. (JE 1:14) Despite these aforementioned concerns, he injected claimant with Toradol and prescribed ibuprofen 800 mg and cyclobenzaprine. (JE 1:14) He also ordered a lumbar MRI. MRI showed degenerative changes in a disc bulge at L5 S1 to the right possibly irritating the right SI nerve root. This was consistent with her symptoms and Dr. Miller referred her to an orthopedic specialist. (JE 1:18) Claimant testified that Dr. Miller told her she should look for a different job however that was not documented in her notes.

On November 22, 2017, claimant was seen by Trevor Schmitz, M.D., at Iowa Ortho. (JE 3:1) She complained of persistent low back pain radiating to the right thigh. The severity was 7 on a 10-scale and symptoms are aggravated by lying, sitting, standing and walking. The symptoms were relieved by pain medications. (JE 3:1) Dr. Schmitz reviewed the MRI and took note of the mild disc bulging at L4 – L5. (JE 3:2) Showed no significant evidence of high-grade stenosis at this level but at L5 – S1 she had a right paracentral disc herniation with some cephalad extrusion. (JE 3:2) He believed that it was likely she had S1 nerve root impingement on the right. (JE 3:2) However on examination, she had diffuse right leg weakness and pain which was not consistent with her MRI findings. (JE 3:2) Dr. Schmitz recommended she undergo an MRI of her thoracic spine as well as EMG of her bilateral lower extremities define the origin of the claimant's pain. (JE 3:2)

In the meantime, claimant attended physical therapy. (JE 4:1) During ambulation into the clinic on November 27, 2017, claimant demonstrated slight decreased weight bearing through right lower extremity compared to the left as well as mild to moderate decreased weight bearing through the right lower extremity as compared to the left. (JE 4:1) As therapy continued, claimant complained of mild to moderate tenderness to palpation with symptoms not located to specific tissues or regions, pain and difficulty with sleeping, sitting greater than 15 minutes, standing longer than 20 minutes, inability to bear weight to the right lower extremity, and pain upon forward bending. (JE 4:3) There were some tests and treatment not carried out due to claimant's inability to lay supine or endure the test. Many tests were unable to be rated given cog wheeling. (JE 4:4) After two weeks of rehabilitation, claimant had slight improvements in tolerance to weight-bearing however many of the goals were not met. (JE 4:6) Due to further testing recommended by Dr. Schmitz, physical therapy was suspended. (JE 4:6)

The thoracic spine MRI on December 12, 2017, revealed disc degeneration predominantly at the mid to lower thoracic levels with mild disc bulging at T7 – T8. (JE 2:2) An EMG study was performed on December 12, 2017 and the results were normal. (JE 3.5) After the test, claimant returned to Dr. Schmitz's office ambulating with a wheeled walker. (JE 3:8) Dr. Schmitz felt that the claimant's MRI and EMG testing were not consistent with her right lower extremity weakness with give way pain. (JE 3:9) Because of the right paracentral disc herniation at L5 – S1, Dr. Schmitz recommended a transforaminal epidural steroid injection for diagnostic and therapeutic purposes. (JE

3:9) This procedure took place on December 19, 2017. (JE 3:12) However, the injection did not help. (JE 3:14) She returned to Dr. Schmitz's office on December 27, 2017 with ongoing complaints of pain extending into the calf. (JE 3:14) She ambulated into the clinic with an antalgic gait but no walker. (JE 3:14) From his perspective there was nothing in her EMG or MRI which would warrant any further restrictions that would limit her activities of daily living and he discharged her with the invitation to return on an as-needed basis. (JE 3:15)

Due to Dr. Schmitz's determination that claimant's degenerative condition did not qualify her as a surgical candidate, she was returned to Dr. Miller who prescribed her 800 mg of ibuprofen, methocarbanal, Gabapentin and physical therapy. (JE 1:21) On January 25, 2018, claimant returned to Dr. Miller's office with complaints of increasing back pain that worsened while walking. (JE 1:22) The pain was now extending down the right leg into the right foot. (JE 1:22) Her pain rating was 8 to 9 on a 10-scale and she felt that physical therapy was increasing her pain rather than decreasing it. (JE 1:23) Dr. Miller described her as "very dramatic today. Multiple pain behaviors. Crying with range of motion testing and palpation and straight leg raising." (JE 1:23) Dr. Miller felt there was no other care he could provide to her and discharged her with no restrictions. (JE 1:23)

On that same day, claimant presented herself to urgent care with complaints of a recurrent and worsening right-sided low back pain. (JE 6:9) She was observed to walk with a significant limp and had significant point tenderness to her right lower lumbar region at her right SI joint along with weakness in her leg. (JE 6:9) An MRI was recommended.

On February 19, 2018, claimant sought out a second opinion from Saima Z. Shahid, M.D. (JE 6:12) She presented with recurrent and worsening right-sided low back pain radiating down her right leg. (JE 3:6) On examination, claimant exhibited tenderness to palpation over the lumbosacral region, the para spinous areas of the thoraco lumbar, the right buttock, and SI joint. (JE 6:16) Her gait was smooth and symmetrical and her range of motion was normal. (JE 6:16) Dr. Shahid referred claimant to an orthopedic specialist for a second opinion.

