BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

RAY OPPMAN, Claimant, vs. EATON CORPORATION, Employer, and OLD REPUBLIC INSURANCE COMPANY, Insurance Carrier, SECOND INJURY FUND OF IOWA, Defendants.	File No. 1649999.01 A P P E A L D E C I S I O N Head Notes: 1402.20; 1402.40; 1402.60; 1403.10; 1803; 1804; 2206; 2501; 2701; 2907

Defendants Eaton Corporation, employer, and its insurer, Old Republic Insurance Company, (hereinafter "defendants") appeal from an arbitration decision filed on November 9, 2022. Claimant Ray Oppman and defendant Second Injury Fund of Iowa (hereinafter "the Fund") respond to the appeal. The case was heard on March 24, 2022, and it was considered fully submitted in front of the deputy workers' compensation commissioner on May 20, 2022.

In the arbitration decision, the deputy commissioner found claimant met his burden of proof to establish he sustained a sequela injury to his low back caused by the stipulated January 23, 2018, work-related right knee injury, thus entitling claimant to receive industrial disability benefits for the work injury. The deputy commissioner found claimant's pre-existing pulmonary issues and obesity were exacerbated by the work injury. The deputy commissioner found claimant proved he is permanently and totally disabled as a result of the work injury. The deputy commissioner found claimant is not entitled to receive benefits from the Fund because claimant did not sustain a second qualifying injury. The deputy commissioner found defendants are responsible for claimant's past medical expenses for his low back condition itemized in Joint Exhibit (hereinafter "JE") 18. The deputy commissioner found claimant is entitled to alternate medical care under Iowa Code section 85.27 with Shelley Wells, D.O. The deputy commissioner ordered defendant-employer and defendant-insurance carrier to pay claimant's costs of the arbitration proceeding itemized in JE 19.

Defendants assert on appeal that the deputy commissioner erred in finding claimant sustained a sequela injury to his low back caused by the work injury. Defendants assert the deputy commissioner erred in finding claimant's pulmonary issues and obesity were exacerbated by the work injury. Defendants assert the deputy commissioner erred in finding claimant proved he is permanently and totally disabled as a result of the work injury, and defendants assert claimant's recovery is limited to the functional loss to his right knee. Defendants assert if it is found on appeal that claimant is entitled to industrial disability it should be found claimant has sustained very little industrial disability. Defendants assert it should be found on appeal that claimant is not entitled to reimbursement for medical costs or alternate care for his low back condition.

Claimant and the Fund assert on appeal that the arbitration decision should be affirmed in its entirety.

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

I performed a de novo review of the evidentiary record and the detailed arguments of the parties. Pursuant to Iowa Code sections 17A.15 and 86.24, the arbitration decision filed on November 9, 2022, is affirmed in its entirety with my additional and substituted analysis.

Without further analysis, I affirm the deputy commissioner's finding that claimant is not entitled to receive benefits from the Fund because claimant did not sustain a second qualifying injury. I affirm the deputy commissioner's finding that defendants are responsible for claimant's past medical expenses for his low back condition itemized in JE 18. I affirm the deputy commissioner's finding that claimant is entitled to alternate medical care under Iowa Code section 85.27 with Dr. Wells. I affirm the deputy commissioner's order that defendants pay claimant's costs of the arbitration proceeding itemized in JE 19.

With my additional and substituted analysis, I affirm the deputy commissioner's findings that claimant sustained a sequela injury to his low back caused by the work injury, which entitles claimant to receive industrial disability benefits, and I affirm the deputy commissioner's finding that claimant is permanently and totally disabled.

Joshua Baker, D.O., a family medicine physician, initially treated claimant for his right knee pain on January 23, 2018, the date of the work injury. (JE 4, p. 15) Dr. Baker works in the same clinic as claimant's primary care provider, Dennis Colby, D.O. Claimant reported he slipped on a slippery, oily surface at work causing his right leg to abduct, and then he felt significant pain and popping in his knee, predominantly in the middle. (JE 4, p. 16) Claimant complained of a "[s]ignificant instability sensation." (Id.) Dr. Baker examined claimant, documented claimant had normal range of motion for flexion and extension, complete laxity of the valgus and varus testing as well as anterior drawer and Lachman testing, tenderness at the medial and lateral joint lines, no tenderness at the proximal fibular head, and no medial or lateral patellar tracking, and noted claimant had an antalgic gait. (Id.) Dr. Baker assessed claimant with sprains of

the right knee medial collateral, lateral collateral, and anterior cruciate ligaments, opined claimant's condition was work-related, recommended an MRI, prescribed a hinged knee brace and crutches, and imposed restrictions of no ambulation to and from claimant's workstation with sitting duty only. (JE 4, pp. 15-18)

Claimant underwent a right knee MRI on February 1, 2018. (JE 4, p. 21) The reviewing radiologist listed an impression of:

> 1. Full thickness anterior cruciate ligament tear, associated with bone contusions of the posterolateral tibial plateau and metaphysis and the anterior aspect of the lateral femoral condyle.
>
> 2. Large joint effusion.
>
> 3. Full thickness tears of the lateral collateral and medial collateral ligaments.
>
> 4. Medial meniscal tear.
>
> 5. Popliteus muscle strain associated with popliteus tenosynovitis.
>
> 6. Medial and lateral capsular edema is greatest medially where there appears to be a full-thickness tear of the posterior fibers of the medial patellar femoral ligament. This is associated with vastus medialis muscular edema.
>
> 7. Mild tricompartmental primary osteoarthritic changes.

