BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

JOHN WHITMARSH, Claimant, vs. MEINEKE CAR CARE CENTER, Employer, and PEKIN INSURANCE COMPANY, Insurance Carrier, Defendants.	FILED APR 19 2017 WORKERS COMPENSATION	File No. 5043686 ARBITRATION DECISION Head Note Nos.: 1108, 1402.40

STATEMENT OF THE CASE

Claimant, John Whitmarsh, filed a petition in arbitration seeking workers' compensation benefits from Meineke Car Care Center, employer, and Pekin Insurance Company, insurance carrier, both as defendants, as a result of a stipulated injury sustained on July 23, 2012. This matter came on for hearing before Deputy Workers' Compensation Commissioner Erica J. Fitch, on October 4, 2016, in Davenport, Iowa. The record in this case consists of claimant's exhibits 1 through 6, defendants' exhibits A through O, and the testimony of the claimant. The parties submitted post-hearing briefs, the matter being fully submitted on November 7, 2016.

ISSUES

The parties submitted the following issues for determination:

1. Whether the stipulated injury is a cause of permanent disability;

2. The extent of claimant's permanent disability, including whether the disability is to a scheduled member or is an industrial disability; and

3. Whether defendants are responsible for claimed medical expenses.

The parties filed a hearing report at the commencement of the arbitration hearing. On the hearing report, the parties entered into various stipulations. All of those stipulations were accepted and are hereby incorporated into this arbitration

decision and no factual or legal issues relative to the parties' stipulations will be raised or discussed in this decision. The parties are now bound by their stipulations.

FINDINGS OF FACT

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

Claimant's testimony was generally consistent as compared to the evidentiary record and his deposition testimony. Claimant was very personable and his demeanor at the time of evidentiary hearing gave the undersigned no reason to doubt claimant's veracity. Claimant is found credible.

Claimant was 46 years of age at the time of hearing. He resides in East Moline, Illinois with his wife; he is the father of six children. (Claimant's testimony; Exhibit M, pages 3-4; Ex. N, p. 3) Claimant graduated high school in 1989; he participated in vocational training and subsequently earned certifications in auto body and welding. (Claimant's testimony; Ex. M, pp. 5-6; Ex. N, p. 4) Claimant's employment history includes: groundskeeper, welder, millwright, automotive technician, concrete work, truck lube and maintenance technician, and assistant manager at an automotive service shop. At defendant-employer, claimant worked in sales and as an automotive technician. (Claimant's testimony; Ex. M, pp. 8-9; Ex. N, pp. 4-6)

On July 23, 2012, claimant was at work, breaking through a brick wall with a sledgehammer. He fell forward into the wall and lacerated his right index finger, resulting in significant bleeding. He attempted to slow the bleeding and then presented to the hospital. (Claimant's testimony) At the Genesis Medical Center Emergency Department, claimant was diagnosed with a right index finger avulsion laceration. (Ex. A, p. 5) An x-ray of claimant's right index finger revealed findings consistent with debris or foreign bodies, but no fracture or dislocation. (Ex. A, p. 1) Emergency room personnel performed irrigation and debridement, placed stiches, issued a prescription for antibiotics, and referred claimant for orthopedic evaluation. (Ex. B, p. 1)

Claimant testified following the laceration, his finger itched and he continued to scratch his right index finger. Claimant testified he also experienced burning, numbness and tingling of the finger. (Claimant's testimony)

The following day, July 24, 2012, claimant presented to ORA Orthopedics (ORA) for evaluation by Shawn Wynn, M.D. Claimant reported pain and swelling of his right index finger, with the pain radiating into his hand. Dr. Wynn examined claimant and reviewed x-rays. He assessed a right index finger laceration and recommended continued conservative treatment, consisting of wound care, antibiotics, and gentle range of motion exercises. Dr. Wynn released claimant to return to work under restrictions limiting claimant to a clean and dry environment and no lifting, pushing, pulling or tight gripping with the right hand. (Ex. B, pp. 1-2)

Claimant returned to Dr. Wynn for evaluation on July 31, 2012 and reported finger pain at a level 4 to 5 on a 10-point scale. Dr. Wynn performed an examination and reviewed newly taken x-rays. He opined the x-rays revealed what appeared to be a foreign body over the proximal phalanx of claimant's right index finger. He recommended proceeding with incision, drainage and foreign body removal. (Ex. B, pp. 3-4)

On August 2, 2012, Dr. Wynn performed outpatient surgery, consisting of irrigation and debridement, as well as foreign body removal from the right index finger. During surgery, Dr. Wynn located what appeared to be concrete material in claimant's right index finger. (Ex. B, p. 5; Ex. C, pp. 1-2)