Claimant underwent a second opinion with Kurt Smith, M.D., on March 6, 2018. (JE 3:16) She exhibited limited range of motion in the lumbar spine, full weight-bearing with antalgic gait, mild lumbar spasms, and tenderness in the para spinous, deltoid and buttock region. (JE 3:17) She exhibited poor effort in the lower extremity strength test. (JE 3:18) Dr. Smith wrote "objective findings do not support subjective symptoms, diffuse poor motor effort when testing the right lower extremity which does not follow a radicular pattern. Improved motor function on the right lower extremity when distracted." (JE3-18) Dr. Smith did not find that surgery was indicated and recommended a functional capacity evaluation.

Before claimant could be seen by an orthopedic specialist recommended by her family care physician, she returned to Dr. Shahid on March 21, 2018, for follow-up on an emergency room visit where she was seen and diagnosed with bronchitis and given cough medication. (JE 6:18) Claimant also expressed pain regarding her chronic low

back and requested a refill of pain pills. (JE 6:21) Dr. Shahid refilled the claimant's tramadol but no other prescriptions. (JE 6:22) There is no notation of whether claimants gait was smooth and stable or antalgic; however, in the review of symptoms section musculoskeletal was negative for joint pain or swelling. (JE 6:21)

On March 28, 2018, claimant presented at the Methodist emergency room with complaints of mid to lower back pain with radicular symptoms into the right leg down to the foot. (JE 7:3) The musculoskeletal examination was positive for back pain and right lower extremity myalgias but negative for a gait problem. (JE 7:5) She was positive for numbness but negative for weakness. (JE 7:5) She was able to ambulate into and out of the emergency department on her own. She could turn her head spontaneously and look around the room without signs of pain or difficulty, she had normal range of motion, normal strength no sensory deficit, but did exhibit tenderness at the thoracic back and lumbar back. (JE 7:6) She was able to stand from a seated position independently, ambulated slowly and slightly favoring the right lower extremity. No foot drop was noted. She was able to bend at the waist minimally, leaning forward approximately 30°. (JE 7:7) She showed no signs of any emergent spinal condition and encouraged her to follow up with her personal care providers. (JE 7:7) It was also noted that with encouragement the claimant's range of motion and strength improved. (JE 7:6) She was given a prescription for hydrocodone and Medrol. (JE 7:7)

On April 5, 2018, claimant underwent an evaluation with Dr. William Bolden, M.D., for a second opinion regarding her low back, right posterior thigh and right calf pain with numbness on the lateral side of her right foot. (Ex. 4:1) During the examination, claimant presented with negative straight leg raising on the left and positive on the right. She had normal reflexes of the knees and ankles. Her left ankle reflex was present but her right ankle reflex was absent. She had decreased S1 sensation in the right foot compared to the left and she had giveaway weakness diffusely in the right leg. (Ex. 4:4) He agreed with the radiologist interpretation the claimant had a herniated disc at L5 – S1 with S1 nerve impingement. (Ex. 4:4) Clinically, Dr. Boulden found claimant to have signs and symptoms of S1 nerve entrapment based on clinical examination with some non-anatomical findings of diffuse weakness in the right leg. (Ex. 4:4) He concluded that more than likely she was going to need a surgical intervention but would try S1 neural foraminal injections first. (Ex. 4:4) Based on the histories and medical records, Dr. Bolden concluded that claimant's work had caused her problems or aggravated it to the point where she was symptomatic from the herniated disc. (Ex. 4:4)

On April 13, 2018, claimant presented to Iowa Ortho for a L5 – S1 epidural steroid injection. (JE 3:20) It was noted the patient walked to the procedure room on her own, underwent the procedure, and walked to the lobby. (JE 3:20) She returned to Dr. Smith's office on April 27, 2018 noting that claimant had only had minimal improvement after the injection. (JE 3:23)

On May 9, 2018, claimant was seen by Dr. Schmitz for follow-up of her low back pain. (JE 3:25) She ambulated into the clinic without an assistive device but with antalgic gait. (JE 3:25) She had diffused right-sided low back tenderness to palpation with no palpable spasm or subluxation but diffuse right lower extremity tingling and

numbness. (JE 3:25) Examination of the lower extremities revealed normal alignment without obvious wasting and she had painless functional range of motion at the hips, knees, ankles and feet. (JE 3:25) She exhibited extreme lower right extremity motor strength and giveaway weakness throughout. (JE 3:25) She could not lift her right leg off the table but was able to walk in and out of the clinic without difficulty (JE 34 25) Dr. Schmitz wrote, “She has several findings on examination consistent with nonanatomic source for her pain. She has major discrepancies and physical examination. With the strength testing she has on examination she should not be able to walk. She is, however, ambulating out of clinic without difficulty.” (JE 3:26) He opted to refer claimant back to Dr. Smith for further management but believed claimant was at maximum medical improvement. (JE 3:26)

On May 23, 2018, claimant underwent a functional capacity evaluation conducted by John Kruzich. (JE 5:1) The overall results of the functional capacity evaluation were considered to be invalid secondary to inconsistent performance and/or poor effort on behalf of the claimant. (JE 5:1)

Claimant presented with the following symptoms:

> Constant right lower back pain which ranges in intensity; constant numbness and tingling throughout the right posterior lower extremity and lateral aspect of the right foot; diminished active trunk range of motion; diminished right lower extremity strength/stamina for functional activities.