(JE 4, p. 22)

During a follow-up appointment with Dr. Baker on February 13, 2018, claimant stated he was able to work from a seated position, but ambulating on slippery surfaces with crutches was a problem for him. (JE 4, p. 33) Dr. Baker reviewed claimant's MRI and noted "[claimant] clearly needs orthopedic surgery consultation for this need arrangement. We are trying to arrange for this." (JE 4, p. 34) Dr. Baker documented he spoke with defendants' case manager and a surgery consultation was delayed because causation needed to be determined. (Id.) Dr. Baker imposed restrictions of seated work only and no ambulation on oily, icey, or slippery surfaces because of a fall risk, and stated he did not need to see claimant again given he needed to see orthopedic surgery to treat his problem. (JE 4, pp. 34-35)

On February 16, 2018, claimant presented to the emergency room after falling on the ice and landing on his right knee. (JE 4, p. 37) An x-ray revealed no acute findings. (JE 4, p. 38)

On March 12, 2018, claimant attended an appointment with Mark Palit, M.D., an orthopedic surgeon, for his right knee pain. (JE 4, p. 43) Dr. Palit examined claimant, he documented claimant had close to full range of motion in his knee, and noted claimant's imaging showed an "intensive injury including ACL rupture, medial meniscus tear, lateral collateral ligament tear and medial collateral ligament tear." (Id.) Dr. Palit documented claimant's "injury is quite extensive" and he recommended a referral to the University of Iowa Hospitals and Clinics (UIHC) for possible right knee reconstruction. (Id.)

On April 5, 2018, claimant attended an appointment with Matthew Bollier, M.D., an orthopedic surgeon at UIHC, regarding his right knee pain. (JE 5, p. 208) Dr. Bollier noted claimant's MRI and exam revealed he had a complete ACL rupture, MCL injury, and medial meniscus tear of his right knee and he recommended surgery. (JE 5, p. 209) At that time claimant weighed 375 pounds. (JE 5, p. 210)

Dr. Bollier performed surgery on claimant on May 2, 2018, and listed post-operative diagnoses of right ACL tear, MCL tear, and medial meniscus tear. (JE 5, p. 217)

On May 8, 2018, claimant returned to Dr. Baker complaining his foot was swollen and his toes had turned purple following surgery. (JE 4, pp. 49-50) Dr. Baker found claimant had no vascular compromise, recommended a compression stocking for the swelling, and recommended claimant follow-up with Dr. Bollier. (JE 4, p. 51) Following surgery Dr. Bollier recommended physical therapy, which defendants approved. (JE 4, p. 53)

On May 25, 2018, claimant attended his first physical therapy session. The physical therapist documented claimant was ambulating with a "mildly antalgic gait," and noted on exam claimant had limited right knee range of motion, weakness and "impaired gait mechanics affecting functional mobility." (JE 4, pp. 55-56)

When claimant returned to physical therapy on June 1, 2018, the physical therapist documented claimant's range of motion had improved and his gait had improved. (JE 4, p. 63) During his next session on June 5, 2018, claimant reported his back had been bothering him and his left leg had been more sore and swollen because he had been favoring his right leg since his surgery. (JE 4, p. 65)

During a follow-up appointment on June 14, 2018, Dr. Bollier documented claimant complained of "stabbing posterior right knee pain on occasion when his knee straightens too far as well as numbness at the interior knee," and "aching and burning low back pain with standing and walking, which resolves when sitting or lying down" and radiating left ankle pain and swelling in his lower extremities. (JE 5, p. 225)

During treatment sessions, the physical therapist noted claimant initially demonstrated an antalgic gait during each session, but his gait improved and was grossly symmetrical with cues. (JE 4, pp. 67, 69, 71, 74) The physical therapist issued a progress note on June 13, 2018, documenting claimant's gait was "nearly symmetrical

with conscious effort and verbal cues." (JE 4, p. 73) The physical therapist continued to work with claimant on his gait symmetry, which she documented had improved, while noting claimant had increased weakness and decreased activity tolerance. (JE 4, p. 81)

During a physical therapy session on June 29, 2018, the physical therapist documented claimant was working on improving his gait symmetry and he had improved his right stance, left wing and upright posture, noting "[p]rogressed to gait in PT gym x 150' Patient demonstrates improving but not yet normalized mechanics." (JE 4, p. 83)

When claimant returned to physical therapy on July 3, 2018, the physical therapist documented claimant was able to move "at a very fast pace" with "a slight decreased R stance but gait mechanics are improving" while ambulating 200 feet in the physical therapy gym. (JE 4, p. 85)

On July 18, 2018, claimant attended an appointment with Dr. Colby for his asthma and reported he was experiencing low back pain when standing for a long time. (JE 4, p. 91) That same day claimant attended a physical therapy session. (JE 4, pp. 93-94) The physical therapist documented claimant's knee stability and gait mechanics were improving, he had left ankle pain affecting his gait mechanics, his activity tolerance is limited by his co-morbidities, and the therapist noted she would continue to work on improving claimant's strength and gait. (JE 4, p. 93)