Claimant returned to Dr. Wynn on August 13, 2012 in post-surgical follow up. Dr. Wynn described claimant as "fine" overall, with complaints of a slight gap in the incision and intermittent drainage. On examination, Dr. Wynn noted a healing laceration with a slight gap, no obvious erythema, no drainage, decreased range of motion and strength, and normal neurological and vascular status. Dr. Wynn noted no signs of infection and advised claimant to continue proper wound care. (Ex. B, p. 7) Dr. Wynn released claimant to return to work in a clean and dry environment, with no lifting, pushing, or pulling with the right hand. (Ex. B, pp. 6-7)

Claimant returned to ORA on August 21, 2012 and was examined by Tricia Johnson, APN. Ms. Johnson described claimant as "doing okay," with some pain ranging from a level 1 or 2 to a level 6 or 7. Claimant denied numbness or tingling of the right index finger. On examination, Ms. Johnson noted slight swelling of the right index finger and limited flexion of the DIP and PIP joints. Ms. Johnson removed claimant's sutures and encouraged gentle range of motion exercises. (Ex. B, p. 8) She imposed work restrictions of no lifting, pushing or pulling with the right hand. (Ex. B, pp. 8-9)

On August 29, 2012, claimant returned to ORA and was examined by Ms. Johnson. Claimant reported the incision was healing well, with the exception of a flap of skin which tended to catch on items. Claimant reported pain at a level 2 or 3, but no numbness or tingling. Ms. Johnson excised the skin flap at claimant's request. (Ex. B, p. 10)

Claimant returned to Dr. Wynn on September 4, 2012. Dr. Wynn noted claimant expressed no complaints, with the exception of some soreness and stiffness of the finger. Dr. Wynn noted claimant did not complain of numbness or tingling of the right upper extremity. On examination, Dr. Wynn noted mild swelling around the PIP joint, decreased range of motion of the PIP and DIP joints, decreased strength, and normal neurological and vascular status. He described the wound as appearing well-healed, recommended more aggressive range of motion and strengthening activities, and released claimant to work without restrictions. (Ex. B, pp. 11-12)

Claimant returned to Dr. Wynn on September 25, 2012. Dr. Wynn noted claimant complained of some soreness and throbbing and an inability to fully flex the

finger, but expressed no complaints of numbness and tingling. On examination, Dr. Wynn noted minimal swelling, decreased range of motion of the PIP and DIP joints, and normal neurological and vascular status. Claimant expressed comfort working without restrictions. Dr. Wynn placed claimant at maximum medical improvement (MMI) and advised him to return as needed. Dr. Wynn recommended claimant continue working toward full range of motion, but cautioned that some patients lose some motion with such injuries. (Ex. B, pp. 13-14)

On November 5, 2012, claimant returned to Dr. Wynn with further complaints. Dr. Wynn noted claimant reported that "shortly after" his last evaluation, claimant "started getting some burning in his index finger" and slowly developed itching and numbness of his hand. The symptoms subsequently radiated up claimant's arm into the scapular region, cervical spine and chest. At the time of evaluation, claimant complained of a burning sensation in his index finger and radiating numbness and tingling. (Ex. B, p. 15) Dr. Wynn performed an examination and ordered EMG/nerve conduction studies of claimant's right upper extremity to evaluate the possibility of nerve root impingement or irritation. He imposed no restrictions on claimant's activities. (Ex. B, pp. 15-16) Dr. Wynn also opined he was "not sure if this has anything to do with" claimant's finger injury and resulting surgery. (Ex. B, p. 15)

Claimant testified that following surgery, he began to suffer with a burning sensation and some pain in his right index finger and hand. He testified that eventually, the pain reached up his arm. Claimant maintained he informed Dr. Wynn of his symptoms, but was told he remained in the healing process. (Claimant's testimony)

Pursuant to Dr. Wynn's orders, on November 21, 2012, claimant underwent EMG/nerve conduction studies of his right upper extremity. Neurologist, Brian Anseeuw, M.D., opined the study was normal, without evidence of compressive neuropathy or radiculopathy of the right upper extremity. (Ex. E, pp. 1-3)

On November 28, 2012, claimant returned to Dr. Wynn. Dr. Wynn opined claimant's EMG/nerve conduction studies were normal. He performed a physical examination and opined claimant's findings did not suggest a radicular issue or nerve compression. Dr. Wynn indicated it was possible claimant demonstrated hypersensitivity of the surrounding nerves, with the nerves being inflamed and irritated. He issued a prescription for Neurontin. (Ex. B, pp. 17-19)