(JE 5:5) Her pain rating was 8 on a 10-scale. (JE 5:5) While in the standing position, the claimant presented with a normal cervical spine alignment, level shoulders, increased lumbar lordosis, even iliac crests, and decreased weight-bearing to the right lower extremity. Pain was reported with palpation to the area of the right lower back. The claimant demonstrated right lower extremity active range of motion measurements inconsistent with demonstrated physical abilities. Cogwheeling was noted throughout the right lower extremity during manual muscle testing indicating feigned weakness. The claimant’s gait pattern appeared antalgic with decreased weight bearing to the right lower extremity and shortened stride length on the right. The gait pattern exhibited when the claimant walked forward was present but when the claimant walked backward it was not as pronounced. The claimant was unable to heal or toe walk. Dural stretching of the bilateral lower extremities was negative for reports of radicular symptoms while some testing was positive for reports of radicular symptoms in the proximal, posterior right thigh. Therefore the results of the dural stretch and slump test did not correlate. (JE 5:6)

On June 19, 2018, claimant returned to Dr. Shahid for low back pain. (JE 6:25) She was requesting a refill of the tramadol that she had been prescribed in the past. (JE 6:26) This prescription could not be refilled as she had been turned away from the clinic. (JE 6:26) She was not in any acute distress, and the ortho examination revealed tenderness to palpation in the lumbosacral region, tenderness to palpation in both hip areas, however, straight leg raise test was unremarkable on both extremities. (JE 6:26)

Dr. Smith examined claimant on June 27, 2018 and he deemed her at maximum medical improvement due to the invalid functional capacity evaluation along with his own findings and her unchanged symptoms. (Ex. 3:29)

On September 13, 2018, claimant presented at the emergency department with complaints of new back pain starting a week ago. (JE 7:8)

> Back Pain-New < 28 days.
>
> Patient reports back pain started 1 week ago. Patient diagnosed with herniated disc in lumbar spine. Patient reports having increased numbness and tingling with the loss of bowel control. . . .
>
> . . . .
>
> She has not had any bowel or bladder issues today. She notes numbness to low back and bilateral legs that began about one month ago. Numbness is worsened to right side. She says she has been dragging her right foot when she walks.

(JE 7:8-9)

At this time, she reported increased numbness and tingling with loss of bowel control. (JE 7:8) Prior to that day, she had been working light duty but testified that her workload had increased due to a needy resident who had called on her to do things that claimant felt were outside her restrictions. On examination, she had normal range of motion but lower lumbar tenderness. She was able to ambulate without assistance but dragged her right lower extremity. She had a positive straight leg test on the right, loss of sensation to the right lower extremity and almost stocking glove distribution for medial thigh down. (JE 7:12) An MRI of the lumbar spine was conducted which showed a right far lateral L5 – S1 disc protrusion causing moderate right neuroforaminal narrowing and disc desiccation and mild central disc protrusion at L4 – L5 with a focus of hyperintense T2 signal in the posterior disc suggestive of an annular fissure. (JE 7:15) She was administered a Toradol, diazepam, and gadoteridol via injection. (JE 7:16) Claimant was discharged home with oxycodone and Medrol. (JE 7:17)

After claimant's personal insurance approved a consultation with a back surgeon, claimant began care with Nicholas Wetjen, M.D., at Iowa Clinic Neurological and Spine Center. (JE 8:1) The first visit was on September 17, 2018, and claimant presented with severe back pain that worsened while walking and bending and radiated down the right leg. (JE 8:2) It was difficult for Dr. Wetjen to get an assessment of the claimant's strength due to significant pain. He reviewed the MRI scan and recommended claimant undergo a right-sided transverse lumbar inter body fusion at L5 – S1. (JE 8:2)

Claimant returned to Dr. Schmitz's office on October 1, 2018 in follow-up to the new MRI that was conducted at Unity Point on September 13, 2018 at the emergency room. (JE 3:31) She again exhibited extreme lower right extremity weakness. (JE 3:32) He did not find that her new MRI drastically changed from her previous MRI. (JE 3:32)