When claimant returned to physical therapy on July 24, 2018, the therapist noted, "[p]atient demonstrates good right knee stability during gait. He has lateral trunk lean with stance. Gait mechanics change depending on amount of soreness in right knee vs left ankle. (JE 4, p. 97) As of July 31, 2018, claimant had not met all of his physical therapy goals and was working on the goal of ambulating with a symmetrical gait. (JE 4, pp. 100-105)

On August 9, 2018, claimant reported increased back pain and spasms to the physical therapist. (JE 4, p. 108) Claimant stated his back pain and spasms are worse with standing and better with sitting. (Id.) The physical therapist documented "[h]e reports he did not have back pain before the injury and feels it is due to the change in his alignment and walking mechanics." (Id.) During a session the next day claimant reported "his back is still really bothering him and plans on possibly going to the chiropractor next week." (JE 4, p. 109) When he returned on August 13, 2018, claimant reported he was "having a lot of back pain still," he planned to go to the chiropractor that day, and his knee was doing fine. (JE 4, p. 112)

Claimant continued to report having back pain and back spasms to Dr. Bollier's office at UIHC. (JE 5, pp. 232-233, 235) He called UIHC on August 16, 2018, and a nurse with Dr. Bollier's office documented:

> he has to park in the parking lot at work, his back hurts him to walk into his workplace. He thinks that his back hurts him because of his gait since he had surgery done. He hasn't been walking much and now that he

> is back to work, he has to walk. I asked him about his physical therapy. Yes, he is doing therapy 2-3 times per week. He had to cancel PT today because when he got to the convenient store on his way to work, his back hurt him so bad that he couldn't go into work today.

(JE 5, p. 233)

Claimant attended a physical therapy session on August 20, 2018, complaining of increased back pain at the end of the workday. (JE 4, p. 114) Claimant reported squatting and picking up items bothers his back and he reported his back is worse with standing and better with sitting and flexing forward. (JE 4, p. 114) Claimant stated he had missed work that day and Friday due to increased back pain. (JE 4, p. 114) During a physical therapy session on August 29, 2018, claimant reported he was working eight hours at a time and that his knee was doing well and just becomes a little stiff. (JE 4, p. 123)

When claimant returned to physical therapy on August 31, 2018, the physical therapist documented claimant was putting forth good effort in therapy and had made gradual improvements in his right lower extremity strength, stability, and balance, however, his back pain was becoming worse over time and standing had become increasingly painful and difficult. (JE 4, p. 125) The physical therapist documented "[a]s of most recent session on 8/31/18 gait was antalgic and more limited by his left leg pain, unable to reassess since increase in back and leg pain." (Id.) The therapist also noted claimant's back pain and shortness of breath are barriers to treatment. (Id.)

On September 4, 2018, claimant returned to Dr. Baker complaining of right-sided moderate to severe back pain for the past three months. (JE 4, pp. 127-128) Dr. Baker noted he "has been walking with a funny gait because of his knee problem" and he has some radiation of the pain with numbness into his buttocks." (JE 4, p. 128) Dr. Baker assessed claimant with low back pain, unspecific back pain laterality with sciatica and lumbar degenerative disc disease. (Id.) Dr. Baker documented "[t]his appears to be uncomplicated lumbar muscle strain which is suspect is related to his abnormal walking, given his recent knee surgery, weight gain, morbid obesity." (JE 4, p. 129) Dr. Baker noted claimant had undergone a significant amount of physical therapy for his knee, which should have made his back problems significantly better, but did not. (JE 4, p. 129)

During a follow-up visit with Dr. Bollier on September 17, 2018, claimant complained of dull right knee pain and "stabbing, burning, radiating and cramping low back pain," noting his knee felt more stable since surgery. (JE 5, p. 235) Claimant complained of back pain and spasms he attributed to limping. (Id.) Dr. Bollier noted:

> At this point post-operatively he may resume full activity with regard to his knee. Would anticipate his soreness and strength to continue to improve over time. We recommend that he discuss working in a position that does not require him to work on an oily floor with his employer. He should continue to follow with his PCP for his back symptoms. We

> explained that per work comp rules, the back pain is not considered a work injury. Do think the [*sic*] needs treatment and evaluation for that with his PCP. Mr. Opperman has reached MMI for his right knee and has no activity restrictions.

(JE 5, pp. 235-236)

Dr. Bollier did not identify what "work comp rules" he was referring to in his office note.

Using Table 17-33 of the Guides to the Evaluation of Permanent Impairment (AMA Press, 5th Ed. 2001) ("AMA Guides"), Dr. Bollier assigned two percent lower extremity impairment for a partial medial meniscectomy and he released claimant without restrictions. (JE 5, p. 236)

Given claimant's ongoing low back complaints, Dr. Baker ordered a lumbar spine MRI. (JE 4, pp. 134-135) The reviewing radiologist listed an impression of:

> 1. Degenerative changes throughout lumbar spine, most advanced at L1-2 level with diffuse disc bulge and severe central canal narrowing.
>
> 2. Fairly prominent epidural fat within the lumbar spine.
>
> 3. No severe foraminal narrowing at any level.