Claimant returned to Dr. Wynn in follow up on January 2, 2013. At that time, Dr. Wynn noted claimant was beginning to progressively develop more numbness and tingling of the right upper extremity. Dr. Wynn performed a physical examination and indicated claimant seemed to possess symptoms of nerve compression and irritation. Dr. Wynn opined he was unsure "what [was] going on" with claimant and expressed uncertainty as to a proper course of care. Accordingly, he referred claimant to hand surgeon, Thomas VonGillern, M.D., for evaluation. (Ex. B, p. 20)

Pursuant to Dr. Wynn's referral, Dr. VonGillern evaluated claimant on January 29, 2013. Claimant reported suffering with right hand pain and itching since

undergoing surgery; he also complained of hand throbbing and numbness, as well as tingling of the hand, arm and shoulder. Dr. VonGillern ordered x-rays of claimant's right hand and performed an examination. Dr. VonGillern assessed possible right carpal tunnel and/or cubital tunnel syndrome. He ordered EMG studies of claimant's bilateral upper extremities, prescribed Naproxen, and recommended nighttime splinting. He imposed work restrictions on use of claimant's right hand. (Ex. B, pp. 22-23)

Claimant ceased working at defendant-employer in January 2013. (Claimant's testimony; Ex. N, p. 6) He has not attempted to return to work since this date. (Ex. M, p. 10; Ex. N, p. 19)

On February 14, 2013, claimant returned to Dr. Anseeuw for EMG/nerve conduction studies of the bilateral upper extremities. Dr. Anseeuw opined the studies were normal, without evidence of compressive neuropathy or radiculopathy. (Ex. E, pp. 4-5)

Claimant returned to Dr. VonGillern on February 23, 2013. Dr. VonGillern opined claimant's EMG results were normal. He maintained his diagnosis of possible early right carpal tunnel and cubital tunnel syndrome, but referred claimant for vascular studies of the blood flow and pressure of claimant's right hand. (Ex. B, pp. 24-25)

On February 28, 2013, claimant presented to Advanced Pain Management of Illinois for consultation by Demaceo Howard, M.D., regarding right hand and arm pain. Claimant complained of right hand pain, numbness and tingling extending up his right arm, present since surgery. Dr. Howard performed a physical examination and noted equal arm and forearm circumference; no obvious skin, hair or muscle change; equal temperature; no tenderness; and no discoloration or muscle wasting. Dr. Howard assessed chronic pain and hand pain, yet opined claimant did not meet a diagnosis of chronic regional pain syndrome (CRPS). He removed claimant from work pending follow up, prescribed Lyrica, and ordered a course of occupational therapy. (Ex. D, pp. 1-2)

Claimant returned to Dr. Howard in follow up on March 26, 2013. On this date, Dr. Howard opined claimant reported symptoms "far outside of his initial injury," including numbness and tingling "throughout his body." Dr. Howard noted claimant was "dissatisfied" with Dr. Howard's "facial reaction" to the description of symptoms and claimant left the appointment. (Ex. D, p. 3)

On April 1, 2013, claimant returned to Dr. Anseeuw; on this occasion, Dr. Anseeuw performed a neurological evaluation. Claimant complained of itching and pain of the right index finger dating to the work injury and resulting surgery. He reported the itching later extended up his right arm into the shoulder and neck. Additionally, claimant reported that three weeks prior to evaluation, he developed itching in his right leg, then in left leg and extending up into his mid-back. (Ex. E, p. 6) Dr. Anseeuw performed physical and neurological examinations. He assessed paresthesias and ordered a series of blood work and MRIs of claimant's brain, cervical spine and thoracic spine. (Ex. E, pp. 7-8)

Claimant underwent the recommended series of MRIs on April 15, 2013. (Ex. F, pp. 1-4) He returned to Dr. Anseeuw on April 18, 2013. Dr. Anseeuw opined claimant's MRIs revealed abnormalities of white matter. He performed repeat physical and neurological exams. Dr. Anseeuw assessed paresthesias and demyelinating disease of the central nervous system. He recommended a lumbar puncture and referred claimant to the INI Neurological Institute. (Ex. E, pp. 9-10)

On May 1, 2013, claimant presented to UnityPoint Health INI Neurology and was evaluated by Dennis Garwacki, M.D. Claimant reported development of burning and itching a couple weeks following surgery. He reported the itching and numbness of his hand remained and over the course of approximately 2 to 3 weeks, gradually spread into his forearm, shoulder and neck. (Ex. 1, p. 1) Dr. Garwacki also noted claimant reported additional complaints and opined claimant's MRIs and clinical history were compatible with a diagnosis of multiple sclerosis (MS). (Ex. 1, pp. 2-3) With respect to the cause of claimant's right hand symptoms, Dr. Garwacki indicated it was "hard to be sure," commenting the symptoms seemed to come on after surgery, but claimant's EMGs did not reveal evidence of low motor neuron disease. Dr. Garwacki opined it "could be that the surgery could have precipitated his first clinical attack of MS." Dr. Garwacki ordered a course of testing and treatment for suspected MS. (Ex. 1, p. 3)