> I had a lengthy discussion with Ms. Cameron once again today in clinic. She is now stating she is having bowel incontinence which is intermittent in nature. She denies any significant saddle anesthesia. She would not allow me to perform a rectal examination today in clinic. She said she has had multiple rectal examinations and states she already has surgery scheduled. On magnetic resonance imaging she has RIGHT L5 nerve root impingement only. Her magnetic resonance imaging has not drastically changed. She does not have cauda equina compression and I do not think has multiple nerve root involvement. She once again is unable to move her leg when I ask her to do so on examination but is ambulating out of my clinic without significant difficulty other with what appears to be a circumduction gait. She has diffuse numbness and tingling in every dermatome in her leg. I discussed with her she had foraminal stenosis at L5-S1 with intraforaminal disk extension from the subarticular recess out into the extraforaminal region. I think this would warrant a transfacet decompression and fusion. I do not think that this operation is likely to drastically improve her symptoms given the fact that she does not appear to have multiple nerve root involvement on magnetic resonance imaging. I will see her back on an as-needed basis as it sounds as though she has surgery scheduled this week, and I certainly wish her best of luck with that. She would also not allow be to do a perirectal examination or rectal examination today in clinic given the fact that she already has surgery scheduled. If she has any questions or concerns she will [not] hesitate to contact us.

(JE 3:32)

In a letter authored by the claimant's counsel, Dr. Wetjen concluded that it was more likely than not that her work activities on October 22, 2017 caused or materially aggravated her low back condition causing the symptoms that necessitated the surgery on October 5, 2018. (Ex. 5:1)

Surgery took place on October 16, 2018 (JE 8:3) Claimant testified that she woke up after surgery with so much pain that she requested an amputation. Because of the claimant's reports of pain, Dr. Wetjen performed a revision of the hardware on October 18, 2018, due to bilateral L5 screws suspicious for contact of the bilateral L5 nerve roots particularly on the right side along with the possibility of the left S1 screw coming into contact with the bilateral S1 nerve roots. (JE 8:7; 8-11-12)

On November 28, 2018, claimant returned for postoperative visit with symptoms of reduced strength of the lower extremities and pain in the right foot. (JE 8:15)

On February 27, 2019, claimant returned for a postoperative visit. (JE A: 17) Claimant reported improvement including increased strength in her foot and decreased pain. (JE 8:17) Her gait and stance were still abnormal and she had weakness on the right side. (JE 8:16) Dr. Wetjen opined that while the claimant was making good progress, the remaining weakness in the right leg would limit her going forward. (JE

8:18) He felt that her job as a certified nurse's assistant was going to cause too much stress on her spine with lifting, bending, and twisting movement. (JE 8:18)

At the request of the claimant, she was evaluated by Daryl Short at Work Well for functional capacity. (Ex. 2:1) Mr. Short found that claimant was consistent and cooperative and that her heart rate changes in body mechanic adjustments were reflective of a consistent effort. (Ex. 2:1) At the functional capacity evaluation, she rated her pain as 5 on a 10-scale in her right lower extremity and 3 on a 10-scale in her low back. (Ex. 2:2) At the end of the evaluation, her pain increased to 7 on a 10-scale. (Ex. 2:2) Due to claimant's decreased strength and endurance of her low back and right lower extremity, Mr. Short found the claimant was essentially in an unemployable condition. She could not meet the capabilities of even the sedentary category of physical demand work. (Ex. 2:2)

Following the functional capacity evaluation, Dr. Wetjen signed off on a letter prepared for him by claimant's counsel agreeing that claimant had permanent nerve damage from her work injury on October 22, 2017 that would likely be permanent. (Ex 5:4) He further agreed that claimant would likely not be able to fulfill the duties of a certified nurse's associate and adopted the permanent work restrictions suggested by the functional capacity evaluation completed by Mr. Short. (Ex. 5:4)

On April 2, 2019, claimant underwent an independent medical examination with John Kuhnlein, D.O. (Ex. 1:1) Dr. Kuhnlein had initially saw the claimant on September 5, 2018, but at that time it was determined that she would need further care and so the evaluation was delayed with no report issued. (Ex. 1:1) During the April 2019 visit claimant presented with an exaggerated waddling gait that did not change in reverse dread. She had week this on the right foot when rising on her heels and toes. She was able to squat partially because of her body habitus and no groaning or grimacing was noted. (Ex. 1:9) Her lumbar flexion and extension were reduced and pain was reported to be greater in extension and flexion. Right side bending was 20° and left side bending was 30°. The lower spinal level appeared to be hyperlordotic although based upon her body habitus it was somewhat difficult to tell. (Ex. 1:9) She had tenderness under the scars of her surgery and to the right with palpation along with right gluteal tenderness. Lumbar percussion was positive over the central scar. (Ex. 1:9) The right ankle jerk reflex was absent and weakness was noted in the proximal hip flexors and in the right great toe dorsiflexion. She otherwise had normal motor strength in both lower extremities. Seated leg raising was negative. (Ex. 1:9) Pinprick, vibratory, and light touch sensation were decreased below the knee and L5 to S1 distribution. Right straight leg testing was 60° with positive evidence of radiculopathy back pain extending down the right leg below the knee and into the foot. The left straight leg raising was 70° with complaint of back pain but no evidence of radiculopathy. (Ex. 1:10) Adduction and internal rotation of right hip produce complaints of back and right leg adduction but internal rotation of the left hip was unremarkable. (Ex. 1:10)