(JE 4, p. 135)

After receiving the findings Dr. Baker referred claimant to Ronald Kloc, D.O., a pain specialist. (JE 4, p. 137)

On October 16, 2018, claimant attended an appointment with Dr. Kloc for his back pain. (JE 7, p. 298) Dr. Kloc examined claimant, assessed him with spinal stenosis lumbar claudication, lumbosacral neuritis, and severe central spinal stenosis at L1-L2 with neurogenic claudication and recommended lumbar epidural steroid injections or surgery. (JE 7, p. 300) Claimant chose to undergo injections and did not want to proceed with surgery. (Id.)

Claimant underwent his first lumbar epidural steroid injection on October 31, 2018. (JE 7, p. 302) Claimant reported relief from the injection and underwent a second injection on November 28, 2018. (JE 7, p. 305) Claimant cancelled his third injection because he was receiving intravenous antibiotics for an unrelated infection in his leg. (JE 7, p. 307) After the infection resolved, claimant underwent a third injection on April 18, 2019, and reported relief from the injection. (JE 7, pp. 309-310)

Dr. Kuhnlein conducted an IME for claimant on April 9, 2019, and issued his report on April 23, 2019. (JE 9) Dr. Kuhnlein examined claimant and reviewed his

medical records. (Id.) Dr. Kuhnlein diagnosed claimant with anterior cruciate ligament tear, full-thickness medial collateral ligament tear, full thickness lateral collateral ligament tear and partial medial meniscal tear with May 2, 2018, right knee ACL reconstruction, MCL reconstruction, partial medial meniscectomy, and L1-L2 spinal stenosis with possible claudication. (JE 9, p. 323) Dr. Kuhnlein found claimant had no prior right knee injuries and found claimant's knee injury and surgical treatment were related to the January 23, 2018, work injury. (Id.) With respect to claimant's low back condition, Dr. Kuhnlein opined:

> Mr. Oppman relates the low back pain started within a couple of weeks of the surgery, as his gait changed when he was limping after the surgery, and there were other changes in his activities of daily living, such as the inability to bend the right knee to put his socks on that caused him to change the way he performed his activities of daily living. Mr. Oppman is a morbidly obese gentleman, and that also impacted the way he had to do things after the surgery. The L1-L2 spinal stenosis predated the injury but was asymptomatic. The changes in his gait and activities of daily living "lit up" this pre-existing spinal stenosis and made it symptomatic, based on the beneficial response to the L1-L2 epidural injections performed by Dr. Kloc. It is more likely than not that this low back pain and possible claudication developed as a sequela to the January 23, 2018, right knee injury and May 2, 2018, knee surgery based on gait changes and the differences in his activities of daily living.

(JE 9, p. 324)

Using the AMA Guides, Dr. Kuhnlein found:

> Turning to Table 17-10, Page 537, and when comparing the right to the unaffected left knee, there would be no impairment for decrements in range of motion, as both knees had similar ranges of motion. The sensory deficits in the scars are in the femoral nerve distribution. Turning to Table 17-37, Page 552, an initial 2% right lower extremity impairment would be assigned for the sensory deficits. However, following the instructions on page 550, this value must be multiplied by the modifier from Table 16-10, Page 482. I would use the 25% modifier. When these values are multiplied together (2% x25%) and rounded according to the instructions on Page 20, this is a 1% right lower extremity impairment for the sensory deficit. Turning to Table 17-33, Page 546, 2% right lower extremity impairment could be assigned for the medial meniscectomy. 7% right lower extremity impairment could be assigned for collateral ligament laxity.
>
> Not all impairments in the lower extremity may be combined together. This is covered in Table 17-2, Page 526. In this case, combining the DRE values with the sensory deficit is appropriate. Using the Combined Values Chart on page 604, when these values are combined (7% x2% x 1%) this

> is a 10% right lower extremity impairment. Turning to Table 17-3, Page 527, this would convert to a 4% whole person impairment if indicated.
>
> Comparing this impairment to that of Dr. Bollier, he noted sensory deficit that was not ratable. He did not find any mild ligamentous laxity, and so assigned impairment only for the medial meniscectomy. This would account for the differences between the two impairments.
>
> The DRE method is indicated according to pages 379-380. Turning to Table 15-3, page 384, I would place Mr. Oppman into DRE Lumbar Category II and assign 5% whole person impairment.
>
> Turning to the Combined Values Charter on Page 604, when these values are combined (5% x4%) this is a 9% whole person impairment.