Claimant returned to Dr. Garwacki on May 10, 2013 for examination. Dr. Garwacki reviewed testing and imaging results and issued a diagnosis of MS. He initiated a course of treatment for claimant's MS and a social worker met with claimant to assist with claimant's application for public aid for necessary medical care. (Ex. G, pp. 1-2)

In July 2013, claimant submitted an application for Social Security Disability benefits with the assistance of staff at Dr. Garwacki's office. (Claimant's testimony; Ex. N, p. 7) He listed MS as the primary basis of his application. (Ex. H, p. 6)

Dr. Anseeuw subsequently participated in a conference with defendants' counsel. On October 16, 2013, Dr. Anseeuw signed a letter drafted by defendants' counsel purporting to summarize his opinions as expressed in that conference. Dr. Anseeuw agreed claimant presented on April 1, 2013 with complaints of itching of the right index finger, arm, shoulder and neck, as well as of the bilateral legs and back. He agreed that at the April 18, 2013 evaluation, Dr. Anseeuw gave a differential diagnosis of demyelinating disease of the central nervous system and referred claimant for further evaluation. He agreed claimant was subsequently diagnosed with MS and opined an MS diagnosis was consistent with claimant's examination findings. (Ex. E, pp. 12-13) Dr. Anseeuw opined he was unable to state within a reasonable degree of medical certainty that the July 23, 2012 work injury was a substantial and/or significant factor in the "diagnosed multiple sclerosis and/or the neurological symptoms associated with such a diagnosis." (Ex. E, p. 13)

Claimant continued to follow up with Dr. Garwacki for the MS diagnosis. At an appointment on February 4, 2014, claimant reported increased symptoms.

Dr. Garwacki opined claimant suffered with an increase in exacerbations over the prior six months, prescribed gabapentin, and ordered a repeat series of MRIs. (Ex. I, pp. 1-2)

Claimant returned to Dr. Garwacki on February 26, 2014. Dr. Garwacki opined claimant's MRIs revealed more significant findings, including new enhancing lesions. (Ex. I, p. 4) Dr. Garwacki noted claimant "basically began having problems" following hand surgery and claimant questioned whether his MS was related to the work injury and/or surgery. Dr. Garwacki opined he "really" did not believe the condition "was related to anything like that." (Ex. G, p. 3; Ex. I, p. 3) He explained:

> There is no history that trauma brings on MS. The only catch could be maybe the anxiety associated with it could have triggered it at that time, but it would have to be there in a preexisting state.

(Ex. G, p. 3; Ex. I, p. 3)

On May 8, 2014, claimant presented to his personal provider, Michael Bollaert, M.D., of UnityPoint Family Medicine. Dr. Bollaert noted claimant returned for repeat evaluation of pain and paresthesias of claimant's right hand, wrist and forearm. Dr. Bollaert performed an examination and indicated he was "really not clear what to make" of claimant's symptoms. He assessed right hand pain and paresthesias and opined claimant's symptoms seemed like nerve pain with a nerve-related etiology which had been unresponsive to treatment. He referred claimant for a pain clinic consultation. (Ex. I, p. 5)

Pursuant to Dr. Bollaert's recommendation, on June 6, 2014, claimant presented for a chronic pain consult with anesthesiologist, Jeffrey Fullenkamp, D.O. of UnityPoint Health. Dr. Fullenkamp noted claimant's pain was located in the neck, radiating down his right arm. (Ex. I, p. 6) Dr. Fullenkamp recommended and subsequently performed a stellate ganglion block. (Ex. I, p. 10)

On June 19, 2014, claimant provided deposition testimony. On that date, claimant testified he developed itching and burning of his right index finger "[r]ight away" following the work injury. After surgery, claimant testified the symptoms continued in his index finger and within a month, spread to the palm and base of the thumb of his right hand. Symptoms then progressed into numbness of the remaining digits and hand, wrist pain, and eventually reached to his right shoulder within a period of a few months. (Ex. N, p. 9)

At the referral of Dr. Fullenkamp, on July 21, 2014, claimant presented to the UnityPoint Health Pain Clinic and was evaluated by anesthesiologist, Maruti Kari, M.D. Claimant complained of right upper extremity pain, weakness and burning. Claimant reported the pain began on July 23, 2012 with a work injury which was treated in the emergency room and surgically by Dr. Wynn 10 days later. Dr. Kari noted "[d]uring this time," claimant suffered from intense burning, itching and pain "that radiated from his right shoulder down to his injured finger;" claimant also reported increased sweating of the right upper extremity. Claimant reported 30 to 40 percent improvement following the

stellate ganglion block performed by Dr. Fullenkamp approximately 3 days prior. (Ex. 2, p. 1; Ex. I, p. 12)