Dr. Kuhnlein diagnosed claimant with chronic low back pain with residual right L5 to S1 radiculopathy. (Ex. 1:10) He further concluded that claimant sustained an initial low back pain with radicular features on or about February 16, 2017. The original work-related condition essentially resolved by April 17, 2017. She sustained a new and

separate back injury on October 22, 2017. She subsequently had an epidural injection on December 19, 2017 and a subsequent surgery performed by Dr. Wetjen. (Ex 1:10)

Dr. Kuhnlein recommended exercise and weight loss, the use of Naprosyn instead of ibuprofen, chronic pain management that would include weaning her off oxycodone. (Ex. 1:10) She demonstrated weakness rather than true foot drop but recommended she wear an AFO brace. (Ex 1:10) He placed claimant at maximum medical improvement as of April 16, 2019 and assigned a 25 percent whole person impairment. (Ex 1:11)

His restrictions are as follows:

> Given the length of time that she has been off work, she faces a number of barriers to recovery and return to work. The functional capacity evaluation suggests that she may be unemployable if she cannot increase strength and endurance of the low back and right leg, and she had several months of physical therapy before the functional capacity evaluation was performed.
>
> Material handling restrictions would include lifting at most 10 pounds rarely from floor to waist, 10 pounds rarely from waist to shoulder as long as weights are kept closed the axial plane of her body, and 10 pounds rarely over the shoulder.
>
> Nonmaterial handling restrictions would include sitting, standing, or walking on an as needed basis with the ability to change positions for comfort. She can stoop or squat rarely. She can rarely bend at the waist when standing, although she can bed at the waist when sitting. She cannot crawl. She can rarely kneel. She cannot work on ladders or at height. Ms. Cameron can rarely climb stairs. She cannot work at or above shoulder height. She can grip or grasp without restrictions below shoulder height. She cannot operate foot operated industrial machinery.
>
> There are no vision, hearing, or communication restrictions. She can travel for work only if she can take breaks from time to time to stretch. She can use hand or power tools on a rare basis within the material handling restrictions outlined above. There are no environmental restrictions. If working on uneven surfaces, good footgear would be appropriate. There are no personal protective equipment restrictions. She cannot work on production lines. There are no shiftwork issues.

(Ex 1:11)

On May 14, 2019, claimant returned to the Iowa Clinic Pain Management Center where she was seen by Chandra Brown, ARNP. (JE 8:21) At this time, claimant had returned to work feeding patients but continued to have low back pain and worsening spasms in her toes. (JE 8:21) She continued to take oxycodone, gabapentin, Cymbalta and Flexeril. (JE 8:21) She reported pain of 8 on a 10-scale, with numbness, leg weakness and limping. (JE 8:22) Percocet was added as a prescription. (JE 8:23)

On June 5, 2019, Dr. Schmitz issued a lengthy letter regarding claimant's low back pain and the possible causation of that pain. (JE 3:34) Dr. Schmitz opined the claimant did not sustain any permanent injury as a result of the work incident on February 16, 2017 or the October 22, 2017 injury. (JE 3:34 – 35) He believed that claimant had exaggerated pain behaviors with several findings consistent with a nonanatomic source for her pain. (JE 3:35) He was not confident that she had sustained any injury to her back as a result of the October 22, 2017 incident. (JE 3:35) He also stated that "the scientific evidence we have with regard to the cause of lumbar disc herniations is at this point clear." (JE 3:35) Dr. Schmitz goes on to quote the AMA Guides to the Evaluation of Disease and Injury Causation, Chapter 8, page 32,

> In summary, there is insufficient scientific evidence to attribute the cause of lumbar disc herniation to any minor trauma event or ergonomic risk factor. The case is in which there is just a temporal association between an event and the onset of sciatica from a disc herniation logically represent when the herniation occurs, but not why it occurs.

(JE 3:35)

Because of claimant's subjective findings, he did not believe surgery was appropriate. (JE 3:37) Lumbar fusion surgery carries risk which was evident in the claimant's postoperative course. (JE 3:37) After the surgery, which resulted in four misplaced screws and even after the revision, two screws are misplaced on the left leaving the claimant with significant right lower extremity weakness. Further, she has a protruding cage. (JE 3:37) Dr. Schmitz had significant concerns that the October 2018 revision surgery will not be her last, particularly, given the claimant's weight which will place a significant stress on a construct that has poorly positioned instrumentation. (JE 3:37) He opined that claimant was worse off post surgery, as well as being on chronic narcotics with a physical presentation drastically worse than she was presurgery. (JE 3:37) He recommended a second functional capacity evaluation. (JE 3:38)

On June 10, 2019, claimant underwent a second functional capacity evaluation. The overall results of the functional capacity evaluation this time were considered consistent. (JE 5:10) Based upon the evaluation, claimant was placed in the light to light medium physical demand level. (JE 5:10) Claimant presented with the following symptoms:

> Constant central to right lower back discomfort which ranges in intensity; diminished active trunk range of motion; constant numbness along the posterior aspect of the distal right lower extremity; constant numbness along the lateral aspect of the right foot; frequent muscular spasms in the right foot; and diminished right lower extremity strength/stamina for functional activities.