(JE 7, pp. 324-325)

Dr. Kuhnlein noted it is impossible to assign permanent restrictions only for claimant's knee and back conditions because claimant has multiple significant other conditions that impact his functional ability, including significant dyspnea and wheezing after walking one or two steps, morbid obesity, and bilateral lower extremity edema. (JE 7, p. 325) As a result, Dr. Kuhnlein assigned overall restrictions and stated he mentioned restrictions for the back and knee the best he could, as follows:

> Material handling restrictions would include lifting 20 pounds occasionally from floor to waist, 20 pounds occasionally from waist to shoulder, and 20 pounds occasionally over the shoulder, but because of his lung conditions, he would not be able to do anything other than lift the weight. He would be unable to do anything useful with it because of his pulmonary condition and carrying the weight would be difficult because of his right knee and bilateral lower extremity edema.
>
> Nonmaterial handling restrictions would include sitting, standing, or walking on an as able basis with the ability to change positions for comfort. These functions would be limited by a combination of his pulmonary condition, his knee condition, and his other leg conditions. Mr. Oppman can stoop or squat rarely, limited by a combination of his pulmonary condition, his knee and back condition, and his other peripheral leg condition. Mr. Oppman can occasionally bend because of his back condition, but he also becomes dyspneic with this activity. Mr. Oppman cannot crawl because of a combination of his knee condition, his other lower extremity edema issues, his pulmonary condition, and his back condition. Mr. Oppman can rarely kneel because of his knee condition. Mr. Oppman cannot work on ladders or at height because of his pulmonary and knee conditions, as he would be unable to maintain a three-point safety stance safely. Mr. Oppman can very rarely climb stairs, primarily because of his pulmonary condition, but also because of his knee condition to a lesser degree. He can work at or above

> shoulder height occasionally because of his back condition and the "moment arm" phenomenon in the lumbar spine with such material handling activities, but he would not be able to do many activities because of his pulmonary condition. He can grip or grasp without restrictions. He is not able to operate industrial machinery with his lower extremities, because of a combination of his lung conditions – he would become too dyspneic to operate the machine effectively – his right knee, and his other lower extremity conditions.
>
> There are no vision, hearing, or communication restrictions. Mr. Oppman can travel for work, as long as he can take stretch breaks from time to time. Mr. Oppman can use hand or power tools on an occasional basis. He should avoid working on oily or slick surfaces because of the risk that he might fall, affecting his back and knee. If working on uneven surfaces, good footgear would be appropriate to prevent falls because of the knee condition. There are no personal protective equipment restrictions. Mr. Oppman cannot work on production lines because of his lung condition, knee condition, and the edema in both legs. There are no shiftwork issues.

(JE 9, pp. 325-326)

On September 22, 2020, Dr. Baker signed an opinion letter for claimant's counsel. (JE 10) Dr. Baker summarized his treatment and claimant's history of back pain and gait problems and he opined, "[o]n a more likely than not basis, I conclude that abnormal gait and weight gain, from Ray Oppman's right knee surgery as a result of his January 23, 2018, work injury, materially aggravated, accelerated or sped up the degenerative process in his lumbar back resulting in [his] referral of Ray" to Dr. Kloc. (JE 10, p. 331) Dr. Baker agreed claimant's complaints were consistent with what he found on physical exam. (Id.)

Claimant was eventually referred to Dr. Wells, a pain specialist, in 2021. During his first evaluation on June 14, 2021, Dr. Wells reviewed claimant's prior imaging, assessed claimant with lumbar spondylosis, facet arthritis of the lumbosacral region, and lumbar spinal stenosis without neurogenic claudication and ordered a diagnostic facet block. (JE 4, p. 188) Claimant received the lumbar medial branch block and reported very good relief for five or six days. (JE 4, p. 192) Dr. Wells ordered a second block. (Id.) Dr. Wells documented claimant received 80 percent relief from the blocks for about a week and she ordered radiofrequency ablation. (JE 4, p. 197) Dr. Wells performed a right lumbar radiofrequency ablation at L4-5 and L5-S1 on October 5, 2021. (JE 4, p. 199) The ablation was successful and claimant reported pain relief of 50 to 60 percent. (JE 4, pp. 201, 207)

Joseph Chen, M.D., a physiatrist, conducted an IME for defendant-employer and defendant-insurance carrier on January 19, 2022, and issued his report on January 20, 2022. (JE 12) Dr. Chen reviewed claimant's medical records and examined him. (Id.)

Dr. Chen diagnosed claimant with an anterior cruciate ligament tear, medial meniscal tear, and medial and lateral collateral ligament tears, surgical reconstruction of the anterior cruciate ligament with repair of the medial collateral ligament and partial medial meniscectomy, lumbar spondylosis with degenerative joint disease at L1-L2 with central spinal stenosis, but no evidence of lumbosacral radiculopathy. (JE 12, p. 340)

On the issue of causation, Dr. Chen opined,

> It is my medical opinion that Mr. Oppman's right knee condition did not lead to his low back symptoms. Mr. Oppman reports that he began having right sided back pain after completing surgery for his right knee. Records indicate that Mr. Oppman did not report any back pain following his initial work injury on January 23, 2018, or even after slipping and falling on the ice when going in to work to sign papers in February 2018.