Following examination, Dr. Kari assessed MS and neuropathic pain of the right upper extremity. Dr. Kari recommended home physical therapy and completion of a series of stellate ganglion blocks. (Ex. 2, pp. 4-5; Ex. I, pp. 15-16) Dr. Kari noted most features of MS and neuropathic pain were "similar," but indicated some of claimant's symptoms "may point towards a coexisting neuropathic component with sympathetically mediated pain." (Ex. 2, p. 4; Ex. I, p. 15) He continued:

> It is difficult to establish whether the injury and subsequent neuropathic syndrome exacerbated a dormant form of multiple sclerosis or multiple sclerosis predisposed him to develop the neuropathic syndrome.

(Ex. 2, pp. 4-5; Ex. I, pp. 15-16)

Dr. Kari performed the recommended stellate ganglion blocks on July 29 and August 5, 2014. (Ex. 2, pp. 6-8)

Claimant returned to Dr. Kari on September 11, 2014 and reported good relief for 4 to 5 days following the stellate ganglion blocks. Claimant reported the pain had since begun to return and he continued to experience weakness of the right upper extremity and difficulty with fine motor movements. Claimant complained of pain in the right arm at a level 5 on a 10-point scale, radiating up toward the neck and down to the hand. Additionally, he reported new onset of symptoms in the left forearm and hand. (Ex. 2, pp. 10-11) Dr. Kari assessed moderate to severe neuropathic pain of the right upper extremity secondary to injury. He opined claimant had failed conservative management, with the next step in treatment being placement of a cervical epidural catheter to continuously infuse a combination of local anesthetic and clonidine for a sympatholytic affect. (Ex. 2, p. 13)

On September 30, 2014, Dr. Kari placed the recommended continuous cervical epidural catheter. Claimant received infusion while in the hospital. He was discharged from the hospital on October 1, 2014, but was advised to continue inpatient infusion for several days. At the time of discharge, claimant reported 90 percent pain relief and complete resolution of itching. Dr. Kari issued a diagnosis of CRPS of the right upper extremity. (Ex. 2, pp. 14-18) Despite Dr. Kari's orders of continued infusion, the catheter was removed after approximately 24 hours at claimant's request, due to insurance coverage concerns. (Ex. 2, pp. 26, 35)

Claimant continued to follow up with Dr. Kari. On October 9, 2014, claimant reported 80 percent improvement in symptoms, with a decrease of numbness in his arms and hands. Claimant reported the decrease was particularly evident in the morning, but numbness increased throughout the day. (Ex. 2, p. 20)

Claimant underwent repeat MRIs on October 20, 2014. (Ex. I, p. 18)

At follow up with Dr. Kari on November 20, 2014, claimant reported experiencing pain at a level 2 in the morning. He reported pain progressed throughout the day, reaching a point of inability to move his arm. Dr. Kari noted the pain locations varied within the right arm on a day-to-day basis. (Ex. 2, p. 24) Dr. Kari reviewed claimant's MRIs of October 20, 2014 and assessed right upper extremity neuropathic pain with an "active problem" of CRPS. He recommended a repeat series of stellate ganglion blocks due to worsening pain. (Ex. 2, p. 25)

Claimant returned to Dr. Kari on December 3, 2014. Dr. Kari performed the first of a series of stellate ganglion blocks, yet expressed belief claimant would receive the best relief with placement of an epidural catheter for 5 to 7 days. (Ex. 2, p. 27) With respect to causation, Dr. Kari opined that the "temporal relation" to the work injury and "the signs and symptoms (unilateral and located in the same extremity where the original injury was)" supported a neuropathic etiology of claimant's condition secondary to the work injury. (Ex. 2, p. 26) Dr. Kari performed the second and third of the series of stellate ganglion blocks on December 10, 2014 and December 17, 2014. (Ex. 2, pp. 28-31)

Claimant returned to Dr. Kari in follow up on February 18, 2015. Following examination, Dr. Kari assessed neuropathic pain of the right upper extremity, with an "active" diagnosis of CRPS. Dr. Kari opined claimant's right upper extremity pain was of "neuropathic etiology with sympathetic component," as evidenced by claimant's significant improvement following stellate ganglion blocks. (Ex. 2, p. 34)

Dr. Kari noted claimant received the most beneficial treatment response to catheter infusion and expressed belief claimant would have received significant relief had the catheter been left in place for 5 days, as originally planned. He identified treatment options including a repeat series of six stellate ganglion blocks, catheter placement, or implantation of a spinal cord stimulator. Dr. Kari recommended beginning with a repeat series of stellate ganglion blocks. Dr. Kari cautioned that claimant's condition was worsening and without intervention, might ultimately result in intractable upper extremity pain and loss of function. (Ex. 2, p. 35)