(JE 5:13) Observational notes include diffuse pain reported was somewhat light palpation to the area of the right lower back, facial grimacing and groaning noted on occasion but not to an extreme degree, decreased strength noted with resistant right hip flexion, and antalgic gait. (JE5:14)

The following recommendations were made.

- Waist to floor lifting – Avoid
- 12" to waist lifting – 12.50 lbs., occasionally
- Waist to shoulder lifting – 22.50 lbs., occasionally
- Waist to overhead lifting – 22.50 lbs., occasionally
- Bilateral carrying – 15 lbs., occasionally
- Horizontal pushing/pulling – 35 lbs. of force, occasionally
- Sitting – Constantly
- Standing work – Frequently, with positional changes as required
- Stair climbing – Frequently
- Sustained Kneeling – Occasionally, with mechanical support for transitional movements
- Squatting – Occasionally, within available range of motion
- Bending - Occasionally

(JE 5:10)

On July 2, 2019, Dr. Kuhnlein issued an addendum to his original expert opinion after reviewing the functional capacity evaluation performed by Mr. Short, the new records from Dr. Wetjen, the FCE provided by Mr. Kruzich and Dr. Schmitz's subsequent records. (Ex 1:15) In the addendum, Dr. Kuhnlein takes issue with Dr. Schmitz's conclusion that the injury of October 2017 was not caused by work duties. (Ex 1:16) In fact, Dr. Schmitz concluded that no work injury occurred on October 2017 as the type of work duties and type of physical action described by the claimant are not consistent with the a lumbar disc herniation. Dr. Kuhnlein writes, "Unfortunately, Dr. Schmitz apparently does not truly understand the concept of reasonable medical certainty, as that is a 51% probability and not the probability used by editors of this book." (Ex 1:16) The book Dr. Kuhnlein referred to was the AMA Guides to the Evaluation of Disease and Injury Causation. (Ex 1:16) Dr. Kuhnlein was also critical of Dr. Schmitz's use of epidemiological causation principles given Dr. Schmitz's use of the term "temporal association" as that type of causation principle should only be used cautiously when discussing individual cases rather than epidemiological causation. (Ex. 1:16)

Not a surgeon himself, Dr. Kuhnlein deferred the reason for the need for surgeries to Dr. Schmitz and Dr. Wetjen. (Ex 1:16) Dr. Kuhnlein then went on to address his previous opinion the claimant had reached maximum medical improvement as of April 16, 2019. (Exhibit 1:16) Given Dr. Wetjen's belief the claimant had not reached maximum medical improvement and Dr. Schmidt stating that he had significant concerns that claimant was going to go on to pseudo-arthrosis, Dr. Kuhnlein revised his opinion to state that she had not yet reached maximum medical improvement. (Ex. 1:16)

Defendants assert claimant is not entitled to temporary benefits because she refused suitable work.

Prior to her work injury, claimant and defendant employer had a misunderstanding regarding her return to work. On July 14, 2017, claimant was written up for failing to show for a scheduled shift. She was scheduled to work from 10:00 p.m. to 6:00 a.m., on Friday night July 14, 2017. (Ex C:1) She did not appear. Claimant testified that she had been taken off of work until she had her baby as she was very sick and advised not to work. Matt Archibald, Director of Human Resources, called her and informed her that she had not followed policy. The conversation became heated and claimant allegedly cursed at Archibald. (Ex C:1) Claimant denies using profanities but does agree the conversation was heated.

Whatever the issues, claimant returned to her CNA duties after the birth of her child. She began seeking medical attention for a low back injury after an October 2017 increase in pain in her low back.

Initially she felt her work was understanding and when she returned to work, defendant employer attempted to accommodate her restrictions by placing her at the assisted living facility. It was lighter duty work as most of the residents are capable of caring for themselves. Claimant would assist in laundry, providing activities, serving meals and passing medications. She was not allowed to push patients or wash dishes as the dishwasher was low and required bending and stooping and lifting heavy dishes.

Claimant had a meeting with Laura, the head of assisted living, and Kim Miles, the head of HR, and they agreed that she should stay at the assisted living facility, however, she would be required to take a pay cut.

On July 18, 2018, Darla Shaffer and Archibald met with claimant to discuss her future employment. (Ex C:2) If she was going to return to the assisted living division, her pay would be cut to $12.50 per hour. She was given until July 31, 2018, to answer him. (Ex. C:2)

On July 24, 2018, claimant agreed that she would take four nights a week at the 10:00 p.m. to 6:30 a.m. shift starting in August. (Ex C:2) Darla Shaffer repeated the wage of $12.50 per hour.

On August 23, 2018, after consulting with an attorney, claimant did not sign the paperwork as it stated that she was on a part-time status which she had not agreed to. (Ex C:2) The parties met again on September 5, 2018 but came to no resolution.