(JE 12, pp. 340-341)

Dr. Chen further opined claimant's right knee condition did not permanently and materially aggravate, accelerate, or "light up" claimant's back condition, stating as follows:

> While Dr. Baker has provided an opinion that Mr. Oppman's antalgic gait and need to perform his activities of daily living in an awkward manner led to his previously asymptomatic spinal stenosis to become symptomatic, it is my medical opinion that there are several better explanations for Mr. Oppman's back pain to have started around May 2018.
>
> Records during Mr. Oppman's post-surgical convalescence indicate that his level of ambulation was extremely limited due to his cardiac and pulmonary conditions. He was noted to only rarely leave his home due to severe dyspnea. It is my medical opinion that the limited ambulation that Mr. Oppman performed after his knee surgery did not contribute to "lighting up" his underlying degenerative lumbar spondylosis/back condition.
>
> It is my medical opinion that more reasonable explanations for Mr. Oppman's low back pain to become symptomatic include his interval gain of more than 30% of his body weight, use of oral prednisone to treat his poorly controlled COPD/asthma, loss of lean spinal and gluteal muscle mass due to prolonged oral steroid meducation [*sic*] use, and a notable decrease in his daily level of physical activity. Any one or all of these factors were more significant contributing factors to have led to Mr. Oppman's pre-existing lumbar spondylosis and degenerative changes to have become symptomatic.

> I tried to clarify with Mr. Oppman his personal risk factors for his lumbar spondylosis, disc degeneration, spinal stenosis, tri-compartmental knee osteoarthritis, and class 3 obesity but he did not appear to be receptive towards further discussion and indicated that he felt I was "working for" the other side.

(JE 12, p. 341)

Using Table 17-33 of the AMA Guides, Dr. Chen assigned claimant nine percent permanent impairment of the right lower extremity for his partial medial meniscectomy and collateral ligament laxity. (JE 12, p. 342) Dr. Chen assigned permanent restrictions of avoiding repetitive squatting with his right knee due to the partial medial meniscectomy. (Id.) Dr. Chen also noted because of claimant's personal conditions, including asthma/COPD, pulmonary hypertension and significant obesity, he may be quite limited in his ability to lift, carry, and perform his prior essential work duties as a machine operator and recommended he successfully pass a fitness for duty exam before returning to work. (Id.)

Defendants provided a copy of additional medical records to Dr. Bollier and asked for his opinion. (Ex. A) Dr. Bollier responded by letter on March 19, 2022, opining:

> I do not think the right knee surgery in May 2018 or any antalgic gait pattern following the surgery is a causative factor in Mr. Oppman's current back pain or complaints. I agree with Dr. Chen who opined that the right knee injury did not cause the low back symptoms. Mr. Oppman has many risk factors for the development of low back pain including lumbar spondylosis with degenerative joint disease, obesity, and poor core muscle mass. Lumbar spine degenerative joint disease develops over many years and is related to wear and tear over time. The right knee injury was not a significant factor in his development of lumbar spine degenerative joint disease.

(Ex. A, p. 2)

Dr. Bollier also opined, without providing any additional analysis, that he did not believe claimant's right knee condition aggravated, accelerated or "lit up" claimant's back condition, or that claimant's surgery was a factor in his weight gain or pulmonary symptoms or aggravated, accelerated, or "lit up" his preexisting obesity or pulmonary conditions. (Ex. A, pp. 3-4) Dr. Bollier found claimant does not require any work restrictions other than not working on an oily floor, and believes claimant could return to work in some capacity despite his right knee and back conditions. (Ex. A, pp. 4-5)

I. Low Back Sequela

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

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

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

The question of medical causation is "essentially within the domain of expert testimony." Cedar Rapids Cmty. Sch. Dist. v. Pease, 807 N.W.2d 839, 844-845 (Iowa 2011). The commissioner, as the trier of fact, must "weigh the evidence and measure the credibility of witnesses." Id. The trier of fact may accept or reject expert testimony, even if uncontroverted, in whole or in part. Frye v. Smith-Doyle Contractors, 569 N.W.2d 154, 156 (Iowa 1997). When considering the weight of an expert opinion, the fact-finder may consider whether the examination occurred shortly after the claimant was injured, the compensation arrangement, the nature and extent of the examination, the expert's education, experience, training, and practice, and "all other factors which bear upon the weight and value" of the opinion. Rockwell Graphic Sys., Inc. v. Prince, 366 N.W.2d 187, 192 (Iowa 1985).

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

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

Musselman v. Cent. Tel. Co., 261 Iowa 352, 359-360, 154 N.W.2d 128, 132 (1967).

An employer is responsible for a sequela injury "that naturally and proximately flow[s] from" an injury arising out of and in the course of employment. Oldham v. Scofield & Welch, 266 N.W.2d 480, 482 (Iowa 1936) ("[i]f an employee suffers a compensable injury and thereafter suffers further disability which is the proximate result of the original injury, such further disability is compensable"); see also Mallory v. Mercy Med. Ctr., 2012 WL 529199, File No. 5029834 (Iowa Workers' Comp. Comm'n Feb. 15, 2012). A sequela may occur as the result of a fall during treatment, an altered gait, or a later injury caused by the original injury.

The deputy commissioner in this case found claimant sustained a sequela injury to his low back based on the opinions of Dr. Kuhnlein and Dr. Baker, claimant's testimony, and the treatment records. The deputy commissioner rejected Dr. Chen's opinion, finding Dr. Chen "did not appear to even utilize the correct legal standard for his medical causation opinion." Defendants assert the deputy commissioner erred in finding claimant sustained a sequela injury to his low back caused by the work injury and they assert the deputy commissioner erred in finding Dr. Chen did not use the correct legal standard in his opinion.