On April 20, 2015 and July 7, 2015, claimant underwent repeat MRIs of his brain and cervical spine. (Ex. G, pp. 5-6; Ex. I, pp. 19-21)

During the period of June 3, 2015 through July 30, 2015, claimant underwent the repeat series of stellate ganglion blocks recommended by Dr. Kari. (Ex. 2, pp. 36, 38, 40-46) Claimant continued to follow up with Dr. Kari. (Ex. 2, p. 47) In August 2015, Dr. Kari referred claimant to a physical therapist for fitting and training in use of a TENS unit. (Ex. 3, pp. 1-2)

Defendants' counsel conferenced with Dr. Wynn regarding his opinions relative to claimant's right index finger condition. On October 20, 2015, Dr. Wynn expressed agreement with statements made by defendants' counsel, including that claimant achieved MMI on September 25, 2012, he sustained no permanent impairment with

respect to his right index finger, and he required no permanent restrictions as a result of the right index finger injury. (Ex. B, pp. 26-27)

The evidentiary record contains a report signed by Dr. Kari dated December 1, 2015. The report was authored following a conference between Dr. Kari and claimant's counsel. (Ex. 4, pp. 1-2; Ex. I, pp. 22-24) The text of the letter is written in Dr. Kari's voice and bears Dr. Kari's signature. However, review of Dr. Kari's records reveals claimant's counsel authored the report and submitted it to Dr. Kari for review and signature, assuming the report's accuracy. (Ex. I, p. 22)

By the letter, Dr. Kari indicated he had issued a diagnosis of CRPS with respect to claimant's right upper extremity pain. In reaching his opinion that claimant's upper extremity symptoms were caused by CRPS as opposed to MS, Dr. Kari indicated he considered several facts: that claimant's upper extremity pain continued despite a lack of MS lesions on timely MRIs; that the lesions, when present, appeared throughout claimant's brain and not solely in an area which would cause hand and arm pain; and that claimant received relief with sympathetic nerve blocks, as MS-related pain would not have responded to this treatment. (Ex. 4, p. 1; Ex. I, p. 23)

Dr. Kari opined the CRPS diagnosis was caused by claimant's July 23, 2012 work injury and exhibited a "classic presentation of CRPS," wherein a minor injury was closely followed by pain and CRPS symptoms. Dr. Kari also commented that claimant's symptoms could also be interpreted as neuropathic pain versus CRPS, yet indicated the appropriate treatment and causal connection opinions remained the same under either diagnosis. (Ex. 4, p. 1; Ex. I, p. 23) He opined claimant's CRPS was limited to the right upper extremity and accordingly, he limited claimant from twisting activities with the right arm. Dr. Kari opined claimant had not achieved MMI and could benefit from a spinal cord stimulator and/or an intrathecal pump. (Ex. 4, pp. 1-2; Ex. I, pp. 23-24)

At an appointment with Dr. Kari on January 27, 2016, claimant reported 70 to 80 percent worsening of symptoms since his prior visit in December 2015. (Ex. 2, pp. 48-49) Dr. Kari performed a repeat stellate ganglion block. (Ex. I, p. 25)

On February 17, 2016, claimant returned to Dr. Kari in follow up. He reported 20 percent improvement in symptoms following the stellate ganglion block. Dr. Kari opined claimant's signs and symptoms were consistent with neuropathic pain, as opposed to CRPS. Accordingly, Dr. Kari assessed MS and right upper extremity neuropathic pain. He opined claimant would benefit from a spinal cord stimulator and referred claimant for cognitive behavioral therapy. He advised claimant to return for a stellate ganglion block. (Ex. 2, pp. 50-51; Ex. I, pp. 25, 29, 30)

Dr. Kari performed repeat stellate ganglion blocks on March 1 and April 12, 2016. (Ex. 2, pp. 52-54) At a follow up appointment on April 26, 2016, claimant informed Dr. Kari he would like to postpone further stellate ganglion blocks until a date closer to his assigned hearing date. (Ex. 2, p. 54)

On May 12, 2016, defendants' counsel authored a letter to Dr. Fullenkamp in follow up of a prior conference; counsel included select medical records for review and requested Dr. Fullenkamp's opinions. Dr. Fullenkamp issued responses on June 2, 2016. Dr. Fullenkamp opined there was "only a small possibility of CRPS" and he was "unsure" as to the appropriateness of that diagnosis. In response to inquiry as to whether he believed claimant's July 23, 2012 finger injury "was a significant or substantial contributing factor" in claimant's "ongoing neurological symptoms (whether CRPS or otherwise)," Dr. Fullenkamp relied no. (Ex. I, p. 32)