She was given the option of staying at assisted living at $12.50 per hour on full-time status returned to the nursing facility at her previous pay of $14.10 per hour. (Ex C:2) Claimant agreed to return to the nursing facility and signed the document stating such. (Ex C:2)

Claimant was off work from September 2018 until April 2019. She returned to work on April 16, 2019 at two hours a day every other day. (Ex. C: 15) Her duties included helping to fold laundry and feed residents.

A meeting was held on May 23, 2019 with the claimant, Dwala Lehman, Administrator, and Matt Archibald to discuss three things: Her return to work with light-duty modifications, the attendance policy, and insubordination.

A revised job description was provided within the restrictions of DPT, however, claimant refused to do the modified work as she felt that they were CNA duties and her doctor had advised against that. (Ex C:5) The attendance policy was presented to her and she was asked to sign the document to represent that she understood the policy. (Ex C:5) She refused to sign without discussing the matter with her lawyer. (Ex C:5) The last issue was the conversation Mr. Archibald and the claimant had with each other on July 14, 2017. (Ex C:5) The conversation devolved. Mr. Archibald claims that claimant called him a liar which claimant disputes, stating that she may have said he was lying which was different. Dwala Lehman, the administrator of the Carlisle Care Center, confirmed Mr. Archibald's statements at hearing. Mr. Archibald then terminated her employment. (Ex. C:5)

CONCLUSIONS OF LAW

The claimant has the burden of proving by a preponderance of the evidence that the alleged injury actually occurred and that it both arose out of and in the course of the employment. Quaker Oats Co. v. Ciha, 552 N.W.2d 143 (Iowa 1996); Miedema v. Dial Corp., 551 N.W.2d 309 (Iowa 1996). The words "arising out of" referred to the cause or source of the injury. The words "in the course of" refer to the time, place, and circumstances of the injury. 2800 Corp. v. Fernandez, 528 N.W.2d 124 (Iowa 1995). An injury arises out of the employment when a causal relationship exists between the injury and the employment. Miedema, 551 N.W.2d 309. The injury must be a rational consequence of a hazard connected with the employment and not merely incidental to the employment. Koehler Electric v. Wills, 608 N.W.2d 1 (Iowa 2000); Miedema, 551 N.W.2d 309. An injury occurs "in the course of" employment when it happens within a period of employment at a place where the employee reasonably may be when performing employment duties and while the employee is fulfilling those duties or doing an activity incidental to them. Ciha, 552 N.W.2d 143.

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).

The parties have stipulated the claimant sustained a work injury on October 22, 2017. The dispute is the extent of the claimant's injury. There are multiple experts who have opined regarding causation and extent. Drs. Wetjen, Kuhnlein and Boulden have all agreed that claimant's low back injury of October 22, 2017, was caused by an incident at work and that the injury necessitated the surgery of October 16, 2018. On the other hand, Dr. Schmitz, Dr. Smith and Dr. Miller believed that claimant's presentation of symptoms did not correlate with the objective findings. Dr. Schmitz found claimant's diffuse complaints of pain, along with a negative EMG, unhelpful injections, and MRI positive for an L5-S1 disk herniation were attributable to a non-anatomic source. He also concluded that surgery was not appropriate for the claimant. Ultimately, Dr. Schmitz was correct. Claimant had a negative outcome following the surgery. It could even be argued that her condition was worse off after the surgery than before.

Prior to claimant's visit to September 2018 emergency department visit, claimant's records noted inconsistent and diffuse pain complaints and pain behaviors. After the claimant's September emergency department visit, claimant's reports of pain in the right lower extremity was accompanied by foot drop and reproducible radicular symptoms. It is notable that emergency department records the history taken from the claimant as follows:

> Back Pain-New < 28 days.
>
> Patient reports back pain started 1 week ago. Patient diagnosed with herniated disc in lumbar spine. Patient reports having increased numbness and tingling with the loss of bowel control. . . .
>
> . . . .
>
> She has not had any bowel or bladder issues today. She notes numbness to low back and bilateral legs that began about one month ago. Numbness is worsened to right side. She says she has been dragging her right foot when she walks.

(JE 7:8-9)

Claimant was then referred to Dr. Wetjen who opined that based on the symptoms presented to him, claimant should undergo surgery. The surgery was not successful and claimant has suffered permanent, disabling symptoms since then.

However, prior to that date, when claimant presented to Dr. Miller, Dr. Schmitz, Dr. Smith, Dr. Shahid, claimant had diffuse non-specific and sometimes contradictory complaints of pain. At one point, claimant was only able to ambulate into Dr. Schmitz's

office using a walker. At other times, her right-sided giveaway weakness was so severe that she could not lift her leg on the table, but she was able to use her right leg to walk and navigate through the clinic and into and out of her car. On February 19, 2018, after several months of complaints of pain of 8 on a 10-scale, claimant sought out the second opinion of Saima Z. Shahid. Her gait was smooth and symmetrical according to Dr. Shahid and claimant's range of motion was normal. Dr. Shahid referred claimant to Dr. Smith who concluded similarly to Dr. Schmitz that claimant's objective findings do not support the subjective symptoms and that there were no objective findings supporting a radicular pattern.