I agree with the deputy commissioner that the opinions of Dr. Kuhnlein and Dr. Baker are more persuasive than the opinion of Dr. Chen, but I disagree with the deputy commissioner's finding that Dr. Chen did not use the correct legal standard for his medical causation opinion. I also find Dr. Bollier's opinions not persuasive.

Dr. Chen first opined the work injury did not cause claimant's low back symptoms because claimant did not complain of low back pain immediately following the work injury or immediately after his fall on the ice in February 2018. (JE 12, pp. 340-341) He then opined claimant's right knee condition could not have materially aggravated, accelerated, or lit up his back condition, focusing on claimant's other medical comorbidities as providing "more reasonable explanations" for claimant's low back pain. (Id.) Dr. Chen does not cite to any literature supporting his assertions, nor does he respond to Dr. Kuhnlein's findings. Contrary to Dr. Chen's assertion, claimant's right knee condition does not have to be the sole proximate cause of his back pain. I do not find Dr. Chen's opinion persuasive.

I, likewise, do not find Dr. Bollier's opinion persuasive. When claimant reported his back pain to Dr. Bollier during treatment, Dr. Bollier documented, "[w]e explained

that per work comp rules, the back pain is not considered a work injury" and he directed claimant to follow up with his primary care provider. (JE 5, p. 236) Dr. Bollier cited to no specific "work comp rules" supporting his assertion. He later agreed with Dr. Chen's opinions and provided no analysis to explain his bare conclusions. I do not find Dr. Bollier's opinion persuasive.

Dr. Kuhnlein noted claimant's low back pain started within a couple weeks of his surgery as his gait changed, he was limping, and he had other changes in his activities of daily living. (JE 9, p. 324) The record evidence supports claimant began complaining of low back pain after his right knee surgery. His physical therapy records document ongoing problems with his gait and with back pain. While claimant's gait improved with physical therapy, claimant continued to have gait issues during physical therapy. Dr. Kuhnlein correctly noted that while claimant's L1-L2 spinal stenosis predated the injury, it was asymptomatic, and was "lit up" and became symptomatic after the injury, noting claimant's beneficial response to epidural injections with Dr. Kloc. (JE 9, p. 324) I find Dr. Kuhnlein's opinion to be the most persuasive, as supported by the record evidence. Claimant has established the January 23, 2018, work injury and related surgery permanent materially aggravated, accelerated, or "lit up" his underlying back condition.

II. Extent of Disability

Given claimant has established he sustained an injury to his body as a whole and defendant-employer terminated claimant's employment, claimant is entitled to industrial disability benefits. Iowa Code § 85.34(2). "Industrial disability is determined by an evaluation of the employee's earning capacity." Cedar Rapids Cmty. Sch. Dist. v. Pease, 807 N.W.2d 839, 852 (Iowa 2011). In considering the employee's earning capacity, the deputy commissioner evaluates several factors, including "consideration of not only the claimant's functional disability, but also [his] age, education, qualifications, experience, and ability to engage in similar employment." Swiss Colony, Inc. v. Deutmeyer, 789 N.W.2d 129, 137-138 (Iowa 2010). The inquiry focuses on the injured employee's "ability to be gainfully employed." Id. at 138. The statute also requires the factfinder "to take into account . . . the number of years in the future it was reasonably anticipated that the employee would work at the time of the injury." Iowa Code § 85.34(2).

The determination of the extent of disability is a mixed issue of law and fact. Neal v. Annett Holdings, Inc., 814 N.W.2d 512, 525 (Iowa 2012). Compensation for permanent partial disability shall begin at the termination of the healing period. Iowa Code § 85.34(2). Compensation shall be paid in relation to 500 weeks as the disability bears to the body as a whole. Id. § 85.34(2)(u).

In Iowa, a claimant may establish permanent total disability under the statute, or through the common law odd-lot doctrine. Michael Eberhart Constr. v. Curtin, 674 N.W.2d 123, 126 (Iowa 2004) (discussing both theories of permanent total disability under Idaho law and concluding the deputy's ruling was not based on both theories, rather, it was only based on the odd-lot doctrine). Under the statute, the claimant may

establish the claimant is totally and permanently disabled if the claimant's medical impairment together with nonmedical factors totals 100 percent. Id. The odd-lot doctrine applies when the claimant has established the claimant has sustained something less than 100 percent disability but is so injured that the claimant is "unable to perform services other than 'those which are so limited in quality, dependability or quantity that a reasonably stable market for them does not exist.'" Id.

"Total disability does not mean a state of absolute helplessness." Wal-Mart Stores, Inc. v. Caselman, 657 N.W.2d 493, 501 (Iowa 2003) (quoting IBP, Inc. v. Al-Gharib, 604 N.W.2d 621, 633 (Iowa 2000)). Total disability "occurs when the injury wholly disables the employee from performing work that the employee's experience, training, intelligence, and physical capacity would otherwise permit the employee to perform." IBP, Inc., 604 N.W.2d at 633.