Following a conference between defendants' counsel and Dr. Kari, defendants' counsel authored a letter requesting Dr. Kari's opinions. Dr. Kari issued responses to the check-the-box inquiries on July 31, 2016. By his responses, Dr. Kari opined claimant's symptoms/condition did not meet the diagnosis of CRPS. Rather, Dr. Kari opined claimant's current symptoms/condition were consistent with a diagnosis of neuropathic pain, as opposed to CRPS. (Ex. I, p. 35)

Dr. Kari authored a letter to claimant's attorney dated September 30, 2016. By the letter, Dr. Kari opined claimant no longer met the criteria for a diagnosis of CRPS. He assessed claimant with neuropathic pain, limited to the right upper extremity. He opined he possessed "no doubt" that claimant's right upper extremity symptoms were caused by the work injury and were not attributable to the MS diagnosis. Dr. Kari highlighted what he deemed to be a significant temporal relationship between the work injury and claimant's development of symptoms in his right arm and hand, as well as the presence of symptoms even in absence of MS lesions. Dr. Kari opined any pain in another part of claimant's body was unrelated to the work injury. (Ex. 5, p. 1)

Dr. Kari opined claimant's neuropathic pain was permanent in nature and would require ongoing treatment, which could include stellate ganglion blocks or a spinal cord stimulator. In the event claimant elected not to proceed with implantation of a stimulator, Dr. Kari indicated he would recommend use of an anticonvulsant medication; he also noted a potential need for pain medication and/or an intrathecal pump. (Ex. 5, p. 1) Dr. Kari opined his treatment was causally related to the work injury, was reasonable and necessary in treatment of claimant's conditions, and the fees charged were fair and reasonable. (Ex. 5, p. 2)

Claimant testified his MS symptoms vary day-to-day. He testified stress increases his symptoms and impacts his stability, as he develops increased numbness of his legs. Claimant testified he utilizes a cane with ambulation, yet his mobility varies significantly. Some days, claimant is unable to walk and he can experience complete numbness from his feet to his chest. He also experiences tingling in his hands and feet which he attributes to MS. Additionally, approximately one and one-half years prior to hearing, claimant began to develop numbness and pain of his left arm. (Claimant's testimony)

Claimant differentiates his MS symptoms from those of his right arm. Claimant testified he first developed symptoms of his right upper extremity, into the shoulder and neck, and only later developed what he perceives as symptoms related to MS.

Claimant testified he suffers with constant numbness of his right arm and has not felt his right arm in three to four years. Claimant testified he lacks feeling and sensation in his right arm and hand; he also lacks dexterity and is unable to grasp an item solely in his right hand. Claimant testified he suffers with daily pain, stretching from his fingers up into his shoulder and the back of his neck. The pain is of a throbbing nature and averages a level 7 on a 10-point scale. Due to pain and numbness, claimant testified he contemplated amputation of his right arm prior to undergoing the series of injections begun by Dr. Fullenkamp. Following such treatments, claimant testified his pain will decrease to a level 3, but then gradually increases. (Claimant's testimony)

CONCLUSIONS OF LAW

The first issue for determination is whether the stipulated injury is a cause of permanent disability.

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

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

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

Claimant suffered a stipulated injury to his right index finger on July 23, 2012. In addition to the right finger injury, claimant claims he developed neurological symptoms secondary to the work injury. Defendants, however, dispute a causal connection between any of claimant's ongoing symptoms and the stipulated right index finger laceration. At evidentiary hearing and by post-hearing brief, claimant clarified his claim with respect to his ongoing neurological symptoms. Claimant clarified he was not

arguing that the July 23, 2012 injury was a factor in causing or aggravating his MS. Claimant also does not argue he suffers with CRPS as a result of the stipulated work injury. Rather, claimant argues the work injury caused neuropathic pain extending from his right hand into his right arm and shoulder. It must therefore be determined if claimant has proven, by a preponderance of the evidence, that he suffers with neuropathic pain independent from the MS diagnosis and that those symptoms are causally related to the stipulated work injury of July 23, 2012.

Given the complexity of claimant's claim, the opinions of medical providers are of paramount importance. In support for his claim, claimant relies upon the opinions of his treating provider, Dr. Kari. Dr. Kari began treating claimant in July 2014 and continued to serve in this capacity at the time of evidentiary hearing. Dr. Kari is, therefore, quite familiar with claimant's complaints and ongoing condition.

Dr. Kari opined he possesses "no doubt" that claimant suffers from neuropathic pain of his right upper extremity which is causally related to the work injury of July 23, 2012. In reaching his opinion, Dr. Kari cited the significant temporal relationship between claimant's work injury and the development of symptoms in claimant's right upper extremity and hand. He also cited the presence of symptoms in this region even in absence of MS lesions.