During an emergency room visit on March 28, 2018, for her back pain, it was noted that she had no negative gait issues and that "with encouragement" both claimant's range of motion and strength improved. Despite her complaints of pain and weakness, she was able to ambulate into and out of the emergency department as well as stand from a seated position independently. While she moved slowly and did exhibit tenderness at the mid and lower back, no foot drop was noted.

On April 5, 2018, claimant underwent an evaluation with Dr. Boulden who opined claimant's symptoms required surgical intervention and that they were the result of a work incident. Dr. Boulden found numbness on the lateral side of her right foot and an absence of ankle reflex on the right but not the left. He agreed that there were some non-anatomical findings of diffuse weakness in the right leg but felt that the numbness, decreased sensation, and positive straight leg test supported the radiologist's interpretation of herniated disc at L5-S1 with S1 nerve entrapment.

A subsequent FCE was deemed invalid due to the efforts, or lack thereof, by the claimant. While Dr. Boulden was a physician of defendant's choice and he found that the claimant needed surgery and that the symptoms claimant presented with on April 5, 2018 were likely the result of a work incident, the opinions of Dr. Schmitz and Dr. Smith were more reliable given the claimant's inconsistent presentation. Some visits she had positive SLR test on the right and others she did not. When she presented to her family physician, she had a smooth gait. When she was on the examination table with Dr. Schmitz, she could not raise her leg because of weakness yet claimant was able to ambulate in and out of the clinic without assistance.

In September, claimant presented at the emergency department with new symptoms. She had increased numbness and tingling with loss of bowel control for the first time. Her straight leg test on the right was positive and she had an "almost stocking glove" distribution loss of sensation from the medial thigh down. She was reported to be dragging her foot. The stocking glove loss of sensation from the medial thigh down to the sole of the foot along with foot drop and loss of bowel control were new issues which correlate with the new injury she related to occurring either a week or a month before. In sum, these were new symptoms that she had not previously presented to Dr. Schmitz or even Dr. Boulden. Dr. Kuhnlein also opined that claimant's pre-existing back pain only had equivocal radicular features that developed into true radiculopathy in September 2018, supporting the concept that claimant sustained an aggravation of a pre-existing condition in September 2018.

Claimant argues that Dr. Schmitz's opinion is invalid because he uses a wrong standard. Dr. Kuhnlein felt that Dr. Schmitz was using an epidemiological causation standard rather than a more probable than not one, particularly when using the temporal association reference. However, temporal association is what medical professionals use in an aggravation case—even Dr. Kuhnlein and Dr. Boulden. When a party argues that there was a pre-existing condition that was aggravated or lit-up by a work incident, their proof is that prior to the work injury the injured worker was asymptomatic and post the work injury, the worker becomes symptomatic. That is the situation we have in the present case. Prior to October 22, 2017, claimant was mostly asymptomatic. Dr. Kuhnlein writes "she had no problems with back or right leg pain after she returned to work from maternity leave." (Ex 1:10) She did have symptoms post October 22, 2017, but she was deemed to be at MMI by Dr. Smith on June 27, 2018.

Thus, the greater weight of the evidence supports a finding that claimant's October 22, 2017, injury was not the cause of the symptoms leading to claimant's surgery on October 2018, but rather claimant experienced a new aggravation in September 2018 which may or may not be caused by her work. That question is unresolved and not the subject matter of this hearing.

As for her October 22, 2017, injury, claimant was released without restrictions on June 27, 2018, by Dr. Smith. (JE 3:29) Based on this as well as the above finding that claimant was released to return to work without restrictions for her pre-September 2018 condition, it is determined that claimant has not carried her burden to prove by a preponderance evidence that the surgery of October 2018 was causally connected to her October 22, 2017, work injury.

That the claimant may have sustained a different work injury arising from a post June 27, 2018, incident, that was not presented at hearing. However, there should be nothing in this decision that would serve as a bar for a later suit as the issue regarding causation or permanency arising out of any incident post June 27, 2018, is not at issue and has not been argued by the parties or examined by the undersigned.

The remaining issues are deemed moot by above finding.

As it relates to the October 22, 2017, injury date, it is found that claimant shall take nothing.

ORDER

THEREFORE, it is ordered:

Claimant shall take nothing

Each party shall pay their own costs.

The cost of the transcript shall be shared by the parties equally.

Signed and filed this __5th__ day of May, 2020.

JENNIFER S. GERRISH-LAMPE
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served, as follows:

Nick Platt (via WCES)

Lee Hook (via WCES)

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 filed via Workers' Compensation Electronic System (WCES) unless the filing party has been granted permission by the Division of Workers' Compensation to file documents in paper form. If such permission has been granted, the notice of appeal must be filed at the following address: Workers' Compensation Commissioner, Iowa Division of Workers' Compensation, 150 Des Moines Street, Des Moines, Iowa 50309-1836. The notice of appeal must be received by the Division of Workers' Compensation 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 legal holiday.