The deputy commissioner found claimant is permanently and totally disabled. In reaching his conclusion, the deputy commissioner found "[claimant's] employer was unable to find any work for him given his condition. While the stated reason for claimant's termination appears to be excessive absenteeism, the reality is there is no gainful work that Mr. Oppman could perform for Eaton because of the slippery surfaces." (Arbitration Decision, p. 11) Defendants assert the deputy commissioner erred in finding defendant-employer did not have any work for claimant and defendants assert the deputy commissioner erred by improperly considering claimant's other personal conditions in finding he is permanently and totally disabled.

As analyzed above, I did not find the causation opinions of Dr. Chen or Dr. Bollier persuasive. I found claimant established he sustained a low back injury sequela caused by the work injury. I also find Dr. Kuhnlein's opinion on permanent impairment most persuasive. Dr. Kuhnlein prepared a detailed report with analysis supporting his conclusions using the AMA Guides. He was the only expert to provide a rating for claimant's low back. I find claimant has established he sustained nine percent whole person impairment. (JE 7, p. 325)

I also adopt Dr. Kuhnlein's restrictions as they relate to claimant's knee and back conditions as claimant's permanent restrictions. Claimant has a permanent lifting restriction of 20 pounds from floor to waist, waist to shoulder, and over the shoulder. He can only occasionally work over shoulder height and rarely kneel as a result of his work injury.

I disagree with the deputy commissioner's finding that defendant-employer was unable to find any work for claimant when he was released to return to work by Dr. Bollier. Claimant returned to work after the work injury and while he was treating with Dr. Bollier. Claimant had unexcused absences on September 20, 2018, October 10, 2018, and October 12, 2018. (JE 5, p. 290) He was terminated on October 15, 2018. I do not find defendant-employer was unable to find any work for claimant when he was released to return to work by Dr. Bollier. I do believe claimant would be unable to return to work with defendant-employer given his current permanent restrictions.

At the time of the hearing, claimant was 48 years old. Claimant graduated from high school in 1992. After graduating from high school, he attained an associate's degree in liberal arts from North Iowa Area Community College and certificates in law enforcement and firefighting. He has never worked in law enforcement or as a firefighter.

Claimant began working for defendant-employer in 1994. Claimant was a valued employee who often worked 10 to 12 hours per day. He worked as a floater and worked on 90 percent of the machines in the plant. Claimant has a number of other serious medical conditions that either preexisted or developed after he injured his right knee and low back. Claimant has a long history of asthma dating back to childhood and morbid obesity. At the time of his first appointment with Dr. Bollier on April 5, 2018, claimant had been taking prednisone daily to manage his asthma for at least three years. He was short of breath and had a history of sleep apnea and used a CPAP at night. (JE 5, p. 208) After Dr. Bollier released him from care claimant was diagnosed with lymphedema, lower extremity edema, left lower extremity cellulitis and necrosis of muscle, chronic right-sided heart failure, chronic heart failure with preserved injection fracture, chronic obstructive pulmonary disease, nocturnal hypoxemia, pulmonary hypertension, cor pulmonale, uncontrolled diabetes type 2, and drug-induced hypokalemia. (JE 5, p. 262-263)

Claimant is a seriously ill, morbidly obese man. I do not find the work injury caused or materially aggravated, accelerated or "lit up" his pulmonary, cardiac, or other health conditions. The work injury caused claimant's right knee condition and materially aggravated, accelerated, and "lit up" his low back condition, and he now requires permanent work restrictions. As correctly noted by the deputy commissioner, despite his personal comorbidities and another prior work injury he worked full-time for defendant-employer for 20 years. Claimant was a motivated worker, despite his breathing problems and large size. Following his termination claimant applied for work but was not hired before the Social Security Administration found he was permanently and totally disabled. Considering all of the factors of industrial disability, I find claimant has established he is permanently and totally disabled under the statute.

ORDER

IT IS THEREFORE ORDERED that the arbitration decision filed on November 9, 2022, is affirmed with my additional and substituted analysis.

There is no Second Injury Fund liability in this matter.

Defendants shall pay claimant permanent total disability benefits at the stipulated weekly rate of six hundred nine and 83/100 ($609.83) from January 23, 2018, the date of the work injury, for as long as claimant remains permanently and totally disabled.

Defendants shall receive credit for all weeks claimant worked following the work injury, as well as for all weeks claimant was paid weekly compensation.

Defendants shall pay accrued weekly benefits in a lump sum together with interest at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two percent.

Defendant-employer and defendant-insurance carrier are responsible for the medical expenses itemized in Joint Exhibit 18.

Pursuant to Iowa Code section 85.27, defendants are responsible for all future medical expenses for the work injury from claimant's treating physicians, including Shelley Wells, D.O.

Pursuant to 876 IAC 4.33, defendants shall pay claimant's costs of the arbitration proceeding itemized in Joint Exhibit 19, and defendants shall pay the cost of the appeal, including the cost of the hearing transcript.

Pursuant to rule 876 Iowa Administrative Code 3.1(2), defendants shall file subsequent reports of injury as required by this agency.

Signed and filed on this 6th day of April, 2023.

Joseph S. Cortese II

JOSEPH S. CORTESE II
WORKERS' COMPENSATION
COMMISSIONER

The parties have been served, as follows:

James Fitzsimmons (via WCES)

Kent Smith (via WCES)

Jonathan Bergman (via WCES)