Multiple physicians have evaluated claimant over the course of the greater than four years between the work injury and evidentiary hearing. Orthopedic surgeon, Dr. Wynn, treated claimant beginning the date after the work injury. He opined claimant sustained no permanent impairment as a result of the work injury. Anesthesiologist, Dr. Fullenkamp, opined the work injury was not a significant or substantial factor in claimant's ongoing neurological symptoms, whether diagnosed as CRPS or neuropathic pain. Neurologist, Dr. Anseeuw, opined he was unable to causally relate the stipulated work injury to claimant's MS and/or associated neurological symptoms.

As the opinions of the medical providers conflict, I must consider whether the facts relied upon by each physician are accurate. In reviewing the entirety of the evidentiary record, I am troubled by the accuracy of Dr. Kari's history with respect to claimant's development of symptoms. Specifically, Dr. Kari's records reflect claimant suffered the injury on July 23, 2012, underwent surgery 10 days later, and that during this timeframe, claimant developed intense burning, itching and pain throughout the entirety of claimant's right hand, arm and shoulder.

Claimant's testimony maintains he developed symptoms immediately after the work injury and symptoms continued from the date of injury, through surgery and thereafter, gradually worsened. However, claimant's accounts vary somewhat as to timing and presence of particular symptoms. I do not believe claimant has willfully and knowingly engaged in deception, but rather, the accuracy of memories fade with time, particularly given the comorbid condition of MS.

As a result, I believe claimant's contemporaneous medical records provide the most accurate picture as to the time frame of development of symptoms. Claimant

began treating with Dr. Wynn the date following the work injury. Dr. Wynn performed claimant's surgery on August 2, 2012 and claimant thereafter followed up with both Dr. Wynn and his nurse, Ms. Johnson. While both Ms. Johnson and Dr. Wynn's notes reflect complaints of pain and swelling of the finger, each provider noted claimant denied numbness and tingling and Dr. Wynn found normal neurological status. Dr. Wynn placed claimant at MMI from the finger injury on September 25, 2012. It was not until November 5, 2012 that claimant returned to Dr. Wynn and reported that "shortly after" the last evaluation, he developed burning of his finger and subsequently, itching, numbness and tingling of the hand, arm, shoulder, neck and chest. Although claimant argues he repeatedly informed Dr. Wynn that he suffered with these symptoms dating to the work injury, I am unconvinced that Dr. Wynn would ignore such symptoms. I am particularly unmoved by this argument, as it was the subsequent reports to Dr. Wynn which triggered a lengthy and thorough course of evaluation, leading to his diagnosis of MS.

Dr. Kari appears to have relied heavily upon a close temporal relationship between claimant's work injury and development of neurological symptoms. Given claimant's contemporaneous medical records, I am unable to find that the history relied upon by Dr. Kari is accurate. Accordingly, I find his opinion as to a potential causal connection between the work injury and claimant's neuropathic pain is entitled to negligible weight. Although Dr. Kari's opinion is entirely plausible, given this flaw and the competing medical opinions in evidence, I am unable to find claimant carried his burden of proof with respect to a causal relationship between his ongoing neuropathic pain symptoms and the stipulated work injury of July 23, 2012.

It is determined claimant has failed to carry his burden of proving by a preponderance of the evidence that his ongoing neurological symptoms are causally related to the stipulated work injury of July 23, 2012.

Claimant offered no medical opinions supporting a determination claimant sustained permanent impairment as a result of the finger laceration and resulting surgery. The only medical provider to opine on claimant's permanent impairment or need for permanent restrictions, if any, is Dr. Wynn. Dr. Wynn opined claimant sustained no permanent impairment and no permanent restrictions were required as a result of the finger injury. As this opinion is unrebutted, it cannot be found that claimant carried his burden of proof on this issue.

As it has been determined that claimant failed to prove the stipulated work injury was a cause of permanent disability, consideration of the issue of extent of claimant's permanent disability is unnecessary, as moot. Claimant also submitted a request for payment of medical expenses incurred relative to claimant's neurological condition, as summarized in Exhibit 6. As it has been determined claimant failed to prove a causal connection between the stipulated work injury and his ongoing neurological symptoms, defendants are not responsible for the claimed medical expenses.

ORDER

THEREFORE, IT IS ORDERED:

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

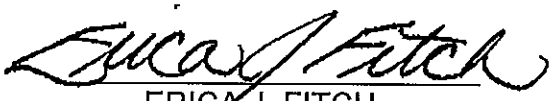
Claimant shall take nothing from these proceedings.

Defendants shall receive credit for benefits paid.

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

Costs are taxed to claimant pursuant to 876 IAC 4.33.

Signed and filed this 19th day of April, 2017.



ERICA J. FITCH
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EJF/srs

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